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

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

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

# INSTRUCTIONS

## FOR UPDATING THE

# IOWA ADMINISTRATIVE CODE

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

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

### **Administrative Services Department[11]**

Replace Chapter 63

### **Landscape Architectural Examining Board[193D]**

Replace Analysis

Replace Chapters 1 and 2

Replace Chapter 4

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

Replace Analysis

Replace Chapter 7

Replace Chapter 75

Replace Chapters 109 and 110

Replace Chapter 120

Replace Chapter 170

### **Inspections and Appeals Department[481]**

Replace Chapter 64

### **Natural Resource Commission[571]**

Replace Chapter 106

### **Public Health Department[641]**

Replace Chapter 41

Replace Chapter 70

Replace Chapter 107

Replace Chapter 136

### **Pharmacy Board[657]**

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Replace Chapter 2

Replace Chapters 10 and 11

Replace Chapter 37

Replace Chapter 100

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

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**Transportation Department[761]**

Replace Chapter 405

Replace Chapter 450

**Workforce Development Department[871]**

Replace Chapter 22

Replace Chapter 24

## CHAPTER 63

## LEAVE

[Prior to 11/5/86, Merit Employment Department[570]]

[Prior to 1/7/04, see 581—Ch 14]

**11—63.1(8A) Attendance.** Appointing authorities shall establish the working schedules, regulations, and required hours of work for employees under their direction. All regulations and schedules shall be made known to the affected employees by appointing authorities. All absences of probationary and permanent employees shall be charged to one of the leave categories provided for in this chapter.

**11—63.2(8A) Vacation leave.**

**63.2(1)** Nontemporary employees shall earn vacation for continuous state employment as follows:

- a. Two unscheduled holidays to be added to the vacation accrual each year.
- b. Two weeks of vacation during the first and through the fourth year of employment.
- c. Three weeks of vacation during the fifth and through the eleventh year of employment.
- d. Four weeks of vacation during the twelfth year and through the nineteenth year of employment.
- e. Four and four-tenths weeks of vacation during the twentieth year and through the twenty-fourth year of employment.
- f. Five weeks of vacation during the twenty-fifth and all subsequent years of employment.

**63.2(2)** Vacation is subject to the following conditions:

a. Vacation shall be subject to the approval of the appointing authority. The appointing authority shall approve vacation so as to maintain the efficient operation of the agency; take into consideration the vacation preferences and needs of the employee; and make every reasonable effort to provide vacation to prevent any loss of vacation accrual.

b. Probationary and permanent part-time employees shall accrue vacation in an amount proportionate to that which would be accrued under full-time employment.

c. Vacation shall not accrue during any absence without pay.

d. An employee who is transferred, promoted, or demoted from one state agency to another shall be credited with the vacation accrued.

e. Employees, including employees who are paid from a pay plan having annual salary rates, who leave state employment for any reason shall be paid, or have payment made according to law, for all accrued vacation. Payment shall be included with the employee's final paycheck and shall be based on the employee's total biweekly regular rate of pay at the time of separation. When other pay is to be included in the calculation, that other pay must have been in effect for at least three pay periods. Vacation shall not be granted after the employee's last day of work.

f. An employee may, at the appointing authority's discretion, be required to use all accrued vacation before being granted any leave without pay, except as otherwise provided in these rules.

g. Vacation shall be charged on the employee's workday basis. Officially designated holidays occurring during an employee's vacation shall not be counted against the employee's accrued vacation.

h. In the event of an illness or disability while on vacation, that portion of the vacation spent under the care of a physician shall be switched retroactively to and charged against the employee's accrued sick leave upon satisfactory proof from the physician of the illness or disability and its duration.

i. Vacation shall not be used in excess of the amount accrued, and shall not be used until the pay period after it is accrued.

j. Vacation shall be cumulative to a maximum of twice the employee's annual rate of accrual, including sick leave conversion. An appointing authority may require an employee to take vacation whenever it would be in the best interests of the agency. The employee shall be given reasonable notice of the appointing authority's decision to require the use of accrued vacation. However, an employee shall not be required to reduce accrued vacation to less than 80 hours.

k. One week of vacation shall be equal to the number of hours in the employee's normal, regular workweek.

l. Any employee who is laid off, or an employee who separated due to qualification for long-term disability benefits or an on-the-job injury or illness and subsequently returns to state employment within

two years following the date of separation, shall have previous continuous service and the period of separation counted toward the vacation accrual rate.

*m.* Reserved.

*n.* Time spent in military service, within the specified time limits of the military training and service Act, shall be considered continuous service for the purpose of computing vacation accrual, provided the employee returns to state service within 90 calendar days following discharge from military duty. Vacation shall not accrue to an employee while on military leave without pay.

*o.* If on June 1 an employee has a balance of 160 or more hours of accrued leave, the employer may, with the approval of the employee, pay the employee for up to 40 hours of the accrued annual leave. This amount will be paid on a separate warrant on the payday which represents the last pay period of the fiscal year. Decisions regarding these payments will be made by each department director and are not subject to the grievance procedure provided for in these rules. This paragraph applies only to employees not covered by a collective bargaining agreement.

**11—63.3(8A) Sick leave with pay.** Probationary and permanent full-time employees, except peace officer employees of the department of natural resources and the department of public safety, shall accrue sick leave as set forth in this paragraph. If the employee's accrued sick leave balance is 750 hours or less, the employee shall accrue one and one-half days of sick leave per month, which is 5.538462 hours per pay period. If the employee's accrued sick leave balance is 1500 hours or less but more than 750 hours, the employee shall accrue one day of sick leave per month, which is 3.692308 hours per pay period. If the employee's accrued sick leave balance is more than 1500 hours, the employee shall accrue one-half day of sick leave per month, which is 1.846154 hours per pay period. Peace officer employees of the department of natural resources and department of public safety shall accrue sick leave at the same rate as the rate provided under the State Police Officers Council collective bargaining agreement. The use of sick leave with pay shall be subject to the following conditions:

**63.3(1)** Accrued sick leave may be used during a period when an employee is unable to work because of medically related disabilities; for physical or mental illness; medical, dental or optical examination, surgery or treatment; or when performance of assigned duties would jeopardize the employee's health or recovery. Medically related disabilities caused by pregnancy or recovery from childbirth shall be covered by sick leave.

**63.3(2)** Sick leave shall not be used as vacation.

**63.3(3)** Sick leave shall not be granted in excess of the amount accrued.

**63.3(4)** There is no limit on the accumulation of sick leave. An employee who has accrued at least 240 hours of sick leave may elect to accrue additional vacation in lieu of the normal sick leave accrual. An employee who has made an election to convert sick leave to vacation will be credited with four hours of vacation for each full month when sick leave is not used during that month. A conversion shall not be made if the accrued sick leave is less than 240 hours in the pay period in which the conversion would be made. The conversion of sick leave shall be prorated for employees who are normally scheduled to work less than full-time (40 hours per week). An employee's maximum vacation accrual may be increased under this subrule up to 96 hours.

**63.3(5)** In all cases when an employee has been absent on sick leave, the employee shall immediately upon return to work submit a statement that the absence was due to illness or other reasons stated in this rule. Where absence exceeds three working days, the reasons for the absence shall be verified by a physician or other authorized practitioner if required by the appointing authority. An appointing authority may require verification for lesser periods of absence and at any time during an absence. In all cases, sick leave shall not be deducted from that accrued until authorized by the appointing authority.

**63.3(6)** Sick leave shall be charged on the employee's workday basis. Officially designated holidays occurring during an employee's sick leave shall not be counted against the employee's accrued sick leave.

**63.3(7)** Sick leave shall not accrue during any absence without pay.

**63.3(8)** Probationary and permanent part-time employees shall accrue sick leave in an amount proportionate to that which would be accrued under full-time employment.

**63.3(9)** An employee who is transferred, promoted, or demoted from one agency to another shall be credited with the sick leave accrued.

**63.3(10)** All accrued sick leave shall be canceled on the date of separation, and no employee shall be reimbursed for accrued sick leave unused at the time of separation except as provided for in Iowa Code section 70A.23, or the applicable collective bargaining agreement. However, if an employee is laid off and is reemployed by any state agency within two years following the date of layoff, or an employee is separated due to an on-the-job injury or illness and is reemployed by any state agency within two years following the date of medical release, the employee's unused accrued sick leave shall be restored, except to the extent that the sick leave hours have been credited to a sick leave bank pursuant to Iowa Code section 70A.23 and the provisions of 11—64.16(8A). Employees participating in the sick leave insurance program who return to permanent employment will not have prior sick leave amounts restored.

**63.3(11)** Employees may also use accrued sick leave, not to exceed a total of 40 hours per fiscal year, for the following purposes:

- a. When a death occurs in the immediate family;
- b. For the temporary care of, or necessary attention to, members of the immediate family.

For purposes of this subrule, “immediate family” means the employee's spouse, children, grandchildren, foster children, stepchildren, legal wards, parents, grandparents, foster parents, stepparents, brothers, foster brothers, stepbrothers, sons-in-law, brothers-in-law, sisters, foster sisters, stepsisters, daughters-in-law, sisters-in-law, aunts, uncles, nieces, nephews, first cousins, corresponding relatives of the employee's spouse and other persons who are members of the employee's household.

This leave shall be granted at the convenience of the employee whenever possible and consistent with the staffing needs of the appointing authority.

**63.3(12)** If an absence because of illness, injury or other proper reason for using sick leave provided for in this rule extends beyond the employee's accrued sick leave, the appointing authority may require or permit additional time off to be charged to any other accrued leave. Employees shall, upon request, be paid accrued compensatory leave in a lump sum. When all accrued sick leave has been used, the employee may be granted leave without pay or terminated except as provided in subrule 63.5(4).

[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 0401C, IAB 10/17/12, effective 11/21/12; ARC 1568C, IAB 8/6/14, effective 9/10/14]

**11—63.4(8A) Family and Medical Leave Act leave.** An employee who has been employed for a cumulative total of 12 months or more in the most recent seven-year period and who has worked at least 1,250 hours during the 12-month period immediately preceding the date leave is to begin shall be eligible for family and medical leave in accordance with the federal Family and Medical Leave Act (FMLA) and 29 CFR Part 825, these rules, and the policies of the department. Eligibility determinations shall be made as of the date that the FMLA leave is to begin. The FMLA leave year begins on the first day of each fiscal year. Eligible employees are entitled to FMLA leave subject to the following conditions:

**63.4(1)** It is the appointing authority's responsibility to designate leave as FMLA leave. The appointing authority shall designate leave as FMLA leave when the leave qualifies for FMLA leave, even if the employee makes no request for FMLA leave or does not want the leave to be counted as FMLA leave. When both spouses are employed by the state, they shall be limited to a combined total of 12 weeks of FMLA leave taken in accordance with paragraph “a” or “c” below. The hourly equivalent for part-time employees shall be prorated based upon the average number of hours worked during the previous 12 months. Leave may be for one or more of the following reasons:

- a. The birth or placement with the employee of a son or daughter (biological child, adopted child, foster child, stepchild, legal ward or a child to whom the employee stands in loco parentis) for adoption or foster care provided the leave is taken within 12 months following any such birth, adoption or foster placement;
- b. The care of a son or daughter under 18 years of age, or older if incapable of self-care because of a mental or physical disability, or spouse with a serious health condition;

*c.* The care of a parent or person who stood in loco parentis to the employee, with a serious health condition;

*d.* A serious health condition that makes an employee unable to work at all or perform any one of the essential functions of the employee's position within the meaning of the Americans with Disabilities Act (ADA), as amended, 42 U.S.C. Section 12101 et seq., and the regulations at 29 CFR Section 1630.2(n).

*e.* A qualifying exigency, as defined in federal FMLA regulations, arising out of the fact that the employee's spouse, son, daughter or parent is a covered servicemember on covered active duty, or has been notified of an impending call or order to covered active duty, in a foreign country.

*f.* To care for a covered servicemember with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the servicemember, pursuant to the FMLA regulations.

**63.4(2)** Leave may be taken on an intermittent basis or on a reduced work schedule basis where this type of leave is medically necessary. The use of intermittent or reduced work schedule leave for circumstances described in paragraph "a" of subrule 63.4(1) shall be at the discretion of the appointing authority. Approval of intermittent or reduced schedule leave for circumstances described in paragraph "b," "c," "d," "e," or "f" of subrule 63.4(1) is mandatory if certified by a health care provider or proper military authority.

**63.4(3)** Use of sick leave shall be in accordance with rule 11—63.3(8A). When FMLA leave is taken pursuant to paragraph "a," "b," "c," "e," or "f" of subrule 63.4(1), an employee must exhaust all paid vacation before unpaid leave is granted. However, sick leave may be used to the extent authorized by subrule 63.3(11). When an employee takes FMLA leave after the birth of a child and the employee has not received a medical release to return to work, the employee must exhaust all accrued sick leave and vacation before unpaid leave is granted. When the employee's medical provider releases the employee to return to work, the employee is no longer eligible to use paid sick leave; however, the employee may use leave as authorized by subrule 63.3(11) and accrued vacation.

When FMLA leave is taken pursuant to paragraph "d" of subrule 63.4(1), an employee must exhaust all paid sick leave, compensatory leave, and vacation before unpaid leave is granted.

**63.4(4)** An employee shall submit a written request, using forms prescribed by the department, to the appointing authority within 30 calendar days prior to the need for FMLA leave when the need for the leave is foreseeable. In situations involving unforeseeable need for leave and leave involving a birth, adoption, foster placement, or planned medical treatment for an illness, the employee must provide notice as soon as practicable after the employee learns of the need for the leave. Notice may be made orally or in writing. Untimely requests or failure to provide notice or mandatory information to the appointing authority may result in delay or denial of the FMLA leave. The failure to follow mandatory leave policies may result in discipline of the employee.

The appointing authority shall provide the employee with all notices required by the federal Family and Medical Leave Act and the policies of the department. Notices shall be provided to employees within the time frames prescribed by the federal regulations and the policies of the department. The appointing authority shall notify the employee using forms prescribed by the department, or verbally when circumstances prevent delivery of the forms. If verbal notification is made, the appointing authority shall take reasonable steps to deliver written notification to the employee within five workdays.

**63.4(5)** The appointing authority may, at the agency's expense, require a second opinion. The appointing authority will designate the health care provider to furnish the second opinion. In making the designation, the appointing authority shall select a provider that is not employed on a regular basis by the appointing authority. If the second opinion differs from the first, the appointing authority may, at the agency's expense, require a third opinion from a health care provider agreeable to both the employee and the appointing authority. The third opinion shall be final and binding on both parties.

**63.4(6)** During the period of leave, the appointing authority shall pay the state's share of the employee's health, dental, basic life, and long-term disability benefit insurance premiums. Failure by the employee to pay the employee's share of the premiums will result in a loss of coverage. The appointing authority shall provide notice to the employee 15 calendar days prior to any retroactive or prospective cancellation of benefits coverage. Upon return from FMLA leave, employees who have

dropped or canceled their health, dental, or life insurance benefits while on FMLA leave will be restored to the same level of benefits as prior to the commencement of leave upon completion of the necessary insurance applications and other forms required by the department.

**63.4(7)** Upon returning from FMLA leave, an employee is entitled to no more rights or benefits than the employee would have received had the leave not been taken. If an employee does not return from leave because of the continuation, reoccurrence or onset of a serious health condition, the appointing authority shall require written certification from the health care provider. If the reason for the employee's failure to return is not a certified serious health condition or other circumstances beyond the control of the employee, the state may recover its share of health and dental benefit insurance premiums paid during the period of leave.

**63.4(8)** The appointing authority may request periodic reports concerning the employee's medical status, and the date the employee may return to work. Requests for periodic reports will be made no more often than necessary depending on the facts and circumstances of each case and shall not exceed one request every 30 days absent extenuating circumstances.

The appointing authority shall require written certification from the health care provider that the employee is able to resume work before allowing an employee with a serious health condition to return from FMLA leave. Upon return from FMLA leave, the employee shall be placed in a position in the same class held prior to the leave, or a class in the same pay grade for which the employee qualifies, with the same pay, benefits, terms and conditions of employment, and geographical proximate location, except that:

*a.* If a reduction in force occurs while the employee is on leave, the employee's right to a position shall be established in accordance with 11—Chapter 60.

*b.* The employee's pay increase eligibility date shall be adjusted for absences of more than 30 calendar days.

**63.4(9)** If an employee unequivocally advises the employer that the employee does not intend to return to work, the employee's entitlement to FMLA leave and associated benefits cease. The failure to return to work upon the expiration of FMLA leave may be considered to be job abandonment.

**63.4(10)** If the employee is unable to perform an essential function of the position because of a physical or mental condition, including the continuation of a serious health condition, the employee has no right to restoration to another position under the FMLA. The appointing authority's obligations may be governed by the Americans with Disabilities Act.

**63.4(11)** An employee remains a participant in the deferred compensation and dependent care programs while on FMLA leave as authorized by these rules and the policies of the department.

**63.4(12)** FMLA leave runs concurrently with other leave programs administered by the department to the extent the leave qualifies as FMLA leave.

**63.4(13)** FMLA leave runs concurrently with a workers' compensation absence when the workers' compensation absence is one that meets the FMLA criteria.

An employee can be offered "restricted light duty," and if such restricted duty is refused, it may result in the loss of workers' compensation benefits. Under the FMLA, the appointing authority may offer restricted duty; however, if the employee refuses, the employee shall lose workers' compensation benefits but is still protected by the FMLA.

Employees on workers' compensation who are on FMLA leave concurrently and who are unable to return to work after the exhaustion of FMLA leave are subject to state workers' compensation laws and will have no job restoration rights under the FMLA.

**63.4(14)** Retention of vacation leave. Notwithstanding subrule 63.4(3), non-contract-covered employees who qualify for FMLA leave are eligible to retain up to two weeks (80 hours) of accrued vacation leave in each fiscal year. An employee must elect, using forms prescribed by the department, to retain vacation by submitting the form to the employer no later than seven calendar days from the date it is determined that the employee's leave is covered by FMLA. An employee will not be permitted to retain more vacation than is in the employee's vacation bank at the time of election. Once the election is made, it cannot be increased; however, it may be reduced, at any time, to less than 80 hours. An employee will not be eligible to retain any donated leave.

For employees covered by a collective bargaining agreement, the retention of vacation leave will be governed by the collective bargaining agreement.

[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 8979B, IAB 8/11/10, effective 9/15/10; ARC 0401C, IAB 10/17/12, effective 11/21/12]

**11—63.5(8A) Leave without pay.** A permanent or probationary employee, on written request and written approval by the appointing authority, may be granted leave without pay for any reason deemed satisfactory to the appointing authority, subject to the following conditions:

**63.5(1)** Leave without pay shall not originally be granted for more than 12 consecutive months. Accrued leave need not be exhausted before leave without pay is granted except that accrued sick leave must be exhausted if the reason for leave without pay is due to a medically related disability. The determination to require the exhaustion of any or all accrued leave shall rest with the appointing authority except as provided in subrule 63.5(4). On written request, prior to the expiration of a granted leave, the appointing authority may, in writing, grant an extension of the leave without pay. The approved leave without pay extension may not be for more than an additional 12 consecutive months, unless otherwise approved by the director.

**63.5(2)** Failure by the employee to report back to work on the date specified in the written request shall be considered a voluntary resignation unless otherwise approved by the appointing authority. A written statement accepting the resignation shall be sent to the employee by the appointing authority and a copy sent to the director.

**63.5(3)** Employees who do not supplement workers' compensation with sick leave, vacation or compensatory leave, and who are kept on the payroll in a nonpay status for more than 30 calendar days, shall be placed on leave without pay for purposes of probationary periods, pay increase eligibility, and other benefits. A written statement to this effect shall be sent to the employee within three days following the action by the appointing authority.

**63.5(4)** When requested in writing and verified by the employee's physician or other licensed practitioner, an employee shall be granted sick leave for at least an eight-week period when the purpose is to provide recovery from a medically related disability. If the employee's accrued sick leave is exhausted prior to completion of the eight-week period, the employee shall be granted additional leave, paid or unpaid, for the remainder of the period, in accordance with these rules. The appointing authority may grant leave in excess of the eight-week period. Paid leave shall not be granted in excess of that accrued. At any time during the period of leave, the appointing authority may require that the employee submit written verification of continuing disability from the employee's physician or other licensed practitioner. In addition to the reason listed, subrule 63.5(2) shall also apply under the following circumstances:

- a. The employee fails or refuses to supply the requested verification of continued disability.
- b. The verification does not clearly show sufficient continuing reason that would prevent the performance of the employee's regular work duties.
- c. The employee is shown to be performing work which is incompatible with the purpose for which the leave without pay was granted.

**63.5(5)** If an employee applies for leave under the Family and Medical Leave Act, any leave without pay under the Family and Medical Leave Act shall run concurrently with the leave granted under this rule.

[ARC 0401C, IAB 10/17/12, effective 11/21/12]

**11—63.6(8A) Rights upon return from leave.**

**63.6(1)** An employee who is on approved leave without pay, disaster service volunteer leave or educational leave must notify the appointing authority from which the employee is on leave of the intent to exercise return from leave rights. Upon return from leave, the employee shall have the right to return to a vacant position in the class held prior to the leave or to a class in the same pay grade for which the employee qualifies. If a vacant position is not available, the reduction in force provisions of 11—Chapter 60 shall apply. An employee on leave without pay, disaster service volunteer leave, or educational leave may request permission from the appointing authority to return to work sooner than the original

approved leave expiration date. Employees on leave without pay for more than 30 calendar days, except for military leave, shall have their pay increase eligibility date adjusted to a later date which reflects the period of leave without pay.

**63.6(2)** An employee who elects to separate from employment for purposes of induction into military service shall have the right to return to employment in accordance with 38 U.S.C. Sections 4301-4334. Upon return, the employee's pay increase eligibility date and unused sick leave at the time of separation shall be restored.

**63.6(3)** At the conclusion of a period of military service, an employee who is on approved military service leave must notify the appointing authority of the intent to return to employment. Upon return from military leave, the employee shall have the right to return to employment in accordance with 38 U.S.C. Sections 4301-4334.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

**11—63.7(8A) Compensatory leave.** Compensatory leave accrued in accordance with 11—subrule 53.11(5) shall be granted at the request of the employee whenever possible. However, the appointing authority need not grant a request for compensatory leave if granting the leave would cause an undue disruption.

**11—63.8(8A) Holiday leave.** Holidays shall be granted in accordance with statutory provisions to employees who are eligible to accrue vacation and sick leave.

**63.8(1)** The value of a holiday for full-time employees shall be eight hours or the number of hours the employee is scheduled to work on that day, whichever is greater. The value of a holiday that falls on a full-time employee's scheduled day off shall be eight hours. Employees who are normally scheduled to work full-time shall not have their holiday compensation prorated for time on leave without pay during the pay period if the employee meets the conditions of subrule 63.8(3).

Compensation for holidays shall be prorated for employees who are normally scheduled to work less than 80 hours in a pay period. Compensation shall be based on the number of hours in pay status during the pay period in which the holiday falls plus the hours that would normally be scheduled for the holiday which shall be included when determining the number of pro-rata holiday hours.

Leave accrued under Iowa Code section 1C.2 as vacation shall be based on the employee's hours in pay status.

Compensation for holidays under this rule shall be either in pay or compensatory leave. The decision to pay or grant compensatory leave shall be made by the appointing authority.

**63.8(2)** For employees who work Monday through Friday, a holiday falling on Sunday shall be observed on the following Monday and a holiday falling on Saturday shall be observed on the preceding Friday. For all other employees, the designated holiday shall be observed on the day it occurs.

**63.8(3)** To be eligible for holiday compensation an employee must be in pay status the last scheduled workday before and the first scheduled workday after the holiday.

An employee who separates from employment and whose last day in pay status precedes a holiday shall not be eligible for payment for that holiday.

**63.8(4)** When the holiday falls on an overtime-covered employee's scheduled workday, and the employee does not get the day off, the employee shall be compensated for the holiday in accordance with subrule 63.8(1) in addition to a premium rate for time worked. The premium rate shall be paid for hours worked during the 24-hour period from 12 a.m. through 11:59 p.m. on the holiday. However, hours compensated at the premium rate shall not be counted as part of the 40 hours when calculating overtime pay.

When the holiday falls on an overtime-covered employee's day off, the employee shall be compensated for the holiday to a maximum of eight hours.

**63.8(5)** When an overtime exempt employee is required to work on a holiday, the employee may be compensated for the time worked in addition to regular holiday pay at the discretion of the appointing authority. When granted, compensation shall be at the employee's regular rate of pay for all hours worked.

**11—63.9(8A) Military leave.** For purposes of subrules 63.9(1) and 63.9(3) and as applied to nontemporary employees whose regularly scheduled work shift is 16 hours or less, “30 days” means 30 work days. For nontemporary employees whose regularly scheduled work shift is more than 16 hours, “30 days” in subrules 63.9(1) and 63.9(3) shall be defined in accordance with the provisions of Iowa Code section 29A.28.

**63.9(1)** A nontemporary employee who is a member of the uniformed services, when ordered by proper authority to serve in the uniformed services, shall be granted leave without loss of pay for 30 days each calendar year. Absences required for military service shall be in accordance with the rules on vacation, compensatory leave, or leave without pay, 38 U.S.C. Sections 4301-4333, and 20 CFR Part 1002. Military leave may be utilized for up to 30 days in each calendar year. Any amount of military leave taken during any part of an employee’s scheduled workday, regardless of the number of hours actually taken, shall count as one day toward the 30 paid day maximum. If the employee’s work shift crosses two calendar days, only one day shall count toward the 30 paid day maximum. Work schedule changes shall not be made for the purpose of avoiding payment for military leave.

**63.9(2)** A nontemporary employee who is ordered by proper authority to military duty as defined in Iowa Code section 29A.28 may elect to be placed on leave without pay or be separated and removed from the payroll.

**63.9(3)** Nontemporary employees who elect to separate from employment when ordered by proper authority to military duty shall be given 30 days of regular pay in a lump sum with their last paycheck. Any previous paid leave days granted for military service in the current calendar year shall be deducted from this 30 days.

Employees who elect to be placed on leave without pay when ordered by proper authority to military duty shall continue to receive regular pay and benefits for 30 days. Any previous paid leave days granted for military service in the current calendar year shall be deducted from this 30 days.

**63.9(4)** At the conclusion of military service, the employee must notify the employee’s appointing authority of the intent to exercise return rights pursuant to 38 U.S.C. Sections 4301-4344.

**63.9(5)** An employee taking military leave may use any vacation or compensatory leave that was accrued prior to service. Employees who elect to use vacation or compensatory leave shall continue to receive benefits in accordance with the state of Iowa’s benefits program policies and procedures. Upon return to employment, the employee’s accrual rate for vacation shall be at the same rate as if the employee had not taken military leave.

**63.9(6)** An employee may maintain health and dental insurance coverage while on military leave for up to 24 months. The employee is responsible for paying the employee’s share of the health and dental insurance premiums if the period of military service is less than 31 days. If more than 30 days, the employee shall be required to pay 102 percent of the full premium under the plan to maintain coverage. Upon return to employment, the employee may elect to have health and dental insurance coverage become effective either on the first day of the month the employee returns to employment or the first day of the month following the month in which the employee returned to employment. Coverage under the plans will not have an exclusion or waiting period upon return to employment. An exclusion or waiting period may be imposed, however, in connection with any illness or injury determined by the Secretary of the U.S. Department of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

**63.9(7)** A person reemployed under this rule shall be treated as not having incurred a break in service with the employer by reason of such person’s period of service in the uniformed services.

[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 3115C, IAB 6/7/17, effective 5/17/17]

**11—63.10(8A) Educational leave.** Educational leave, with or without pay, may be granted at the discretion of the appointing authority for the purpose of assisting state employees to develop skills that will improve their ability to perform their present job responsibilities or to provide training and developmental opportunities for employees that will enable the agency to better meet staffing needs. Education financial assistance shall be in accordance with rule 11—64.10(8A).

**63.10(1) *Length of leave.*** Educational leave shall be requested for a period not to exceed 12 consecutive months. Accrued vacation or compensatory leave need not be exhausted before educational leave is granted. The determination to require the exhaustion of any or all accrued leave shall rest with the appointing authority. The appointing authority may grant an extension of the original leave for an additional 12 months.

**63.10(2) *Selection of applicants.*** While the selection of applicants is at the discretion of the appointing authority, it is the express policy of the state to offer all qualified employees an equal opportunity to be considered for educational leave within the limitations imposed by agency staffing requirements.

**63.10(3) *Educational institutions.*** An employee on educational leave may take course work at any accredited educational institution within the state. Attendance at out-of-state institutions may be approved provided there are geographical or educational considerations which make attendance at institutions within the state impractical.

**63.10(4) *Agency report.*** Rescinded IAB 5/27/15, effective 7/1/15.  
[ARC 8265B, IAB 11/4/09, effective 12/9/09; ARC 2000C, IAB 5/27/15, effective 7/1/15]

**11—63.11(8A) *Election leave.*** An employee who is not covered by the federal Hatch Act and who becomes a candidate for paid, partisan elective office shall, upon the employee's request, be granted leave 30 calendar days before a contested primary, special, or general election. The employee may choose to use accrued vacation or compensatory leave, or leave without pay to cover these periods.

An employee who is elected to a paid, partisan office or appointed to an elective paid, partisan office shall, upon written request to the appointing authority, be granted leave to serve in that office, except where prohibited by federal law. The use of accrued vacation or compensatory leave, or leave without pay to cover this period shall be at the discretion of the employee. The leave provided for in this rule need not exceed six years. An employee shall not be prohibited from returning to employment before the expiration of the period for which the leave was granted.

**11—63.12(8A) *Court appearances and jury duty.*** When in obedience to a subpoena, summons, or direction by proper authority, an employee appears as a witness or a jury member in any public or private litigation in which the employee is not a party to the proceedings, the employee shall be entitled to time off during regularly scheduled work hours with regular compensation, provided the employee gives to the appointing authority any payments received for court appearance or jury service, other than reimbursement for necessary travel or personal expenses. If the employee is directed to appear as a witness by the appointing authority, all time spent shall be considered to be worktime.

**63.12(1)** Hours spent on court or jury leave by an employee outside the employee's scheduled work hours are not subject to this rule, nor shall any payments received for court appearance or jury service be remitted to the appointing authority.

**63.12(2)** The employee shall notify the appointing authority immediately upon receipt of a subpoena, summons, or direction by proper authority to appear.

**63.12(3)** An employee may be required to report to work if there will be at least two hours in the workday, following necessary travel time, during which the employee is not needed for jury service or as a witness.

**63.12(4)** Upon return to work, the employee shall present evidence to the appointing authority of any payments received for court appearance or jury service.

**11—63.13(8A) *Voting leave.*** An employee who is eligible to vote in a public election in the state of Iowa may request time off from work with regular pay for a period not to exceed three hours for the purpose of voting. Leave shall be granted only to the extent that the employee's work hours do not allow a period of three consecutive hours outside the employee's scheduled work hours during which the voting polls are open.

A request for voting leave must be made to the appointing authority on or before the employee's last scheduled shift prior to election day. The time to be taken off shall be designated by the appointing authority.

**11—63.14(8A) Disaster service volunteer leave.** Subject to the approval of the appointing authority, an employee who is a certified disaster service volunteer for the American Red Cross may, at the request of the American Red Cross, be granted leave with pay to participate in disaster relief services relating to a disaster in the state of Iowa. Such leave shall be only for hours regularly scheduled to work and shall not be for more than 15 workdays in a fiscal year. Employees granted such leave shall not lose any rights or benefits of employment while on such leave. An employee while on leave under this rule shall not be deemed to be an employee of the state for the purposes of workers' compensation or for the purposes of the Iowa tort claims Act.

**11—63.15(8A) Absences due to emergency conditions.** When a proper management authority closes a state office or building or directs employees to vacate a state office or building premises, employees may elect to use compensatory leave, vacation, or leave without pay to cover the absence. Employees may, with the approval of the appointing authority, elect to work their scheduled hours even though the state office or building is closed to the general public. Employees may, with the approval of the appointing authority, be permitted to make up lost time within the same workweek.

Employees who are unable to report to work as scheduled or who choose to leave work due to severe weather or other emergency conditions may, with the approval of the appointing authority, use compensatory leave, vacation, or leave without pay to cover the absence.

**11—63.16(8A) Particular contracts governing.** Where provisions of collective bargaining agreements differ from the provisions of this chapter, the provisions of the collective bargaining agreements shall prevail for the employees covered by those agreements.

**11—63.17(8A) Examination and interviewing leave.**

**63.17(1)** Employees may be granted leave to take examinations for positions covered by merit system provisions. Employees may elect to use vacation leave, compensatory leave, or leave without pay at the discretion of the appointing authority.

**63.17(2)** Employees may be granted the use of paid work time to attend interviews during scheduled work hours for jobs within their agency. For agencies that have statewide operations, the appointing authority may restrict the use of paid time to interviews within the central office, institution, county, region, or district office. A reasonable time limit for interviews may be designated by the appointing authority. Employees may be granted leave for interviews outside the agency, central office, institution, county, region, or district office in which case they may elect to use vacation leave, compensatory leave, or leave without pay at the discretion of the appointing authority.

**63.17(3)** Appointing authorities shall post and make known to employees the provisions of this rule.

**11—63.18(8A) Service on committees, boards, and commissions.** State employees who are appointed to serve on committees, boards, commissions, or similar appointments for Iowa state government shall be entitled to regular compensation for such service. Employees shall be paid in accordance with these rules for time spent.

Pursuant to Iowa Code section 70A.1, employees shall not be entitled to additional compensation for such service.

Employees shall have actual and necessary expenses paid.

Employees shall notify the appointing authority at the time of the appointment.

**11—63.19(8A) Donated leave for catastrophic illnesses of employees and family members.** Employees are eligible to donate or receive donated leave hours for catastrophic illnesses of the employee or an immediate family member. Contributions shall be designated as "donated leave" and shall be subject to the rules, policies and procedures of the department.

**63.19(1) Definitions:**

*“Catastrophic illness”* means a physical or mental illness or injury of the employee, as certified by a licensed physician, that will result in the inability of the employee to work for more than 30 workdays on a consecutive or intermittent basis; or that will result in the inability of the employee to report to work for more than 30 workdays due to the need to attend to an immediate family member on a consecutive or intermittent basis.

*“Donated leave”* means vacation leave (hours) donated to employees as a monetary benefit only. Recipient employees will not accrue vacation or sick leave benefits on donated leave hours.

*“Employee”* means a full-time or part-time executive branch employee who is eligible to accrue vacation.

*“Immediate family member”* means the employee’s spouse, parent, son, or daughter, as defined in the federal Family and Medical Leave Act.

**63.19(2) Program eligibility for employee illness.** In order to receive donated leave for a catastrophic illness, an employee must:

- a. Have a catastrophic illness as defined by subrule 63.19(1); and
- b. Have exhausted all paid leave; and
- c. Not be supplementing workers’ compensation to the extent that it exceeds more than 100 percent of the employee’s pay for the employee’s regularly scheduled work hours on a pay-period-by-pay-period basis; and
- d. Not be receiving long-term disability benefits; and
- e. Be approved for and using or have exhausted Family and Medical Leave Act (FMLA) leave hours if eligible; and
- f. Be on approved leave without pay for medical reasons during any hours for which the employee will receive donated leave.

**63.19(3) Program eligibility for immediate family member illness.** In order to receive donated leave for a catastrophic illness of an immediate family member, the immediate family member must have a catastrophic illness as defined in subrule 63.19(1). The employee must:

- a. Have exhausted all paid leave for which eligible; and
- b. Be approved for and using or have exhausted Family and Medical Leave Act leave hours if eligible; and
- c. Be on approved leave without pay for the medical reasons of an immediate family member during any hours for which the employee will receive donated leave.

**63.19(4) Certification requirements.** The employee shall submit an application for donated leave on forms developed by the department. Appointing authorities may, at their department’s expense, seek second medical opinions or updates from physicians regarding the status of an employee’s or employee’s immediate family member’s illness or injury. If the employee is receiving FMLA leave, a second opinion must be obtained from a physician who is not regularly employed by the state.

**63.19(5) Program requirements.**

a. Vacation hours shall be donated in whole-hour increments; however, they may be credited to the recipient in other than whole-hour increments. All of the recipient’s accrued leave must be used before donations will be credited to the recipient. Hours will be credited in increments not to exceed the employee’s regularly scheduled work hours on a pay-period-by-pay-period basis. Recipients will not accrue vacation and sick leave on donated leave hours.

b. Approval of use of donated leave shall be for a period not to exceed one year either on an intermittent or continuous basis for each occurrence.

c. Donated leave shall be irrevocable after it is credited to the recipient. Donated hours not credited to the recipient will not be deducted from the donor’s vacation leave balance. Donated leave shall be credited on a first-in/first-out basis.

d. Donated leave for catastrophic illness will not restrict the right to terminate probationary employees. The period of probationary status and the pay increase eligibility date, if in excess of 30 days, will be extended by the amount of time the employee received donated leave.

*e.* Appointing authorities shall post a form developed by the department indicating that the employee is eligible to receive donated leave and the name of the person to contact for the donation. The appointing authority is not responsible for posting outside the employing department; however, donated leave hours can be received from executive branch employees outside the employing department.

*f.* Leave without pay rules and procedures shall apply to the following benefits: health, dental, life, and long-term disability insurances; pretax; deferred compensation; holiday pay, sick leave and vacation leave accrual, shift differential pay, longevity pay and cash payments. In addition, employees receiving donated leave for catastrophic illness for themselves or their immediate family member will not be eligible for leadworker pay, extraordinary duty pay or special duty pay. If FMLA leave and donated leave for a catastrophic illness are used concurrently, the state is obligated to pay its share of health and dental insurance premiums. The state also maintains an employee's basic life and long-term disability insurances during periods of FMLA leave.

*g.* Employees may choose to continue or terminate optional deductions (e.g., miscellaneous insurance, savings bonds, charitable contributions, or credit union deductions) while using donated leave. Mandatory deductions are taken from gross pay first, then optional deductions as funds are available and as authorized by the employee. Union dues deductions will continue as long as the employee has sufficient earnings to cover the dollar amount certified to the employer after deductions for social security, federal taxes, state taxes, retirement, health and dental insurance, and life insurance.

*h.* Contributions to the employee's dependent care account will not be allowed during a period of leave without pay. Claims will not be paid for dependent care while an employee is on leave without pay.

*i.* If an employee applies for and is approved to receive long-term disability, the employee may continue to receive leave contributions for up to one year on an intermittent or continuous basis or the effective date of the employee's long-term disability, whichever comes first. Donated leave hours not used are not credited to the recipient and are not deducted from the donor's vacation leave balance.

**11—63.20(8A,70A) Bone marrow and organ donation leave.** Employees, excluding employees covered by a collective bargaining agreement that provides otherwise, shall be granted leave pursuant to Iowa Code section 70A.39. An employee who is granted a leave of absence under Iowa Code section 70A.39 shall receive leave without loss of seniority, pay, vacation time, personal days, sick leave, insurance and health coverage benefits, or earned overtime accumulation. The employee shall be compensated at the employee's regular rate of pay for those regular work hours during which the employee is absent from work. An employee deemed to be on leave under Iowa Code section 70A.39 shall not be deemed to be an employee of the state for purposes of workers' compensation or for purposes of the Iowa tort claims Act.

[ARC 8265B, IAB 11/4/09, effective 12/9/09]

These rules are intended to implement Iowa Code section 8A.413 and Iowa Code chapter 70A.

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<sup>1</sup> Effective date of subrule 14.2(12) delayed 70 days by Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83.



# LANDSCAPE ARCHITECTURAL EXAMINING BOARD[193D]

Prior to 3/9/88, see Landscape Architectural Examiners Board[540]  
[Landscape Architectural Examining Board[193D] created by 1986 Iowa Acts, ch 1245, §728  
within the Professional Licensing and Regulation Division[193] of the Commerce Department[181] “umbrella”]

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CHAPTER 1  
DESCRIPTION OF ORGANIZATION  
[Prior to 3/9/88, see Landscape Architectural Examiners Board[540] Ch 1]

**193D—1.1(544B,17A) Definitions.** As used in these rules, the following definitions of words and terms shall apply:

“*Board*” means the Iowa landscape architectural examining board.

“*CLARB*” means the Council of Landscape Architectural Registration Boards.

“*Evidence*” means any document or record of any kind of drawings, specifications, photographs, diplomas, licensee statements, published data and certified personal statements as may be required as a part of any action on the part of the board. Each item of evidence shall be clearly marked to ensure positive and certain identification. It shall be the entire responsibility of the applicant to satisfy the board as to the sufficiency of the record and the evidence.

“*Intern landscape architect*” means an individual who is not licensed and has a degree in landscape architecture and is employed under the direct supervision of a professional landscape architect. The initials “I.L.A.” should not be used.

“*LARE*” means the landscape architecture registration examination.

“*P.L.A., retired*” means the same as “professional landscape architect, retired.”

“*Practice of landscape architecture*” means the performance of professional service or offering to render professional services to clients, including any one or any combination of the professional services defined in Iowa Code section 544B.1(2).

“*Professional landscape architect*” means a person who obtains a license and engages in the practice of landscape architecture under the authority of Iowa Code chapter 544B. For the purpose of these rules, a “professional landscape architect” may be referred to as a “landscape architect” and may use the initials “P.L.A.”

“*Professional landscape architect, retired*” means a person who has retired from working as a landscape architect in all states of licensure and who has requested “landscape architect, retired” status on the licensure renewal form. The retired status would become effective on the first scheduled licensure renewal date. For the purpose of these rules, a “professional landscape architect, retired” may be referred to as a “landscape architect, retired.”

“*Years of practical experience*” means, for each year of practical experience the applicant has worked performing landscape architectural services, a minimum of 2,080 hours per year.

[ARC 0213C, IAB 7/25/12, effective 8/29/12; ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—1.2(544B,17A) Organization and duties.** The board consists of five members who are licensed professional landscape architects and two members who are not licensed professional landscape architects and who represent the general public. The board elects annually from its members a chairperson and a vice chairperson. A quorum of the board shall be four members, and all final motions and actions must receive a vote by a majority of the members of the board. The board enforces the provisions of Iowa Code chapter 544B and maintains a roster of all licensed professional landscape architects in the state.

**1.2(1) Chairperson.** The chairperson shall, when present, preside at meetings, appoint committees, and perform all duties and powers of the chairperson.

**1.2(2) Vice chairperson.** The vice chairperson shall, in the absence or incapacity of the chairperson, exercise the duties and powers of the chairperson.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—1.3(544B,17A) Meetings.** Calls for meetings shall be issued in accordance with Iowa Code section 21.4.

**193D—1.4(544B,17A) Order of business.** The chairperson or the board administrator shall prepare an agenda listing all matters to be discussed at meetings. A copy of this agenda shall be available to each member of the board.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—1.5(22) Public records and fair information practices.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.6(68B) Sales of goods and services.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.7(17A) Petitions for rule making.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.8(17A) Declaratory orders.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.9(252J,261) Denial of issuance or renewal of license for nonpayment of child support or student loan.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.10(17A) Interim waivers and variances.** In addition to the provisions of 193—Chapter 5, the following shall apply for interim rulings:

**1.10(1)** The board chairperson, or vice chairperson if the chairperson is not available, may rule on a petition for waiver or variance when it would not be timely to wait for the next regularly scheduled board meeting for a ruling from the board.

**1.10(2)** The executive officer shall, upon receipt of a petition that meets all applicable criteria established in 193—Chapter 5, present the request to the board chairperson or vice chairperson along with all pertinent information regarding established precedent for granting or denying such requests.

**1.10(3)** The chairperson or vice chairperson shall reserve the right to hold an electronic meeting of the board when prior board precedent does not clearly resolve the request, input of the board is deemed required and the practical result of waiting until the next regularly scheduled meeting would be a denial of the request due to timing issues.

**1.10(4)** A waiver report shall be placed on the agenda of the next regularly scheduled board meeting and recorded in the minutes of the meeting.

**1.10(5)** This rule on interim rulings does not apply if the waiver or variance was filed in a contested case.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—1.11(544B,17A,272C) Investigations and investigatory subpoenas.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.12(544B,17A,272C) Contested case procedures.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—1.13(272C) Impaired licensees.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

These rules are intended to implement Iowa Code sections 544B.3, 544B.5, and 544B.15.

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CHAPTER 2  
EXAMINATIONS AND LICENSING  
[Prior to 3/9/88, see Landscape Architectural Examiners Board[540] Ch 2]

**193D—2.1(544B,17A) Definitions.** Rescinded ARC 3097C, IAB 6/7/17, effective 7/12/17.

**193D—2.2(544B,17A) Application.** An application to take the written examination shall be submitted on the form provided by the board and must be received in the board office no later than the last day of March for the June examination and the last day of September for the December examination. Candidates who successfully complete the examination may make application for certificate of licensure after meeting the requirements of Iowa Code section 544B.9.

**2.2(1)** The “practice of landscape architecture” means the performance of professional services such as consultations, investigations, reconnaissance, research, planning, design, or responsible supervision in connection with projects involving the arrangement of land and the elements thereon for public and private use and enjoyment, including the alignment of roadways and the location of buildings, service areas, parking areas, walkways, steps, ramps, pools and other structures, and the grading of the land, surface and subsoil drainage, erosion control, planting, reforestation, and the preservation of the natural landscape and aesthetic values, in accordance with accepted professional standards of public health, welfare and safety. This practice shall include the location and arrangement of such tangible objects and features as are incidental and necessary to the purposes outlined in this chapter but shall not include the design of structures or facilities with separate and self-contained purposes for habitation or industry, or the design of public streets and highways, utilities, storm and sanitary sewers, and sewage treatment facilities, such as are ordinarily included in the practice of engineering or architecture; and shall not include the making of land surveys or final land plats for official approval or recording. Nothing contained in this chapter shall be construed as authorizing a professional landscape architect to engage in the practice of architecture, engineering, or land surveying.

**2.2(2)** Each applicant shall submit with the formal application for a certificate of licensure evidence of the years of practical experience.

**193D—2.3(544B,17A) Procedure for processing applications.** Each application shall be considered individually by the board. The board authorizes the chairperson to review applications between board meetings. The chairperson will determine if the applications meet the requirements for approval or will need full board review. A personal appearance before the board, if required, shall be at the time and place designated by the board. Failure to supply additional evidence or information within 30 days from the date of the written request from the board, or failure to appear before the board when an appearance is requested, may be considered cause for disapproval of the application. Unless otherwise provided by law, a request for a rehearing before the board shall be filed with the board in accordance with 193—7.39(543,272C). A judicial review can be filed in accordance with Iowa Code section 17A.19. [ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—2.4(544B,17A) Examination of applicants.** Examinations shall be conducted by the board at least once annually. Applicants need not meet preconditions to take the professional landscape architectural licensure examination, but applicants must meet requirements of Iowa Code section 544B.9 for registration.

**193D—2.5(544B,17A) Written examination.** The written examination shall consist of the professional landscape architectural licensure examination published by CLARB and may include supplementary questions developed by the board.

**2.5(1) Instructions.** A copy of examination instructions and notice of the date and location of the examination will be furnished to each applicant at least 30 days in advance of the examination. The examination is divided into several sections. An applicant may sit for any or all of the sections at a single sitting. Sections which are passed are not required to be repeated. An applicant who intends to sit for any sections not previously passed must file an application for reexamination with the proper fee(s)

on a form provided by the board which must be received in the board office no later than the last day of March for the June examination and the last day of September for the December examination.

**2.5(2) Grades.** The board shall notify the examinee of the examination grade.

**2.5(3) Examinations review process.** Candidates may review their own graded examinations using the following procedures:

*a.* Within a maximum of 30 days from the date of the notification of failure, a written request by the candidate may be filed with the Iowa landscape architectural examining board to include:

- (1) Candidate number or name.
- (2) Date of examination.
- (3) Examination section requested to be reviewed.

*b.* The review time for each failed section may be limited by the board.

*c.* A board member or staff person must be present to observe and to provide assistance to the candidate.

*d.* There shall be no copying or tracing allowed; however, a candidate may take notes.

*e.* A candidate shall be allowed to review all of the candidate's examination, including evaluation guides and evaluators' score sheets.

*f.* The candidate shall sign a statement stating the terms of the review procedure.

**193D—2.6(544B,17A) Exemption from written examination.** The board may exempt from written examination an applicant who meets one of the following criteria:

**2.6(1)** The applicant holds a current CLARB certificate;

**2.6(2)** The applicant holds a license to practice landscape architecture issued upon written examination by another jurisdiction, and has submitted a certificate from the jurisdiction of original licensure verifying that the applicant passed the examination in that jurisdiction; or

**2.6(3)** The applicant:

*a.* Holds an active license to practice landscape architecture issued by another jurisdiction whose current licensure requirements, including the examination requirements, are substantially equivalent to or exceed those required for licensure as a landscape architect in Iowa, and during the time period in which the applicant was issued an initial license in the other jurisdiction, that jurisdiction did not require a written examination for initial applicants, but did require board review and approval of education and experience designed to demonstrate competence to practice;

*b.* Was grandparented in under the laws of the other jurisdiction, before written examinations for initial licensure were mandated by the other jurisdiction; and

*c.* Submits a certificate from the jurisdiction of original licensure verifying that the applicant was licensed during the period in which there was no written examination and submits proof of license in good standing.

[ARC 2709C, IAB 9/14/16, effective 10/19/16]

**193D—2.7(544B,17A) Certificate of licensure.** When an applicant has qualified for licensure under this chapter and has paid the required license fee, the secretary shall enroll the applicant's name in the roster of professional landscape architects and issue to the applicant a certificate of licensure signed by the chairperson and vice chairperson of the board.

**2.7(1) License number.** The certificate will indicate the license number of the landscape architect which must appear on the professional landscape architect's seal and on all works signed by the professional landscape architect.

**2.7(2) Certificate.** Only one certificate of licensure shall be issued to a professional landscape architect. The certificate shall be displayed in a conspicuous place at the place of employment.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—2.8(17A,272C,544B) Renewal of certificates of licensure.** Certificates of licensure expire biennially on June 30. In order to maintain authorization to practice in Iowa, a licensee is required to renew the certificate of licensure prior to the expiration date. A licensee who fails to renew by

the expiration date is not authorized to practice landscape architecture in Iowa until the certificate is reinstated as provided in rule 193D—2.9(544B,17A).

**2.8(1)** It is the policy of the board to e-mail to each licensee a notice of the pending expiration date at the licensee's last-known address approximately one month prior to the date the certificate of licensure is scheduled to expire. Failure to receive this notice does not relieve the licensee of the responsibility to timely renew the certificate and pay the renewal fee. A licensee should contact the board office if the licensee does not receive a renewal notice prior to the date of expiration.

**2.8(2)** If grounds exist to deny a timely and sufficient application to renew, the board shall send written notification to the applicant by restricted certified mail, return receipt requested. Grounds may exist to deny an application to renew if, for instance, the licensee failed to satisfy the continuing education as required as a condition for licensure. If the basis for denial is pending disciplinary action or disciplinary investigation that is reasonably expected to culminate in disciplinary action, the board shall proceed as provided in 193—Chapter 7. If the basis for denial is not related to a pending or imminent disciplinary action, the applicant may contest the board's decision as provided in 193—subrule 7.40(1).

**2.8(3)** When a licensee appears to be in violation of mandatory continuing education requirements, the board may, in lieu of proceeding to a contested case hearing on the denial of a renewal application as provided in rule 193—7.40(546,272C), offer the licensee the opportunity to sign a consent order. While the terms of the consent order will be tailored to the specific circumstances at issue, the consent order will typically impose a penalty between \$50 and \$250, depending on the severity of the violation; establish deadlines for compliance; and require that the licensee complete hours equal to double the deficiency in addition to the required hours; and may impose additional educational requirements on the licensee. Any additional hours completed in compliance with the consent order cannot again be claimed at the next renewal. The board will address subsequent offenses on a case-by-case basis. A licensee is free to accept or reject the offer. If the offer of settlement is accepted, the licensee will be issued a renewed certificate of licensure and will be subject to disciplinary action if the terms of the consent order are not complied with. If the offer of settlement is rejected, the matter will be set for hearing, if timely requested by the licensee pursuant to 193—subrule 7.40(1).

**2.8(4)** The board may notify licensees whose certificates of licensure have expired. The failure of the board to provide this courtesy notification or the failure of the licensee to receive the notification shall not extend the date of expiration.

**2.8(5)** A licensee who continues to practice landscape architecture in Iowa after licensure has expired shall be subject to disciplinary action. Such unauthorized activity may also be grounds to deny a licensee's application for reinstatement.

**2.8(6)** Licensees shall notify the board within 30 days of any change of address or business connection.

**2.8(7)** Retired status. A person who held a license as a professional landscape architect, who is retired from the practice of landscape architecture in all states of licensure, and who has applied for and has been granted retired status from the board may use the title "professional landscape architect, retired" or "P.L.A., retired." The retired status would become effective on the first scheduled license renewal date. Applicants do not need to reinstate an expired license to be eligible for retired status. Applicants may apply for retired status on the renewal forms provided by the board. The board will not provide a refund of biennial licensure fees if an application for retired status is granted in a biennium in which the applicant has previously paid the biennial fees for either active or inactive status. Licensees with retired status are exempt from the renewal requirement.

*a. Permitted practices.* A person whose license is in retired status may engage in the practices identified in paragraph 2.8(8)"c." Such person may also provide services as a technical expert before a court, including pre-litigation preparation, discovery, and testimony, on matters directly related to landscape architectural services provided by such person prior to registering with the board in retired status.

*b. Exemption.* A person whose license as a landscape architect has been placed on probation, suspended, revoked, or voluntarily surrendered in connection with a disciplinary investigation or

proceeding shall not be eligible for retired status unless the board, upon appropriate application, first reinstates the license to good standing.

**2.8(8)** Inactive status. This subrule establishes a procedure under which a person issued a certificate of licensure as a landscape architect may apply to the board to register as inactive. Licensure under this subrule is available to a licensee residing within or outside the state of Iowa who is not using the title “landscape architect” while offering services as a landscape architect. A person eligible to register as inactive may, as an alternative to licensure, allow the certificate of licensure to lapse. During any period of inactive status, a person shall not engage in the practice of landscape architecture while using the title “landscape architect” or any other title that might imply that the person is offering services as a landscape architect in violation of Iowa Code section 544B.18. The board will continue to maintain a database of persons registered as inactive, including information which is not routinely maintained after a certificate of licensure has lapsed through the person’s failure to renew. A person who registers as inactive will accordingly receive a renewal notice if the notice is sent by the board, board newsletters, and other mass communications from the board.

*a. Affirmation.* The renewal application shall contain a statement in which the applicant affirms that the applicant will not engage in the practice of landscape architecture while using the title “landscape architect” in violation of Iowa Code section 544B.18, without first complying with all rules governing reinstatement to active status. A person in inactive status may reinstate to active status at any time pursuant to rule 193D—2.9(544B,17A).

*b. Renewal.* A person registered as inactive may renew the person’s certificate of licensure on the biennial schedule described in 193D—2.8(544B,272C,17A). This person shall be exempt from the continuing education requirements and will be charged a reduced renewal fee as provided in 193D—2.10(544B,17A). An inactive certificate of licensure shall lapse if not timely renewed.

*c. Permitted practices.* A person may, while registered as inactive or retired, perform for a client, business, employer, government body, or other entity those services which may lawfully be provided by a person to whom a certificate of licensure has never been issued. For an “inactive” licensee, such services may be performed as long as the person does not in connection with such services use the title “landscape architect” or any other title restricted for use only by landscape architects pursuant to Iowa Code section 544B.18 (with or without additional designations such as “inactive”). Restricted titles may be used only by active landscape architects who are subject to continuing education requirements to ensure that the use of such titles is consistently associated with the maintenance of competency through continuing education. A “professional landscape architect, retired” may use the “professional landscape architect, retired” title; however, the person shall inform anyone to whom the person is providing services that the person once held an active landscape architect license but is no longer actively licensed or permitted to practice landscape architecture.

*d. Prohibited practices.* A person who, while registered as inactive, engages in any of the practices described in Iowa Code section 544B.18 is subject to disciplinary action.

[ARC 0213C, IAB 7/25/12, effective 8/29/12; ARC 3097C, IAB 6/7/17, effective 7/12/17]

### **193D—2.9(544B,17A) Reinstatement.**

**2.9(1)** An individual may reinstate a lapsed certificate of licensure to active status as follows:

- a.* Pay the current renewal fee;
- b.* Pay the reinstatement fee of \$100 plus \$25 per month or partial month of expired licensure up to a maximum of \$750. All applicants for reinstatement shall be assessed the \$100 reinstatement fee. The \$25-per-month fee shall not be assessed if the applicant for reinstatement did not, during the period of lapse, engage in any acts or practices for which an active landscape architect license is required in Iowa. Falsely claiming an exemption from the monthly fee is a ground for discipline; in addition, other grounds for discipline may arise from practicing on a lapsed certificate, license or permit to practice;
- c.* Provide a written statement outlining the professional activities that the applicant performed in Iowa during the period of nonlicensure. The statement shall include a list of all projects with which the applicant had involvement and shall explain the service provided by the applicant; and

*d.* Submit documented evidence of completion of continuing education based on the licensee's date of licensure.

(1) A professional landscape architect who holds a license in Iowa for less than 12 months from the date of initial licensure shall not be required to report continuing education on the June 30 renewal on which the applicant failed to renew and 12 continuing education hours for each year or portion of a year of expired licensure up to a maximum of 48 continuing education hours; however, the hours reported shall not have been earned more than four years prior to the date of the application to reinstate to active status.

(2) A professional landscape architect who holds a license in Iowa for more than 12 months, but less than 24 months from the date of initial licensure, shall be required to report 12 contact hours which should have been reported on the June 30 renewal on which the applicant failed to renew and 12 continuing education hours for each year or portion of a year of expired licensure up to a maximum of 48 continuing education hours; however, the hours reported shall not have been earned more than four years prior to the date of the application to reinstate to active status.

(3) A professional landscape architect who holds a license in Iowa for 24 months or more from the date of initial licensure shall be required to report 24 contact hours which should have been reported on the June 30 renewal on which the applicant failed to renew and 12 continuing education hours for each year or portion of a year of expired licensure up to a maximum of 48 continuing education hours; however, the hours reported shall not have been earned more than four years prior to the date of the application to reinstate to active status.

(4) All continuing education hours must be completed in health, safety, and welfare subjects acquired in structured educational activities and be in compliance with requirements in 193D—Chapter 3. The continuing education hours used for reinstatement may not be used again at the next renewal.

(5) Out-of-state residents may submit a statement from their resident state's licensing board as documented evidence of compliance with their resident state's mandatory continuing education requirements during the period of nonlicensure. The statement shall bear the seal of the licensing board. Out-of-state residents whose resident state has no mandatory continuing education shall comply with the documented evidence requirements outlined in this subrule.

**2.9(2)** An individual may reinstate an inactive license or retired license to an active license as follows:

*a.* The individual shall pay the current active licensure fee. If the individual is reinstating to active status at a date that is less than 12 months from the next biennial renewal date, one-half of the current active licensure fee shall be paid.

*b.* The individual shall submit documented evidence of completion of 24 contact hours of continuing education in health, safety, and welfare subjects in compliance with requirements in 193D—Chapter 3. The continuing education hours used for reinstatement to active status may not be used again at the next renewal.

*c.* Continuing education for subsequent renewals.

(1) At the first biennial renewal date of July 1 that is less than 12 months from the date of the filing of the application to restore the certificate of licensure to active status, the individual shall not be required to report continuing education.

(2) At the first biennial renewal date of July 1 that is more than 12 months, but less than 24 months, from the date of the filing of the application to restore the certificate of licensure to active status, the individual shall report 12 hours of previously unreported continuing education.

*d.* Provide a written statement in which the applicant affirms that the applicant has not engaged in any of the practices in Iowa that are listed in Iowa Code section 544B.1(2) during the period of inactive licensure.

**2.9(3)** An individual shall not be allowed to reinstate to inactive status from retired status.

**2.9(4)** The board shall review reinstatement applications on a case-by-case basis and may, at its discretion, require that the applicant take the LARE as a prerequisite to reinstatement to active status.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—2.10(544B,17A) Fee schedule.** The appropriate fee shall accompany the application.

Fees for examination subjects shall be paid directly to the testing service selected by CLARB.

Exemption fee	\$300
(This certificate of licensure is to be effective to the June 30 which is at least 12 months beyond the date of the application.)	
Wall certificate replacement fee	\$25
Certificate of licensure fee	\$15/month
(This certificate of licensure is to be effective the day of board action until June 30.)	
Biennial licensure fee (active)	\$350
Biennial licensure fee (inactive)	\$100
Late renewal fee	\$25
(for renewals postmarked on or after July 1 and before July 30)	
“Professional landscape architect, retired” status	\$0 (No fee)
Reinstatement of lapsed licensure to active status	\$100 + renewal fee + \$25 per month or partial month of lapsed licensure; not to exceed \$750
Reinstatement of inactive or retired status to active status	\$350
(If less than 12 months from the next biennial renewal, one-half of the current active licensure fee shall be paid.)	

[ARC 0213C, IAB 7/25/12, effective 8/29/12; ARC 3097C, IAB 6/7/17, effective 7/12/17]

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CHAPTER 4  
RULES OF PROFESSIONAL CONDUCT AND DISCIPLINE PROCEDURES

[Prior to 3/9/88, see Landscape Architectural Examiners Board[540] Ch 4]

**193D—4.1(544B,17A) Rules of conduct.** Failure by a licensee to adhere to the provisions of Iowa Code chapters 272C and 544B and rules implementing either chapter shall be grounds for disciplinary action.

**4.1(1) Definitions.** The following definition applies as used in Iowa Code chapter 544B and this chapter, unless the context otherwise requires.

“*Official copy*” means technical submission for purposes of required approval.

**4.1(2) Competence.**

a. When practicing landscape architecture, a professional landscape architect shall act with reasonable care and competence, and shall apply the technical knowledge and skill which is ordinarily applied by a landscape architect of good standing practicing in the same locality.

b. When designing a project, a professional landscape architect shall take into account all applicable state and municipal building laws and regulations. While professional landscape architects may rely on the advice of other professionals (e.g., attorneys, architects, engineers and other qualified persons) as to the intent and meaning of the regulations, once such advice is obtained, a landscape architect shall not knowingly design a project in violation of these laws and regulations.

c. A professional landscape architect shall undertake to perform professional services only when the professional landscape architect together with those whom the professional landscape architect may engage as consultants are qualified by education, training and experience in the specific technical areas involved.

d. No person shall be permitted to practice landscape architecture if, in the board’s judgment upon receipt of medical testimony or evidence, the person’s professional competence is substantially impaired by physical or mental disabilities or substance abuse.

**4.1(3) Conflict of interest.**

a. A professional landscape architect shall not accept compensation for services from more than one party on a project unless the circumstances are fully disclosed and agreed to (such disclosures and agreement to be in writing) by all interested parties.

b. If a professional landscape architect has any business association or direct or indirect financial interest which is substantial enough to influence judgment in connection with the professional landscape architect’s performance of professional services, the professional landscape architect shall fully disclose, in writing, to the client or employer the nature of the business association or financial interest. If the client or employer objects to the association or financial interest, the professional landscape architect shall either terminate such association or interest or offer to give up the commission or employment.

c. A professional landscape architect shall not solicit or accept compensation from material or equipment suppliers in return for specifying or endorsing the products.

d. When acting as the interpreter of building contract documents and the judge of contract performance, a professional landscape architect shall render decisions impartially, favoring neither party to the contract.

**4.1(4) Full disclosure.**

a. A professional landscape architect making public statements on landscape architectural questions shall disclose when compensation is being received for making the statements.

b. A professional landscape architect shall accurately represent to a prospective or existing client or employer the professional landscape architect’s qualifications and the scope of the professional landscape architect’s responsibility in connection with work for which the professional landscape architect is claiming credit.

c. If, in the course of work on a project, a professional landscape architect becomes aware of an action taken by the employer or client against the professional landscape architect’s advice which violates applicable state or municipal building laws and regulations and which will, in the professional landscape architect’s judgment, adversely affect the safety to the public of the finished project, the professional landscape architect shall:

(1) Report the decision to the local building inspector or other public official charged with enforcement of the applicable state or municipal building laws and regulations,

(2) Refuse to consent to the decision, and

(3) In circumstances when the professional landscape architect reasonably believes that other actions will be taken, notwithstanding the landscape architect's objection, terminate the professional landscape architect's services with reference to the project. In the case of a termination in accordance with this clause, the professional landscape architect shall have no liability to the professional landscape architect's client or employer on account of such termination.

*d.* A professional landscape architect shall not deliberately make a materially false statement or deliberately fail to disclose a material fact requested in connection with application for licensure or renewal of license.

*e.* A professional landscape architect shall not assist in the application for licensure of a person known by the professional landscape architect to be unqualified with respect to education, training, experience or character.

*f.* A professional landscape architect possessing knowledge of a violation of these rules by another professional landscape architect shall report the knowledge to the board.

**4.1(5) *Compliance with laws.***

*a.* A professional landscape architect shall not, in the conduct of landscape architectural practice, knowingly violate any state or federal criminal law.

*b.* A professional landscape architect shall neither offer nor make any payment to a government official (whether elected or appointed) with the intent of influencing the official's judgment in connection with a prospective or existing project in which the professional landscape architect is interested.

*c.* A professional landscape architect shall comply with the licensure laws and regulations governing the landscape architect's professional practice in any United States jurisdiction.

**4.1(6) *Professional conduct.***

*a.* Each office maintained for the preparation of drawings, specifications, reports or other professional work shall have a professional landscape architect regularly employed in or assigned to that office who has responsible control of such work.

*b.* A professional landscape architect shall not sign or seal drawings, specifications, reports or other professional work for which the landscape architect does not have direct professional knowledge and direct supervisory control; provided, however, that in the case of the portions of professional work prepared by the landscape architect's consultants, licensed under this or another professional licensure law of this jurisdiction, the professional landscape architect may sign or seal that portion of the professional work if the landscape architect has reviewed that portion, has coordinated its preparation and intends to be responsible for its adequacy.

*c.* A professional landscape architect shall neither offer nor make any gifts to any public official with the intent of influencing the official's judgment in connection with a project in which the professional landscape architect is interested. Nothing in this rule shall prohibit a professional landscape architect from providing landscape architect services as a charitable contribution.

*d.* A professional landscape architect shall not engage in conduct involving fraud or wanton disregard of the rights of others.

**4.1(7) *Seal and certificate of responsibility.***

*a.* Each professional landscape architect shall procure a seal with which to identify all technical submissions issued by the professional landscape architect for use in Iowa as provided in Iowa Code section 544B.12.

*b.* Description of seal. The diameter of the outside circle shall be approximately 1¼ inches. The seal shall include the name of the professional landscape architect and the words "Professional Landscape Architect." The Iowa license number and the word "Iowa" shall be included. The seal shall substantially conform to the sample shown below:



- c. A legible rubber stamp, an electronic image or other facsimile of the seal may be used.
- d. Each technical submission to a client or any public agency, hereinafter referred to as the official copy, shall contain an information block on its first page or on an attached cover sheet with application of a seal by the professional landscape architect in responsible charge and an information block with application of a seal by each professional consultant contributing to the technical submission. The seal and original signature shall be applied only to a final technical submission. Each official copy of a technical submission shall be stapled, bound or otherwise attached together so as to clearly establish the complete extent of the technical submission. Each information block shall display the seal of the individual responsible for that portion of the technical submission. The area of responsibility for each sealing professional shall be designated in the area provided in the information block, so that responsibility for the entire technical submission is clearly established by the combination of the stated seal responsibilities. The information block shall substantially conform to the sample shown below:

SEAL	<p>I hereby certify that the portion of this technical submission described below was prepared by me or under my direct supervision and responsible charge. I am a duly licensed professional landscape architect under the laws of the state of Iowa.</p> <hr/> <p>Printed or typed name or secure electronic signature</p> <hr/> <p>Signature</p> <hr/> <p>Pages or sheets covered by this seal:</p> <hr/>
License Expires:	<hr/> <hr/>

- e. The information requested in each information block must be typed or legibly printed in permanent ink or digital signature as defined in or governed by Iowa Code chapter 554D on each official copy. An electronic signature as defined in or governed by Iowa Code chapter 554D meets the signature requirements of this rule if it is protected by a security procedure, as defined in Iowa Code section 554D.103(14), such as digital signature technology. It is the licensee’s responsibility to ensure, prior to affixing an electronic signature to a landscape architecture document, that security procedures are adequate to (1) verify that the signature is that of a specific person and (2) detect any changes that may be made or attempted after the signature of the specific person is affixed. The seal implies responsibility for the entire technical submission unless the area of responsibility is clearly identified in the information accompanying the seal.
- f. It shall be the responsibility of the professional landscape architect who signed the original submission to forward copies of all changes and amendments to the technical submission, which shall

become a part of the official copy of the technical submission, to the public official charged with the enforcement of the state, county or municipal building code.

g. A professional landscape architect is responsible for the custody and proper use of the seal. Improper use of the seal shall be grounds for disciplinary action.

h. The seal appearing on any technical submission shall be prima facie evidence that said technical submission was prepared by or under the responsible control of the individual named on that seal.

**4.1(8) Communications.** A professional landscape architect shall, when requested, respond to communications from the board within 30 days of the mailing of such communication by certified mail. Failure to respond to such communication may be grounds for disciplinary action against the professional landscape architect.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—4.2(544B,17A) Receipt of complaints.** The board shall receive and review all complaints which the board reasonably believes indicate that a licensee may have committed an act that is cause for disciplinary action.

**4.2(1) Complaints.** Any person may file a complaint with the board charging that a licensee may have committed an act that is in violation of applicable law or rules. The complaint shall be written and signed by the complainant and accompanied with substantial evidence indicating when, where, and how the licensee committed the violation. All complaints filed with the board shall be privileged and held confidential pursuant to Iowa Code section 272C.6(4) by all board members, peer review committee members and staff. A person filing a complaint shall receive immunities in accordance with Iowa Code section 272C.8.

**4.2(2) Board-instigated complaints.** Upon presentation of evidence by a board member, the board's staff, or other state agency, the board may determine that a complaint should be opened and an investigation begun to determine if a licensee may have committed an act that is in violation of applicable law or rules.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—4.3(544B,17A) Peer review committee.** At any point during the complaint procedure or the investigatory procedure and prior to determining whether probable cause exists that a violation has occurred, the board may appoint a peer review committee to assist the board in reaching its decision by conducting an investigation(s) of the complaint.

**4.3(1) Makeup of the peer review committee.** The committee shall consist of one or more professional landscape architects who are selected for their knowledge and experience in the particular aspect of landscape architecture involved in the complaint. The following are ineligible for membership:

- a. Members of the board.
- b. Close relatives of the alleged violator(s) or complainant.
- c. Individuals employed by the same firm or governmental unit as the alleged violator or complainant.

**4.3(2) Authority.** The committee's investigation shall be limited to interviewing of complainants, the alleged violator, individuals with knowledge of the alleged violation, and individuals with knowledge of the alleged violator's reputation in the community. The committee may not hire legal counsel, investigators, secretarial help or any other assistants without written authorization from the board.

**4.3(3) Compensation.** Committee members may receive per diem compensation equal to that received by board members for performing board duties. Committee members may be paid reasonable and necessary expenses that are incurred for travel, meals and lodging while performing committee duties within a budget limitation established by the board.

**193D—4.4(544B,272C) Investigation report of complaints.**

**4.4(1) Board consideration of report to determine further action.** Upon completion of the investigation, the investigator(s) shall prepare for the board's consideration a report containing the

position or defense of the licensee so the board may determine what further action is necessary. The board may:

- a. Order the matter be further investigated.
- b. Allow the licensee who is the subject of the complaint an opportunity to appear before the designated discipline committee for an informal discussion regarding the circumstances of the alleged violation.
- c. Determine there is no probable cause to believe that a violation has occurred and close the case.
- d. Determine there is probable cause to believe that a violation has occurred.

**4.4(2) Informal discussion.**

a. An informal discussion is intended to provide a licensee an opportunity to share the licensee's account of a complaint in an informal setting before the board determines whether probable cause exists to initiate a disciplinary proceeding. A licensee is not required to attend an informal discussion. Because disciplinary investigations are confidential, the licensee may not bring other persons to an informal discussion, but licensees may be represented by legal counsel.

b. Unless disqualification is waived by the licensee, board members or staff who personally investigate a disciplinary complaint are disqualified from making decisions or assisting the decision makers at a later formal hearing. Because board members generally rely upon investigators, peer review committees, or expert consultants to conduct investigations, the issue rarely arises. An informal discussion, however, is a form of investigation because it is conducted in a question-and-answer format. In order to preserve the ability of all board members to participate in board decision making and to receive the advice of staff, a licensee who desires to attend an informal discussion must therefore waive the right to seek disqualification of a board member or staff based solely on the board member's or staff's participation in an informal discussion. A licensee would not waive the right to seek disqualification on any other ground. By electing to attend an informal discussion, a licensee accordingly agrees that participating board members or staff are not disqualified from acting as a presiding officer in a later contested case proceeding or from advising the decision maker.

c. Because an informal discussion constitutes a part of the board's investigation of a pending disciplinary case, the facts discussed at the informal discussion may be considered by the board in the event the matter proceeds to a contested case hearing and those facts are independently introduced into evidence.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

**193D—4.5(544B,272C) Dispensation.** The board shall make findings of fact and conclusions of law and may take one or more of the following actions:

1. Dismiss the charges.
2. Revoke the professional landscape architect's license.
3. Suspend the professional landscape architect's license as authorized by law.
4. Impose civil penalties, the amount of which shall be set at the discretion of the board but shall not exceed \$1000. Civil penalties may be imposed for any of the disciplinary violations of Iowa Code section 544B.15 and Iowa Code sections 272C.9(2), 272C.9(3), and 272C.10, and these rules or for repeated offenses.
5. Impose a period of probation, either with or without conditions.
6. Require reexamination, using one or more parts of the examination given to professional landscape architectural licensee candidates.
7. Require additional professional education, reeducation, or continuing education.
8. Issue a citation or warning.
9. Issue a consent order.
10. Accept voluntary surrender of license. Voluntary surrender of a license is considered a disciplinary action.

[ARC 3097C, IAB 6/7/17, effective 7/12/17]

These rules are intended to implement Iowa Code chapters 17A, 544B and 272C.

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**HUMAN SERVICES DEPARTMENT[441]**

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

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

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CHAPTER 7  
APPEALS AND HEARINGS

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

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

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

PREAMBLE

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

**441—7.1(17A) Definitions.**

“*Administrative hearing*” means a type of hearing that an appellant may elect in which the presiding officer reviews the written record only and makes a decision based on the facts available within the appeal file. An administrative hearing does not require an in-person or teleconference hearing. The final determination to establish whether an administrative hearing may be held will be made by the appeals section or the presiding officer.

“*Administrative law judge*” means an employee of the department of inspections and appeals who conducts appeal hearings.

“*Agency*” means the Iowa department of human services, including any of its local, institutional, or central administrative offices.

“*Aggrieved person*” means a person against whom the department has taken an adverse action. This includes a person who meets any of the conditions in rule 441—7.2(17A).

“*Appeal*” denotes a review and hearing request made by a person who is affected by a decision made by the agency or its designee. An appeal shall be considered a contested case within the meaning of Iowa Code chapter 17A.

“*Appeals advisory committee*” means a committee consisting of central office staff who represent the department in the screening of proposed decisions for the director.

“*Appeals section*” means the unit within the department of human services that receives appeal requests, certifies requests for hearing, and issues final appeal decisions.

“*Appellant*” denotes the person who claims or asserts a right or demand or the party who takes an appeal from a hearing to an Iowa district court.

“*Attribution appeal*” means an appeal to determine if additional resources can be allocated for the community spouse when the other spouse has entered a medical institution or is applying for home-and community-based waiver services. The result of the attribution appeal may affect Medicaid eligibility. An appellant may elect to have an attribution appeal held by administrative hearing.

“*Authorized representative*” means a person or organization designated by an appellant to act on the appellant’s behalf or who has legal authority to act on behalf of the appellant, such as a guardian or power of attorney.

“*Bidder*” means an individual or entity that submits a proposal in response to a competitive procurement issued by the department of human services.

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a “no factual dispute” contested case under Iowa Code section 17A.10A.

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

“*Department of inspections and appeals*” means the state agency that contracts with the department to conduct appeal hearings.

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

“*Due process*” denotes the right of a person affected by an agency decision to receive a notice of decision or notice of action and an opportunity to be heard at an appeal hearing and to present an effective defense.

“*Electronic account*” means a Web-based account established by the department for an applicant or member for communication between the department and the applicant or member.

*“Electronic case record”* means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid or healthy and well kids in Iowa eligibility and enrollment, including all documentation required for eligibility and any information collected or generated as part of a fair hearing process conducted by the department or through the exchange appeals process.

*“Ex parte communication”* means written, oral, or other forms of communication between a party to the appeal and the presiding officer while an appeal is pending when all parties were not given the opportunity to participate.

*“Exchange”* means an American health benefit exchange established pursuant to Section 1311 of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148). This entity makes qualified health plans available to qualified individuals and qualified employers.

*“First-level review”* means a review process that must be exhausted through a managed care organization before an appeal hearing is granted. Once the first-level review process is complete, a notice of decision will be issued by the managed care organization and will identify further appeal rights, if applicable.

*“FMAP-related”* describes coverage groups whose eligibility criteria are derived in relation to the family medical assistance program, directed toward children and their parents or caretakers.

*“Food assistance administrative disqualification hearing”* means a type of hearing used to determine if an individual fraudulently received benefits for which the individual was not eligible. A presiding officer shall determine if the individual will be banned from participating in the food assistance program for a period of time.

*“Group hearings”* denotes an opportunity for two or more persons to present their case jointly when all have the same complaint against agency policy.

*“Informal conference”* means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, and a representative of the department. The purpose of the informal conference is to provide information as to the reasons for the intended adverse action, to answer questions, to explain the basis for the adverse action, to provide an opportunity for the appellant to explain the appellant’s action or position, and to provide an opportunity for the appellant to examine the contents of the case record, including any electronic case record, plus all documents and records to be used by the department at the hearing in accordance with 441—Chapter 9.

*“In person or face-to-face hearing”* means an appeal hearing conducted by an administrative law judge who is physically present in the same location as the appellant.

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

*“Local office”* means the county, institution or district office of the department of human services.

*“Managed care organization”* or *“MCO”* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

*“Party”* means a party as defined in Iowa Code subsection 17A.2(8).

*“Prehearing conference”* means a type of meeting between the appellant and the appellant’s representative, unless precluded by federal law or state statute, a representative of the department and a presiding officer. The purpose of the prehearing conference is to discuss the appealed issue, to inquire as to the potential for voluntary settlement, to establish the hearing date, to establish the location of the hearing including whether the hearing will be by telephone or in person, and to discuss procedural matters relevant to the case.

“*Presiding officer*” means an administrative law judge employed by the department of inspections and appeals. The presiding officer may also be the department’s director or the director’s designee. The presiding officer has the authority to conduct appeal hearings and render proposed and final decisions.

“*Presumption*” denotes an inference as to the existence of a fact not known or drawn from facts that are known.

“*PROMISE JOBS discrimination complaint*” means any written complaint filed in accordance with the provisions of rule 441—7.8(17A) by a PROMISE JOBS participant or the participant’s representative which alleges that an adverse action was taken against the participant on the basis of race, creed, color, sex, national origin, religion, age, physical or mental disability, or political belief.

“*PROMISE JOBS displacement grievance*” means any written complaint filed with a PROMISE JOBS contractee by regular employees or their representatives that alleges that the work assignment of an individual under the PROMISE JOBS program violates any of the prohibitions against displacement of regular workers described in rule 441—93.17(239B).

“*Proposed decision*” means the presiding officer’s recommended findings of fact, conclusions of law, and decision and order in contested cases where the department did not preside.

“*Reconsideration*” means a review process that must be exhausted before an appeal hearing is granted. Such review processes include, but are not limited to, a reconsideration request through:

1. The Iowa Medicaid enterprise (IME),
2. A division or bureau within the department,
3. The mental health and disability services commission,
4. A licensed health care professional as specified in 441—paragraph 9.9(1)“i,” or
5. Any division or bureau within the department, from a bidder in a competitive procurement bid process.

Once the reconsideration process is complete, a notice of decision or notice of action will be issued with appeal rights.

“*Sent*” means deposited in the mail with first-class postage or posted to an individual’s electronic account.

“*SSI-related*” describes medical assistance coverage groups whose eligibility criteria, except for income and resource limits, are derived from the supplemental security income (SSI) program for people who are aged, blind, or disabled.

“*Teleconference hearing*” means an appeal hearing conducted by an administrative law judge over the telephone.

“*Timely notice period*” is the time from the date a notice is sent to the effective date of action. That period of time shall be at least ten calendar days, except in the case of probable fraud of a beneficiary. When probable fraud exists, “timely notice period” shall be at least five calendar days from the date a notice is sent.

“*Vendor*” means a provider of health care under the medical assistance program or a provider of services under a service program.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8994B, IAB 8/11/10, effective 10/1/10; ARC 9254B, IAB 12/1/10, effective 1/1/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1206C, IAB 12/11/13, effective 1/15/14; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

**441—7.2(17A) Conditions of an aggrieved person.** To be eligible for an appeal hearing, a person must meet the definition of “aggrieved person” in rule 441—7.1(17A) and qualify on a program-specific basis.

**7.2(1) Financial assistance.** Financial assistance includes, but is not limited to, the family investment program; refugee cash assistance; child care assistance; emergency or disaster assistance; family or community self-sufficiency grants; family investment program hardship exemptions; and state supplementary assistance dependent person, in-home health-related care, and residential care facility benefits. Issues may include:

- a. A request to be given an application was denied.
- b. An application for assistance has been denied or has not been acted on in a timely manner.
- c. The effective date of assistance is contested.

- d. The amount of benefits granted is contested.
- e. The assistance will be reduced or canceled.
- f. An overpayment of benefits has been established, and repayment is requested.

**7.2(2) Food assistance.** Issues may include:

- a. A request to be given an application was denied.
- b. An application for assistance has been denied or has not been acted on in a timely manner.
- c. The effective date of assistance is contested.
- d. The amount of benefits granted is contested.
- e. The assistance will be reduced or canceled.
- f. A request to receive a credit for benefits from an electronic benefit transfer (EBT) account has been denied.

- g. An overpayment of benefits has been established, and repayment is requested.

**7.2(3) Medical assistance eligibility.** Medical assistance eligibility includes, but is not limited to, FMAP-related coverage groups, SSI-related coverage groups, the breast and cervical cancer treatment program, the health insurance premium payment program, healthy and well kids in Iowa (HAWK-I), the Iowa Health and Wellness Plan, family planning services, and waiver services. Issues may include:

- a. A request to be given an application was denied.
- b. An application has been denied or has not been acted on in a timely manner.
- c. The person's eligibility has been terminated, suspended or reduced.
- d. The level of benefits the person is eligible to receive has been reduced.
- e. A determination of the amount of medical expenses that must be incurred to establish income eligibility for the medically needy program or a determination of income for the purposes of imposing any premiums, enrollment fees or cost sharing is contested.
- f. The level of care requirements have not been met.
- g. The failure to take into account the appellant's choice in assignment to a coverage group.
- h. The effective date of assistance is contested.
- i. The amount or effective date of one of the following is contested:
  - (1) Health insurance premiums,
  - (2) Healthy and well kids in Iowa premiums,
  - (3) Medicaid for employed people with disabilities premiums,
  - (4) Iowa Health and Wellness Plan contributions,
  - (5) Client participation, or
  - (6) Medically needy program spenddown.
- j. An overpayment of benefits has been established, and repayment is requested.

**7.2(4) Fee-for-service medical coverage.** Issues may include:

- a. The level of services that the person is eligible to receive has been reduced.
- b. The level of services provided by a nursing facility is not needed based on a preadmission screening and resident review (PASRR) evaluation.
- c. The effective date of services is contested.
- d. A claim for payment or prior authorization has been denied.
- e. The medical assistance hotline has issued notification that services not received or services for which an individual is billed are not payable by medical assistance.
- f. Nonemergency medical transportation services by the broker designated by the department pursuant to rule 441—78.13(249A) have been denied.

**7.2(5) Managed care organization medical coverage.**

- a. A Medicaid member, an authorized representative or a provider who is acting on behalf of a member has been notified that the first-level review process through a managed care organization has been exhausted and remains dissatisfied with the outcome.
- b. If a provider is acting on behalf of a member by filing this type of appeal, the member's written consent to appeal must be submitted with the appeal request.
- c. If the managed care organization fails to adhere to the notice and timing requirements in 42 CFR 438.408, the Medicaid member, authorized representative or provider who is acting on behalf of

the member is deemed to have exhausted the managed care organization's appeals process. The Medicaid member, authorized representative or provider who is acting on behalf of the member may initiate a state fair hearing.

**7.2(6) Providers.** Providers can be an individual or an entity. Issues may include:

*a.* A license, certification, registration, approval or accreditation has been denied or revoked or has not been acted on in a timely manner.

*b.* A fee-for-service claim for payment or request for prior authorization of payment has been denied in whole or in part and the provider states that the denial was not made according to department policy.

*c.* A medical assistance patient manager contract has been terminated.

*d.* A payment has been withheld to recover a prior overpayment, or an order to repay an overpayment pursuant to 441—subrule 79.4(7) has been received.

*e.* An application for child care quality rating has not been acted upon in a timely fashion.

*f.* A child care quality rating decision is contested.

*g.* A certificate of child care quality rating has been revoked.

*h.* An adverse action has been taken relating to the Iowa electronic health record incentive program pursuant to rule 441—79.16(249A), including:

(1) Provider eligibility determination,

(2) Incentive payments, or

(3) Demonstration of adopting, implementing, upgrading and meaningful use of technology.

*i.* An application or reapplication for licensure was issued as a provisional license.

*j.* A license has been issued for a limited time.

**7.2(7) Social services.** Social services include, but are not limited to, adoption, foster care, and family-centered services. Issues may include:

*a.* A request to be given an application was denied.

*b.* An application for services or payment for adoption subsidy or foster care has been denied or has not been acted on in a timely manner.

*c.* An application or license has been denied based on a record check evaluation.

*d.* A determination that a person must participate in a service program is contested.

*e.* A claim for payment of services has been denied.

*f.* A protective or vendor payment has been established.

*g.* The services have been reduced or canceled.

*h.* An overpayment of services has been established, and repayment is requested.

*i.* An adoptive placement of a child has been denied or delayed when an adoptive family is available outside the jurisdiction with responsibility for handling the child's case.

*j.* A referral to community care was not made as provided in rule 441—186.2(234).

*k.* A referral to community care as provided in rule 441—186.2(234) was made and the community care provider's dispute resolution process has been exhausted.

**7.2(8) Child support recovery.** Issues may include:

*a.* A person is not entitled to a support payment in full or in part because of the date of collection, as provided under rule 441—95.13(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

*b.* A claim or offset is contested as provided in 441—subrule 95.6(3), 95.7(8), or 98.81(3) by a person's alleging a mistake of fact. "Mistake of fact" means a mistake in the identity of the obligor or in whether the delinquency meets the criteria for referral or submission. The issue on appeal shall be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

*c.* A name has been certified for passport sanction as provided in Iowa Code section 252B.5.

*d.* A termination in services has occurred as provided in rule 441—95.14(252B).

**7.2(9) PROMISE JOBS.** Issues may include:

*a.* A claim for participation allowances has been denied, reduced, or canceled.

*b.* The contents of the family investment agreement are not sufficient or necessary for the family to reach self-sufficiency.

- c. The results of informal grievance resolution procedures are contested, an opportunity for an informal grievance resolution has been declined, or a decision was not made within the 14-day period.
- d. PROMISE JOBS services will be canceled due to imposition of a limited benefit plan.
- e. An overpayment of benefits has been established, and repayment is requested.
- f. Acts of discrimination are alleged on the basis of race, creed, color, sex, age, physical or mental disability, religion, national origin, or political belief.

**7.2(10)** *Child abuse registry, dependent adult abuse registry, or record check evaluation.* Issues may include:

- a. A person is alleged responsible for child abuse.
- b. A correction of dependent adult abuse information has been requested.
- c. A record check evaluation restricted or denied employment in a health care facility, state institution, or other facility. “Employment” includes, but is not limited to, service as an employee, a volunteer, a provider, or a contractor. “Facility” includes, but is not limited to, county or multicounty juvenile detention homes and juvenile shelter care homes, child-placing agencies, substance abuse treatment programs, group living foster care facilities, child development homes, child care centers, state resource centers, mental health institutes, and state training schools.
- d. A record check evaluation results in the restriction of participation in an educational training program.

**7.2(11)** *Mental health and disability services.* Issues may include:

- a. An application for state payment under 441—Chapter 153, Division IV, has been denied or has not been acted upon in a timely manner.
- b. Services under the state payment program have been reduced or canceled.
- c. A request to be given an application was denied.
- d. The person’s eligibility has been terminated, suspended or reduced.
- e. The level of benefits or services the person is eligible to receive has been reduced.
- f. The effective date of assistance or services is contested.
- g. The reconsideration process has been exhausted, and a person remains dissatisfied with the outcome.
- h. The amount or effective date of cost-sharing requirements for the autism support program is contested.
- i. A service authorization request for applied behavioral analysis services has been denied or reduced.

**7.2(12)** *HIPAA (Health Insurance Portability and Accountability Act).* A current or former applicant for or recipient of Medicaid or HAWK-I, or a person currently or previously in a department facility whose request:

- a. To restrict use or disclosure of protected health information was denied.
- b. To change how protected health information is provided was denied.
- c. For access to protected health information was denied. When the denial is subject to reconsideration under 441—paragraph 9.9(1) “i,” persons denied access due to a licensed health care professional’s opinion that the information would constitute a danger to that person or another person must first exhaust the reconsideration process.
- d. To amend protected health information was denied.
- e. For an accounting of disclosures was denied.

**7.2(13)** *Drug manufacturers.* A manufacturer that has received a notice of decision regarding disputed drug rebates pursuant to the dispute resolution procedures of a national drug rebate agreement or an Iowa Medicaid supplemental drug rebate agreement disagrees with the decision.

**7.2(14)** *Bidders that have participated in a competitive procurement bid process.* Appeals resulting from a competitive procurement bid process will be handled pursuant to Chapter 7, Division II.

**7.2(15)** *Other individuals or providers.* Individuals or providers that are not listed in rule 441—7.2(17A) may meet the definition of an aggrieved person if the department has taken an adverse action against that individual or provider.

## DIVISION I

**441—7.3(17A) Presiding officer.** Appeal hearings shall be conducted by a presiding officer appointed by the department of inspections and appeals pursuant to Iowa Code section 10A.801. The presiding officer shall not be connected in any way with the previous actions or decisions on which the appeal is made. Nor shall the presiding officer be subject to the authority, direction, or discretion of any person who has prosecuted or advocated in connection with that case, the specific controversy underlying that case, or any pending factually related contested case or controversy involving the same parties.

**441—7.4(17A) Notification of hearing procedures.** Hearing procedures shall be published in the form of rules and shall be made available to all applicants, recipients, appellants, and other interested groups and individuals. Procedures for hearings shall be identified in the notice of hearing issued to all parties as provided in subrule 7.10(7).

**7.4(1)** Hearing procedures must be furnished in electronic and paper format and orally as appropriate. The procedures must be written in plain language and in a manner that is accessible:

*a.* To individuals who are limited English proficient through oral interpretation, written translations, and taglines in non-English languages indicating the availability of language services. The services shall be at no cost to the individual.

*b.* To individuals living with disabilities through the provision of auxiliary aids in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. The services shall be at no cost to the individual.

**7.4(2)** The department shall inform individuals of the availability of the services and how to access such services.

[ARC 1261C, IAB 1/8/14, effective 3/1/14]

**441—7.5(17A) The right to appeal.** An aggrieved person who qualifies for an appeal as stated in rule 441—7.2(17A) may file an appeal. The appeals section shall determine whether a hearing shall be granted.

**7.5(1)** *When a hearing is granted.* A hearing shall be granted to any appellant when the right to a hearing is granted by state or federal law, except as limited in subrules 7.5(2) and 7.5(4).

**7.5(2)** *When a hearing is not granted.* A hearing shall not be granted when:

*a.* One of the following issues is appealed:

- (1) The service is no longer available through the department.
- (2) Repayment of food assistance benefits as a result of trafficking has been requested on Form 470-4179, Notice of Food Assistance Trafficking Debt.
- (3) Payment for a medical claim has been made in accordance with the Medicaid payment schedule for the service billed.
- (4) Children have been removed from or placed in a specific foster care setting.
- (5) Children have not been placed with or have been removed from a preadoptive family.
- (6) A qualified provider or qualified entity has denied a person presumptive eligibility for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44).
- (7) A qualified provider or qualified entity has determined a person to be presumptively eligible for Medicaid under 441—subrule 75.1(30), 75.1(40), or 75.1(44), but presumptive eligibility ends due to the person's failure to file an application.
- (8) Notice has been issued from the treasury offset program for a food assistance overpayment.
- (9) A rate determination for foster group care services has been reviewed under rule 441—152.3(234).
- (10) The maximum provider rate ceiling has been contested for child care assistance under 441—subrule 170.4(7).
- (11) The risk pool board has accepted or rejected an application for assistance from the risk pool fund or the tobacco settlement fund risk pool fund in whole or in part under rules 441—25.66(426B) and 441—25.77(78GA,ch1221).

(12) The appellant has a complaint about child support recovery matters other than those described in numbered paragraph “5” of the definition of an aggrieved person in rule 441—7.1(17A). This includes collection of an annual fee for child support services as specified in Iowa Code chapter 252B.

(13) The appellant has a complaint about a local office employee (when this is the only issue of the appeal).

(14) A request for an exception to policy under 441—subrule 1.8(1) has been denied.

(15) A final decision from a previous hearing with a presiding officer has been implemented.

(16) The issue appealed is not eligible for further hearing based on the doctrine of issue preclusion.

(17) The appeal involves patient treatment interventions outlined in the patient handbook of the civil commitment unit for sexual offenders.

(18) An MCO provider fails to submit a document providing the member’s approval of the request for appeal.

(19) Notice was issued by the exchange regarding determination of eligibility for enrollment in a qualified health plan or for advance payment of the premium tax credit or cost-sharing reductions.

(20) Notice has been issued regarding the completion of a family assessment that indicates no determination of child abuse or neglect has been made and no information has been reported to the child abuse registry.

(21) Notice has been issued regarding an MCO grievance request.

(22) Notice has been issued by an MCO to a provider regarding a claims dispute issue.

*b.* Either state or federal law requires automatic grant adjustment for classes of recipients. The director of the department shall decide whether to grant a hearing in these cases. When the reason for an individual appeal is incorrect grant computation in the application of these automatic adjustments, a hearing may be granted.

*c.* State or federal law or regulation provides for a different forum for appeals.

*d.* The appeal is filed prematurely as:

(1) There is no adverse action by the department,

(2) The appellant has not exhausted the reconsideration process, or

(3) The appellant has not exhausted the first-level review process with a managed care organization except as provided at paragraph 7.2(5) “c.”

*e.* Upon review, it is determined that the appellant does not meet the criteria of an aggrieved person as defined in rule 441—7.1(17A).

*f.* The sole basis for denying, terminating or limiting assistance under 441—Chapter 47 or 441—Chapter 58 is that funds for the respective programs have been reduced, exhausted, eliminated or otherwise encumbered.

*g.* Rescinded IAB 6/7/17, effective 7/12/17.

*h.* The issue appealed is moot.

*i.* The issue appealed has previously been determined in another appeal by the same appellant.

**7.5(3) Group hearings.** The appeals section may respond to a series of individual requests for hearings by requesting the department of inspections and appeals to conduct a single group hearing in cases in which the sole issue involved is one of state or federal law or policy or change in state or federal law or policy. An appellant scheduled for a group hearing may withdraw and request an individual hearing.

**7.5(4) Time limit for granting hearing to an appeal.** Subject to the provisions of subrule 7.5(1), when an appeal is made, the granting of a hearing to that appeal shall be governed by the following timeliness standards:

*a. General standards.* In general, a hearing shall be held if the appeal is made within 30 days after official notification of an action or before the effective date of action. When the appeal is made more than 30 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant’s family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.

4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an agency action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

*b. Food assistance, medical assistance or autism support program standard.* For appeals regarding food assistance, medical assistance or the autism support program, a hearing shall be held if the appeal is made within 90 days after official notification of an action. For appeals regarding a health care decision made by a managed care organization, a hearing shall be held if the appeal is made within 90 days after written notification that the first-level review process through the managed care organization has been exhausted. A hearing shall be held if the appeal is made within 90 days after the appeal is deemed to have exhausted the managed care organization's appeals process, as provided in paragraph 7.2(5) "c."

*c. Offset standards.* For appeals regarding state or federal tax or debtor offsets, a hearing shall be held if the appeal is made within 15 days after official notification of the action. Counties have 30 days to appeal offsets, as provided in 441—subrule 14.4(3). When the appeal is made more than 15 days but less than 90 days after notification, the director shall determine whether a hearing shall be granted.

(1) The director may grant a hearing if one or more of the following conditions existed:

1. There was a serious illness or death of the appellant or a member of the appellant's family.

2. There was a family emergency or household disaster, such as a fire, flood, or tornado.

3. The appellant offers a good cause beyond the appellant's control, which can be substantiated.

4. There was a failure to receive the department's notification for a reason not attributable to the appellant. Lack of a forwarding address is attributable to the appellant. A hearing may be granted if an appellant provides proof that a forwarding address was not supplied due to fear of domestic violence, homelessness, or other good cause.

(2) The time in which to appeal an offset action shall not exceed 90 days. Appeals made more than 90 days after notification shall not be heard.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

*d. Abuse standard.*

(1) For appeals regarding dependent adult abuse, a hearing shall be held if the appeal is made within six months after official notification of the action as provided in Iowa Code section 235B.10.

(2) For appeals regarding child abuse, a hearing shall be held if the appeal is made by a person alleged responsible for the abuse within 90 days after official notification of the action as provided in Iowa Code section 235A.19. A subject of a child abuse report, other than the alleged person responsible for the abuse, may file a motion to intervene in the hearing within 10 calendar days after the appeal notification.

(3) The day after the official notice is sent is the first day of the period within which an appeal must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

*e. Displacement and discrimination standard.* PROMISE JOBS displacement and discrimination appeals shall be granted hearing on the following basis:

(1) An appeal of an informal grievance resolution on a PROMISE JOBS displacement grievance shall be made in writing within 10 days of issuance (i.e., mailing) of the resolution decision or within 24 days of the filing of the displacement grievance, whichever is the shorter time period, unless good cause for late filing as described in subparagraph 7.5(4) "a"(1) is found.

(2) An appeal of a PROMISE JOBS discrimination complaint shall be made within the time frames provided in paragraph 7.5(4) “a” in relation to the action alleged to have involved discrimination.

*f. Risk assessment standard.* An appeal of a sex offender risk assessment shall be made in writing within 14 calendar days of issuance of the notice.

**7.5(5) Informal settlements.** The time limit for submitting an appeal is not extended while attempts at informal settlement are in progress.

**7.5(6) Appeals of family investment program (FIP), refugee cash assistance (RCA), and PROMISE JOBS overpayments.**

*a.* Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a FIP, RCA, or PROMISE JOBS overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-4683, Notice of FIP or RCA Overpayment; or
- (2) Form 470-4688, Notice of PROMISE JOBS Overpayment.

*b.* A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “a.”

*c.* Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the recovery of an overpayment through benefit reduction, as described at rule 441—46.25(239B), but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a FIP or RCA overpayment.

**7.5(7) Appeals of medical assistance, state supplementary assistance (SSA), and HAWK-I program overpayments.**

*a.* Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence and amount of a medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) program overpayment begins when the department sends the first notice informing the person of the overpayment. The notice shall be sent on:

- (1) Form 470-2891, Notice of Medical Assistance Overpayment; or
- (2) Form 470-3984, Notice of Healthy and Well Kids in Iowa (HAWK-I) Premium Overpayment.

*b.* A hearing shall not be held if an appeal is filed in response to a second or subsequent notice as identified in paragraph “a.”

*c.* A program overpayment means medical assistance, state supplementary assistance, or healthy and well kids in Iowa (HAWK-I) assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(7) relates to overpayments received by recipients, not by providers of the medical assistance program.

**7.5(8) Appeal rights under the family investment program limited benefit plan.** A participant only has the right to appeal the establishment of the limited benefit plan once at the time the department issues the timely and adequate notice that establishes the limited benefit plan. However, when the reason for the appeal is based on an incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

**7.5(9) Appeals of child care assistance benefit overpayments.**

*a.* Subject to the time limits described in subrule 7.5(4), a person’s right to appeal the existence, computation, and amount of a child care assistance benefit overissuance or overpayment begins when the department sends the first notice informing the person of the child care assistance overpayment. The notice shall be sent on Form 470-4530, Notice of Child Care Assistance Overpayment.

*b.* A hearing shall not be held if an appeal is filed in response to a second or subsequent notice about the same overpayment.

*c.* A program overpayment means child care assistance was received by or on behalf of a person in excess of that allowed by law, rules or regulations for any given month or in excess of the dollar amount of assistance. Subrule 7.5(9) relates to overpayments received by recipients and child care providers. Either entity may be responsible for repayment.

**7.5(10) Appeals of food assistance overpayments.**

*a.* Subject to the time limits described in subrule 7.5(4), a person's right to appeal the existence, computation, and amount of a food assistance overpayment begins when the department sends the first notice informing the person of the food assistance overpayment. The notice shall be sent on Form 470-4668, Notice of Food Assistance Overpayment.

*b.* Subject to the time limits described in subrule 7.5(4), a person's right to appeal the recovery of an overpayment through benefit reduction, but not the existence, computation, or amount of an overpayment, begins when the person receives Notice of Decision or Notice of Action, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), informing the person that benefits will be reduced to recover a food assistance overpayment.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0583C, IAB 2/6/13, effective 4/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

#### **441—7.6(17A) Informing persons of their rights.**

**7.6(1) *Written and oral notification.*** The department shall advise each applicant and recipient of the right to appeal any adverse decision affecting the person's status.

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

- (1) The right to request a hearing.
- (2) The procedure for requesting a hearing.
- (3) The right to be represented by others at the hearing unless otherwise specified by statute or federal regulation.
- (4) Provisions, if any, for payment of legal fees by the department.

*b.* Written notification shall be given on the application form and on all notices of decisions. Oral explanation shall also be given regarding the policy on appeals during the application process and at the time of any contemplated action by the agency when the need for an explanation is indicated.

*c.* Persons not familiar with English shall be provided a translation into the language understood by them in written form or orally. Appellants are entitled to have an interpreter present during appeal hearings. In all cases when a person is illiterate or semiliterate, the person shall be advised of each right to the satisfaction of the person's understanding.

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

**7.6(2) *Authorized representation or responsible party.*** Persons may be represented for purposes of this chapter by an authorized representative or an individual or organization recognized by the department as acting responsibly for an applicant or beneficiary pursuant to policy governing a particular program (hereinafter referred to as a "responsible party"), unless otherwise specified by statute or federal regulations.

*a.* The designation of an authorized representative must be in writing and include the signature of the person designating the authorized representative. Legal documentation of authority to act on behalf of a person, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a signed designation by the person.

*b.* An authorized representative or responsible party must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or beneficiary provided by the department.

*c.* A provider or staff member or volunteer of an organization serving as an authorized representative or responsible party must sign an agreement that such provider, staff member or volunteer will adhere to the regulations in Part 431, Subpart F, of 42 CFR Chapter IV and in 45 CFR 155.260(f) (relating to confidentiality of information), § 447.10 of 42 CFR Chapter IV (relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf), as well as other relevant state and federal laws concerning conflict of interest and confidentiality of information.

*d.* An authorized representative or responsible party may file an appeal on the appellant's behalf, receive copies of appeal correspondence, and act on behalf of the appellant in all other matters regarding the appeal.

*e.* The authorized representative or responsible party is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation to the same extent as the individual the authorized representative or responsible party represents.

*f.* The power to act as an authorized representative is valid until the appellant modifies the authorization or notifies the department that the representative is no longer authorized to act on the appellant's behalf, or the authorized representative informs the agency that the authorized representative is no longer acting in such capacity, or there is a change in the legal authority upon which the individual's or organization's authority was based. Such notice must be in writing and include the appellant's, authorized representative's or responsible party's signature as appropriate.

*g.* Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority may be submitted online via the department's Web site, by mail, by electronic mail, by facsimile transmission or in person.

*h.* For purposes of this rule, the department shall accept electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission.

*i.* Designations of authorized representatives, legal documentation of authority to act on behalf of a person, and modifications or terminations of designations or legal authority previously submitted to the department that comply with the requirements of this rule will continue to apply for purposes of appeals, consistent with their terms.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 1261C, IAB 1/8/14, effective 3/1/14]

**441—7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance.**

**7.7(1) Notification.**

*a.* Whenever the department proposes to cancel or reduce assistance or services or to revoke a license, certification, approval, registration, or accreditation, it shall give timely and adequate notice of the pending action, except:

(1) When a service is deleted from the state's comprehensive annual service plan in the social services block grant program at the onset of a new program year, or

(2) As provided in subrule 7.7(2).

*b.* For the purpose of this subrule, "assistance" includes food assistance, medical assistance, the family investment program, refugee cash assistance, child care assistance, emergency assistance, family or community self-sufficiency grant, PROMISE JOBS, state supplementary assistance, healthy and well kids in Iowa (HAWK-I) program, foster care, adoption, aftercare services, or other programs or services provided by the department.

*c.* The department shall give adequate notice of the approval or denial of assistance or services; the approval or denial of a license, certification, approval, registration, or accreditation; and pending action for a state or federal tax or debtor offset.

*d.* "Timely" means that the notice is sent at least ten calendar days before the date the action would become effective. The timely notice period shall begin on the day after the notice is sent.

*e.* "Adequate" means a written notice that includes:

(1) A statement of what action is being taken,

(2) The effective date of such action,

(3) A clear statement of the specific reasons supporting the intended action,

(4) The corresponding rule reference,

(5) An explanation of the appellant's right to appeal, and

(6) The circumstances under which assistance is continued when an appeal is filed.

**7.7(2) Dispensing with timely notice.** Timely notice may be dispensed with, but adequate notice shall be sent no later than the date benefits would have been issued when:

- a. There is factual information confirming the death of a recipient or of the family investment program payee when there is no relative available to serve as a new payee.
- b. The recipient provides a clear written, signed statement that the recipient no longer wishes assistance, or gives information which requires termination or reduction of assistance, and the recipient has indicated, in writing, that the recipient understands this must be the consequence of supplying the information.
- c. The recipient has been admitted or committed to an institution that does not qualify for payment under an assistance program.
- d. The recipient has been placed in skilled nursing care, intermediate care, or long-term hospitalization.
- e. The recipient's whereabouts are unknown and mail directed to the recipient has been returned by the post office indicating no known forwarding address. When the recipient's whereabouts become known during the payment period covered by the returned warrant, the warrant shall be made available to the recipient.
- f. The agency establishes that the recipient has been accepted for assistance in another state.
- g. Cash assistance or food assistance is changed because a child is removed from the home as a result of a judicial determination or is voluntarily placed in foster care.
- h. A change in the level of medical care is prescribed by the recipient's physician.
- i. A special allowance or service granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance or service shall terminate at the end of the specified period.
- j. The notice involves an adverse determination made with regard to the preadmission screening requirements.
- k. The department terminates or reduces benefits or makes changes based on a completed Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), Review/Recertification Eligibility Document, as described at 441— subrule 40.27(3) or rule 441—75.52(249A).
- l. The agency terminates benefits for failure to return a completed report form, as described in paragraph "k."
- m. The agency approves or denies an application for assistance.
- n. The agency implements a mass change based on law or rule changes that affect a group of recipients.

**7.7(3) Action due to probable fraud.** When the agency obtains facts indicating that assistance should be canceled, suspended, or reduced because of the probable fraud of the recipient, and, where possible, the facts have been verified through collateral sources, notice of the action shall be timely when sent at least five calendar days before the action would become effective. The notice shall be sent by certified mail, return receipt requested.

**7.7(4) Conference during the timely notice period.** Rescinded IAB 7/10/13, effective 9/1/13.

**7.7(5) Notification not required.** Notification is not required in the following instances:

- a. When services in the social service block grant preexpenditure report are changed from one plan year to the next, or when the plan is amended because funds are no longer available.
- b. When service has been time-limited in the social service block grant preexpenditure report, and as a result the service is no longer available.
- c. When the placement of a person(s) in foster care is changed.
- d. When payment has been in accordance with the Medicaid payment schedule for the service billed because there is no adverse action.

**7.7(6) Reinstatement.**

- a. Whenever the department determines that a previously canceled case must remain canceled for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).
- b. Whenever the department determines that a previously canceled case is eligible for reinstatement at a lower level of benefits, for a reason other than that covered by the original notice, timely and adequate notice shall be sent except as specified in subrule 7.7(2).

c. Food assistance cases are eligible for reinstatement only in circumstances found in rule 441—65.44(234). FIP cases are eligible for reinstatement only in circumstances found in 441—subrule 40.22(5).

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

#### **441—7.8(17A) Opportunity for hearing.**

**7.8(1) Initiating an appeal.** To initiate an appeal, a person, the person's authorized representative or an individual or organization recognized by the department as acting responsibly for the person pursuant to policy governing a particular program must state in writing that the person disagrees with a decision, action, or failure to act on the person's case.

a. Food assistance, medical assistance, child care assistance and family investment program appeals may be made in person, by telephone or in writing as specified in subrule 7.8(2).

b. All other appeals, subject to paragraph 7.8(1)“a,” shall be made in writing.

c. A written request may be submitted via the appeals section's Web site or may be delivered by mail, electronic mail, facsimile transmission or personal delivery to the appeals section, to the local office, or to the department office that took the adverse action.

d. A request by telephone or in person may be made to the appeals section or to the department office that took the adverse action.

e. A Medicaid provider requesting a hearing on behalf of the member must have the prior express written consent of the member or the member's lawfully appointed guardian, except when appealing a medical assistance eligibility determination. No hearing will be granted unless the provider submits a document providing the member's consent to the request for a hearing.

**7.8(2) Filing the appeal.** The appellant shall be encouraged, but not required, to make written appeal on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, and the worker shall provide any instructions or assistance required in completing the form. When the appellant is unwilling to complete or sign this form, nothing in this rule shall be construed to preclude the right to perfect the appeal, as long as the appeal is in writing (except for food assistance, medical assistance, child care assistance and family investment program appeals) and has been communicated to the department by the appellant or appellant's representative.

A written appeal submitted by mail is filed on the date postmarked on the envelope sent to the department, or, when the postmarked envelope is not available, on the date the appeal is stamped received by the agency. When an appeal is submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile, the appeal is filed on the date it is submitted. The electronic delivery method shall record the date and time the appeal request was submitted. If there is no date recorded by the electronic delivery method, the date of filing is the date the appeal is stamped received by the agency. Receipt date of all appeals shall be documented by the office where the appeal is received.

**7.8(3) Informal conference.** When requested by the appellant, an informal conference with a representative of the department or one of its contracted partners, including a managed care organization, shall be held as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the informal conference, unless precluded by federal rule or state statute.

An informal conference need not be requested for the appellant to examine the contents of the case record, including any electronic case record, as provided in subrule 7.13(1) and 441—Chapter 9.

**7.8(4) Prehearing conference.** When requested, a prehearing conference may be held with the appellant, a representative of the department and a presiding officer as soon as possible after the appeal has been filed. An appellant's representative shall be allowed to attend and participate in the prehearing conference, unless precluded by federal rule or state statute.

**7.8(5) Interference.** Neither an informal conference nor a prehearing conference shall be used to discourage appellants from proceeding with their appeals. The right of appeal shall not be limited or

interfered with in any way, even though the person's complaint may be without basis in fact, or because of the person's own misinterpretation of law, agency policy, or methods of implementing policy.

**7.8(6) *Right to deny or dismiss an appeal.*** The appeals section or the department of inspections and appeals has the right to deny or dismiss the appeal when:

- a. It has been withdrawn by the appellant pursuant to subrule 7.8(8).
- b. The sole issue is one of state or federal law requiring automatic grant adjustments for classes of recipients.
- c. It has been abandoned.
- d. The agency, by written notice, withdraws the action appealed and restores the appellant's status that existed before the action appealed was taken.
- e. The agency implements action and issues a notice of decision or notice of action to correct an error made by the agency which resulted in the appeal.

Abandonment may be deemed to have occurred when the appellant, the appellant's authorized representative, or the department fails, without good cause, to appear at the prehearing or hearing.

**7.8(7) *Denial of due process.*** Facts of harassing, threats of prosecution, denial of pertinent information needed by the appellant in preparing the appeal, as a result of the appellant's communicated desire to proceed with the appeal shall be taken into consideration by the administrative law judge in reaching a proposed decision.

**7.8(8) *Withdrawal.*** When the appellant desires to voluntarily withdraw an appeal, the worker, the presiding officer, or the appeals section shall accept a request from the appellant to withdraw the appeal by telephone, in writing or in person. A written request may be submitted in person, by mail or through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile. The appellant may use Form 470-0492 or 470-0492(S), Request for Withdrawal of Appeal, for this purpose. For child abuse and dependent adult abuse appeals, the request to withdraw an appeal must be made in writing and signed by the appellant or the appellant's legal counsel.

**7.8(9) *Department's responsibilities.*** Unless the appeal is voluntarily withdrawn, the department worker or agent responsible for representing the department at the hearing shall:

- a. Within one working day of receipt of an appeal request, forward Form 470-0487 or 470-0487(S), Appeal and Request for Hearing, the written appeal, the postmarked envelope, if there is one, and a copy of the notification of the proposed adverse action to the appeals section.
- b. Forward a summary and supporting documentation of the worker's or agent's factual basis for the proposed action to the appeals section within ten days of the receipt of the appeal.
- c. Provide the appellant and the appellant's representative copies of all materials sent to the appeals section or the presiding officer to be considered in reaching a decision on the appeal at the same time as the materials are sent to the appeals section or the presiding officer.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 0819C, IAB 7/10/13, effective 9/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

#### **441—7.9(17A) Continuation of assistance pending a final decision on appeal.**

**7.9(1) *General standards for when assistance continues.***

a. Assistance, subject to paragraph 7.9(1)"b," shall not be suspended, reduced, restricted, or canceled, nor shall a license, registration, certification, approval, or accreditation be revoked or other proposed adverse action be taken pending a final decision on an appeal when:

- (1) An appeal is filed before the effective date of the intended action; or
- (2) The appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits or services.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

b. If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

c. Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(2)"c."

*d.* The appellant may ask to have the appellant's benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

*e.* Once benefits are continued or reinstated, the department will not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(2).

**7.9(2) *General standards for when assistance does not continue.*** Assistance shall be suspended, reduced, restricted, or canceled; a license, registration, certification, approval, or accreditation shall be revoked; and other proposed action shall be taken pending a final decision on appeal when:

*a.* An appeal is not filed before the effective date of the intended action or within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

*b.* Benefits or services were time-limited through a certification period or prior authorization for which notice was given when established or for which adequate notice was provided.

*c.* The appellant directs the worker in writing to proceed with the intended action.

*d.* Adverse action was taken because the appellant failed to return a complete review form.

**7.9(3) *When assistance continues for food assistance.***

*a.* Assistance, subject to paragraph 7.9(3)"*b.*," shall not be suspended, reduced, restricted, or canceled or other proposed adverse action taken pending a final decision on an appeal when the appellant requests a hearing within ten days from receipt of a notice suspending, reducing, restricting, or canceling benefits.

The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

*b.* If it is determined at a hearing that the issue involves only federal or state law or policy, assistance will be immediately discontinued.

*c.* Assistance shall be continued on the basis authorized immediately prior to the notice of adverse action, subject to paragraph 7.9(4)"*c.*"

*d.* The appellant may ask to have the appellant's benefits continue on Form 470-0487 or 470-0487(S), Appeal and Request for Hearing. If the form does not positively indicate that the appellant has waived continuation of benefits, the department shall assume that continuation of benefits is desired.

*e.* Once benefits are continued or reinstated, the department must not reduce or terminate benefits while the appeal is pending, subject to subrule 7.9(4).

**7.9(4) *When assistance does not continue for food assistance.*** Assistance shall be suspended, reduced, restricted, or canceled or other proposed action shall be taken pending a final decision on appeal when:

*a.* An appeal is not filed within ten days from the date notice is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

*b.* Benefits or services were time-limited through a certification period or for which adequate notice was provided.

*c.* The appellant directs the worker in writing to proceed with the intended action.

*d.* Adverse action was taken because the appellant failed to return a complete review form.

**7.9(5) *When assistance continues for managed care organization health care services.***

*a.* Health care services may not be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

(1) An appeal is filed timely. "Timely" means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

(2) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

- (3) The services were ordered by an authorized provider;
- (4) The original period covered by the original authorization has not expired; and
- (5) The appellant requests that health care services be continued.

*b.* If, at the appellant's request, the managed care organization continues or reinstates the member's health care services while the appeal is pending, the benefits must continue until one of the following occurs:

- (1) The appellant withdraws the appeal.
- (2) The appellant fails to request an appeal within ten calendar days from the date the managed care organization mails the notice of action.
- (3) A hearing decision is issued that is adverse to the appellant.

**7.9(6)** *When assistance does not continue for health care services managed by a managed care organization.* Health care services may be reduced, limited, suspended, canceled or other proposed adverse action taken pending a final decision on an appeal when:

*a.* An appeal is not filed timely. "Timely" means the appeal is filed on or before the effective date of the adverse benefit determination or within ten calendar days of the date the managed care organization sent the notice of adverse benefit determination. The date on which the notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period;

*b.* The appeal does not involve the termination, suspension, or reduction of a previously authorized course of treatment;

*c.* The services were not ordered by an authorized provider;

*d.* The original period covered by the original authorization has expired; or

*e.* The appellant fails to request that health care services be continued.

**7.9(7)** *Recovery of excess assistance paid pending a final decision on appeal.* Continued assistance is subject to recovery by the department if the department's action is affirmed, except as specified at subrule 7.9(9).

When the department's action is sustained, excess assistance paid pending a final decision shall be recovered to the date of the decision. This recovery is not an appealable issue. However, appeals may be heard on the computation of excess assistance paid pending a final decision.

**7.9(8)** *Recovery of excess assistance paid when the appellant's benefits are changed prior to a final decision.* Recovery of excess assistance paid will be made to the date of change which affects the improper payment. The recovery shall be made when the appellant's benefits are changed due to one of the following reasons:

*a.* A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law or policy and not one of incorrect grant computation, and the grant is adjusted.

*b.* A change affecting the appellant's grant occurs while the final decision is pending and the appellant fails to request a hearing after notice of the change.

**7.9(9)** *Recovery of assistance when a new limited benefit plan is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new limited benefit plan period is established. A new limited benefit plan period shall be established when the department is affirmed in a timely appeal of the establishment of the limited benefit plan. All of the following conditions shall exist:

*a.* The appeal is filed either:

(1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the limited benefit plan, or

(2) Within ten days from the date on which a notice establishing the beginning date of the limited benefit plan is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.

*b.* Assistance is continued pending the final decision of the appeal.

*c.* The department's action is affirmed.

**7.9(10)** *Recovery of assistance when a new ineligibility period is established for the use of an electronic access card at a prohibited location.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new ineligibility period is established for the use of an electronic access card at a prohibited location. A new ineligibility period pursuant to 441—paragraph 41.25(11)“e” shall be established when the department is affirmed in an appeal of the establishment of an ineligibility period for the use of an electronic access card at a prohibited location. All of the following conditions shall exist:

- a. The appeal is filed either:
  - (1) Before the effective date of the intended action on the notice of decision or notice of action establishing the beginning date of the ineligibility period, or
  - (2) Within ten days from the date on which a notice establishing the beginning date of the ineligibility period is received. The date on which notice is received is considered to be five days after the date on the notice, unless the beneficiary shows that the beneficiary did not receive the notice within the five-day period.
- b. Assistance is continued pending the final decision of the appeal.
- c. The department’s action is affirmed.

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**441—7.10(17A) Procedural considerations.**

**7.10(1)** *Registration.* Upon receipt of the notice of appeal, the appeals section shall register the appeal.

**7.10(2)** *Acknowledgment.*

a. Upon receipt of the notice of appeal, the appeals section shall send an acknowledgment of receipt of the appeal to the appellant, representative, or both. A copy of the acknowledgment of receipt of appeal will be sent to the appropriate departmental office.

b. For an appeal regarding child abuse, all subjects other than the person alleged responsible (appellant) will be notified of the opportunity to file a motion to intervene as provided in Iowa Code section 235A.19.

c. The department shall advise the person of any legal services which may be available and that the person may be represented by counsel at the person’s own expense.

**7.10(3)** *Granting a hearing.* The appeals section shall determine whether an appellant may be granted a hearing and the issues to be discussed at that hearing in accordance with the applicable rules, state statutes, or federal regulations.

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

b. The appeals of those appellants who are denied a hearing shall not be closed until issuance of a letter to the appellant and the appellant’s representative, advising of the denial of hearing and the basis upon which that denial is made. Any appellant that disagrees with a denial of hearing may present additional information relative to the reason for denial and request reconsideration by the appeals section or a hearing over the denial.

**7.10(4)** *Hearing scheduled.* For those records certified for hearing, the department of inspections and appeals shall establish the date, time, method and place of the hearing, with due regard for the convenience of the appellant as set forth in 481—Chapter 10 of the department of inspections and appeals’ rules unless otherwise designated by federal or state statute or regulation.

a. In cases involving individual appellants, the hearing shall be held by teleconference call or in the appropriate department office.

b. In cases of appeals by agencies, the hearing shall be scheduled by teleconference call or at the most appropriate department office.

c. In cases involving the determination of the community spouse resource allowance, the hearing shall be held within 30 days of the date of the appeal request.

*d.* In cases involving an appeal of a sex offender risk assessment, the hearing or administrative review shall be held within 30 days of the date of the appeal request.

*e.* Emergency assistance appeals shall be expedited.

*f.* In cases involving appellants who indicate that their lives, physical or mental health, or ability to attain, maintain or regain maximum function could seriously be jeopardized if they wait for standard resolution of their appeals, the hearing shall be held within three working days of the date on the appeal request if:

(1) The managed care organization handled the first-level review expeditiously; and

(2) The appellant or a provider acting on the appellant's behalf requested an expedited appeal hearing.

**7.10(5) Method of hearing.** The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. Upon advance request, a witness shall be permitted to appear by teleconference unless the administrative law judge determines that the physical presence of the witness is necessary for the administration of justice and does not impose an undue burden on the witness. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A). The appellant may request to have a presiding officer render a decision for attribution appeals through an administrative hearing.

**7.10(6) Reschedule requests.** Requests by the appellant or the department to set another date, time, method or place of hearing shall be made to the department of inspections and appeals directly except as otherwise noted. The granting of the requests will be at the discretion of the department of inspections and appeals.

*a.* The appellant may request that the teleconference hearing be rescheduled as an in-person hearing. All requests made to the appeals section or to the department of inspections and appeals for a teleconference hearing to be rescheduled as an in-person hearing shall be granted. Any appellant request for an in-person hearing made to the appeals section shall be communicated to the department of inspections and appeals immediately.

*b.* For food assistance appeals, the hearing may be rescheduled if requested by the appellant; however, the postponement shall not exceed 30 days.

*c.* For intentional program violation appeals, the hearing may be rescheduled provided that the request for postponement is made at least ten days in advance of the date of the scheduled hearing. The hearing shall not be postponed for more than a total of 30 days.

*d.* Reschedule requests made by the department shall only be granted in instances of inclement weather when the department office is closed. The department's representative shall arrange coverage by a coworker in instances including, but not limited to, when inclement weather is present, but the department office remains open or when a family emergency, sudden illness or death occurs.

*e.* All other requests, subject to paragraph 7.10(6) "a," concerning the scheduling of a hearing shall be made to the department of inspections and appeals directly.

**7.10(7) Notification.** For those appeals certified for hearing, the department of inspections and appeals shall send a notice to the appellant at least ten calendar days in advance of the hearing date.

*a.* The notice, as prescribed in Iowa Code section 17A.12(2), shall set forth:

(1) The date, time, method and place of the hearing;

(2) That evidence may be presented orally or documented to establish pertinent facts; and

(3) That the appellant may question or refute any testimony, may bring witnesses of the appellant's choice and may be represented by others, including an attorney, subject to federal law and state statute. The department will not pay for the cost of legal representation.

*b.* A copy of this notice shall be forwarded to the department employee who took the action and to other persons when circumstances peculiar to the case indicate that the notification may be desirable.

*c.* Notices of hearing regarding an intentional program violation shall be served upon the appellant by first-class mail, postage prepaid, addressed to the appellant at the last-known address at least 30 days

in advance of the date the hearing is scheduled. All other notices of hearing shall be mailed by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

**441—7.11(17A) Information and referral for legal services.** The local office shall advise persons appealing any agency decision of legal services in the community that are willing to assist them.

**441—7.12(17A) Subpoenas.** The department shall have all subpoena power conferred upon it by statute. Departmental subpoenas shall be issued to a party on request or will be served by the department when requested at least one week in advance of the hearing date.

**441—7.13(17A) Rights of appellants during hearings.**

**7.13(1) Examination of the evidence.** The department shall provide the appellant, or representative, opportunity prior to, as well as during, the hearing, to examine all materials permitted under rule 441—9.1(17A,22) or to be offered as evidence. Off the record, or confidential information which the appellant or representative does not have the opportunity to examine shall not be included in the record of the proceedings or considered in reaching a decision.

**7.13(2) Conduct of hearing.**

*a.* The hearing shall be conducted by an administrative law judge designated by the department of inspections and appeals. It shall be an informal rather than a formal judicial procedure and shall be designed to serve the best interest of the appellant. The appellant shall have the right to introduce any evidence on points at issue believed necessary, to challenge and cross-examine any statement made by others, and to present evidence in rebuttal. A verbatim record shall be kept of the evidence presented.

*b.* For an appeal hearing regarding child abuse, the administrative law judge, upon request of any party to the hearing, may stay the hearing until the conclusion of the adjudicatory phase of a pending juvenile or district court case relating to the data or findings as provided in Iowa Code section 235A.19.

**7.13(3) Opportunity for response.** Opportunity shall be afforded all parties to respond and present evidence and arguments on all issues involved and to be represented by counsel at their own expense.

**7.13(4) Default.** If a party to the appeal fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing pursuant to subrules 7.13(1), 7.13(2) and 7.13(3) and render a proposed decision on the merits in the absence of the defaulting party.

*a.* Where appropriate and not contrary to law, any party may move for a default decision against a party who has failed to file a required pleading or has failed to appear after proper service for a hearing. A proposed decision on the merits may be issued in the absence of a defaulting party.

*b.* A default decision or a proposed decision rendered on the merits in the absence of the defaulting party may award any relief against the defaulting party consistent with the relief requested before the default, but the relief awarded against the defaulting party may not exceed the requested relief before the default.

*c.* Proceedings after a default decision are specified in subrule 7.13(5).

*d.* Proceedings after a hearing and a proposed decision on the merits in the absence of a defaulting party are specified in subrule 7.13(6).

**7.13(5) Proceedings after default decision.**

*a.* Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless a motion to vacate the decision is filed within the time allowed for an appeal of a proposed decision by subrule 7.16(5).

*b.* A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding. A party must file the motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. The department or its representative shall file a motion to vacate as specified in subrule 7.16(6). Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact. Each affidavit must be attached

to the motion. In lieu of submitting an affidavit, the moving party may submit business records or other acceptable documentation from a disinterested third party that substantiates the claim of good cause.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the appeals section.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

c. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

d. "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party's immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

e. Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

f. Once the time limit to appeal a proposed decision has expired, the contested case hearing shall proceed accordingly, after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

g. Upon a final decision denying a motion to vacate, the default decision becomes final agency action.

**7.13(6)** *Proceedings after hearing and proposed decision on the merits in the absence of a defaulting party.*

a. Proposed decisions on the merits after a party has failed to appear or participate in a contested case become final agency action unless:

(1) A motion to vacate the proposed decision is filed by the defaulting party based on good cause for the failure to appear or participate, within the time allowed for an appeal of a proposed decision by subrule 7.16(5); or

(2) Any party requests review on the merits by the director pursuant to rule 441—7.16(17A).

b. If a motion to vacate and a request for review on the merits are both made in a timely manner after a proposed decision on the merits in the absence of a defaulting party, the review by the director on the merits of the appeal shall be stayed pending the outcome of the motion to vacate.

c. A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for the party's failure to appear or participate at the contested case proceeding. A party must file a motion with the Department of Human Services, Appeals Section, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

(1) The appeals section shall be responsible for serving all parties with the motion to vacate. All parties to the appeal shall have ten days from service by the appeals section to respond to the motion to vacate. All parties to the appeal shall be allowed to conduct discovery as to the issue of good cause and shall be allowed to present evidence on the issue before a decision on the motion, if a request to do so is included in that party's response. If the department responds to any party's motion to vacate, all parties shall be allowed another ten days to respond to the appeals section.

(2) The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists to set aside the default.

*d.* Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

*e.* "Good cause" for purposes of this rule is defined as an emergency circumstance that is beyond the control of the party and that prevents the party from being able to participate in the hearing.

(1) Examples of good cause include, but are not limited to:

1. Sudden, severe illness or accident involving the party or the party's immediate family (spouse, partner, children, parents, sibling).

2. Death or serious illness in the party's immediate family.

3. Other circumstances evidencing an emergency situation which was beyond the party's control and was not reasonably foreseeable.

(2) Examples of circumstances that do not constitute good cause include, but are not limited to:

1. A lost or misplaced notice of hearing.

2. Confusion as to the date and time for the hearing.

3. Failure to follow the directions on the notice of hearing.

4. Oversleeping.

5. Other acts demonstrating a lack of due care by the party.

*f.* Upon determining whether good cause exists, the presiding officer shall issue a proposed decision on the motion to vacate, which shall be subject to review by the director pursuant to rule 441—7.16(17A).

*g.* Once the time limit to appeal a proposed decision has expired, a new contested case hearing shall be held after proper service of notice to all parties. The situation shall be treated as the filing of a new appeal for purposes of calculating time limits, with the filing date being the date the decision granting the motion to vacate became final.

*h.* Upon a final decision denying a motion to vacate, the proposed decision on the merits in the absence of a defaulting party becomes final unless there is request for review on the merits by the director made pursuant to paragraph 7.13(6) "a" or "j."

*i.* Any review on the merits by the director requested pursuant to paragraph 7.13(6) "a" and stayed pursuant to paragraph 7.13(6) "b" pending a decision on a motion to vacate shall be conducted upon a final decision denying the motion to vacate.

*j.* Upon a final decision denying a motion to vacate a proposed decision issued in the absence of a defaulting party, any party to the contested case proceeding may request a review on the merits by the director pursuant to rule 441—7.16(17A), treating the date that the denial of the motion to vacate became final as the date of the proposed decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0304C, IAB 9/5/12, effective 11/1/12; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 3093C, IAB 6/7/17, effective 7/12/17]

#### **441—7.14(17A) Limitation of persons attending.**

**7.14(1)** The hearing shall be limited in attendance to the following persons, unless otherwise specified by statute or federal regulations: appellant, appellant's representative, agency employees, agency's legal representatives, other persons present for the purpose of offering testimony pertinent to the issues in controversy, and others upon mutual agreement of the parties. The administrative law judge may sequester witnesses during the hearing. Nothing in this rule shall be construed to allow

members of the press, news media, or any other citizens' group to attend the hearing without the written consent of the appellant.

**7.14(2)** For an appeal hearing regarding child abuse:

*a.* Subjects who file a motion to intervene, as provided in Iowa Code section 235A.19, will have the opportunity to appear at the prehearing conference. Any motion to intervene shall be considered by the administrative law judge at the prehearing conference.

*b.* The department shall not be considered to be a party who can adequately represent the interests of any other subject.

*c.* Subjects allowed to intervene as specified in subrule 7.5(4) will be considered parties to the hearing and will be allowed to attend the proceedings as provided in Iowa Code section 235A.19.

[ARC 0487C, IAB 12/12/12, effective 2/1/13]

**441—7.15(17A) Medical examination.** When the hearing involves medical issues, a medical assessment or examination by a person or physician other than the one involved in the decision under question shall be obtained and the report made a part of the hearing record when the administrative law judge or appellant considers it necessary. Any medical examination required shall be performed by a physician satisfactory to the appellant and the department at agency expense.

Forms 470-0502, Authorization for Examination and Claim for Payment, and 470-0447, Report on Incapacity, shall be utilized in obtaining medical information to be used in the appeal and to authorize payment for the examination.

**441—7.16(17A) The appeal decision.**

**7.16(1)** *Record.* The record in a contested case shall include, in addition to those materials specified in Iowa Code section 17A.12(6):

*a.* The notice of appeal.

*b.* All evidence received or considered and all other submissions, including the verbatim record of the hearing.

**7.16(2)** *Findings of fact.* Any party may submit proposed findings of fact. The presiding officer will rule on the proposed findings of fact. Findings of fact shall be based solely on the evidence in the record and on matters officially noticed in the record. The findings of fact and conclusions of law in the proposed or final decision shall be limited to contested issues of fact, policy, or law.

**7.16(3)** *Proposed decision.* Following the reception of evidence, the presiding officer shall issue a proposed decision, consisting of the issues of the appeal, the decision, the findings of fact and the conclusions of law. Each item shall be separately stated under individual headings. The proposed decision shall be sent by first-class mail, postage prepaid, addressed to the appellant at the appellant's last-known address.

**7.16(4)** *Appeal of the proposed decision.* After issuing a proposed decision, the administrative law judge shall submit it to the appeals section with copies to the appeals advisory committee.

*a.* The appellant, appellant's representative, a subject allowed to intervene as specified in subrule 7.5(4), the representative of a subject allowed to intervene as specified in subrule 7.5(4), or the department may appeal for the director's review of the proposed decision.

*b.* When the appellant, a subject allowed to intervene as specified in subrule 7.5(4), or the department has not appealed the proposed decision or when an appeal for the director's review of the proposed decision is not granted, the proposed decision shall become the final decision.

*c.* The director's review on appeal of the proposed decision shall be on the basis of the record as defined in subrule 7.16(1), except that the director need not listen to the verbatim record of the hearing in a review or appeal. The review or appeal shall be limited to issues raised prior to that time and specified by the party requesting the appeal or review. The director may designate another to act on the director's behalf in making final decisions.

**7.16(5)** *Time limit for appeal of a proposed decision.* Appeal for the director's review of the proposed decision must be made in writing to the director. The written request must be mailed or submitted in person or through an electronic delivery method, such as electronic mail, submission of an online form,

or facsimile. The request must be postmarked or received within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

**7.16(6) *Appeal of the proposed decision by the department.*** The appeals advisory committee acts as an initial screening device for the director and may recommend that the director review a proposed decision. That recommendation is not binding upon the director, and the director may decide to review a proposed decision without that committee's recommendation.

A request by the department for director's review of the proposed decision must be made in writing. The written request must be submitted to the appeals section in person or submitted through an electronic delivery method, such as electronic mail or facsimile, within ten calendar days of the date on which the proposed decision was sent. The day after the proposed decision is sent is the first day of the time period within which a request for director's review must be filed. When the time limit for filing falls on a holiday or a weekend, the time will be extended to the next workday.

When the director grants a review of a proposed decision on the department's request, the appeals section shall notify all other parties to the appeal of the review and send a copy of the request to all other parties. All other parties shall be provided ten calendar days from the date of notification to submit further written arguments or objections for consideration upon review.

Written arguments or objections must be mailed or submitted in person to the appeals section or submitted through an electronic delivery method, such as electronic mail, submission of an online form, or facsimile.

The day after the notification is sent is the first day of the time period within which a response to the department's request for review must be filed. When the time limit for responding falls on a holiday or a weekend, the time will be extended to the next workday.

**7.16(7) *Appeal of the proposed decision by the appellant.*** When the director grants a review of a proposed decision all other parties shall be so notified.

**7.16(8) *Opportunity for oral presentation of appeal of the proposed decision.*** In cases where there is an appeal of a proposed decision each party shall be afforded an opportunity to present oral arguments with the consent of the director. Any party wishing oral argument shall specifically request it. When granted, all parties shall be notified of the time and place.

**7.16(9) *Time limits.***

*a.* A final decision on the appeal shall be issued within the following time frames:

(1) Appeals for all programs, except food assistance, shall be rendered within 90 days from the date of the appeal.

(2) Food assistance-only decisions shall be rendered within 60 days.

(3) PROMISE JOBS displacement grievance decisions shall be rendered within 90 days from the date the displacement grievance was filed with the PROMISE JOBS contractee.

*b.* Failure to reach a decision within the time frames set forth in paragraph 7.16(9) "a" shall not affect the merits of the appellant's appeal.

*c.* Time frames may be extended based on continuances or additional time frames as approved by the presiding officer. Should the appellant request a delay in the hearing in order to prepare the case or for other essential reasons, reasonable time, not to exceed 30 days except with the approval of the administrative law judge, shall be granted and the extra time shall be added to the maximum for final administrative action.

*d.* For an appeal regarding child abuse, if the proposed decision is not appealed within 10 days from the date of the proposed decision, the proposed decision shall be the final agency action. If a party files an appeal within 10 days from the date of the proposed decision, the director has 45 days from the date of the proposed decision to issue a ruling. If the director does not rule within that 45-day period, the proposed decision becomes the final decision as provided in Iowa Code section 235A.19.

*e.* The department shall take prompt, definite and final administrative action to carry out the decision rendered within seven calendar days of receipt of a copy of the final decision. When the final decision is favorable to the appellant, or when the department decides in favor of the appellant before

the hearing, the department shall make any additional corrective payments due, retroactive to the date of the incorrect action.

**7.16(10) Final decision.** The department shall mail the final decision to the appellant at the appellant's last-known address by first-class mail, postage prepaid.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1261C, IAB 1/8/14, effective 3/1/14; ARC 1611C, IAB 9/3/14, effective 11/1/14; ARC 3093C, IAB 6/7/17, effective 7/12/17]

**441—7.17(17A) Exhausting administrative remedies.** To have exhausted all adequate administrative remedies, a party need not request a rehearing under Iowa Code section 17A.16(2) where the party accepts the findings of fact as prepared by the administrative law judge, but wishes to challenge the conclusions of law, or departmental policy.

**441—7.18(17A) Ex parte communication.**

**7.18(1) Prohibited communication.** There shall be no written, oral, or other type of communication between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in the case while an appeal is pending, without all parties being notified of an opportunity to participate, unless specifically authorized by statute or rule.

a. This provision does not prevent the presiding officer from communicating with members of the agency or seeking the advice or help of persons other than those defined in paragraph "c."

b. Persons described in paragraph "c" shall not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

c. For purposes of this rule:

(1) People with a direct or indirect interest in a case include any member of the appeals advisory committee and any person engaged in personally investigating, prosecuting, or advocating in either the case under appeal or a pending factually related case involving the same parties.

(2) The term "personally investigating" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term 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.

**7.18(2) Commencement of prohibition.** Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

**7.18(3) When communication is ex parte.** Rescinded IAB 4/30/03, effective 7/1/03.

**7.18(4) Avoidance of ex parte communication.** To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Written communications shall be provided to all parties to the appeal.

**7.18(5) Communications not prohibited.** Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

**7.18(6) Disclosure of prohibited communications.** A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified from the case. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be disclosed. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any

party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of communication.

**7.18(7) Disclosure of prior receipt of information through ex parte communication.** Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

**7.18(8) Imposition of sanctions.** The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by department personnel shall be reported to the department for possible sanctions, including censure, suspension, dismissal, or other disciplinary action.

**441—7.19(17A) Accessibility of hearing decisions.** Summary reports of all hearing decisions shall be made available to local offices and the public upon request. The information shall be presented in a manner consistent with requirements for safeguarding personal information concerning applicants and recipients.

[ARC 3093C, IAB 6/7/17, effective 7/12/17]

**441—7.20(17A) Right of judicial review and stays of agency action.**

**7.20(1) Right of judicial review.** If a director's review is requested, the final decision shall advise the appellant or the appellant's representative of the right to judicial review by the district court. When the appellant or the appellant's representative is dissatisfied with the final decision and requests judicial review of the decision to the district court, the department shall furnish copies of the documents or supporting papers to district court, including a written transcript of the hearing. An appeal of the final decision to district court does not itself stay execution or enforcement of an agency action.

**7.20(2) Stays of agency action.**

*a.* Any party to a contested case proceeding may petition the director for a stay or other temporary remedies pending judicial review, of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

*b.* In determining whether to grant a stay pending judicial review, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

*c.* A stay may be vacated by the director pending judicial review upon application of the department or any other party.

**441—7.21(17A) Food assistance hearings and appeals.**

**7.21(1) Appeal hearings.** All appeal hearings in the food assistance program shall be conducted in accordance with 7 CFR 273.15.

**7.21(2) Food assistance administrative disqualification hearings.** All food assistance administrative disqualification hearings shall be conducted in accordance with 7 CFR 273.16.

**7.21(3) Conduct of a food assistance administrative disqualification hearing.** Hearings over disqualification of a household member for an intentional program violation shall be conducted by a presiding officer.

*a.* The department of inspections and appeals shall serve an Intentional Program Violation Hearing Notice upon the household member both by certified mail, return receipt requested, and by first-class mail, postage prepaid, addressed to household member at the last-known address 30 calendar days before the initial hearing date.

*b.* The household member or that person's representative may request to postpone the hearing for up to 30 days, provided the request is made at least 10 calendar days before the scheduled hearing date.

c. At the hearing, the presiding officer shall advise the household member or that person's representative that the household member has the right to refuse to answer questions during the hearing and that the state or federal government may use the information in a civil or criminal action.

**7.21(4) Consolidating hearings.** Appeal hearings and food assistance administrative disqualification hearings may be consolidated if the issues arise out of the same or related circumstances, and the household member has been provided with notice of the consolidation by the department of inspections and appeals.

a. If the hearings are combined, the time frames for conducting a food assistance administrative disqualification hearing shall apply.

b. If the hearings are combined for the purpose of setting the amount of the overpayment at the same time as determining whether or not an intentional program violation has occurred, the household shall lose its right to a subsequent hearing on the amount of the overpayment.

**7.21(5) Attendance at hearing.** The household member shall be allowed ten days from the scheduled hearing to present reasons indicating good cause for not attending the hearing.

a. The appeals section shall certify the motion to vacate to the department of inspections and appeals for the presiding officer to review the motion, hold any additional proceedings, as appropriate, and determine if good cause exists for the default as specified in subrule 7.13(5). Timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party.

b. Unless good cause is determined, when the household member or that person's representative cannot be located or fails to appear at the scheduled hearing, the hearing shall be conducted without that person. In that instance, the presiding officer shall consider the evidence and determine if the evidence is clear and convincing that an intentional program violation was committed.

c. If the household member who failed to appear at the hearing is found to have committed an intentional program violation, but the presiding officer later determines that this person or the person's representative had good cause for not appearing, the previous hearing decision shall no longer be valid. A new hearing shall be conducted.

**7.21(6) Food assistance administrative disqualification hearing decisions.** The presiding officer shall base the determination of an intentional program violation on clear and convincing evidence that demonstrates the person committed, and intended to commit, an intentional program violation.

a. The proposed and final hearing decisions shall be made in accordance with rule 441—7.16(17A) unless otherwise specified.

b. The appeals section shall notify the household member and the local office of the final decision within 90 days of the date the household member is notified in writing that the hearing has been scheduled. If the hearing was postponed pursuant to subrule 7.21(3), paragraph "b," the 90 days for notifying the household member of the final decision shall be extended for as many days as the hearing is postponed.

c. The department shall take no action to disqualify a person from receiving food assistance before receiving the final appeal decision finding that the person has committed an intentional program violation.

d. No further administrative appeal procedure shall exist after the final decision is issued. The determination of an intentional program violation shall not be reversed by a subsequent hearing decision. However, the person may appeal the case to the Iowa district court.

e. When a court decision reverses a determination of an intentional program violation, the appeals section shall notify the local office of the specifics of the court decision.

[ARC 8003B, IAB 7/29/09, effective 9/2/09; ARC 3093C, IAB 6/7/17, effective 7/12/17]

**441—7.22(17A) FIP disqualification hearings.** Rescinded IAB 4/30/03, effective 7/1/03.

**441—7.23(17A) Contested cases with no factual dispute.** If the parties in a contested case agree that there is no dispute of material fact, the parties may present all admissible evidence either by stipulation, or as otherwise agreed, in lieu of an evidentiary hearing. If an agreement is reached, the parties shall

jointly submit a schedule for submission of the record, briefs and oral arguments to the presiding officer for approval.

**441—7.24(17A) Emergency adjudicative proceedings.**

**7.24(1) Necessary emergency action.** To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the United States Constitution and the Iowa Constitution and other provisions of law, the department of inspections and appeals may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the agency by emergency adjudicative order. Before issuing an emergency adjudicative order, the department of inspections and appeals shall consider factors including, but not limited to, the following:

- a. Whether there has been sufficient factual investigation to ensure that the agency is proceeding on the basis of reliable information.
- b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing.
- c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare.
- d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare.
- e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

**7.24(2) Issuance of order.**

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger and the department's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by using one or more of the following procedures:

- (1) Personal delivery.
- (2) Certified mail, return receipt requested, to the last address on file with the department.
- (3) Certified mail to the last address on file with the department.
- (4) First-class mail to the last address on file with the department.
- (5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that department orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

**7.24(3) Oral notice.** Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

**7.24(4) Completion of proceedings.** After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger. Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

[ARC 3093C, IAB 6/7/17, effective 7/12/17]

**441—7.25 to 7.40** Reserved.

DIVISION II  
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

**441—7.41(17A) Scope and applicability.** The rules in Division II apply to appeals based on the department's competitive procurement bid process.  
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**7.43(6) *Method of hearing.*** The department of inspections and appeals shall determine whether the appeal hearing is to be conducted in person, by videoconference or by teleconference call. The parties to the appeal may participate from multiple sites for videoconference or teleconference hearings. Any appellant is entitled to an in-person hearing if the appellant requests one. All parties shall be granted the same rights during a teleconference hearing as specified in rule 441—7.13(17A).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**441—7.46(17A) Request for review of the proposed decision.** A request for review of the proposed decision shall follow the provisions outlined in subrules 7.16(5) to 7.16(7).

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

**441—7.47(17A) Other procedural considerations.**

**7.47(1) Consolidation—severance.**

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

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

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

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

**7.47(2) Presiding officer.** Appeal hearings shall be conducted by an administrative law judge appointed by the department of inspections and appeals pursuant to rule 441—7.3(17A).

**7.47(3) Rights of appellants during hearings.** All rights afforded appellants at rule 441—7.13(17A) shall apply.

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

**441—7.48(17A) Appeal record.**

**7.48(1)** The appeal record shall consist of all items specified in subrule 7.16(1).

**7.48(2)** The party that requests a transcription of the proceedings shall bear the cost.

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

**441—7.49(17A) Pleadings.**

**7.49(1)** Pleadings may be required by rule, by the notice of hearing or by order of the presiding officer.

**7.49(2) Petition.** When an action of the department is appealed and pleadings are required under subrule 7.49(1), the aggrieved party shall file the petition.

*a.* Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

*b.* The petition shall state in separately numbered paragraphs the following:

- (1) On whose behalf the petition is filed;
- (2) The particular provisions of the statutes and rules involved;
- (3) The relief demanded and the facts and law relied upon for relief; and
- (4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

**7.49(3) Answer.** If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

*a.* Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

*b.* The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

*c.* The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

*d.* Any allegation in the petition not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

**7.49(4) Amendment.** Any notice of hearing, petition or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed and to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.  
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.50(17A) Ex parte communications.** The rules regarding ex parte communications listed at 441—7.18(17A) apply.  
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

**441—7.51(17A) Right of judicial review.** The rules regarding right of judicial review listed at 441—7.20(17A) apply.  
[ARC 1206C, IAB 12/11/13, effective 1/15/14]

These rules are intended to implement Iowa Code chapter 17A.

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<sup>◊</sup> Two or more ARCs



CHAPTER 75  
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]  
[Prior to 7/1/83, Social Services[770] Ch 75]  
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter establishes the conditions of eligibility for the medical assistance program administered by the department of human services pursuant to Iowa Code chapter 249A and addresses related matters. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.  
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

DIVISION I  
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

**441—75.1(249A) Persons covered.**

**75.1(1)** *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

- a. Persons denied RCA because the amount of payment would be less than \$10.
- b. Rescinded IAB 7/30/08, effective 10/1/08.
- c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

**75.1(2)** Rescinded IAB 10/8/97, effective 12/1/97.

**75.1(3)** *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

**75.1(4)** *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

**75.1(5)** *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

**75.1(6)** *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

**75.1(7)** *Persons receiving care in a medical facility who would be eligible under a special income standard.*

- a. Subject to paragraphs “b” and “c” below, Medicaid shall be available to persons who:
  - (1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).
  - (2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

*b.* For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

*c.* Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A “period of 30 days” is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain “under the jurisdiction of the institution” a person must first have been physically admitted to the institution.

**75.1(8)** *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of “essential person” in effect in the public assistance program on December 31, 1973.

**75.1(9)** *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249.

**75.1(10)** *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an adoption assistance agreement for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

*a.* The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

*b.* The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

**75.1(11)** *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

*a.* The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

*b.* Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

- (1) Failure to provide information, or
- (2) Failure to comply with other procedural requirements.

**75.1(12)** *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

**75.1(13)** *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

- a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and
- b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and
- c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

**75.1(14)** *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

- a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed \$2,000 for applicant households or \$5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.
- b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).
- c. Rescinded IAB 11/1/00, effective 1/1/01.

**75.1(15)** *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2) "a," "b," "c," and "d" shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1) "a" but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8) "c" and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

**75.1(16)** *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state currently has an adoption assistance agreement in effect for the child.

d. The state with the adoption assistance agreement:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

**75.1(17)** *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

**75.1(18)** *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

**75.1(19)** *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the \$30 or the \$30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

**75.1(20)** *Newborn children.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Effective April 1, 2009, eligibility begins

with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

**75.1(21)** *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

**75.1(22)** *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

**75.1(23)** *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

**75.1(24)** *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

**75.1(25)** *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

**75.1(26)** Rescinded IAB 10/8/97, effective 12/1/97.

**75.1(27)** *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

**75.1(28)** *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8) "b" and "c," shall be treated in accordance with paragraphs 75.57(9) "b" and "c."

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed \$10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

*f.* An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

*g.* Rescinded IAB 11/1/89, effective 1/1/90.

*h.* When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

*i.* A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

*j.* If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

**75.1(29)** *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

*a.* The person's monthly income does not exceed 100 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(1) The amount of income shall be determined as under the federal Supplemental Security Income (SSI) program.

(2) Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

*b.* The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits. The amount of resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4).

*c.* The effective date of eligibility is the first of the month after the month of decision.

**75.1(30)** *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

*a.* A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.
2. Rural health clinic services (if contained in the state plan).
3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

*b.* The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

*c.* Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

*d.* In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

*e.* Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

*f.* The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

*g.* A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

**75.1(31)** *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, “family” shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. “Family” also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

*a.* Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

*b.* In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

*c.* The 12 months’ Medicaid transitional coverage begins the day following termination of FMAP eligibility.

*d.* When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph “*f*” below apply.

*e.* Rescinded IAB 8/12/98, effective 10/1/98.

*f.* Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

*g.* During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

*h.* If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs “*g*” and “*i*” of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)“*f*” and 75.57(2)“*l*.”

*i.* Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional

six-month period as required in paragraph 75.1(31)“h,” unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. The family offers a good cause beyond the family’s control.
4. There was a failure to receive the department’s notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client’s achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family’s average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

*j.* These provisions apply to specified relatives defined at paragraph 75.55(1)“a,” including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

*k.* The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph “g” or “i” above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

**75.1(32)** *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

*a.* An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

*b.* A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

**75.1(33)** *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

*a.* Qualified disabled and working persons are persons who meet the following requirements:

(1) The person’s monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person’s resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

*b.* The amount of the person’s income and resources shall be determined as under the SSI program.

**75.1(34) Specified low-income Medicare beneficiaries.** Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

*a.* The person's monthly income exceeds 100 percent of the federal poverty level but is less than 120 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

*b.* The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.

*c.* The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

*d.* The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

**75.1(35) Medically needy persons.**

*a. Coverage groups.* Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

*b. Resources and income of all persons considered.*

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35) "b"(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

*c. Resources.*

(1) The resource limit for adults in SSI-related households shall be \$10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

*d. Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9) “b,” “c,” “g,” “h,” and “i” regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months’ net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

*e. Medically needy income level (MNIL).*

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	\$483	\$483	\$566	\$666	\$733	\$816	\$891	\$975	\$1058	\$1158

Each additional person \$116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35) “b” shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months’ MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

*f. Verification of medical expenses to be used in spenddown calculation.* The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the

provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

*g. Spenddown calculation.*

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.
2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.
3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs “1” through “3” above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

*h. Medicaid services.* Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

*i. Reviews.* Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

*j. Redetermination.* When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

*k. Recertifications.* A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

*l. Disability determinations.* An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.
- (3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

**75.1(36) Expanded specified low-income Medicare beneficiaries.** As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

- a. The person is not otherwise eligible for Medicaid.
- b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- c. The person's resources do not exceed the maximum amount of resources that a person may have to obtain the full low-income subsidy for Medicare Part D drug benefits.
- d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.
- e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

**75.1(37) Home health specified low-income Medicare beneficiaries.** Rescinded IAB 10/30/02, effective 1/1/03.

**75.1(38) Continued Medicaid for disabled children from August 22, 1996.** Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

**75.1(39) Working persons with disabilities.**

- a. Medical assistance shall be available to all persons who meet all of the following conditions:
  - (1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.
  - (2) They are less than 65 years of age.
  - (3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards. However, income attributable to a social security cost-of-living adjustment shall be included only in determining eligibility based on a subsequently published federal poverty level.
  - (4) They receive earned income from employment or self-employment or are eligible under paragraph 75.1(39)“c.”
  - (5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to \$10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph 75.1(39)“a”(1) above.
  - (6) They have paid any premium assessed under paragraph 75.1(39)“b” below.
- b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person, except that income attributable to a social

security cost-of-living adjustment shall be included only in determining premium liability based on a subsequently published federal poverty level. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established based on projected average monthly income. The monthly premium established shall not be increased for any reason before the next eligibility review. The premium shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$34
165% of Federal Poverty Level	\$47
180% of Federal Poverty Level	\$56
200% of Federal Poverty Level	\$66
225% of Federal Poverty Level	\$77
250% of Federal Poverty Level	\$89
300% of Federal Poverty Level	\$112
350% of Federal Poverty Level	\$137
400% of Federal Poverty Level	\$161
450% of Federal Poverty Level	\$186
550% of Federal Poverty Level	\$232
650% of Federal Poverty Level	\$280
750% of Federal Poverty Level	\$329
850% of Federal Poverty Level	\$389
1000% of Federal Poverty Level	\$467
1150% of Federal Poverty Level	\$547
1300% of Federal Poverty Level	\$631
1480% of Federal Poverty Level	\$729
1530% of Federal Poverty Level	\$746
1590% of Federal Poverty Level	\$778
1660% of Federal Poverty Level	\$812
1740% of Federal Poverty Level	\$852

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following

month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the full premium must be received by the department on or before the last day of the month following the month the premium is to cover.

(8) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to Form 470-3902, MEPD Billing Statement.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3902, MEPD Billing Statement, shall be used for billing and collection.

c. Members in this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule. Members shall submit Form 470-4856, MEPD Intent to Return to Work, to report on the end of their employment and their intent to return to employment.

d. For purposes of this subrule, the following definitions apply:

"*Assistive technology*" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"*Assistive technology accounts*" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

“*Assistive technology device*” is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

“*Assistive technology service*” means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

“*Family*,” if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, “family” includes the individual’s spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual’s family. An individual living alone or with others not listed above shall be considered to be a family of one.

“*Medical savings account*” means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

“*Retirement account*” means any retirement or pension fund or account, listed in Iowa Code section 627.6(8) “f” as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

**75.1(40)** *People who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph “a” continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph “a” shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or
- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to

need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

**75.1(41)** *Persons eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available as provided in this subrule.

*a. Eligibility.* The following are eligible for assistance under this coverage group if they are not otherwise enrolled in Medicaid (other than IowaCare):

(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 have reached childbearing age, are under 55 years of age, are capable of bearing children but are not pregnant, and have income that does not exceed 305 percent of the federal poverty level, as determined according to paragraph 75.1(41)“c.”

(3) Men who are under 55 years of age, who are capable of fathering children, and who have income that does not exceed 305 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) A person requesting assistance based on subparagraph 75.1(41)“a”(2) or 75.1(41)“a”(3) shall file an application as required in rule 441—76.1(249A).

*c. Determining income eligibility.* The department shall determine the countable income of an applicant applying under subparagraph 75.1(41)“a”(2) or 75.1(41)“a”(3) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in 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 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 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 subrule 75.57(2).

(5) Disregard of changes. A person 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 441—75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

**75.1(43) Medicaid for children with disabilities.** Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

- a. The child is under 19 years of age.
- b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.
- c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.
- d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, the income of all persons included in the child's household shall be determined as provided for SSI-related groups under subrule 75.13(2).

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

**75.1(44) Presumptive eligibility for children.** Medical assistance shall be available to children under the age of 19 who are determined by a qualified entity to be presumptively eligible for medical assistance pursuant to this subrule.

a. *Qualified entity.* A "qualified entity" is an entity described in paragraphs (1) through (10) of the definition of the term at 42 CFR 435.1101, as amended to October 1, 2008, that:

(1) Has been determined by the department to be capable of making presumptive determinations of eligibility, and

(2) Has signed an agreement with the department as a qualified entity.

*b. Application process.* Families requesting assistance for children under this subrule shall apply with a qualified entity using the form specified in 441—paragraph 76.1(1) “f.” The qualified entity shall use the department’s Web-based system to make the presumptive eligibility determination, based on the information provided in the application.

(1) All presumptive eligibility applications shall be forwarded to the department for a full Medicaid or HAWK-I eligibility determination, regardless of the child’s presumptive eligibility status.

(2) The date a valid application was received by the qualified entity establishes the date of application for purposes of determining the effective date of Medicaid or HAWK-I eligibility unless the qualified entity received the application on a weekend or state holiday. Applications received by the qualified entity on a weekend or a state holiday shall be considered to be received on the first business day following the weekend or state holiday.

(3) The qualified entity shall issue Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, to inform the applicant of the decision on the application as soon as possible but no later than within two working days after the date the determination is made.

(4) Timely and adequate notice requirements and appeal rights of the Medicaid program shall not apply to presumptive eligibility decisions made by a qualified entity.

*c. Eligibility requirements.* To be determined presumptively eligible for medical assistance, a child shall meet the following eligibility requirements.

(1) Age. The child must be under the age of 19.

(2) Household income. Household income must be less than 300 percent of the federal poverty level for a household of the same size. For this purpose, the household shall include the applicant child and any sibling (of whole or half blood, or adoptive), spouse, parent, or stepparent living with the applicant child. This determination shall be based on the household’s gross income, with no deductions, diversions, or disregards.

(3) Citizenship or qualified alien status. The child must be a citizen of the United States or a qualified alien as defined in subrule 75.11(2).

(4) Iowa residency. The child must be a resident of Iowa.

(5) Prior presumptive eligibility. A child shall not be determined presumptively eligible more than once in a 12-month period. The first month of the 12-month period begins with the month the application is received by the qualified entity.

*d. Period of presumptive eligibility.* Presumptive eligibility shall begin with the date that presumptive eligibility is determined and shall continue until the earliest of the following dates:

(1) The last day of the next calendar month;

(2) The day the child is determined eligible for Medicaid;

(3) The last day of the month that the child is determined eligible for HAWK-I; or

(4) The day the child is determined ineligible for Medicaid and HAWK-I. Withdrawal of the Medicaid or HAWK-I application before eligibility is determined shall not affect the child’s eligibility during the presumptive period.

*e. Services covered.* Children determined presumptively eligible under this subrule shall be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services. Payment of claims for Medicaid services provided to a child during the presumptive eligibility period, including EPSDT services, is not dependent upon a determination of Medicaid or HAWK-I eligibility by the department.

**75.1(45) Medicaid for former foster care youth.** Effective January 1, 2014, medical assistance shall be available to a person who meets all of the following conditions:

*a.* The person is at least 18 years of age (or such higher age to which foster care is provided to the person) and under 26 years of age;

*b.* The person is not described in or enrolled under any of Subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Social Security Act or is described in any of such subclauses but

has income that exceeds the level of income applicable under Iowa's state Medicaid plan for eligibility to enroll for medical assistance under such subclause;

*c.* The person was in foster care under the responsibility of Iowa on the date of attaining 18 years of age or such higher age to which foster care is provided; and

*d.* The person was enrolled in the Iowa Medicaid program under Title XIX of the Social Security Act while in such foster care.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6. [ARC 7741B, IAB 5/6/09, effective 7/1/09; ARC 7833B, IAB 6/3/09, effective 8/1/09; ARC 7929B, IAB 7/1/09, effective 7/1/09; ARC 7931B, IAB 7/1/09, effective 7/1/09; ARC 8095B, IAB 9/9/09, effective 10/14/09; ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8261B, IAB 11/4/09, effective 10/15/09; ARC 8439B, IAB 1/13/10, effective 3/1/10; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8713B, IAB 5/5/10, effective 8/1/10; ARC 8897B, IAB 6/30/10, effective 9/1/10; ARC 9581B, IAB 6/29/11, effective 8/3/11; ARC 9647B, IAB 8/10/11, effective 8/1/11; ARC 9956B, IAB 1/11/12, effective 1/1/12; ARC 0149C, IAB 6/13/12, effective 8/1/12; ARC 0579C, IAB 2/6/13, effective 4/1/13; ARC 0820C, IAB 7/10/13, effective 8/1/13; ARC 0990C, IAB 9/4/13, effective 1/1/14; ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 1482C, IAB 6/11/14, effective 8/1/14; ARC 2029C, IAB 6/10/15, effective 8/1/15; ARC 2557C, IAB 6/8/16, effective 8/1/16; ARC 3094C, IAB 6/7/17, effective 8/1/17]

**441—75.2(249A) Medical resources.** Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

**75.2(1)** The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

*a.* Persons who have been approved by the Social Security Administration for Supplemental Security Income shall complete Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information, and return it to the department.

*b.* Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-0364, 470-0364(M), 470-0364(MS), or 470-0364(S), SSI Medicaid Information.

**75.2(2)** As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

*a.* Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

*b.* Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

- (1) File a claim or submit an application for any reasonably available medical resource, and
- (2) Cooperate in the processing of the claim or application.

*c.* Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

**75.2(3)** Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

- a.* Physical or emotional harm to the member for whom medical resources are being sought.
- b.* Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

**75.2(4)** Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

*a.* The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

*b.* When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.  
[ARC 7546B, IAB 2/11/09, effective 4/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 8785B, IAB 6/2/10, effective 8/1/10]

**441—75.3(249A) Acceptance of other financial benefits.** An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

**75.3(1)** When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

**75.3(2)** The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

**75.3(3)** When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

**75.3(4)** The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—75.4(249A) Medical assistance lien.**

**75.4(1)** When the medical assistance program pays for a member's medical care or expenses, the department shall have a lien upon all monetary claims which the member may have against third parties for those expenses. Monetary claims shall include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien shall be to the extent of the medical assistance payments only.

*a.* A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

*b.* The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

*c.* All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

**75.4(2)** The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

**75.4(3)** In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

*a.* The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

*b.* Rescinded IAB 9/4/91, effective 11/1/91.

*c.* The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

*d.* The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

*e.* When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning

the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

*f.* The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

**75.4(4)** Third party and provider responsibilities.

*a.* The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

*b.* The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

*c.* An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

**75.4(5)** Department's lien.

*a.* The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

*b.* When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

*c.* When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

*d.* The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

**75.4(6)** For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

**75.4(7)** The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.  
[ARC 9696B, IAB 9/7/11, effective 9/1/11; ARC 9881B, IAB 11/30/11, effective 1/4/12]

**441—75.5(249A) Determination of countable income and resources for persons in a medical institution.** In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

**75.5(1)** Determining income from property.

*a. Nontrust property.* Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

*b. Trust property.* Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

**75.5(2)** Division of income between married people for SSI-related coverage groups.

*a. Institutionalized spouse and community spouse.* If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

*b. Spouses institutionalized and living together.* Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

*c. Spouses institutionalized and living apart.* Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

**75.5(3)** Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

*a. When determined.* The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

*b. Information required.* The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

*c. Resources considered.* The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)“a” live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is \$1500 or less per spouse.

(10) An amount, not in excess of \$1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of \$1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

*d. Method of attribution.* The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than \$24,000, then \$24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to

the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

*e. Notice and appeal rights.* The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

- (1) That the attribution is incorrect, or
- (2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

*f. Appeals.* Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2) "d" shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3) "f"(5).

**75.5(4) Consideration of resources of married people.**

*a.* One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

*b.* One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

*c.* Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

*d.* Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

**75.5(5)** Consideration of resources for persons in a medical institution who have purchased and used a qualified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules in 191—Chapter 39 or 72.

*a. Eligibility.* A person may be eligible for medical assistance under this subrule if:

(1) The person is the beneficiary of a qualified long-term care insurance policy or is enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 39 or 72; and

(2) The person is eligible for medical assistance under 75.1(6), 75.1(7), or 75.1(18) except for excess resources; and

(3) The excess resources causing ineligibility under the listed coverage groups do not exceed the “asset adjustment” provided in this subrule.

*b. Definition.* “Asset adjustment” shall mean a \$1 disregard of resources for each \$1 that has been paid out under the person’s qualified or approved long-term care insurance policy.

*c. Estate recovery.* An amount equal to the benefits paid out under a member’s qualified or approved long-term care insurance policy will be exempt from recovery from the estate of the member or the member’s spouse for payments made by the medical assistance program on behalf of the member.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4, and 249A.35 and chapter 514H.

[ARC 8443B, IAB 1/13/10, effective 3/1/10]

**441—75.6(249A) Entrance fee for continuing care retirement community or life care community.** When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual’s Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual’s other resources or income be insufficient to pay for such care;

2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and

3. The entrance fee does not confer an ownership interest in the community.

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

**441—75.7(249A) Furnishing of social security number.**

**75.7(1)** As a condition of eligibility, except as provided by subrule 75.7(2), all social security numbers issued to each individual (including children) for whom Medicaid is sought must be furnished to the department.

**75.7(2)** The requirement of subrule 75.7(1) does not apply to an individual who:

*a.* Is not eligible to receive a social security number;

*b.* Does not have a social security number and may only be issued a social security number for a valid nonwork reason in accordance with 20 CFR § 422.104; or

*c.* Refuses to obtain a social security number because of a well-established religious objection. For this purpose, a well-established religious objection means that the individual:

(1) Is a member of a recognized religious sect or division of the sect; and

(2) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

**75.7(3)** If a social security number has not been issued or is not known, the individual seeking Medicaid must cooperate with the department in applying for a social security number with the Social Security Administration or in requesting the Social Security Administration to furnish the number.

[ARC 1134C, IAB 10/30/13, effective 10/2/13]

**441—75.8(249A) Medical assistance corrective payments.** If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage

began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

**75.8(1)** These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

**75.8(2)** Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

**75.8(3)** If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

**75.8(4)** Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

**75.8(5)** Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

#### **441—75.9(249A) Treatment of Medicaid qualifying trusts.**

**75.9(1)** A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

**75.9(2)** The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

*a.* Trust income considered available shall be counted as income.

*b.* Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

*c.* To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

**441—75.10(249A) Residency requirements.** Residency in Iowa is a condition of eligibility for medical assistance.

#### **75.10(1) Definitions.**

*a. Institutions.* For purposes of this rule, “institution” means an “institution” or a “medical institution” as those terms are defined in 42 CFR § 435.1010 as amended to July 13, 2007. For purposes of state placement, “institution” also includes foster care homes licensed as set forth in 45 CFR § 1355.20 as amended to January 6, 2012, and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

*b. Incapable of expressing intent regarding residency.* For purposes of this rule, an individual is considered to be “incapable of indicating intent regarding residency” if the individual:

1. Has an IQ of 49 or less or has a mental age of seven or less;
2. Has been judged legally incompetent; or

3. Has been determined to be incapable of indicating intent regarding residency by a physician, psychologist or other person licensed by the state in the field of intellectual disability.

**75.10(2) Determination of residency.** State residency is determined according to the following criteria. If more than one criterion applies, the applicable criterion listed first determines the individual's residency:

*a.* Cases of disputed residency. If two or more states do not agree on an individual's state of residence, the state where the individual is physically located is the state of residence.

*b.* Temporary absence from state of residence. An individual who was a resident of a state pursuant to the other criteria of this rule, who is temporarily absent from that state, and who intends to return to that state when the purpose of the absence has been accomplished remains a resident of that state during the absence, unless another state has determined that the person is a resident there for Medicaid purposes.

*c.* Individuals placed by a state in an out-of-state institution. If any agency of a state, including an entity recognized under state law as being under contract with the state for such purposes, arranges for an individual to be placed in an institution located in another state, the state arranging or actually making the placement is considered the individual's state of residence during that placement.

(1) Any action beyond providing information to the individual and the individual's family constitutes arranging or making a placement. However, the following actions do not constitute arranging or making a placement:

1. Providing basic information to individuals about another state's Medicaid program and information about the availability of health care services and facilities in another state.

2. Assisting an individual in locating an institution in another state, provided the individual is not incapable of indicating intent regarding residency and independently decides to move.

(2) When a competent individual leaves an out-of-state institution in which the individual was placed by a state, that individual's state of residence is the state where the individual is physically located.

*d.* Individuals receiving a state supplementary assistance payment. Individuals who are receiving a state supplementary assistance payment pursuant to 42 U.S.C. § 1382e (including payments from Iowa pursuant to rules 441—50.1(249) through 441—54.8(249), 441—81.23(249A), 441—82.19(249A), 441—85.47(249A), or 441—177.1(249) through 441—177.11(249)) are considered to be residents of the state paying the supplementary assistance.

*e.* Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care or adoption assistance payments for a child under Title IV-E of the Social Security Act are considered to be residents of the state where the child lives.

*f.* Individuals aged 21 and over who are residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and intends to reside.

*g.* Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency before the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency before the age of 21, the state of residence is:

(1) That of the parent applying for Medicaid on the individual's behalf if the parents reside in separate states (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(3) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(4) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

*h.* Individuals aged 21 and over who are residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21. For an individual aged 21 or over who is residing in an institution and who became incapable of indicating intent regarding residency at or after the age of 21, the state of residence is the state in which the individual is physically present.

*i.* Individuals aged 21 and over who are not residing in an institution and who are incapable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is incapable of indicating intent regarding residency, the state of residence is the state where the individual is living.

*j.* Individuals aged 21 and over who are not residing in an institution and who are capable of indicating intent regarding residency. For an individual aged 21 or over who is not residing in an institution and who is not incapable of indicating intent regarding residency, the state of residence is the state where the individual is living and either:

- (1) Intends to reside, with or without a fixed address; or
- (2) Entered with a job commitment or to seek employment, whether or not currently employed.

*k.* Individuals under the age of 21 who are residing in an institution and who are not married or emancipated. For an individual under the age of 21 who is residing in an institution and who is neither married nor emancipated, the state of residence is:

(1) The parent's or legal guardian's state of residence at the time of placement (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent);

(2) The current state of residence of the parent or legal guardian who files the application if the individual is residing in an institution in that state (if a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of that of the parent); or

(3) The state of residence of the individual or party who files an application if the individual has been abandoned by the individual's parent(s), does not have a legal guardian, and is residing in an institution in that state.

*l.* Individuals under the age of 21 who are capable of indicating intent regarding residency and who are married or emancipated. For an individual under the age of 21 who is not incapable of indicating intent regarding residency and who is married or emancipated from the individual's parent, the state of residence is determined in accordance with paragraph 75.10(2) "j."

*m.* Other individuals under the age of 21. For an individual under the age of 21 who is not described in paragraph 75.10(2) "k" or "l," the state of residence is:

- (1) The state where the individual resides, with or without a fixed address; or
- (2) The state of residency of the parent or caretaker, determined in accordance with paragraph 75.10(2) "j," with whom the individual resides.

This rule is intended to implement Iowa Code section 249A.3.  
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

#### **441—75.11(249A) Citizenship or alienage requirements.**

##### **75.11(1) Definitions.**

*"Care and services necessary for the treatment of an emergency medical condition"* means services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care for an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

*"Emergency medical condition"* means a medical condition of sudden onset (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

“*Federal means-tested program*” means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph “1,” be eligible to have payments made on the child’s behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general’s sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:
  - Deliver in-kind services at the community level, including through public or private nonprofit agencies;
  - Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources; and
  - Are necessary for the protection of life or safety.
8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.
9. Means-tested programs under the Elementary and Secondary Education Act of 1965.
10. Benefits under the Head Start Act.
11. Benefits funded through an employment and training program of the U.S. Department of Labor.

“*Qualified alien*” means an alien:

1. Who is lawfully admitted for permanent residence in the United States under the Immigration and Nationality Act (INA);
2. Who is granted asylum in the United States under Section 208 of the INA;
3. Who is a refugee admitted to the United States under Section 207 of the INA;
4. Who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. Whose deportation from the United States is withheld under Section 243(h) of the INA as in effect before April 1, 1997, or under Section 241(b)(3) of the INA as amended to December 20, 2010;
6. Who is granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. Who is an Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V);
8. Who is a Cuban/Haitian entrant to the United States as described in 8 U.S.C. Section 1641(b)(7);
9. Who is a battered alien as described in 8 U.S.C. Section 1641(c);
10. Who is certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010;
11. Who is an American Indian born in Canada to whom Section 289 of the INA applies or is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e); or
12. Who is under the age of 21 and is lawfully residing in the United States as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

“*Qualifying quarters*” includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II

of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

**75.11(2) Citizenship and alienage.**

*a.* To be eligible for Medicaid, a person must be one of the following:

- (1) A citizen or national of the United States.
- (2) A qualified alien residing in the United States before August 22, 1996.
- (3) A qualified alien under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the Immigration and Nationality Act (INA).
- (5) An alien who has been granted asylum under Section 208 of the INA.
- (6) An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA.
- (7) A qualified alien veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
- (9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.
- (10) A qualified alien who has resided in the United States for a period of at least five years.
- (11) An Amerasian admitted as described in 8 U.S.C. Section 1612(b)(2)(A)(i)(V).
- (12) A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7).
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 20, 2010.
- (14) An American Indian born in Canada to whom Section 289 of the INA applies or who is a member of a federally recognized Indian Tribe as defined in 25 U.S.C. Section 450b(e).
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

*b.* As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship or alien status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or alien status by signing the application form which contains a similar declaration at time of review.

(3) An attestation of citizenship or alien status completed on any one of the following forms shall meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to 441—subrule 76.1(8):

1. Application for Food Assistance, Form 470-0306 or 470-0307 (Spanish);
2. Health and Financial Support Application, Form 470-0462 or 470-0462(S); or
3. Review/Recertification Eligibility Document, Form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS).

*c.* Except as provided in paragraph “*f*,” applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph “*b*” shall present satisfactory documentation of citizenship or nationality as defined in paragraph “*d*,” “*e*,” or “*i*.” A reference to a form in paragraph “*d*” or “*e*” includes any successor form. An applicant or member shall have a reasonable period to obtain and provide required documentation of citizenship or nationality.

(1) For the purposes of this requirement, the “reasonable period” begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2)“*i*”(2) is issued to an applicant or member, whichever is later, and continues for 90 days.

(2) Medicaid shall be approved for new applicants and continue for members not previously required to provide documentation of citizenship or nationality until the end of the reasonable period to obtain and provide required documentation of citizenship or nationality. However, the receipt of Medicaid or HAWK-I benefits pending documentation of citizenship or nationality is limited to one reasonable period of up to 90 days under either program for each individual. An applicant or member who has already received benefits during any portion of a reasonable period shall not be granted coverage for a second reasonable period except as required to protect the confidentiality of an individual who received only limited Medicaid benefits provided pursuant to subrule 75.1(41) during the first period.

(3) Retroactive eligibility pursuant to 441—subrule 76.5(1) is available only after documentation of citizenship or nationality has been provided pursuant to paragraph “d,” “e,” or “i.” The retroactive months are outside the “reasonable period” during which Medicaid coverage may be provided without required documentation of citizenship or nationality.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver’s license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.

(6) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the Secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph “b” is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is assisted by child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is receiving foster care maintenance or adoption assistance payments funded under Part E of Title IV of the federal Social Security Act.

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

(7) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) as the newborn of a Medicaid-eligible mother.

(8) The person is or was eligible for medical assistance pursuant to 42 U.S.C. Section 1397ll(e) as the newborn of a mother eligible for assistance under a State Children's Health Insurance Program (SCHIP) pursuant to Title XXI of the Social Security Act.

g. If no other identity documentation allowed by subparagraph 75.11(2)“e”(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)“e”(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

i. In lieu of a document listed in paragraph “d” or “e,” satisfactory documentation of citizenship or nationality may also be presented pursuant to this paragraph.

(1) Provision of an individual's name, social security number, and date of birth to the department shall constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the Social Security Administration produces a response that substantiates the individual's citizenship.

(2) If submission of the name, social security number, and date of birth to the Social Security Administration does not produce a response that substantiates the individual's citizenship, the department shall issue a written notice to the applicant or member giving the applicant or member 90 days to correct any errors in the name, social security number, or date of birth submitted, to correct any errors in the Social Security Administration's records, or to provide other documentation of citizenship or nationality pursuant to paragraph “d” or “e.”

**75.11(3) Deeming of sponsor's income and resources.**

a. When an alien admitted for lawful permanent residence is sponsored by a person who executed an affidavit of support as described in 8 U.S.C. Section 1631(a)(1) on behalf of the alien, the income

and resources of the alien shall be deemed to include the income and resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount deemed to the sponsored alien shall be the total gross countable income and resources of the sponsor and the sponsor's spouse for the FMAP-related or SSI-related coverage group applicable to the sponsored alien's household as described in 441—75.13(249A) less the following deductions:

(1) For FMAP-related coverage groups: The same income deductions, diversions, and disregards allowed for stepparent cases as described at 75.57(8) "b" and a \$1,500 resource deduction.

(2) For SSI-related coverage groups: The deductions described at 20 CFR 416.1166a and 416.1204, as amended to April 1, 2010.

*b.* An indigent alien is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. An alien shall be considered indigent if the following are true:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

*c.* A battered alien as described in 8 U.S.C. Section 1641(c) is exempt from the deeming of a sponsor's income and resources for 12 months.

*d.* Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title II of the Immigration and Nationality Act.

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with 40 qualifying quarters as defined at subrule 75.11(1).

(3) The sponsored alien or the sponsor dies.

(4) The sponsored alien is a child under age 21.

(5) For SSI-related Medicaid, the sponsored alien becomes blind or disabled as defined under Title XVI of the Social Security Act after admission to the United States as a lawful permanent resident.

(6) For SSI-related Medicaid, three years after the date the sponsored alien was admitted to the United States as a lawful permanent resident.

**75.11(4) Eligibility for payment of emergency medical services.** Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

*a.* The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

*b.* The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7932B, IAB 7/1/09, effective 7/1/09; ARC 8096B, IAB 9/9/09, effective 10/14/09; ARC 8642B, IAB 4/7/10, effective 6/1/10; ARC 8786B, IAB 6/2/10, effective 6/1/10; ARC 9439B, IAB 4/6/11, effective 6/1/11]

**441—75.12(249A) Inmates of public institutions.** A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, "inmate of a public institution" and "public institution" are defined by 42 CFR Section 435.1010 as amended to August 25, 2011.

**75.12(1) Suspension.** Medical assistance shall be suspended, rather than canceled, for the first 12 continuous calendar months that a person is an inmate of a public institution if all of the following conditions are met:

*a.* The department is notified of the person's entry into the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person entered the institution; or

(2) Other verified notice received by the department.

*b.* The person has entered a public institution on or after January 1, 2012, and has been in the public institution for 30 days or more.

*c.* On the date of entry into the public institution, the person was a Medicaid member.

*d.* The person is eligible for medical assistance as an individual except for institutional status.

**75.12(2) Coverage during suspension.** While medical assistance is suspended, payment will be made only for services received while the person is not an inmate of a public institution.

**75.12(3) Reinstatement.** The Medicaid case for an inmate who is released from a public institution while Medicaid is suspended will be reopened without an application if both of the following conditions are met:

*a.* The department is notified of the person's release from the public institution through either:

(1) A monthly report which is provided to the department by the public institution and includes the person's name, date of birth, and social security number and the date the person was released from the institution; or

(2) Other verified notice received by the department.

*b.* All information available to the department indicates that the person is currently eligible for Iowa Medicaid as an individual.

This rule is intended to implement Iowa Code section 249A.3 and 2011 Iowa Acts, Senate File 482, division IX.

[ARC 9957B, IAB 1/11/12, effective 1/1/12]

#### **441—75.13(249A) Categorical relatedness.**

**75.13(1) FMAP-related Medicaid eligibility.** Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

**75.13(2) SSI-related Medicaid.** Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

*a. SSI policy reference.* The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

*b. Income considered.* For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

*c. Trust contributions.* Income that a person contributes to a trust as specified at 75.24(3)“b” shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

*d. Conditional eligibility.* For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

*e. Valuation of life estates and remainder interests.* In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by

multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

**75.13(3)** *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

**441—75.14(249A) Establishing paternity and obtaining support.**

**75.14(1)** As a condition of eligibility, adult Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for themselves and for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when the applicant or member has good cause for refusal to cooperate as defined in subrule 75.14(8).

a. The adult applicant or member shall cooperate in the following:

- (1) Identifying and locating the parent of the child for whom Medicaid is requested.
- (2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.
- (3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.
- (4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the adult applicant or member upon request:

(1) Appearing at the income maintenance unit or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or member that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. Upon request, the adult applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. Upon request, the adult applicant or member shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The child support recovery unit shall make the determination of whether or not the adult applicant or member has cooperated for the purposes of this rule.

**75.14(2)** Failure of an adult applicant or member to cooperate shall result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2) "a," "b," and "c" shall be allowed when otherwise applicable.

**75.14(3)** Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

**75.14(4)** Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

**75.14(5)** Rescinded IAB 6/2/10, effective 8/1/10.

**75.14(6)** Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

**75.14(7)** Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) that require an adult applicant or member to assign any rights to medical support and payments for medical care.

**75.14(8)** Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

*a.* The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought; or
- (2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.
- (3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

*b.* The income maintenance unit shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child was conceived as the result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

*c.* Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

*d.* When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

**75.14(9)** Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

*a.* Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as

an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

*b.* The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or member that good cause for refusal to cooperate may be claimed and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or member will be excused from the cooperation requirement.

(5) Advise the applicant or member that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

*c.* When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or member that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or member that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the income maintenance unit shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or member that the child support recovery unit may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or member that the child support recovery unit may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or member if done without the applicant's or member's participation.

*d.* The applicant or member who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or member shall:

(1) Specify the circumstances that the applicant or member believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

**75.14(10)** Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

*a.* The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the case record.

*b.* The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

*c.* When the income maintenance unit determines that good cause does not exist:

(1) The applicant or member shall be so notified and be afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

*d.* The income maintenance unit shall make a good cause determination based on the corroborative evidence supplied by the applicant or member only after the income maintenance unit has examined the evidence and found that it actually verifies the good cause claim.

*e.* Before making a final determination of good cause for refusing to cooperate, the income maintenance unit shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

*f.* The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

*g.* Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or member has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

*h.* The income maintenance unit shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

**75.14(11) Proof of good cause.** The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

*a.* A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or member with knowledge of the circumstances which provide the basis for the good cause claim.

*b.* When, after examining the corroborative evidence submitted by the applicant or member, the income maintenance unit wishes to request additional corroborative evidence which is needed to permit a good cause determination, the income maintenance unit shall:

- (1) Promptly notify the applicant or member that additional corroborative evidence is needed, and
- (2) Specify the type of document which is needed.

*c.* When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

- (1) Advise the applicant or member how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

*d.* When a claim is based on the applicant's or member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

*e.* The income maintenance unit may further verify the good cause claim when the applicant's or member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

*f.* When it conducts an investigation of a good cause claim, the income maintenance unit shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Before making the necessary contact, notify the applicant or member so the applicant or member may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

**75.14(12)** Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

*a.* The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

*b.* The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

*c.* When the income maintenance unit excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, the income maintenance unit shall notify the applicant or member to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.  
[ARC 8785B, IAB 6/2/10, effective 8/1/10]

**441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity.** Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds \$500,000, the individual shall not be eligible for medical assistance with respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

**75.15(1)** The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest \$1,000.

**75.15(2)** Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

- a. The individual's spouse; or
- b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

**441—75.16(249A) Client participation in payment for medical institution care.** Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

**75.16(1) *Income considered in determining client participation.*** The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. *FMAP-related clients.* The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

- (1) The client has a parent or child at home.
- (2) The family's income is considered together in determining eligibility.

b. *SSI-related clients who are employed.* If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. *SSI-related clients returning home within three months.* If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. *Married couples.*

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. *State supplementary assistance recipients.* The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. *Foster care recipients.* The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

g. *Clients receiving a VA pension.* The amount of \$90 of veteran's pension income shall be exempt from client participation if the client is a veteran or a surviving spouse of a veteran who:

- (1) Receives a reduced pension pursuant to 38 U.S.C. Section 5503(d)(2), or
- (2) Resides at the Iowa Veterans Home and does not have a spouse or minor child.

**75.16(2) *Allowable deductions from income.*** In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. *Ongoing personal needs allowance.* All clients shall retain \$50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client has a trust described in Section 1917(d)(4) of the Social Security Act (including medical assistance income trusts and special needs trusts), a reasonable amount paid or set aside for

necessary expenses of the trust is added to the personal needs allowance. This amount shall not exceed \$10 per month except with court approval.

(2) If the client has earned income, an additional \$65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

*b. Personal needs in the month of entry.*

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

*c. Personal needs in the month of discharge.* The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

*d. Maintenance needs of spouse and other dependents.*

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

*e. Maintenance needs of children (without spouse).* When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

*f. Client's medical expenses.* A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party and were not incurred for long-term care services during the imposition of a transfer of assets penalty period pursuant to rule 441—75.23(249A). This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.  
[ARC 8444B, IAB 1/13/10, effective 3/1/10]

**441—75.17(249A) Verification of pregnancy.** For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

**75.17(1) Multiple pregnancy.** If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

**75.17(2) Cost of examination.** When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

**441—75.18(249A) Continuous eligibility for pregnant women.** A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

**441—75.19(249A) Continuous eligibility for children.** A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

**75.19(1) Exceptions to coverage.** This rule does not apply to the following children:

*a.* Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

*b.* Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

*c.* Children whose medical assistance is state-funded only.

*d.* Children who are eligible only in a retroactive month.

*e.* Children whose citizenship is not verified within the "reasonable period" described at paragraph 75.11(2) "c."

**75.19(2) Duration of coverage.** Coverage under this rule shall extend through the earliest of the following months:

*a.* The month of the household's annual eligibility review;

*b.* The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

**75.19(3) *Assignment of review date.*** Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

[ARC 8786B, IAB 6/2/10, effective 6/1/10]

**441—75.20(249A) Disability requirements for SSI-related Medicaid.**

**75.20(1) *Applicants receiving federal benefits.*** An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

**75.20(2) *Applicants not receiving federal benefits.*** When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

**75.20(3) *Time frames for decisions.*** Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

**75.20(4) *Reviews of disability.*** In connection with any independent determination of disability, the department will determine whether reexamination of the member's disability will be required for periodic eligibility reviews. When a disability review is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2) "b."

**75.20(5)** *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

**75.20(6)** *Disability redeterminations for members who attain age 18.* If a member is eligible based on an independent determination of disability made under the standards applicable to persons under 18 years of age, the department shall redetermine the member's disability after the member attains the age of 18 years. The member's disability shall be redetermined:

- a. Using the standards applicable to persons who are 18 years of age or older, and
- b. Regardless of whether a review of the member's disability would otherwise be due.

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

[ARC 9044B, IAB 9/8/10, effective 11/1/10]

**441—75.21(249A) Health insurance premium payment (HIPP) program.** Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

**75.21(1)** *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

- a. A household member is currently enrolled in the plan; and
- b. The health plan is cost-effective as defined in subrule 75.21(2).

**75.21(2)** *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

- e. Annual administrative expenditures of \$50 per Medicaid member covered under the health plan.
- f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least \$5 per month per household.

**75.21(3) Coverage of non-Medicaid-eligible family members.**

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

**75.21(4) Exceptions to payment.** Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34). Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

k. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

l. The health plan pays secondary to another plan.

m. The only Medicaid members covered by the health plan are currently in foster care.

n. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

**75.21(5) Duplicate policies.** When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

**75.21(6) Discontinuation of premium payments.**

*a.* When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

*b.* When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

*c.* If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

*d.* If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

*e.* If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

**75.21(7) Effective date of premium payment.** The effective date of premium payments for a cost-effective health plan shall be determined as follows:

*a.* Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

*b.* If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

*c.* If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

*d.* In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

*e.* The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

*f.* The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

**75.21(8) Method of premium payment.** Payments of premiums will be made directly to the insurance carrier except as follows:

*a.* The department may arrange for payment to an employer in order to circumvent a payroll deduction.

*b.* When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

*c.* When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

*d.* Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

*e.* Reimbursements may also be paid by direct deposit to the member's own account in a financial institution or by means of electronic benefits transfer.

**75.21(9) *Payment of claims.*** Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

**75.21(10) *Reviews of cost-effectiveness and eligibility.*** Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

*a.* For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

*b.* For individual health plans, the client shall complete HIPP Private Policy Review, Form 470-3017, for the review.

*c.* Failure of the household to cooperate in the review process shall result in cancellation of premium payment.

*d.* Redeterminations shall be completed whenever:

- (1) A premium rate, deductible, or coinsurance changes,
- (2) A person covered under the policy loses full Medicaid eligibility,
- (3) Changes in employment or hours of employment affect the availability of health insurance,
- (4) The insurance carrier changes,
- (5) The policyholder leaves the Medicaid home, or
- (6) There is a decrease in the services covered under the policy.

*e.* The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person.

*f.* If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15) "a," shall be considered if available and cost-effective.

*g.* When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

**75.21(11) *Time frames for determining cost-effectiveness.*** The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

**75.21(12) *Notices.***

*a.* An adequate notice shall be provided to the household under the following circumstances:

- (1) To inform the household of the initial decision on cost-effectiveness and premium payment.
- (2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.
- (3) The health plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

*b.* The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

- (1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

**75.21(13) 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(14) Reinstatement of eligibility.**

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

**75.21(15) Amount of premium paid.**

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(2) and 75.21(3).

**75.21(16) Reporting changes.** Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 8503B, IAB 2/10/10, effective 1/13/10; ARC 1447C, IAB 4/30/14, effective 7/1/14; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—75.22(249A) AIDS/HIV health insurance premium payment program.** For the purposes of this rule, “AIDS” and “HIV” are defined in accordance with Iowa Code section 141A.1.

**75.22(1) Conditions of eligibility.** The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet

a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

*d.* A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

*e.* Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

*f.* Liquid resources shall not exceed \$10,000 per household. The following are examples of countable resources:

- (1) Unobligated cash.
- (2) Bank accounts.
- (3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

*g.* The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

**75.22(2) Application process.**

*a. Application.* Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

*b. Time limit for decision.* Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

*c. Eligible on the day of decision.* No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

*d. Waiting list.* After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

**75.22(3) Presumed eligibility** The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

**75.22(4) Family coverage.** When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

**75.22(5) Method of premium payment.** Premiums shall be paid in accordance with the provisions of subrule 75.21(8).

**75.22(6) Effective date of premium payment.** Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

**75.22(7) Reviews.** The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

**75.22(8) Termination of assistance.** Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

**75.22(9) Notices.**

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

**75.22(10) Confidentiality.** The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

**441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993.** In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

**75.23(1) Ineligibility for services.** When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

*a. Institutionalized individual.* When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or
2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

*b. Noninstitutionalized individual.* When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or
2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

*c. Client participation after period of ineligibility.* Expenses incurred for long-term care services during a transfer of assets penalty period may not be deducted as medical expenses in determining client participation pursuant to subrule 75.16(2).

**75.23(2) Look-back date.**

*a. Transfer before February 8, 2006.* For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

- (1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

*b. Transfer on or after February 8, 2006.* For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

**75.23(3) *Period of ineligibility.*** The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in subrule 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2016, through June 30, 2017, this average statewide cost shall be \$5,809.13 per month or \$191.09 per day.

**75.23(4) *Reduction of period of ineligibility.*** The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

**75.23(5) *Exceptions.*** An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

*a.* The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child of the individual who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

*b.* The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a child of the individual who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c or to a trust established solely for the benefit of such a child.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

*c.* A satisfactory showing is made that one of the following is true:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

*d.* The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
2. Household goods.
3. A vehicle required by the client for transportation.
4. Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

**75.23(6) *Assets held in common.*** In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

**75.23(7) *Transfer by spouse.*** In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

**75.23(8) *Definitions.*** In this rule the following definitions apply:

*"Assets"* shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

*"Income"* shall be defined by 42 U.S.C. Section 1382a.

*"Institutionalized individual"* shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

*"Resources"* shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

*"Transfer or disposal of assets"* means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2) "b"(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11) "c");
5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11) "d"); or
6. Transferring or disclaiming the right to income not yet received.

**75.23(9) *Purchase of annuities.*** Funds used to purchase an annuity for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of when the annuity was purchased or whether the conditions described in this subrule were met.

*a.* The entire amount used to purchase an annuity on or after February 8, 2006, with a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in paragraph 75.23(9)“*b*” and also meets the condition described in paragraph 75.23(9)“*c*.”

*b.* To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)“*a*” must meet one of the following conditions:

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

*c.* To be exempted from treatment as an asset transferred at less than fair market value, an annuity described in paragraph 75.23(9)“*a*” must have Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

*d.* The entire amount used to purchase an annuity on or after February 8, 2006, with the spouse of a Medicaid applicant or member as the annuitant shall be treated as assets transferred for less than fair market value unless Iowa is named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant’s spouse, if either is institutionalized. Iowa may be named either:

(1) In the first position; or

(2) In the second position after the spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

**75.23(10)** *Purchase of promissory notes, loans, or mortgages.*

*a.* Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual’s application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

*b.* Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)“a” were met.

**75.23(11) Purchase of life estates.**

a. The entire amount used to purchase a life estate in another individual’s home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual’s home for more than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7834B, IAB 6/3/09, effective 7/8/09; ARC 8444B, IAB 1/13/10, effective 3/1/10; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9404B, IAB 3/9/11, effective 5/1/11; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16]

**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, 2016, to June 30, 2017, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$5,267 per month.
- (2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is \$28,915 per month.
- (3) The average statewide charge to a resident of a mental health institute is \$29,708 per month.
- (4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$7,999 per month.
- (5) The average statewide charge to a home- and community-based waiver applicant or member 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; ARC 8898B, IAB 6/30/10, effective 7/1/10; ARC 9582B, IAB 6/29/11, effective 7/1/11; ARC 0192C, IAB 7/11/12, effective 7/1/12; ARC 0822C, IAB 7/10/13, effective 7/1/13; ARC 0821C, IAB 7/10/13, effective 7/1/13; ARC 1484C, IAB 6/11/14, effective 7/1/14; ARC 1483C, IAB 6/11/14, effective 7/1/14; ARC 2027C, IAB 6/10/15, effective 7/1/15; ARC 2605C, IAB 7/6/16, effective 7/1/16]

**441—75.25(249A) Definitions.** Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“*Aged*” shall mean a person 65 years of age or older.

“*Applicant*” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person’s own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Blind*” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“*Break in assistance*” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“*Central office*” shall mean the state administrative office of the department of human services.

“*Certification period*” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“*Client*” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*CMAP-related medically needy*” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“*Community spouse*” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Conditionally eligible*” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“*Coverage group*” shall mean a group of persons who meet certain common eligibility requirements.

“*Department*” shall mean the Iowa department of human services.

“*Disabled*” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“*FMAP-related medically needy*” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“*Health insurance*” shall mean protection which provides payment of benefits for covered sickness or injury.

“*Incurred medical expenses*” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“*Institutionalized person*” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“*Institutionalized spouse*” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“*Local office*” shall mean the county office of the department of human services or the mental health institute or hospital school.

“*Medically needy income level (MNIL)*” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“*Member*” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“*Necessary medical and remedial services*” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

“*Noncovered Medicaid services*” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

“*Nursing facility services*” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“*Obligated medical expense*” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“*Ongoing eligibility*” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“*Pay and chase*” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“*Payee*” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“*Recertification*” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“*Recipient*” shall mean a person who is receiving assistance including receiving assistance for another person.

“*Responsible relative*” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“*Retroactive certification period*” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“*Retroactive period*” shall mean the three calendar months immediately preceding the month in which an application is filed.

“*Spenddown*” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“*SSI-related*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“*SSI-related medically needy*” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“*Supply*” shall mean the requested information is received by the department by the specified due date.

“*Transfer of assets*” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“*Unborn child*” shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[ARC 7935B, IAB 7/1/09, effective 9/1/09; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—75.26(249A) References to the family investment program.** Rescinded IAB 10/8/97, effective 12/1/97.

**441—75.27(249A) AIDS/HIV settlement payments.** The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

**75.27(1) Class settlement payments.** Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

**75.27(2) Other settlement payments.** Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

**441—75.28(249A) Recovery.**

**75.28(1) Definitions.**

“*Administrative overpayment*” means medical assistance incorrectly paid to or for the client because of continuing assistance during the appeal process or allowing a deduction for the Medicare Part B premium in determining client participation while the department arranges to pay the Medicare premium directly.

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

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

“*Client*” means a current or former Medicaid member.

“*Client error*” means medical assistance incorrectly paid to or for the client because the client or client’s representative failed to disclose information, or gave false or misleading statements, oral or written, regarding the client’s income, resources, or other eligibility and benefit factors. “*Client error*” also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report as defined in rule 441—76.15(249A).

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

“*Premiums paid for medical assistance*” means monthly premiums assessed to a member or household for Medicaid, IowaCare or the Iowa Health and Wellness Plan coverage.

**75.28(2) Amount subject to recovery.** The department shall recover from a client all Medicaid funds incorrectly expended to or on behalf of the client and all unpaid premiums assessed by the department for medical assistance. The incorrect expenditures or unpaid premiums may result from client or agency error or administrative overpayment.

**75.28(3) Notification.** All clients shall be promptly notified on Form 470-2891, Notice of Medical Assistance Overpayment, when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

*a.* Notification of incorrect expenditures shall include:

- (1) For whom assistance was paid;
- (2) The period during which assistance was incorrectly paid;
- (3) The amount of assistance subject to recovery; and
- (4) The reason for the incorrect expenditure.

*b.* Notification of unpaid premiums shall include:

- (1) The amount of the premium; and
- (2) The month covered by the medical assistance premium.

**75.28(4) Source of recovery.** Recovery shall be made from the client or from parents of children under the age of 21 when the parents completed the application and had responsibility for reporting changes. Recovery may come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

**75.28(5) Repayment.** The repayment of incorrectly expended Medicaid funds shall be made to the department. However, repayment of funds incorrectly paid to a nursing facility, a Medicare-certified skilled nursing facility, a psychiatric medical institution for children, an intermediate care facility for persons with an intellectual disability, or mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department shall then recover the funds from the facility through a vendor adjustment.

**75.28(6) Appeals.** The client shall have the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 7.

**75.28(7) Estate recovery.** Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section 249A.53(2) "d." The classification of the debt is defined at Iowa Code section 633.425(7).

*a. Definitions.*

*"Capitated payment/rate"* means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

*"Estate."* For the purpose of this subrule, the "estate" of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

*"Managed care organization"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

*b. Debt due for member 55 years of age or older.* Receipt of medical assistance when a member is 55 years of age or older creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994.

*c. Debt due for member under the age of 55 in a medical institution.*

(1) Receipt of medical assistance creates a debt due to the department from the member's estate upon the member's death for all medical assistance provided on the member's behalf on or after July 1, 1994, when the member:

1. Is under the age of 55; and
2. Is a resident of a nursing facility, an intermediate care facility for persons with an intellectual disability, or a mental health institute; and

3. Cannot reasonably be expected to be discharged and return home.

(2) If the member is discharged from the facility and returns home before staying six consecutive months, no debt will be assessed for medical assistance payments made on the member's behalf for the time in the institution.

(3) If the member remains in the facility for six consecutive months or longer or dies before staying six consecutive months, the department shall presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due shall be established. The department shall notify the member of the presumption and the establishment of a debt due.

*d. Request for a determination of ability to return home.* Upon receipt of a notice of the establishment of a debt due based on the presumption that the member cannot return home, the member or someone acting on the member's behalf may request that the department determine whether the member can or could reasonably have been expected to return home.

(1) When a written request is made within 30 days of the notice that a debt due will be established, no debt due shall be established until the department has made a decision on the member's ability to return home. If the determination is that there is or was no ability to return home, a debt due shall be established for all medical assistance as of the date of entry into the institution.

(2) When a written request is made more than 30 days after the notice that a debt due will be established, a debt due will be established for medical assistance provided before the request even if the determination is that the member can or could have returned home.

*e. Determination of ability to return home.* When the member or someone acting on the member's behalf requests that the department determine if the member can or could have returned home, the determination shall be made by the Iowa Medicaid enterprise (IME) medical services unit.

(1) The IME medical services unit cannot make a determination until the member has been in an institution at least six months or after the death of the member, whichever is earlier. The IME medical services unit will notify the member or the member's representative and the department of the determination.

(2) If the determination is that the member can or could return home, the IME medical services unit shall establish the date the return is expected or could have been expected to occur.

(3) If the determination is that the member cannot or could not return home, a debt due will be established unless the member or the member's representative asks for a reconsideration of the decision. The IME medical services unit will notify the member or the member's representative and the department of the reconsideration decision.

(4) If the reconsideration decision is that the member cannot or could not return home, a debt due will be established against the member unless the decision is appealed pursuant to 441—Chapter 7. The appeal decision will determine the final outcome for the establishment of a debt due and the period when the debt is established.

*f. Debt collection.*

(1) A nursing facility participating in the medical assistance program shall notify the IME revenue collection unit upon the death of a member residing in the facility by submitting Form 470-4331, Estate Recovery Program Nursing Home Referral.

(2) Upon receipt of Form 470-4331 or a report of a member's death through other means, the IME revenue collection unit will use Form 470-4339, Medical Assistance Debt Response, to request a statement of the member's assets from the member's personal representative. The representative shall sign and return Form 470-4339 indicating whether assets remain and, if so, what the assets are and what higher priority expenses exist. EXCEPTION: The procedures in this subparagraph are not necessary when a probate estate has been opened, because probate procedures provide for an inventory, an accounting, and a final report of the estate.

*g. Waiving the collection of the debt.*

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. Reduction in the amount received from the member's estate by a surviving spouse or by a surviving child who is under the age of 21, blind, or permanently and totally disabled at the time of the member's death.

2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, "income" and "resources" shall be defined as being under the family investment program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section 249A.53(2).

(3) The department shall determine whether undue hardship exists on a case-by-case basis. Appeals of adverse decisions regarding an undue hardship determination may be filed in accordance with 441—Chapter 7.

*h. Amount waived.* If collection of all or part of a debt is waived pursuant to paragraph 75.28(7) “g,” to the extent that the person received the member’s estate, the amount waived shall be a debt due from the following:

- (1) The estate of the member’s surviving spouse, upon the death of the spouse.
- (2) The estate of the member’s surviving child who is blind or has a disability, upon the death of the child.
- (3) A surviving child who was under 21 years of age at the time of the member’s death, when the child reaches the age of 21.
- (4) The estate of a surviving child who was under 21 years of age at the time of the member’s death, if the child dies before reaching the age of 21.
- (5) The hardship waiver recipient, when the hardship no longer exists.
- (6) The estate of the recipient of the undue hardship waiver, at the time of death of the hardship waiver recipient.

*i. Impact of asset disregard on debt due.* The estate of a member who is eligible for medical assistance under subrule 75.5(5) shall not be subject to a claim for medical assistance paid on the member’s behalf up to the amount of the assets disregarded by asset disregard. Medical assistance paid on behalf of the member before these conditions shall be recovered from the estate, regardless of the member’s having purchased precertified or approved insurance.

*j. Interest on debt.* Interest shall accrue on a debt due under this subrule at the rate provided pursuant to Iowa Code section 535.3, beginning six months after the death of a Medicaid member, the surviving spouse, or the surviving child, or upon the child’s reaching the age of 21.

*k. Reimbursement to county.* If a county reimburses the department for medical assistance provided under this subrule and the amount of medical assistance is subsequently repaid through a medical assistance income trust or a medical assistance special needs trust as defined in Iowa Code chapter 633C, the department shall reimburse the county on a proportionate basis.  
[ARC 1134C, IAB 10/30/13, effective 10/2/13; ARC 2361C, IAB 1/6/16, effective 1/1/16]

**441—75.29(249A) Investigation by quality control or the department of inspections and appeals.** An applicant or member shall cooperate with the department when the applicant’s or member’s case is selected by quality control or the department of inspections and appeals for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect medical assistance eligibility. (See department of inspections and appeals rules in 481—Chapter 72.) Failure to cooperate shall serve as a basis for denial of an application or cancellation of medical assistance unless the Medicaid eligibility is determined by the Social Security Administration. Once a person’s eligibility is denied or canceled for failure to cooperate, the person may reapply but shall not be determined eligible until cooperation occurs.  
[ARC 1134C, IAB 10/30/13, effective 10/2/13]

**441—75.30(249A) Member lock-in.** Rescinded ARC 2361C, IAB 1/6/16, effective 1/1/16.

**441—75.31 to 75.49** Reserved.

DIVISION II  
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO  
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

**441—75.50(249A) Definitions.** The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

“*Applicant*” shall mean a person who is requesting assistance on the person’s own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“*Application period*” means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

“*Assistance unit*” includes any person whose income is considered when determining eligibility.

“*Bona fide offer*” means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

“*Central office*” shall mean the state administrative office of the department of human services.

“*Change in income*” means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

“*Change in work expenses*” means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

“*Department*” shall mean the Iowa department of human services.

“*Dependent*” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“*Dependent child*” or “*dependent children*” means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

“*Income in-kind*” is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

“*Initial two months*” means the first two consecutive months for which eligibility is granted.

“*Medical institution,*” when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

“*Needy specified relative*” means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

“*Nonrecurring lump sum unearned income*” means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers’ compensation.

“*Parent*” means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

“*Prospective budgeting*” means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

“*Recipient*” means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

“*Schedule of needs*” means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

“*Stepparent*” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent by ceremonial or common-law marriage.

“*Unborn child*” shall include an unborn child during the entire term of the pregnancy.

“*Uniformed service*” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

**441—75.51(249A) Reinstatement of eligibility.** Rescinded IAB 2/10/10, effective 3/1/10.

**441—75.52(249A) Continuing eligibility.**

**75.52(1) Reviews.** Eligibility factors shall be reviewed at least annually for the FMAP-related programs. Reviews shall be conducted using information contained in and verification supplied with the review form specified in subrule 75.52(3).

**75.52(2) Additional reviews.** A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member’s circumstances comes to the attention of a staff member.

**75.52(3) Forms.**

a. Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-2881(S), or 470-2881(MS), Review/Recertification Eligibility Document (RRED), with the following exceptions:

(1) When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the annual review.

(2) Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

b. The department shall supply the review form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the review form is issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the following month.

(2) When the review form is not issued in the department’s regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date the form is mailed by the department.

(3) A copy of a review form received by fax or electronically shall have the same effect as an original form.

c. The review information for foster children or children in subsidized adoption or subsidized guardianship shall be submitted on Form 470-2914, Foster Care, Adoption, and Guardianship Medicaid Review.

**75.52(4) Client responsibilities.** For the purposes of this subrule, “clients” shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete the required review form when requested by the department in accordance with subrule 75.52(3). If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1) “f” and 75.57(2) “l.”

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) A stepparent recovering from an incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

- (8) Receipt of a social security number.
  - (9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)“b.”
  - (10) Health insurance premiums or coverage.
  - d. All clients shall timely report any change in the following circumstances at any time:
    - (1) Members of the household.
    - (2) Change of mailing or living address.
    - (3) Sources of income.
    - (4) Health insurance premiums or coverage.
  - e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.
  - f. A report shall be considered timely when made within ten days from the date:
    - (1) A person enters or leaves the household.
    - (2) The mailing or living address changes.
    - (3) A source of income changes.
    - (4) A health insurance premium or coverage change is effective.
    - (5) Of any change in income.
    - (6) Of any change in care expenses.
  - g. When a change is not reported as required in paragraphs 75.52(4)“c” through “e,” any excess Medicaid paid shall be subject to recovery.
  - h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)“c” through “e.”
- 75.52(5) Effective date.** After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.
- a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).
  - b. Rescinded IAB 10/4/00, effective 10/1/00.
  - c. When an individual included in the eligible group becomes ineligible, that individual’s Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).
- [ARC 8260B, IAB 11/4/09, effective 1/1/10; ARC 8500B, IAB 2/10/10, effective 3/1/10]

**441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups.** Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

**75.53(1) Definition of resident.** A resident of Iowa is one:

- a. Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or
- b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

**75.53(2) Retention of residence.** Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

**75.53(3) Suitability of home.** The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

**75.53(4) *Absence from the home.***

*a.* An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph “*b.*”

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home. “Uniformed service” means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

*b.* The needs of an individual who is temporarily out of the home are included in the eligible group if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician’s statement. Failure to return within one year from the date of entry into the medical institution will result in the individual’s needs being removed from the eligible group.

(2) A child is out of the home to secure education or training as defined in paragraph 75.54(1) “*b*” as long as the child remains a dependent.

(3) A parent or specified relative is temporarily out of the home to secure education or training and was in the eligible group before leaving the home to secure education or training. For this purpose, “education or training” means any academic or vocational training program that prepares a person for a specific professional or vocational area of employment.

(4) An individual is out of the home for reasons other than reasons in subparagraphs 75.53(4) “*b*”(1) through (3) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual’s needs being removed from the eligible group.

[ARC 0579C, IAB 2/6/13, effective 4/1/13]

**441—75.54(249A) Eligibility factors specific to child.**

**75.54(1) *Age.*** Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

*a.* A child is eligible for the entire month in which the child’s eighteenth birthday occurs, unless the birthday falls on the first day of the month.

*b.* Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child’s education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

**75.54(2) *Residing with a relative.*** The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

*a.* Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

*b.* Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

**75.54(3)** *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

**75.54(4)** *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

**441—75.55(249A) Eligibility factors specific to specified relatives.**

**75.55(1)** *Specified relationship.*

*a.* A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

*b.* A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

**75.55(2)** *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

*a.* When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts may be made by the child support recovery unit.

*b.* When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the department shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

[ARC 8785B, IAB 6/2/10, effective 8/1/10]

**441—75.56(249A) Resources.**

**75.56(1)** *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

*a.* A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined

purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1) "n" or "o," the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of \$3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of \$3,000 shall be counted toward the resource limit in paragraph 75.56(1) "e." When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the \$5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9) "c" reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed \$10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph "e."

o. Nonhomestead property that produces income consistent with the property's fair market value.

**75.56(2) Persons considered.**

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

**75.56(3) Homestead defined.** The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

**75.56(4) Liquidation.** When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1) "d" and 75.57(7) "ag." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

**75.56(5) Net market value defined.** Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

**75.56(6) Availability.**

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or member owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Rescinded IAB 6/30/99, effective 9/1/99.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

d. When the applicant or member owns nonhomestead property, the property shall be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

**75.56(7) Damage judgments and insurance settlements.**

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month

the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

*b.* Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

**75.56(8) Conservatorships.**

*a.* Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

(2) When the department worker questions whether the funds in a conservatorship are available, the worker shall refer the conservatorship to the central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

*b.* Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1) “*e*” and 75.24(2) “*b*.”

**75.56(9) Not considered a resource.** Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

**441—75.57(249A) Income.** When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered.

1. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month’s needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3).

2. The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3).

3. Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1) “*e*,” 75.57(6) “*u*,” and 75.57(7) “*o*.” Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided.

**75.57(1) Unearned income.** Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

*a.* Social security income is the amount of the entitlement before withholding of a Medicare premium.

*b.* Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

*c.* Rescinded IAB 2/11/98, effective 2/1/98.

*d.* When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

*e.* Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

*f.* The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0485(S), 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

**75.57(2) Earned income.** Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing

the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

*a.* Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

*b.* Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)“*b*” and self-supporting parents on underage parent cases as described at paragraph 75.57(8)“*c*” shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed \$175 per month, or \$200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual’s employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense shall be allowed when paid to any person except a parent or legal guardian of the child, another member of the eligible group, or any person whose needs are met by diversion of income from any person in the eligible group.

*c.* Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)“*a*” and “*b*” and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)“*a*”(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

*d.* Rescinded IAB 6/30/99, effective 9/1/99.

*e.* A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person’s own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

*f.* The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

*g.* When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

*h.* In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) \$41 plus an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or \$41 for a roomer, or an amount equivalent to the monthly maximum food assistance program benefit for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

*i.* Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2) "j."

*j.* In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

*k.* Rescinded IAB 6/30/99, effective 9/1/99.

*l.* The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

**75.57(3) Shared living arrangements.** When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

**75.57(4) Diversion of income.**

*a.* Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8) "b."

*b.* Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

**75.57(5) Income of unmarried specified relatives under the age of 19.**

*a.* Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

*b.* Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8) "c."

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

**75.57(6) Exempt as income and resources.** The following shall be exempt as income and resources:

*a.* Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

*b.* The value of the food assistance program benefit.

*c.* The value of the United States Department of Agriculture donated foods (surplus commodities).

*d.* The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

*e.* Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

- f.* Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.
- g.* Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.
- h.* Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.
- i.* Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.
- j.* Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.
- k.* Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.
- l.* Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.
- m.* The income of a supplemental security income recipient.
- n.* Income of an ineligible child.
- o.* Income in-kind.
- p.* Family support subsidy program payments.
- q.* Grants obtained and used under conditions that preclude their use for current living costs.
- r.* All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.
- s.* Subsidized guardianship program payments.
- t.* Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.
- u.* The first \$50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed \$50 per month per eligible group.
- v.* Bona fide loans. Evidence of a bona fide loan may include any of the following:
  - (1) The loan is obtained from an institution or person engaged in the business of making loans.
  - (2) There is a written agreement to repay the money within a specified time.
  - (3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.
- w.* Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).
- x.* The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.
- y.* Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.
- z.* Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

*aa.* Payments received from the Radiation Exposure Compensation Act.

*ab.* Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2) "a," "b," and "c" shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

**75.57(7) Exempt as income.** The following are exempt as income.

- a.* Reimbursements from a third party.
- b.* Reimbursement from the employer for a job-related expense.
- c.* The following nonrecurring lump sum payments:
  - (1) Income tax refund.
  - (2) Retroactive supplemental security income benefits.
  - (3) Settlements for the payment of medical expenses.
  - (4) Refunds of security deposits on rental property or utilities.
  - (5) That part of a lump sum received and expended for funeral and burial expenses.
  - (6) That part of a lump sum both received and expended for the repair or replacement of resources.
- d.* Payments received by the family for providing foster care when the family is operating a licensed foster home.
- e.* A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.
 

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.
- f.* Federal or state earned income tax credit.
- g.* Supplementation from county funds, providing:
  - (1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or
  - (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.
- h.* Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.
- i.* A retroactive corrective family investment program (FIP) payment.
- j.* The training allowance issued by the division of vocational rehabilitation, department of education.
- k.* Payments from the PROMISE JOBS program.
- l.* The training allowance issued by the department for the blind.
- m.* Payments from passengers in a car pool.
- n.* Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.
- o.* Rescinded IAB 10/4/00, effective 10/1/00.
- p.* Rescinded IAB 10/4/00, effective 10/1/00.
- q.* Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.
- r.* Rescinded IAB 10/4/00, effective 10/1/00.
- s.* Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

*t.* Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

*u.* Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)“*b*”(1) and (2). The exemption applies through the entire month of the person’s twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

*v.* Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)“*c*” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

*w.* Incentive payments received from participation in the adolescent pregnancy prevention programs.

*x.* Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

*y.* Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

*z.* Interest and dividend income.

*aa.* Rescinded IAB 10/4/00, effective 10/1/00.

*ab.* Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

*ac.* Income that an individual contributes to a trust as specified at paragraph 75.24(3)“*b*” shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

*ad.* Benefits paid to the eligible household under the family investment program (FIP).

*ae.* Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

*af.* Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than \$1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the \$1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than \$1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

*ag.* Payments from property sold under an installment contract as specified in paragraphs 75.56(4) "b" and 75.57(1) "d."

*ah.* All census earnings received by temporary workers from the Bureau of the Census.

*ai.* Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

**75.57(8)** *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

*a. Treatment of income in excluded parent cases.* A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2) "a," "b," and "c," and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

*b. Treatment of income in stepparent cases.* The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2) "b"(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8) "b"(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8) "b"(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9) "a"(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5)

shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)“f.”

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent’s dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

*c. Treatment of income in underage parent cases.* In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent’s own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)“b”(1) through (7). Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the self-supporting parent’s ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)“b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)“b”(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)“b”(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)“b”(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse’s ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

**75.57(9) Budgeting process.**

*a.* Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified

at paragraph 75.57(2)“c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)“c” shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)“d” and “e” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible group pursuant to paragraph 75.52(4)“c” is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

*b.* Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)“i.”

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

*c.* Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)“b” and “c,” shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers’ compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any

income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

*d.* The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2) “*b*,” shall be dropped.

*e.* In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual’s needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

*f.* Rescinded IAB 10/4/00, effective 10/1/00.

*g.* Rescinded IAB 2/11/98, effective 2/1/98.

*h.* Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

*i.* Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual’s annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income

shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

**75.57(10)** *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

**75.57(11)** *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

[**ARC 8500B**, IAB 2/10/10, effective 3/1/10; **ARC 8556B**, IAB 3/10/10, effective 2/10/10; **ARC 9043B**, IAB 9/8/10, effective 11/1/10]

#### **441—75.58(249A) Need standards.**

**75.58(1)** *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

*a.* The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

*b.* The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent

children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

**75.58(2) Schedule of needs.** The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

#### SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

#### CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
- (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

**441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.**

**75.59(1) Exclusions from the eligible group.** In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

**75.59(2) Needs, income, and resource exclusions.** The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

**75.59(3) Medicaid entitlement.** Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

**75.59(4) Situations where parent's needs are excluded.** In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2) "a," "b," and "c."

**75.59(5) Situations where child's needs, income, and resources are excluded.** In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

**441—75.60(249A) Pending SSI approval.** When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

**441—75.61 to 75.69** Reserved.

DIVISION III  
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

**441—75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI).** Notwithstanding any other provision of this chapter, effective January 1, 2014, financial eligibility for medical assistance shall be determined using "modified adjusted gross income" (MAGI) and "household income" pursuant to 42 U.S.C. § 1396a(e)(14), to the extent required by that section as a condition of federal funding under Title XIX of the Social Security Act. For this purpose, financial eligibility for medical assistance includes any applicable purpose for which a determination of income is required, including the imposition of any premiums or cost sharing. From January 1, 2014, through June 30, 2014, subject to a waiver of the requirements of 42 U.S.C. § 1396a(e)(14) by the federal Centers for Medicare and Medicaid Services, use of MAGI and "household income" shall not be considered to be required by that section for persons otherwise eligible for family planning services under subrule 75.1(41).

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**441—75.71(249A) Income limits.** Notwithstanding any other provision of this chapter, effective January 1, 2014, the following income limits apply to the following coverage groups, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
Family Medical Assistance Program and Child Medical Assistance Program	441—subrule 75.1(14) and 441—subrule 75.1(15); 42 CFR Part 435.110; Title XIX of the Social Security Act, Section 1931	1	\$447
		2	\$716
		3	\$872
		4	\$1,033
		5	\$1,177
		6	\$1,330
		7	\$1,481
		8	\$1,633
		9	\$1,784
		10	\$1,950
			over 10
Mothers and Children, for pregnant women and for infants under one year of age	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		375% of the federal poverty level for the household
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.1(28); 42 CFR Part 435.116; Title XIX of the Social Security Act, Section 1902		167% of the federal poverty level for the household
Medicaid for Independent Young Adults	441—subrule 75.1(42); Title XIX of the Social Security Act, Section 1902(a)(10)(A)(ii)(VII)		254% of the federal poverty level for the household

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CHAPTER 109  
CHILD CARE CENTERS

[Filed as Chapter 108, 2/14/75 and renumbered 7/1/75]

[Prior to 7/1/83, Social Services[770] Ch 109]

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PREAMBLE

The intent of this chapter is to specify minimum requirements for licensed child care centers and preschools and to define those child-caring environments that are governed by the licensing standards. The licensing standards govern licensing procedures, administration, parental participation, personnel, records, health and safety policies, physical facilities, activity programs, and food services.

**441—109.1(237A) Definitions.**

“*Adult*” means a person 18 years of age or older.

“*Child*” means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

“*Child care*” means the care, supervision, or guidance of a child by a person other than the parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis in a place other than the child’s home, but does not include care, supervision, or guidance of a child by any of the following:

1. An instructional program for children attending prekindergarten as defined by the state board of education under Iowa Code section 256.11 or a higher level and are at least four years of age and administered by a public or nonpublic school system accredited by the department of education or the state board of regents or a nonpublic school system which is not accredited by the department of education or the state board of regents.
2. Any of the following church-related programs:
  - An instructional program.
  - A youth program other than a preschool, before or after school child care program, or other child care program.
  - A program providing care to children on church premises while the children’s parents are attending church-related or church-sponsored activities on the church premises.
3. Short-term classes of less than two weeks’ duration held between school terms or during a break within a school term.
4. A child care center for sick children operated as part of a pediatrics unit in a hospital licensed by the department of inspections and appeals pursuant to Iowa Code chapter 135B.
5. A program operated not more than one day per week by volunteers that meets all the following conditions:
  - Not more than 11 children are served per volunteer.
  - The program operates for less than 4 hours during any 24-hour period.
  - The program is provided at no cost to the children’s parent, guardian, or custodian.
6. A program administered by a political subdivision of the state which is primarily for recreational or social purposes and is limited to children who are five years of age or older and attending school.
7. An after-school program continuously offered throughout the school year to children who are at least five years of age and enrolled in school and attend the program intermittently, or a summer-only program for such children. The program must be provided through a nominal membership fee or at no cost.
8. A special activity program which meets less than four hours per day for the sole purpose of the special activity. Special activity programs include but are not limited to music or dance classes, organized athletic or sports programs, recreational classes, scouting programs, and hobby or craft clubs or classes.

9. A nationally accredited camp.
10. A structured program for the purpose of providing therapeutic, rehabilitative, or supervisory services to children under any of the following:
  - A purchase of service or managed care contract with the department.
  - A contract approved by a local decategorization governance board.
  - An arrangement approved by a juvenile court order.
11. Care provided on site to children of parents residing in an emergency, homeless, or domestic violence shelter.
12. A child care facility providing respite care to a licensed foster family home for a period of 24 hours or more to a child who is placed with that licensed foster family home.
13. A program offered to a child whose parent, guardian, or custodian is engaged solely in a recreational or social activity, remains immediately available and accessible on the physical premises on which the child's care is provided, and does not engage in employment while the care is provided. However, if the recreational or social activity is provided in a fitness center or on the premises of a nonprofit organization, the parent, guardian, or custodian of the child may be employed to teach or lead the activity.

*“Child care center”* or *“center”* means a facility providing child day care for seven or more children, except when the facility is registered as a child development home. For the purposes of this chapter, the word *“center”* shall apply to a child care center or preschool, unless otherwise specified.

*“Child care facility”* or *“facility”* means a child care center, a preschool, or a registered child development home.

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

*“Direct responsibility for child care”* means being charged with the care, supervision, or guidance of a child.

*“Extended evening care”* means child care provided by a child care center between the hours of 9 p.m. and 5 a.m.

*“Facility”* means a building or physical plant established for the purpose of providing child day care.

*“Get-well center”* means a facility that cares for a child with an acute illness of short duration for short enrollment periods.

*“Involvement with child care”* means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

*“National Health and Safety Performance Standards”* means the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs produced by the American Public Health Association and the American Academy of Pediatrics with the support of the Maternal and Child Health Bureau, Department of Health and Human Services.

*“Parent”* means parent or legal guardian.

*“Person subject to an evaluation”* means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for licensure or is licensed.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.

*“Preschool”* means a child day care facility which provides care to children aged three through five, for periods of time not exceeding three hours per day. The preschool's program is designed to help the children develop intellectual, social and motor skills, and to extend their interest in and understanding of the world about them.

*“Regulatory fee”* means the amount payable to the department for licensure of a child care center based on the capacity of the center.

“*Requesting entity*” means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can have involvement with child care. The requesting entity must be a child care facility as defined in Iowa Code chapter 237A.

“*Transgression*” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

“*Unrestricted access*” means that a person has contact with a child alone or is directly responsible for child care.

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#### **441—109.2(237A) Licensure procedures.**

##### **109.2(1) *Application for license.***

*a.* Any adult or agency has the right to apply for a license. The application for a license shall be made to the department on a department-provided application for a license to operate a child care center.

*b.* Requested reports including the fire marshal’s report and other information relevant to the licensing determination shall be furnished to the department upon application and renewal. A building owned or leased by a school district or accredited nonpublic school that complies with rules adopted by the state fire marshal for school buildings is considered appropriate for use by a child care facility.

*c.* When a center makes a sufficient application for an initial license, the center may operate for a period of up to 120 calendar days from the date of issuance of the form granting permission to open without a license, pending a final licensing decision. A center has made a sufficient application when it has submitted the following to the department:

- (1) An application for a license.
- (2) An approved fire marshal’s report.
- (3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.
- (4) Information sufficient to determine that the center director meets minimum personnel qualifications.
- (5) The regulatory fee as specified in subrule 109.2(7), and the fee is received by the department’s division of fiscal management.

*d.* Applicants shall be notified of approval or denial of initial applications within 120 days from the date the application is submitted.

(1) If the applicant has been issued a form granting permission to open without a license, the applicant shall be notified of approval or denial within 120 calendar days of the date of issuance of the form.

(2) No full or provisional license shall be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(7).

*e.* The department shall not act on a licensing application for 12 months after an applicant’s child care center license has been denied or revoked.

*f.* When the department has denied or revoked a license, the applicant or person shall be prohibited from involvement with child care unless the department specifically permits involvement through a record check decision.

##### **109.2(2) *License.***

*a.* An applicant showing compliance with center licensing laws and these rules, including department approval of center plans and procedures and submission of the regulatory fee as specified in subrule 109.2(7) to the department by the date due, shall be issued a license for 24 months. In

determining whether or not a center is in compliance with the intent of a licensing standard outlined in this chapter, the department shall make the final decision.

*b.* A new license shall be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

*c.* A new license shall be applied for when another adult or agency assumes ownership or legal responsibility for the center.

**109.2(3) Provisional license.**

*a.* A provisional license may be issued or a previously issued license may be reduced to a provisional license for a period up to one year when the center does not meet all standards imposed by law and these rules.

*b.* A provisional license shall be renewable when written plans giving specific dates for completion to bring the center up to standards are submitted to and approved by the department. A provisional license shall not be reissued for more than two consecutive years when the lack of compliance with the same standards has not been corrected within two years.

*c.* When the center submits documentation or it can otherwise be verified that the center complies with standards imposed by law or these rules, the license shall be upgraded to a full license.

**109.2(4) Denial.** Initial applications or renewals shall be denied when:

*a.* The center does not comply with center licensing laws and these rules in order to qualify for a full or provisional license.

*b.* The center is operating in a manner which the department determines impairs the safety, health, or well-being of children in care.

*c.* A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

*d.* Information provided either orally or in writing to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

*e.* The center is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

*f.* The regulatory fee as specified in subrule 109.2(7) is not received by the department's division of fiscal management by the due date indicated on the child care center licensing fee invoice.

**109.2(5) Revocation and suspension.** A license shall be revoked or suspended if corrective action has not been taken when:

*a.* The center does not comply with center licensing laws or these rules.

*b.* The center is operating in a manner which the department determines impairs the safety, health, or well-being of the children in care.

*c.* A person subject to an evaluation has transgressions that merit prohibition of involvement with child care and of licensure, as determined by the department.

*d.* Information provided to the department or contained in the center's files is shown to have been falsified by the provider or with the provider's knowledge.

*e.* The facility is not able to obtain an approved fire marshal's certificate as prescribed by the state fire marshal or fails to comply in correcting or repairing any deficiencies in the time determined by the fire marshal or the fire marshal determines the facility is not safe for occupancy.

*f.* The regulatory fee as specified in subrule 109.2(7) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

**109.2(6) Adverse actions.**

*a.* Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7.

*b.* An applicant or licensee affected by an adverse action may request a hearing by means of a written request directed to the Department of Human Services, Appeals Section, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The request shall be submitted within 30 days after the date the department mailed the official notice containing the nature of the denial, revocation, or suspension.

*c.* A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license shall be conspicuously posted at the main entrance to the facility where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny, suspend or revoke the license. If the action to deny, suspend, or revoke is upheld, the center shall return the license to the department.

*d.* If the center's license is denied, suspended or revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility provides child care. The center shall cooperate with the department in providing the names and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

**109.2(7) Regulatory fees.** A fee based upon center capacity is due to the department before the issuance of the license in accordance with this subrule.

*a. Fee structure.* The amount of the fee is based on the capacity of the center as indicated below:

<u>Center Capacity</u>	<u>Fee Amount</u>
0 to 20 children	\$50
21 to 50 children	\$75
51 to 100 children	\$100
101 to 150 children	\$125
151 or more children	\$150

*b. Determination of capacity.* The licensing consultant shall determine center capacity by dividing the amount of usable space by the amount of space required per child, as specified in subrule 109.11(1) and subparagraphs 109.11(3) "a"(2) and (3). Upon approval by the department, the final determination of center capacity may include evaluation of other factors that influence capacity, as long as physical space requirements per child as defined in subrule 109.11(1) and subparagraphs 109.11(3) "a"(2) and (3) are maintained.

*c. Notification.* Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee shall sign and provide the child care center licensing fee invoice to the center.

*d. Payment.* The center shall return the child care center licensing fee invoice to the department with the licensing fee payment within 30 calendar days from the date of the licensing consultant's or designee's signature on the invoice. Payment may be in the form of cash, check, money order, or cashier's check.

(1) Payment must be received before the department will issue a full or provisional license.

(2) Regulatory fees are nonrefundable and nontransferable.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 2646C, IAB 8/3/16, effective 10/1/16]

**441—109.3(237A) Inspection and evaluation.** The department shall conduct an on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and shall determine compliance with licensing standards imposed by licensing laws and these rules when a complaint is received.

**109.3(1)** At least one unannounced on-site visit shall be conducted each calendar year.

**109.3(2)** After each visit and complaint, the department shall document whether a center was in compliance with center licensing standards imposed by licensing laws and these rules.

**109.3(3)** The written documentation of the department's conclusion as to whether a center was in compliance with licensing standards for all licensing visits and complaints shall be available to the public. However, the identity of the complainant shall be withheld unless expressly waived by the complainant.

**441—109.4(237A) Administration.**

**109.4(1) Purpose and objectives.** Incorporated and unincorporated centers shall submit a written statement of purpose and objectives. The plan and practices of operation shall be consistent with this statement.

**109.4(2) Required written policies.** The child care center owner, board or director shall:

- a. Develop fee policies and financial agreements for the children served.
- b. Develop and implement policies for enrollment and discharge of children, field trips and non-center activities, transportation, discipline, nutrition, and health and safety policies.
- c. Develop a curriculum or program structure that uses developmentally appropriate practices and an activity program appropriate to the developmental level and needs of the children.
- d. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of 441—Chapter 109 where applicable to staff.

e. Develop and implement a written plan for ongoing training and staff development in compliance with professional growth and development requirements established by the department in rule 441—109.7(237A).

f. Make available for review a copy of the center policies and program to all staff at the time of employment and each parent at the time a child is admitted to the center. A copy of the fee policies and financial agreements shall be provided to each parent at the time a child is admitted to the center.

g. Develop and implement a policy for responding to incidents of biting that includes the following elements.

- (1) An explanation of the center's perspective on biting.
- (2) A description of how the center will respond to individual biting incidents and episodes of ongoing biting.
- (3) A description of how the center will assess the adequacy of caregiver supervision and the context and the environment in which the biting occurred.
- (4) A description of how the center will respond to the individual child or caregiver who was bitten.
- (5) A description of the process for notification of parents of children involved in the incident.
- (6) A description of how the incident will be documented.
- (7) A description of how confidentiality will be protected.
- (8) A description of first-aid procedures that the center will use in response to biting incidents.

h. Develop a policy to ensure that people do not have unauthorized access to children at the center. The policy shall be subject to review for minimum safety standards by the licensing consultant. The policy shall include but is not limited to the following:

(1) The center's criteria for allowing people to be on the property of the facility when children are present.

(2) A description of how center staff will supervise and monitor people who are permitted on the property of the center when children are present, but who have not been cleared for involvement with child care through the formal record check process as outlined in subrule 109.6(6). The description shall include definitions of "supervision" and "monitoring."

(3) A description of how responsibility for supervision and monitoring of people in the center will be delegated to center staff, which includes provisions that address conflicts of interest.

(4) A description of how the policy will be shared with parents, guardians, and custodians of all children who are enrolled at the center.

i. Develop and implement a policy for protection of each child's confidentiality.

**109.4(3) Required postings.**

a. Postings are required for the certificate of license, notice of exposure of children to a communicable disease, and notice of decision to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status. The center's license, reflecting current regulatory status, and all other required postings shall be conspicuously placed at the main entrance to the center. If the center is located in a building used for additional purposes and shares the main entrance to the building, the required postings shall be conspicuously placed in the center in an area that is frequented daily by parents or the public.

b. Postings are required for mandatory reporter requirements, the notice of availability of the handbook required in subrule 109.4(5), and the program activities and shall be placed in an area that is frequented daily by parents or the public.

**109.4(4) *Mandatory reporters.*** Requirements and procedures for mandatory reporting of suspected child abuse as defined in Iowa Code section 232.69 shall be posted where they can be read by staff and parents. Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

**109.4(5) *Handbook.*** A copy of “Child Care Centers and Preschools Licensing Standards and Procedures” shall be available in the child care center, and a notice stating that a copy is available for review upon request from the center director shall be conspicuously posted. The name, office mailing address and telephone number of the child care consultant shall be included in the notice.

**109.4(6) *Certificate of license.*** The child care license shall be posted in a conspicuous place and shall state the particular premises in which child care may be offered and the number of children who may be cared for at any one time. Notwithstanding the requirements in rule 441—109.8(237A), no greater number of children than is authorized by the license shall be cared for at any one time.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 2646C, IAB 8/3/16, effective 10/1/16]

#### **441—109.5(237A) Parental participation.**

**109.5(1) *Unlimited access.*** Parents shall be afforded unlimited access to their children and to the provider caring for their children during the center’s hours of operation or whenever their children are in the care of a provider, unless parental contact is prohibited by court order. The provider shall inform all parents of this policy in writing at the time the child is admitted to the center.

**109.5(2) *Parental evaluation.*** If requested by the department, centers shall assist the department in conducting an annual survey of parents being served by their center. The department shall notify centers of the time frames for distribution and completion of the survey and the procedures for returning the survey to the department. The purpose of the survey shall be to increase parents’ understanding of developmentally appropriate and safe practice, solicit statewide information regarding parental satisfaction with the quality of care being provided to children and obtain the parents’ perspective regarding the center’s compliance with licensing requirements.

[ARC 2646C, IAB 8/3/16, effective 10/1/16]

**441—109.6(237A) Personnel.** The board or director of the center shall develop policies for hiring and maintaining staff that demonstrate competence in working with children and that meet the following minimum requirements:

**109.6(1) *Center director requirements.*** Centers that have multiple sites shall have a center director or on-site supervisor in each center. The center director is responsible for the overall functions of the center, including supervising staff, designing curriculum and administering programs. The director shall ensure services are provided for the children within the framework of the licensing requirements and the center’s statement of purpose and objectives. The center director shall have overall responsibility for carrying out the program and ensuring the safety and protection of the children. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the director meets the following minimum qualifications:

- a. Is at least 21 years of age.
- b. Has obtained a high school diploma or passed a general education development test.
- c. Has completed at least one course in business administration or 12 contact hours in administrative-related training related to personnel, supervision, record keeping, or budgeting or has one year of administrative-related experience.
- d. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa’s training for the mandatory reporting of child abuse.
- e. Has achieved a total of 100 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT- RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's or higher degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 100 points, a minimum of two categories must be used, no more than 75 points may be achieved in any one category, and at least 20 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For directors in centers predominantly serving children with special needs, the directors may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For directors in centers serving predominantly school-age children, the directors may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

**109.6(2) On-site supervisor.** The on-site supervisor is responsible for the daily supervision of the center and must be on site daily either during the hours of operation that children are present or a minimum of eight hours of the center's hours of operation. Information shall be submitted in writing to the child care consultant prior to the start of employment. Final determination shall be made by the department. Information shall be submitted sufficient to determine that the on-site supervisor meets the following minimum qualifications:

- a. Is an adult.
- b. Has obtained a high school diploma or passed a general education development test.
- c. Has certification in infant, child, and adult cardiopulmonary resuscitation (CPR), first aid, and Iowa's mandatory reporting of child abuse.
- d. Has achieved a total of 75 points obtained through a combination of education, experience, and child development-related training as outlined in the following chart:

EDUCATION		EXPERIENCE (Points multiplied by years of experience)		CHILD DEVELOPMENT- RELATED TRAINING
Bachelor's or higher degree in early childhood, child development, or elementary education	75	Full-time (20 hours or more per week) in a child care center or preschool setting	20	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	50	Part-time (less than 20 hours per week) in a child care center or preschool setting	10	
Child development associate (CDA) or one-year diploma in child development from a community college or technical school	40	Full-time (20 hours or more per week) child development-related experience	10	
Bachelor's or higher degree in a non-child-related field	40	Part-time (less than 20 hours per week) child development-related experience	5	
Associate's degree in a non-child-related field or completion of at least two years of a four-year degree	20	Registered child development home provider	10	
		Nonregistered family home provider	5	

(1) In obtaining the total of 75 points, a minimum of two categories must be used, no more than 50 points may be achieved in any one category, and at least 10 points shall be obtained from the experience category.

(2) Points obtained in the child development-related training category shall have been taken within the past five years.

(3) For on-site supervisors in centers predominantly serving children with special needs, the on-site supervisor may substitute a disabilities-related or nursing degree for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, experience in working with children with special needs in an administrative or direct care capacity shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

(4) For on-site supervisors in centers serving predominantly school-age children, the on-site supervisor may substitute a degree in secondary education, physical education, recreation or related fields for the bachelor's degree in early childhood, child development or elementary education in determining point totals. In addition, child-related experience working with school-age children shall be equivalent to full-time experience in a child care center or preschool in determining point totals.

**109.6(3) Director and on-site supervisor functions combined.** In a center where the functions of the center director and the on-site supervisor are accomplished by the same person, the educational and experience requirements for a center director shall apply. If the center director is serving in the role of the on-site supervisor, the director shall be on site daily either during the hours of operation or a minimum of at least eight hours of the center's hours of operation. If the staff person designated as the on-site supervisor is temporarily absent from the center, another responsible adult staff shall be designated as the interim on-site supervisor.

**109.6(4) Transition period for staff.** Rescinded IAB 8/3/16, effective 10/1/16.

**109.6(5) Volunteers and substitutes.** A volunteer shall be at least 16 years of age. All volunteers and substitutes shall:

a. Sign a statement indicating whether or not they have one of the following:

(1) A conviction of any law in any state or any record of founded child abuse or dependent adult abuse in any state.

(2) A communicable disease or other health concern that could pose a threat to the health, safety, or well-being of the children.

b. Sign a statement indicating the volunteer or substitute has been informed of the volunteer's or substitute's responsibilities as a mandatory reporter.

c. Undergo the record check process when any of the following criteria are met:

- (1) The volunteer or substitute is included in meeting the required child-to-staff ratio;
- (2) The volunteer or substitute has direct responsibility for a child or children; or
- (3) The volunteer or substitute has access to a child or children with no other staff present.

d. Have on file at the facility a record containing the statements required in paragraphs 109.6(5) "a" and "b" and documentation of any record check process. The record shall be maintained as required in paragraph 109.9(1) "b."

**109.6(6) Record checks.**

a. *Applicability.*

(1) Criminal and child abuse record checks shall be conducted for:

1. Each owner, director, staff member, substitute, volunteer, or subcontracted staff person with direct responsibility for child care or with access to a child when the child is alone;

2. Anyone living in the child care facility who is 14 years of age or older.

(2) Parents, guardians, and custodians are exempt from the record check process in relation to access to their own children or wards.

(3) Professional staff who hold a current, valid license issued by the educational examiners board are exempt from the record check process in relation to children in the center to whom they provide professional services consistent with Iowa Code chapter 272 and rules adopted by the educational examiners board.

b. *Authorization.* A requesting entity shall request a record check evaluation prior to the employment of a person subject to record checks. The person subject to record checks shall complete the DHS criminal history record check form and any other forms required by the department of public safety to authorize the release of records.

c. *Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal records, including the sex offender registry, shall be completed before the person's involvement with child care at the center. Iowa records checks shall be repeated at a minimum of every two years and when the department or the center becomes aware of any possible transgressions. The department is not responsible for the cost of conducting the Iowa records check.

(1) The child care center may access the single-contact repository (SING) as necessary to conduct a criminal and child abuse record check of the person in Iowa. If the results of the check indicate a potential transgression, the center shall send a copy of the results to the department for determination of whether or not the person may be involved with child care, regardless of the person's status with the center.

(2) Unless a record check has already been conducted in accordance with subparagraph (1), the department shall conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. When the department conducts the records check, the fee shall be \$35 for each record check. The center shall submit the fee before the department initiates the record check process. Payment must be in the form of cash, check, money order, or cashier's check. The department may access SING to conduct the records check. The department may also conduct dependent adult abuse, sex offender, and other public or civil offense record checks in Iowa for a person who is subject to a record check.

(3) Centers that participate in student intern programs may seek a waiver for substitution of the state record check process with a check performed by the student's educational institution. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

d. *National criminal history checks.* National criminal history checks based on fingerprints are required for all persons subject to record checks under this subrule effective with a center's initial licensure or relicensure on or after June 1, 2010. The national criminal history check shall be repeated for each person every four years and when the department or center becomes aware of any new transgressions committed by that person in another state. The department is not responsible for the cost of conducting the national criminal history check.

(1) The child care center is responsible for obtaining the fingerprints of all persons subject to record checks. Fingerprints may be taken by law enforcement agencies, by agencies or companies that specialize in taking fingerprints, or by center staff or subcontractors who have received appropriate training in the taking of fingerprints.

(2) If the results of the Iowa records checks do not warrant prohibition of the person's involvement with child care or otherwise present protective concerns, the person may be involved with child care on a provisional basis until the national criminal history check and evaluation have been completed.

(3) The child care center shall provide fingerprints to the department of public safety no later than 30 days after the subject's approval for employment at the center. The center shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(4) Centers that are required to submit fingerprint-based checks of the FBI national criminal database to comply with federal regulations may seek a waiver to substitute that record check for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(5) Centers that participate in student intern programs may seek a waiver to substitute the fingerprint-based check of the FBI national criminal database performed by the student's educational institution for the procedure required in this subrule. Requests for a waiver shall be submitted on Form 470-4893, Record Check Waiver, to the address listed on the form.

(6) A center considering involvement of a person who has had a national criminal history check at another center may request information from that center. That center may provide the following information in writing upon a center's request, using Form 470-4896, National Criminal History Check Confirmation:

1. Date of most recent national criminal history check conducted by the center on the person in question, and

2. Whether or not the national check process resulted in clearance of the person for involvement with child care.

(7) If the results of the national criminal history check indicate that the person has committed a transgression, the center, if interested in continuing the person's involvement in child care, shall send a copy of the results to the department for evaluation. The department shall determine whether or not the person may be involved with child care.

(8) A center shall submit all required fingerprints to the department of public safety before the issuance or renewal of the center's license.

*e. Mandatory prohibition.* A person with the following convictions or founded abuse reports is prohibited from involvement with child care:

- (1) Founded child or dependent adult abuse that was determined to be sexual abuse.

- (2) Placement on the sex offender registry.

- (3) Felony child endangerment or neglect or abandonment of a dependent person.

- (4) Felony domestic abuse.

- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.

- (6) Forcible felony.

*f. Mandatory time-limited prohibition.*

(1) A person with the following convictions or founded abuse reports is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.

2. Founded child abuse that was determined to be physical abuse.

(2) After the five-year prohibition period imposed pursuant to 109.6(6) "f"(1), the person may request the department to perform an evaluation under paragraph 109.6(6) "g" to determine whether prohibition of the person's involvement with child care continues to be warranted.

*g. Evaluation required.* For all other transgressions, and as requested under subparagraph 109.6(6) "f"(2), the department shall notify the requesting entity that an evaluation shall be conducted to determine whether prohibition of the person's involvement with child care is warranted.

(1) The person with the transgression shall complete the record check evaluation form. The requesting entity shall provide the form and any other documents to the department within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and the requesting entity to return this form by the specified date shall result in denial or revocation of the license or denial of employment. The department shall not process evaluations that are not signed by the person subject to an evaluation.

(2) The department may use information from the department's case records in performing the evaluation.

(3) The requesting entity may provide, or the department may request from the person subject to an evaluation or from the requesting entity, information to assist in performance of the evaluation that includes, but is not limited to, the following:

1. Documentation of criminal justice proceedings.
2. Documentation of rehabilitation.
3. Written employment references or applications.
4. Documentation of substance abuse education or treatment.
5. Criminal history records, child abuse information, and dependent adult abuse information from other states.

6. Documentation of the person's prior residences.

(4) Any person or agency that might have pertinent information regarding criminal or abuse history and rehabilitation of the prospective employee may be contacted.

(5) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(6) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The person's position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

*h. Evaluation decision.* Within 30 days of receipt of a completed record check evaluation, the department shall make a decision on the person's involvement with child care. The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements and corrective action plan under this paragraph.

(1) The department shall mail to the requesting entity and the person on whom the evaluation was completed the record check decision that explains the decision reached regarding the evaluation of the transgression.

(2) If the department determines through an evaluation of a person's transgressions that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(3) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions and corrective action plan relating to the person's involvement with child care.

(4) The department shall send a letter to the employer that informs the employer whether the person subject to an evaluation has been approved or denied involvement with child care. If the person has been approved, the letter shall inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

*i. Notice to parents.* The administrator of the department shall notify the parents, guardians, and legal custodians of each child for whom the person provides child care if there has been founded child abuse committed by an owner, director, or staff member of the child care center. The center shall cooperate with the department in providing the names and addresses of the parents, guardians, and legal custodians of each child for whom the facility provides child care.

**109.6(7) Use of controlled substances and medications.** All owners, personnel, and volunteers shall be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 9441B, IAB 4/6/11, effective 6/1/11; ARC 0418C, IAB 10/31/12, effective 1/1/13; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 1809C, IAB 1/7/15, effective 3/1/15; ARC 2646C, IAB 8/3/16, effective 10/1/16]

**441—109.7(237A) Professional growth and development.** The center director, on-site supervisor, and staff counted as part of the staff ratio shall meet the following minimum staff training requirements:

**109.7(1) Required training within the first three months of employment.** During their first three months of employment, all staff shall receive the following training:

*a.* Two hours of Iowa's training for mandatory reporting of child abuse.

*b.* At least one hour of training regarding universal precautions and infectious disease control.

*c.* Certification in American Red Cross, American Heart Association, American Safety and Health Institute, or MEDIC First Aid infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

*d.* Certification in infant, child, and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization, including the American Red Cross, American Heart Association, the National Safety Council, the American Safety and Health Institute, or MEDIC First Aid or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.

*e.* Minimum health and safety trainings, approved by the department, in the following areas and every five years thereafter:

- (1) Prevention and control of infectious disease, including immunizations.
- (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
- (3) Administration of medication, consistent with standards for parental consent.
- (4) Prevention of and response to emergencies due to food and allergic reactions.
- (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- (6) Prevention of shaken baby syndrome and abusive head trauma.
- (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- (9) Precautions in transporting children.
- (10) Child development, on or after August 1, 2017.

Minimum health and safety training may be required prior to the five-year period if content has significant changes which warrant that the training be renewed.

**109.7(2) Center directors and all staff.**

*a.* During their first year of employment, all center directors and all staff shall receive the following training:

- (1) Ten contact hours of training from one or more of the following content areas:
  1. Planning a safe, healthy learning environment (includes nutrition).
  2. Steps to advance children's physical and intellectual development.
  3. Positive ways to support children's social and emotional development (includes guidance and discipline).
  4. Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
  5. Strategies to manage an effective program operation (includes business practices).
  6. Maintaining a commitment to professionalism.
  7. Observing and recording children's behavior.
  8. Principles of child growth and development.
- (2) Training received for cardiopulmonary resuscitation (CPR), first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

(3) Staff who have completed a comprehensive training package of at least ten contact hours offered through a child care resource and referral agency or community college within six months prior to initial employment shall have the first year's ten contact hours of training waived.

*b.* Following their first year of employment, all center directors and all staff shall:

- (1) Maintain current certification for Iowa's training for the mandatory reporting of child abuse; infant, child and adult CPR; and infant, child and adult first aid.
- (2) Receive six contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2) "a"(1). A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.
- (3) Center directors and on-site supervisors shall receive eight contact hours of training annually from one or more of the content areas listed in subparagraph 109.7(2) "a"(1).

*c.* Initial training obtained as identified in paragraph 109.7(1) "e" may be counted toward annual training hours during the year of employment in which the training is taken.

*d.* Training identified in paragraph 109.7(1) "e" shall not count towards annual professional development more than once.

**109.7(3) Staff employed in centers that operate summer-only programs.** During their first three months of employment, all staff shall receive the following training:

- a.* Two hours of Iowa's training for mandatory reporting of child abuse.
- b.* At least one hour of training regarding universal precautions and infectious disease control.
- c.* Certification in American Red Cross, American Heart Association, American Safety and Health Institute, or MEDIC First Aid infant, child, and adult cardiopulmonary resuscitation (CPR) or equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.
- d.* Certification in infant, child, and adult first aid that uses a nationally recognized curriculum or is received from a nationally recognized training organization, including the American Red Cross, American Heart Association, the National Safety Council, the American Safety and Health Institute, or MEDIC First Aid or an equivalent certification approved by the department. A valid certificate indicating the date of training and expiration date shall be maintained.
- e.* Minimum health and safety trainings, approved by the department, in the following areas:
  - (1) Prevention and control of infectious disease, including immunizations.
  - (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
  - (3) Administration of medication, consistent with standards for parental consent.

- (4) Prevention of and response to emergencies due to food and allergic reactions.
- (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- (6) Prevention of shaken baby syndrome and abusive head trauma.
- (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- (9) Precautions in transporting children.

**109.7(4) *Training plans.*** Training shall supplement the educational and experience requirements in rule 441—109.6(237A) and shall enhance the staff's skill in working with the developmental and cultural characteristics of the children served.

**109.7(5) *Substitution.*** A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

**109.7(6) *Approved training.***

*a.* The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
- (2) A community college.
- (3) Iowa State University Extension.
- (4) A child care resource and referral agency.
- (5) An area education agency.
- (6) The regents' center for early developmental education at the University of Northern Iowa.
- (7) A hospital (for health and safety, first-aid, and CPR training).
- (8) The American Red Cross, the American Heart Association, the National Safety Council, or Medic First Aid (for first-aid and CPR training).
- (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
- (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
- (11) The Child and Adult Care Food Program and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
- (12) The Iowa department of public health, department of education, or department of human services.
- (13) Head Start agencies or the Head Start technical assistance system.
- (14) Organizations that are certified by the International Association for Continuing Education and Training (IACET).

*b.* Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph "a" or an entity approved under paragraph "g." Approved training shall be made available to Iowa child care providers through the child care provider training registry beginning July 1, 2009.

*c.* Training received in a group setting may include distance learning opportunities such as training conducted over the Iowa communications network, on-line courses, or Web conferencing (webinars) if:

- (1) The training meets the requirements in subrule 109.7(7);
- (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and

(3) The training organization meets the requirements listed in this subrule or is approved by the department.

*d.* The department will not approve more than eight hours of training delivered in a single day.

*e.* The department may randomly monitor any state-approved training for quality control purposes.

*f.* Training conducted with staff either during the hours of operation of the facility, staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff shall not be actively engaged in care and supervision and simultaneously participate in training.

*g.* A training organization not approved by the department may submit for review to the department a request for child care training approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.

**109.7(7) *Elements of training.*** Training provided to Iowa child care providers shall offer:

*a.* Instruction that is consistent with:

(1) Iowa child care regulatory standards;

(2) The Iowa early learning standards; and

(3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

*b.* Content equal to at least one contact hour of training.

*c.* An opportunity for ongoing interaction and timely feedback, including questions and answers within the contact hours.

*d.* A certificate of training for each participant that includes:

(1) The name of the participant.

(2) The title of the training.

(3) The dates of training.

(4) The content area addressed.

(5) The name of the training organization.

(6) The name of the instructor.

(7) The number of contact hours.

**109.7(8) *Training for supervisors and designees.*** The director, on-site supervisor, and any person designated a lead in the absence of supervisory staff shall have completed all preservice/orientation training outlined in subrule 109.7(1).

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

#### **441—109.8(237A) Staff ratio requirements.**

**109.8(1) *Staff requirements.*** Persons counted as part of the staff ratio shall meet the following requirements:

*a.* Be at least 16 years of age. If less than 18 years of age, the staff shall be under the direct supervision of an adult.

*b.* Be involved with children in programming activities.

*c.* At least one staff person on duty in the center and outdoor play area when children are present and present on field trips shall be over the age of 18 and hold current certification in first aid and cardiopulmonary resuscitation (CPR) as required in rule 441—109.7(237A).

**109.8(2) *Staff ratio.*** The staff-to-child ratio shall be as follows:

<u>Age of children</u>	<u>Minimum ratio of staff to children</u>
Two weeks to two years	One to every four children
Two years	One to every six children
Three years	One to every eight children
Four years	One to every twelve children
Five years to ten years	One to every fifteen children
Ten years and over	One to every twenty children

a. Combinations of age groupings for children four years of age and older may be allowed and may have staff ratio determined on the age of the majority of the children in the group. If children three years of age and under are included in the combined age group, the staff ratio for children aged three and under shall be maintained for these children. Preschools shall have staff ratios determined on the age of the majority of the children, including children who are three years of age.

b. If a child between the ages of 18 and 24 months is placed outside the infant area, as defined at subrule 109.11(2), the staff ratio of 1 to 4 shall be maintained as would otherwise be required for the group until the child reaches the age of two.

c. Every child-occupied program room shall have adult supervision present in the room.

d. During nap time, at least one staff shall be present in every room where children are resting. Staff ratio requirements may be reduced to one staff per room where children are resting for a period of time not to exceed one hour provided staff ratio coverage can be maintained in the center. The staff ratio shall always be maintained in the infant area.

e. The minimum staff ratio shall be maintained at mealtimes and for any outdoor activities at the center.

f. When seven or more children over the age of three are present on the licensed premises or are being transported in one vehicle, at least two adult staff shall be present. Only one adult is required when a center is transporting children in a center-owned vehicle with parent authorization for the sole purpose of transporting children to and from school. When a center contracts with another entity to provide transportation other than for the purpose of transporting school-age children to or from school, at least one adult staff in addition to the driver shall be present if at least seven children provided care by the center are transported.

g. Any child care center-sponsored program activity involving five or more children conducted away from the licensed facility shall provide a minimum of one additional staff over the required staff ratio for the protection of the children.

h. For a period of two hours or less at the beginning or end of the center's hours of operation, one staff may care for six or fewer children, provided no more than two of the children are under the age of two years and there are no more than six children in the center.

i. For centers or preschools serving school-age children, the ratio for school-age children may be exceeded for a period of no more than four hours during a day when school classes start late or are dismissed early due to inclement weather or structural damage provided the children are already enrolled at the center and the center does not exceed the licensed capacity.

[ARC 2646C, IAB 8/3/16, effective 10/1/16]

#### **441—109.9(237A) Records.**

**109.9(1) Personnel records.** The center shall maintain personnel information sufficient to ensure that persons employed in the center meet minimum staff and training requirements and do not pose any threat to the health, safety, or well-being of the children. Each employee's file shall contain, at a minimum, the following:

a. A statement signed by each individual indicating whether or not the individual has any conviction of violating any law in any state or has any record of founded child abuse or dependent adult abuse in any state.

b. Copies of all records checks kept in accordance with state and federal law regarding confidentiality of records checks. These records shall include:

(1) A copy of a DHS criminal history record check form or any other permission form approved by the department of public safety for conducting an Iowa or national criminal history record check.

(2) A copy of a request for child abuse information form, when applicable.

(3) Copies of the results of Iowa records checks conducted through the SING for review by the department upon request.

(4) Copies of national criminal history check results.

(5) Any department-issued documents sent to the center related to a records check, regardless of findings.

c. Reserved.

d. A physical examination report. Personnel shall have good health as evidenced by a preemployment physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed within six months prior to beginning employment by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner; and shall be repeated at least every three years.

e. Documentation showing the minimum staff training requirements as outlined at rule 441—109.7(237A) are met, including current certifications in first aid and cardiopulmonary resuscitation (CPR) and Iowa's training for the mandatory reporting of child abuse.

f. A photocopy of a valid driver's license if the staff will be involved in the transportation of children.

**109.9(2) *Child's file.*** Centers shall maintain sufficient information in a file for each child, which shall be updated at least annually or when the parent notifies the center of a change or the center becomes aware of a change, to ensure that:

a. A parent or an emergency contact authorized by the parent can be contacted at any time the child is in the care of the center.

b. Appropriate emergency medical and dental services can be secured for the child while in the center's care.

c. Information is available in the center regarding the specific health and medical needs of a child, including information regarding any professionally prescribed treatment. Information shall include a physical examination report as required at subrule 109.10(1). For a center serving school-age children that operates in the same school facility in which the child attends school, documentation shall include a statement signed by the parent that the immunization information is available in the school file.

d. A child is released only to authorized persons.

e. Documentation of injuries, accidents, or other incidents involving the child is maintained.

f. Parent authorization is obtained for a child to attend center-sponsored field trips and non-center activities. If parental authorization is obtained on an authorization form inclusive of all children participating in the activity, the authorization form shall be kept on file at the center.

g. For any child with allergies, a written emergency plan is available in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.

**109.9(3) *Immunization certificates.*** Signed and dated Iowa immunization certificates, provided by the state department of public health, shall be on file for each child enrolled as prescribed by the department of public health at 641—Chapter 7.

**109.9(4) *Daily activities.*** For each child under two years of age, the center shall make a daily written record. At the end of the child's day at the center, the daily written record shall be provided verbally or in writing to the parent or the person who removes the child from the center. The record shall contain information on each of these areas:

a. The time periods in which the child has slept.

b. The amount of food consumed and the times at which the child has eaten.

c. The time of and any irregularities in the child's elimination patterns.

d. The general disposition of the child.

e. A general summary of the activities in which the child participated.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 0996C, IAB 9/4/13, effective 11/1/13; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

**441—109.10(237A) Health and safety policies.** The child care center shall establish definite health policies, including the criteria for excluding a sick child from the center. The policies shall be consistent with the recommendations of the National Health and Safety Performance Standards and shall include, but are not limited to:

**109.10(1) Physical examination report.**

a. *Preschool-age children.* For each child five years of age and younger not enrolled in kindergarten, the child care center shall require an admission physical examination report, submitted within 30 days from the date of admission, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner. The date of the physical examination shall be no more than 12 months prior to the first day of attendance at the center. The written report shall include past health history, status of present health including allergies, medications, and acute or chronic conditions, and recommendations for continued care when necessary. Annually thereafter, a statement of health condition, signed by a licensed medical doctor, doctor of osteopathy, physician's assistant or advanced registered nurse practitioner, shall be submitted that includes any change in functioning, allergies, medications, or acute or chronic conditions.

b. *School-age children.* For each child five years of age and older and enrolled in school, the child care center shall require, prior to admission, a statement of health status signed by the parent or legal guardian that certifies that the child is free of communicable disease and that specifies any allergies, medications, or acute or chronic conditions. The statement from the parent shall be submitted annually thereafter.

c. *Religious exemption.* Nothing in this rule shall be construed to require medical treatment or immunization for staff or the child of any person who is a member of a church or religious organization which has guidelines governing medical treatment for disease that are contrary to these rules. In these instances, an official statement from the organization shall be incorporated in the personnel or child's file.

**109.10(2) Medical and dental emergencies.** The center shall have sufficient information and authorization to meet the medical and dental emergencies of children. The center shall have written procedures for medical and dental emergencies and shall ensure, through orientation and training, that all staff are knowledgeable of and able to implement the procedures.

**109.10(3) Medications.** The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications, including the following:

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

b. For every day an authorization for medication is in effect and the child is in attendance, there shall be a notation of administration including the name of the medicine, date, time, dosage given or applied, and the initials of the person administering the medication or the reason the medication was not given.

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

d. A child care staff member shall not provide medications to a child if the staff member has not completed preservice/orientation training that includes medication administration.

**109.10(4) Daily contact.** Each child shall have direct contact with a staff person upon arrival for early detection of apparent illness, communicable disease, or unusual condition or behavior which may adversely affect the child or the group. The center shall post notice at the main entrance to the center where it is visible to parents and the public of exposure of a child receiving care by the center to a

communicable disease, the symptoms, and the period of communicability. If the center is located in a building used for other purposes and shares the main entrance to the building, the notice shall be conspicuously posted in the center in an area that is frequented daily by parents or the public.

**109.10(5) *Infectious disease control.*** Centers shall establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily excrement or discharge, including blood and breast milk. Soiled diapers shall be stored in containers separate from other waste.

**109.10(6) *Quiet area for ill or injured.*** The center shall provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person shall be notified of the child's status in the event of a serious illness or emergency.

**109.10(7) *Staff hand washing.*** The center shall ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease. All staff shall wash their hands at the following times:

- a. Upon arrival at the center.
- b. Immediately before eating or participating in any food service activity.
- c. After diapering a child.
- d. Before leaving the rest room either with a child or by themselves.
- e. Before and after administering nonemergency first aid to a child if gloves are not worn.
- f. After handling animals and cleaning cages.

**109.10(8) *Children's hand washing.*** The center shall ensure that staff assist children in personal hygiene sufficient to prevent or minimize the transmission of illness or disease. For each infant or child with a disability, a separate cloth for washing and one for rinsing may be used in place of running water. Children's hands shall be washed at the following times:

- a. Immediately before eating or participating in any food service activity.
- b. After using the rest room or being diapered.
- c. After handling animals.

**109.10(9) *First-aid kit.*** The center shall ensure that a clearly labeled first-aid kit is available and easily accessible to staff at all times whenever children are in the center, in the outdoor play area, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children.

**109.10(10) *Recording incidents.***

a. Incidents involving a child, including minor injuries, minor changes in health status, or other minor behavioral concerns, shall be reported to the parents, guardians, and legal custodians on the day of the incident. Incidents resulting in an injury to a child shall be reported to the parent on the day of the incident.

b. Incidents resulting in a serious injury, as defined in Iowa Code section 702.18, to a child in the child care facility or in the care of child care facility staff or incidents resulting in a significant change in the health status of a child shall be verbally reported to the parents, guardians, and legal custodians immediately.

(1) Serious injuries shall be reported to the department within 24 hours of the incident.

(2) Serious injuries shall be documented and information maintained in the child's file as required by subrule 109.9(2).

c. The parents, guardians, and legal custodians of any child included in incidents involving inappropriate, sexually acting-out behavior shall be notified immediately after the incident. A written report fully documenting every incident shall be provided to the parent or person authorized to remove the child from the center. The written report shall be prepared by the staff member who observed the incident, and a copy shall be retained in the child's file.

**109.10(11) *Smoking.*** Smoking and the use of tobacco products shall be prohibited at all times in the center and in every vehicle used to transport children. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during hours of operation of the center. Nonsmoking signs shall be posted at every entrance of the child care center and in every vehicle used to transport children. All signs shall include:

- a. The telephone number for reporting complaints, and
- b. The Internet address of the department of public health ([www.iowasmokefreeair.gov](http://www.iowasmokefreeair.gov)).

**109.10(12) Transportation.** As outlined in Iowa Code section 321.446, all children transported in a motor vehicle subject to registration, except a bus, shall be individually secured by a safety belt, safety seat, or harness in accordance with federal motor vehicle safety standards and the manufacturer's instructions.

a. Children under the age of 6 shall be secured during transit in a federally approved child restraint system. Children under 1 year of age and weighing less than 20 pounds shall be secured during transit in a rear-facing child restraint system.

b. Children under the age of 12 shall not be located in the front seating section of the vehicle.

c. Drivers of vehicles shall possess a valid driver's license and shall not operate a vehicle while under the influence of alcohol, illegal drugs, prescription or nonprescription drugs that could impair the drivers' ability to operate a motor vehicle.

d. Vehicles that are owned or leased by the center shall receive regular maintenance and inspection according to manufacturer-recommended guidelines for vehicle and tire maintenance and inspection.

**109.10(13) Field trip emergency numbers.** Emergency telephone numbers for each child shall be taken by staff when transporting children to and from school and on field trips and non-center-sponsored activities away from the premises.

**109.10(14) Pets.** Animals kept on site shall be in good health with no evidence of disease, be of such disposition as to not pose a safety threat to children, and be maintained in a clean and sanitary manner. Documentation of current vaccinations shall be available for all cats and dogs. No ferrets, reptiles, including turtles, or birds of the parrot family shall be kept on site. Pets shall not be allowed in kitchen or food preparation areas.

**109.10(15) Emergency plans.**

a. The center shall have written emergency plans and diagrams for responding to fire, tornado, and flood (if area is susceptible to flood), and plans for responding to intruders within the center, intoxicated parents, and lost or abducted children. In addition, the center shall have guidelines for responding or evacuating in case of blizzards, power failures, bomb threats, chemical spills, earthquakes, or other disasters that could create structural damage to the center or pose health hazards. If the center is located within a ten-mile radius of a nuclear power plant or research facility, the center shall also have plans for nuclear evacuations. Emergency plans shall include written procedures including plans for the following:

(1) Evacuation to safely leave the facility.

(2) Relocation to a common, safe location after evacuation.

(3) Shelter-in-place to take immediate shelter when the current location is unsafe to leave due to the emergency issue.

(4) Lockdown to protect children and providers from an external situation.

(5) Communication and reunification with parents or other adults responsible for the children which shall include emergency telephone numbers.

(6) Continuity of operations.

(7) To address the needs of individual children, including those with functional or access needs.

b. Emergency instructions, telephone numbers, and diagrams for fire, tornado, and flood (if area is susceptible to floods) shall be visibly posted by all program and outdoor exits. Emergency plan procedures shall be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills shall be maintained for the current and previous year.

c. The center shall develop procedures for annual staff and volunteer training on these emergency plans and shall include information on responding to fire, tornadoes, intruders, intoxicated parents, and lost or abducted children in the orientation provided to new employees and volunteers.

d. The center shall conduct a daily check to ensure that all exits are unobstructed.

**109.10(16) Supervision and access.**

a. The center director and on-site supervisor shall ensure that each staff member, substitute, or volunteer knows the number and names of children assigned to that staff member, substitute, or volunteer for care. Assigned staff, substitutes, and volunteers shall provide careful supervision.

b. Any person in the center who is not an owner, staff member, substitute, or volunteer who has a record check and department approval to be involved with child care shall not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. Persons who are exempt from the record check process are granted access in accordance with 109.6(6)“a”(2) unless the provisions of paragraph 109.10(16)“d” apply.

d. A sex offender who has been convicted of a sex offense against a minor and who is required to register with the Iowa sex offender registry under the provisions contained in Iowa Code chapter 692A shall not operate, manage, be employed by, or act as a contractor or volunteer at a child care center. The sex offender also shall not be present upon the property of a child care center without the written permission of the center director, except for the time reasonably necessary to transport the offender’s own minor child or ward to and from the center.

(1) Written permission shall include the conditions under which the sex offender may be present, including:

1. The precise location in the center where the sex offender may be present;
2. The reason for the sex offender’s presence at the facility;
3. The duration of the sex offender’s presence;
4. Description of the supervision that the center staff will provide the sex offender to ensure that no child is alone with the sex offender.

(2) Before giving written permission, the center director shall consult with the center licensing consultant. The written permission shall be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[ARC 8650B, IAB 4/7/10, effective 6/1/10; ARC 1209C, IAB 12/11/13, effective 2/1/14; ARC 2646C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17; ARC 3096C, IAB 6/7/17, effective 8/1/17]

#### **441—109.11(237A) Physical facilities.**

**109.11(1) Room size.** The program room size shall be a minimum of 80 square feet of useable floor space or sufficient floor space to provide 35 square feet of useable floor space per child. In rooms where floor space occupied by cribs is counted as useable floor space, there shall be 40 square feet of floor space per child. Kitchens, bathrooms, halls, lobby areas, storage areas and other areas of the center not designed as activity space for children shall not be used as regular program space or counted as useable floor space.

**109.11(2) Infants’ area.** An area shall be provided properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older. Children over 18 months of age may be grouped outside this area if appropriate to the developmental needs of the child. Upon the recommendation of a child’s physician or the area education agency serving the child, a child who is two years of age or older with a disability that results in significant developmental delays in physical and cognitive functioning who does not pose a threat to the safety of the infants may, if appropriate and for a limited time approved by the department, remain in the infant area.

#### **109.11(3) Facility requirements.**

a. The center shall ensure that:

- (1) The facility and premises are sanitary, safe and hazard-free.
- (2) Adequate indoor and outdoor program space that is adjacent to the center is provided. Centers shall have a safe outdoor program area with at least sufficient square footage to accommodate 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area shall include safe play equipment and an area of shade.
- (3) Sufficient program space is provided for dining to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures.
- (4) Sufficient lighting shall be provided to allow children to adequately perform developmental tasks without eye strain.
- (5) Sufficient ventilation is provided to maintain adequate indoor air quality.

(6) Sufficient heating is provided to allow children to perform tasks comfortably without excessive clothing.

(7) Sufficient cooling is provided to allow children to perform tasks without being excessively warm or subject to heat exposure.

(8) Sufficient bathroom and diapering facilities are provided to attend immediately to children's toileting needs and maintained to reduce the transmission of disease.

(9) Equipment, including kitchen appliances, placed in a program area is maintained so as not to result in burns, shock or injury to children.

(10) Sanitation and safety procedures for the center are developed and implemented to reduce the risk of injury or harm to children and reduce the transmission of disease.

*b.* Approval may be given by the department to waive the outdoor space requirement for programs of three hours or less, provided there is suitable substitute space and equipment available.

*c.* Approval may be given by the department for centers operating in a densely developed area to use alternative outdoor play areas in lieu of adjacent outdoor play areas.

*d.* The director or designated person shall complete and keep a record of at least monthly inspections of the outdoor recreation area and equipment for the purpose of assessing and rectifying potential safety hazards. If the outdoor play area is not used for a period of time due to inclement weather conditions, the center shall document the reasons why the monthly inspection did not occur and shall complete and document an inspection prior to resuming use of the area.

*e.* Centers that operate in a public school building, including before and after school programs and summer programs serving school-age children, may receive limited exemption from a facility requirement at subrule 109.11(3), particularly relating to ventilation and bathroom facilities, if complying with the requirement would require a structural or mechanical change to the school building. Centers shall ensure that the space occupied by the center is sanitary, safe, and hazard-free and shall conduct monthly playground inspections or provide documentation that one has been completed by the public school personnel.

**109.11(4) Bathroom facilities.** At least one functioning toilet and one sink for each 15 children shall be provided in a room with natural or artificial ventilation. Training seats or chairs may be used for children under two years of age. New construction after November 1, 1995, shall provide for at least one sink in the same area as the toilet and, for centers serving children two weeks to two years of age, shall provide for at least one sink in the central diapering area. At least one sink shall be provided in program rooms for infants and toddlers or in an adjacent area other than the kitchen. New construction after April 1, 1998, shall have at least one sink provided in the program rooms for infants and toddlers.

**109.11(5) Telephone.** A working nonpay telephone shall be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison information center posted adjacent to the telephone. The street address and telephone number of the center shall be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained near the telephone.

**109.11(6) Kitchen appliances and microwaves.** Gas or electric ranges or ovens shall not be placed in the program area. If kitchen appliances are maintained in the program area for food preparation activities, the area shall be sectioned off and shall not be counted as useable floor space for room size. Centers using microwave ovens for warming infant bottles or infant food shall ensure that the formula or food item is not served immediately to the child after being removed from the microwave. The infant bottle shall be shaken or food stirred and the formula or food item tested by the caregiver before being fed to the infant. Breast milk shall not be warmed in a microwave.

**109.11(7) Environmental hazards.**

*a.* Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1960 shall conduct a visual assessment for lead hazards that exist in the form of peeling or chipping paint. If the presence of peeling or chipping paint is found, the paint shall be presumed to be lead-based paint unless a certified inspector as defined in department of public health rules at 641—Chapter 70 determines that it is not lead-based paint. If the presence of peeling or chipping paint

is found, interim controls using safe work methods as defined by the state department of public health shall be accomplished prior to a full license being issued.

*b.* Within one year of being issued an initial or renewal license, centers operating in facilities that are at ground level, use a basement area as program space, or have a basement beneath the program area shall have radon testing performed as prescribed by the state department of public health at 641—Chapter 43. Testing shall be required if test kits are available from the local health department or the Iowa Radon Coalition. Retesting shall be accomplished at least every two years from the date of the initial measurement if test kits are available from the local health department or the Iowa Radon Coalition. If testing determines confirmed radon gas levels in excess of 4.0 picocurie per liter, a plan using radon mitigation procedures established by the state department of public health shall be developed with and approved by the state department of public health prior to a full license being issued.

*c.* To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis prior to the heating season, have a professional inspect all fuel-burning appliances, including oil and gas furnaces, gas water heaters, gas ranges and ovens, and gas dryers, to ensure the appliances are in good working order with proper ventilation. All centers shall install one carbon monoxide detector on each floor of the center that is listed with Underwriters Laboratory (UL) as conforming to UL Standard 2034.

*d.* Centers that operate before and after school programs and summer-only programs that serve only school-age children and that operate in a public school building are exempted from testing for lead, radon, and carbon monoxide.

#### **441—109.12(237A) Activity program requirements.**

**109.12(1) *Activities.*** The center shall have a written curriculum or program structure that uses developmentally appropriate practices and a written program of activities planned according to the developmental level of the children. The center shall post a schedule of the program in a visible place. The child care program shall complement but not duplicate the school curriculum. The program shall be designed to provide children with:

- a.* A curriculum or program of activities that promotes self-esteem and positive self-image; social interaction; self-expression and communication skills; creative expression; and problem-solving skills.
- b.* A balance of active and quiet activities; individual and group activities; indoor and outdoor activities; and staff-initiated and child-initiated activities.
- c.* Activities which promote both gross and fine motor development.
- d.* Experiences in harmony with the ethnic and cultural backgrounds of the children.
- e.* A supervised nap or quiet time for all children under the age of six not enrolled in school who are present at the center for five or more hours.

**109.12(2) *Discipline.*** The center shall have a written policy on the discipline of children which provides for positive guidance, with direction for resolving conflict and the setting of well-defined limits. The written policy shall be provided to staff at the start of employment and to parents at time of admission. The center shall not use as a form of discipline:

- a.* Corporal punishment including spanking, shaking, and slapping.
- b.* Punishment which is humiliating or frightening or which causes pain or discomfort to the child. Children shall never be locked in a room, closet, box or other device. Mechanical restraints shall never be used as a form of discipline. When restraints are part of a treatment plan for a child with a disability authorized by the parent and a psychologist or psychiatrist, staff shall receive training on the safe and appropriate use of the restraint.
- c.* Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.
- d.* No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

**109.12(3) *Policies for children requiring special accommodations.*** Reasonable accommodations, based on the special needs of the child, shall be made in providing care to a child with a disability. Accommodation can be a specific treatment prescribed by a professional or a parent, or a modification of equipment, or removal of physical barriers. The accommodation shall be recorded in the child's file.

**109.12(4) *Play equipment, materials and furniture.*** The center shall provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products. Play equipment, materials, and furniture shall meet the developmental, activity, and special needs of the children.

Rooms shall be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding shall be provided for all children who nap. The center shall develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing shall be maintained between equipment to reduce the transmission of disease, to allow ease of movement and participation by children and to allow staff sufficient space to attend to the needs of the children during routine care and emergency procedures. The center shall provide sufficient toilet articles for each child for hand washing. Parents may provide items for oral hygiene (if appropriate to the developmental age and needs of the child). The center shall ensure that sanitary procedures are followed for use and storage of the articles.

**109.12(5) *Infant environment.*** A child care center serving children two weeks to two years old must provide an environment which protects the children from physical harm, but is not so restrictive as to inhibit physical, intellectual, emotional, and social development.

*a.* Stimulation shall be provided to each child through being held, rocked, played with and talked with throughout the time care is provided. Insofar as possible, the same adult should provide complete care for the same child.

*b.* Each infant and toddler shall be diapered in a sanitary manner as frequently as needed at a central diapering area. Diapering, sanitation, and hand-washing procedures shall be posted and implemented in every diapering area. There shall be at least one changing table for every 15 infants.

*c.* Highchairs or hook-on seats shall be equipped with a safety strap which shall be engaged when the chair is in use and shall be constructed so the chair will not topple.

*d.* Safe, washable toys, large enough so they cannot be swallowed and with no removable parts, shall be provided. All hard-surface toys used by children shall be sanitized daily.

*e.* The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Requirements are as follows:

(1) Infants shall always be placed on their backs for sleep.

(2) Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission federal standards.

(3) Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for sleeping including, but not limited to, an infant seat, car seat, swing, or bouncy seat.

(4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

(5) No co-sleeping shall be allowed.

(6) Sleeping infants shall be actively observed by sight and sound.

(7) If an alternate sleeping position is needed, a signed physician authorization with statement of medical reason is required.

*f.* A crib or criblike furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the Consumer Product Safety Commission or ASTM International for juvenile products shall be provided for each child under two years of age if developmentally appropriate. Crib railings shall be fully raised and secured when the child is in the crib. A crib or criblike furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or criblike furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

*g.* Infant walkers shall not be used.

*h.* For programs operating five hours or less on a daily basis, the center shall have a sufficient number of cribs or criblike furniture which has a waterproof mattress covering and sufficient bedding

to enable a child to rest comfortably and which meets the current standards from the Consumer Product Safety Commission or the American Society for Testing and Materials for juvenile products for children who may nap during the time in attendance. Cribs or criblike furniture shall be used by only one child at a time and shall be maintained in a clean and sanitary manner.

[ARC 2646C, IAB 8/3/16, effective 10/1/16]

**441—109.13(237A) Extended evening care.** A center providing extended evening care shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

**109.13(1) Facility requirements.**

a. The center shall ensure that sufficient cribs, beds, cots and bedding are provided appropriate to the child's age and that sufficient furniture, lighting, and activity materials are available for the children. Equipment and materials shall be maintained in a safe and sanitary manner.

b. The center shall ensure that a separate space is maintained for school-age boys and girls to provide privacy during bathroom and bedtime activities. Bathroom doors used by children shall be nonlockable.

c. The center shall ensure that parents have provided the personal effects needed to meet their child's personal hygiene and prepare for sleep. The center shall supplement those items needed for personal hygiene which the parent does not provide. The center shall obtain written information from the parent regarding the child's snacking, toileting, personal hygiene and bedtime routines.

**109.13(2) Activities.**

a. Evening activities shall be primarily self-selected by the child.

b. Every child-occupied room except those rooms used only by school-age children for sleeping shall have adult supervision present in the room. Staff counted for purposes of meeting child-to-staff ratios shall be present and awake at all times. In rooms where only school-age children are sleeping, visual monitoring equipment may be used. If a visual monitor is used, the monitoring must allow for all children to be visible at all times. Staff shall be present in the room with the monitor and shall enter the room used for sleeping to conduct a check of the children every 15 minutes.

**441—109.14(237A) Get-well center.** A get-well center shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the additional requirements and exceptions set forth below.

**109.14(1) Staff requirements.**

a. The center shall have a medical advisor for the center's health policy. The medical advisor shall be a medical doctor or a doctor of osteopathy currently in pediatrics or family practice.

b. A center shall have a licensed LPN or RN on duty at all times that children are present. If the nurse on duty is an LPN, the medical advisor or an RN shall be available in the proximate area as defined in state board of nursing rules at 655—6.1(152).

**109.14(2) Health policies.**

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards, approved and signed by the owner or the chair of the board and by the medical advisor before the center can begin operations. Changes in the health policy shall be approved by the medical advisor and submitted in writing to the department. A written summary of the health policy shall be given to the parent when a child is enrolled in the center. The center's health policy at a minimum shall address procedures in the following areas:

(1) Medical consultation, medical emergencies, triage policies, storage and administration of medications, dietary considerations, sanitation and infection control, categorization of illness, length of enrollment periods, exclusion policy, and employee health policy.

(2) Reportable disease policies as required by the state department of public health.

b. The child shall be given a brief evaluation by an LPN or RN upon each arrival at the center.

c. The parent shall receive a brief written summary when the child is picked up at the end of the day. The summary must include:

- (1) Admitting symptoms.
- (2) Medications administered and time they were administered.
- (3) Nutritional intake.
- (4) Rest periods.
- (5) Output.
- (6) Temperature.

**109.14(3) Exceptions.** The following exceptions to 441—Chapter 109 shall be applied to get-well centers:

*a.* A center shall maintain a minimum staff ratio of one-to-four for infants and one-to-five for children over the age of two.

*b.* All staff that have contact with children shall have a minimum of 17 clock hours of special training in caring for mildly ill children. Current certification of the training shall be contained in the personnel files. Special training shall be department-approved and include the following:

(1) Four hours' training in infant and child cardiopulmonary resuscitation (CPR), four hours' training in pediatric first aid, and one hour of training in infection control within the first month of employment.

(2) Six hours' training in care of ill children, and two hours' training in child abuse identification and reporting within the first six months of employment and every five years thereafter.

*c.* There shall be 40 square feet of program space per child.

*d.* There shall be a sink with hot and cold running water in every child-occupied room.

*e.* Outdoor space may be waived with the approval of the department if the program is in an area adjacent to the pediatrics unit of a hospital.

*f.* Grouping of children shall be allowed by categorization of illness or by transmission route without regard to age, and shall be in separate rooms with full walls and doors.

**441—109.15(237A) Food services.** Centers participating in the USDA Child and Adult Care Food Program (CACFP) may have requirements that differ from those outlined in this rule in obtaining CACFP reimbursement and shall consult with a state CACFP consultant.

**109.15(1) Nutritionally balanced meals or snacks.** The center shall serve each child a full, nutritionally balanced meal or snack as defined by the USDA Child and Adult Care Food Program (CACFP) guidelines and shall ensure that staff provide supervision at the table during snacks and meals. Children remaining at the center two hours or longer shall be offered food at intervals of not less than two hours or more than three hours apart unless the child is asleep.

**109.15(2) Menu planning.** The center shall follow the minimum CACFP menu patterns for meals and snacks and serving sizes for children aged infant to 13 years. Menus shall be planned at least one week in advance, made available to parents, and kept on file at the center. Substitutions in the menu, including substitutions made for infants, shall be noted and kept on file. Foods with a high incident rate of causing choking in young children shall be avoided or modified. Provisions of this subrule notwithstanding, exceptions shall be allowed for special diets because of medical reasons in accordance with the child's needs and written instructions of a licensed physician or health care provider.

**109.15(3) Feeding of children under two years of age.**

*a.* All children under 12 months of age shall be fed on demand, unless the parent provides other written instructions. Meals and snacks provided by the center shall follow the CACFP infant menu patterns. Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Menu patterns may be modified according to written instructions from the parent, physician or health care provider. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

*b.* All children under six months of age shall be held or placed in a sitting-up position sufficient to prevent aspiration during feeding. No bottles shall be propped for children of any age. A child shall not be placed in a crib with a bottle or left sleeping with a bottle. Spoon feeding shall be adapted to the developmental capabilities of the child.

*c.* Single-service, ready-to-feed formulas, concentrated or powdered formula following the manufacturer's instructions or breast milk shall be used for children 12 months of age and younger unless otherwise ordered by a parent or physician.

*d.* Whole milk for children under age two who are not on formula or breast milk unless otherwise directed by a physician.

*e.* Cleaned and sanitized bottles and nipples shall be used for bottles prepared on site. Prepared bottles shall be kept under refrigeration when not in use.

**109.15(4) Food brought from home.**

*a.* The center shall establish policies regarding food brought from home for children under five years of age who are not enrolled in school. A copy of the written policy shall be given to the parent at admission. Food brought from home for children under five years of age who are not enrolled in school shall be monitored and supplemented if necessary to ensure CACFP guidelines are maintained.

*b.* The center may not restrict a parent from providing meals brought from home for school-age children or apply nutritional standards to the meals.

*c.* Perishable foods brought from home shall be maintained to avoid contamination or spoilage.

*d.* Snacks that may not meet CACFP nutrition guidelines may be provided by parents for special occasions such as birthdays or holidays.

**109.15(5) Food preparation, storage, and sanitation.** Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the National Health and Safety Performance Standards and provide:

*a.* Sufficient refrigeration appropriate to the perishable food to prevent spoilage or the growth of bacteria.

*b.* Sanitary and safe methods in food preparation, serving, and storage sufficient to prevent the transmission of disease, infestation of insects and rodents, and the spoilage of food. Staff preparing food who have injuries on their hands shall wear protective gloves. Staff serving food shall have clean hands or wear protective gloves and use clean serving utensils.

*c.* Sanitary methods for dish-washing techniques sufficient to prevent the transmission of disease.

*d.* Sanitary methods for garbage disposal sufficient to prevent the transmission of disease and infestation of insects and rodents.

**109.15(6) Water supply.** The center shall ensure that suitable water and sanitary drinking facilities are available and accessible to children. Centers that serve infants and toddlers shall provide individual cups for drinking in addition to drinking fountains that may be available in the center.

*a.* Private water supplies shall be of satisfactory bacteriological quality as shown by an annual laboratory analysis. Water for the analysis shall be drawn between May 1 and June 30 of each year. When the center provides care for children under two years of age, a nitrate analysis shall also be obtained.

*b.* When public or private water supplies are determined unsuitable for drinking, commercially bottled water certified as chemically and bacteriologically potable or water treated through a process approved by the health department or designee shall be provided.

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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CHAPTER 110  
CHILD DEVELOPMENT HOMES

PREAMBLE

This chapter establishes registration procedures for child development homes. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigations.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.1(237A) Definitions.**

“*Adult*” means a person 18 years of age or older.

“*Assistant*” means a responsible person 14 years of age or older. The assistant may never be left alone with children. Ultimate responsibility for supervision is with the child care provider.

“*Child*” means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

“*Child care*” means the care, supervision, or guidance of a child by a person other than the child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. “*Child care*” shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

“*Child care facility*” or “*facility*” means a child care center, a preschool, or a registered child development home.

“*Child care home*” means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

“*Child development home*” means a person or program registered under this chapter that may provide child care to six or more children at any one time.

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

“*Involvement with child care*” means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

“*Parent*” means parent or legal guardian.

“*Part-time hours*” means the hours that child development homes in categories B and C are allowed to exceed their maximum preschool- or school-age capacity. A provider may use a total of up to 180 hours per month as part-time hours. No more than two children using part-time hours may be in the child development home at any one time.

“*Person subject to an evaluation*” means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for registration or is registered.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

“*Provider*” means the person or program that applies for registration to provide child care and is approved as a child development home.

“*Registration*” means the process by which child care providers certify that they comply with rules adopted by the department.

“*Registration certificate*” means the written document issued by the department to publicly state that the provider has certified in writing compliance with the minimum requirements for registration of a child development home.

“*School*” means kindergarten or a higher grade level.

“*Transgression*” means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.
5. Department revocation or denial of a child care facility registration or license due to the person’s continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.2(237A) Application for registration.** A provider shall apply for registration on Form 470-3384, Application for Child Development Home Registration, provided by the department’s local office or, if available, on the department’s Web site. The provider shall also use Form 470-3384 to inform the department of any changes in circumstances that would affect the registration.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.3(237A) Renewal of registration.** Renewal of registration shall be completed every 24 months. To request renewal, a provider shall submit Form 470-3384, Application for Child Development Home Registration, and copies of certificates of training, which shall be retained in the registration file. The registration renewal process shall include completion of child abuse, sex offender, and criminal record checks.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.4(237A) Compliance checks.** Prior to registration, a compliance visit to inspect for compliance with health, safety, and fire standards shall be completed.

An unannounced compliance visit shall be conducted not less than annually to check for compliance with health, safety, and fire standards as well as all child care regulatory standards. Completed evaluation checklists shall be placed in the registration files.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.5(237A) Parental access.** Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child development home, unless parental contact is prohibited by court order.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.6(237A) Number of children.** The number of children in a child development home shall conform to the following standards:

**110.6(1) Limit.** Except as provided in subrule 110.6(3), no greater number of children shall be received for care at any one time than the number authorized on the registration certificate.

**110.6(2) Children counted.** To determine the number of children cared for at any one time in a child development home, each child present in the child development home shall be considered to be receiving care unless the child is described by one of the following exceptions:

*a.* The child’s parent, guardian, or custodian established or operates the child development home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

*b.* The child has been present in the child development home for more than 72 consecutive hours and meets the requirements of the exception in paragraph 110.6(2)“*a*” as though the person who established or operates the child development home is the child’s parent, guardian, or custodian.

**110.6(3) Exception for emergency school closing.** On days when schools are closed due to emergencies such as inclement weather or physical plant failure, a child development home may have

additional children present in accordance with the authorization for the registration category of the home and subject to all of the following conditions:

- a. The child development home has prior written approval from the parent or guardian of each child present in the home concerning the presence of additional children in the home.
- b. The child development home has a department-approved assistant, aged 14 or older, on duty to assist the care provider, as required for the registration category of the home.
- c. One or more of the following conditions are applicable to each of the additional children present in the child development home:
  - (1) The home provides care to the child on a regular basis for periods of less than two hours.
  - (2) If the child were not present in the child development home, the child would be unattended.
  - (3) The home regularly provides care to a sibling of the child.
- d. The provider shall maintain a written record including the date of the emergency school closing, the reason for the closing, and the number of children in care on that date.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.7(237A) Provider requirements.**

**110.7(1) Provider.** The provider shall:

- a. Give careful supervision at all times.
- b. Exchange information with the parent of each child frequently to enhance the quality of care.
- c. Give consistent, dependable care and be capable of handling emergencies.
- d. Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.
- e. Be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair the provider's ability to give careful supervision.

**110.7(2) Substitutes.** The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

- a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.
- b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.
- c. The substitute must be 18 years of age or older.
- d. Use of a substitute shall be limited to:
  - (1) No more than 25 hours per month.
  - (2) An additional period of up to two weeks in a 12-month period.
- e. The provider shall maintain a written record of the number of hours care is provided by a substitute, including the date of the care and the name of the substitute.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.8(237A) Standards.** Conditions in the home shall be safe, sanitary, and free of hazards. The provider shall certify that the child development home meets the following standards and also the standards in either rule 441—110.13(237A), 441—110.14(237A), or 441—110.15(237A), specific to the category of home for which the provider requests registration.

**110.8(1) Facility requirements.**

a. The home shall have a nonpay, working landline or mobile telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be written on paper and readily accessible by the telephone. The home must prominently display all emergency information, and all travel vehicles must have a paper copy of emergency parent contact information.

b. Electrical wiring shall be maintained, and all accessible electrical outlets shall be tamper-resistant outlets or shall be safely capped. Electrical cords shall be properly used. Improper use

includes the running of cords under rugs, over hooks, or through door openings or other use that has been known to be hazardous.

*c.* Combustible materials shall be kept a minimum of three feet away from furnaces, stoves, water heaters, and gas dryers.

*d.* Approved safety gates at stairways and doors shall be provided and used as needed.

*e.* Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

*f.* A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

*g.* The home shall have at least one 2A 10BC-rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

*h.* The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed according to the manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

*i.* Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. "No smoking" signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

(1) The telephone number for reporting complaints, and

(2) The Internet address of the department of public health ([www.iowasmokefreeair.gov](http://www.iowasmokefreeair.gov)).

*j.* Homes served by private sewer systems shall be in compliance with discharge restrictions identified at 567—Chapter 69. Discharge of untreated waste water from private sewage disposal systems is prohibited. Compliance shall be verified by the local board of health at the time of registration renewal and new registration.

*k.* A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child development home registration or a renewal of the registration. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of chipping or peeling paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

*l.* The child development home shall be located in a single-family residence that is owned, rented, or leased by the person, or, for dual registrations, at least one of the persons, who is named on the child development home's certificate of registration.

*m.* Any driver who transports children for any purpose shall have a valid driver's license and adequate motor vehicle insurance that authorizes the driver to operate the type of vehicle being driven. Child restraint devices shall be utilized in compliance with Iowa Code section 321.446.

*n.* Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that the bird is free

of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

*o.* Using an injury report form, the provider shall document all injuries that require first aid or medical care. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

*p.* The provider shall have written policies regarding the care of mildly ill children and the exclusion of children due to illness and shall inform parents of these policies.

*q.* The provider shall have written policy and procedures for responding to health-related emergencies.

*r.* The certificate of registration shall be displayed in a conspicuous place.

*s.* Serious injuries.

(1) Serious injuries, as defined in Iowa Code section 702.18, that occur in a child care facility or when a child is in the care of child care facility staff shall be reported to the department within 24 hours of the incident.

(2) Serious injuries shall be documented and information maintained in the child's file as required by subrule 110.9(4).

**110.8(2) Use of outdoor space.**

*a.* A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by the drainage or ponding of sewage, household waste, or storm water.

*b.* When there is a swimming or wading pool on the premises:

(1) The wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high.

(4) An uncovered in-ground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high and flush with the ground.

*c.* If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

**110.8(3) Medications and hazardous materials.**

*a.* All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

*b.* A first-aid kit shall be available and easily accessible whenever children are in the child development home, in the outdoor play area, in vehicles used to transport children, and on field trips.

The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children. The kit shall, at a minimum, include adhesive bandages, bottled water, disposable tweezers, and disposable plastic gloves.

c. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children. Any medication administered to a child shall be recorded, and the record shall indicate the name of the medication, the date and time of administration, and the amount administered.

d. All new providers and providers renewing registrations after September 30, 2016, shall not provide medications to a child if the provider has not completed preservice/orientation training that includes medication administration.

**110.8(4) *Emergency plans.*** Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

a. Fire and tornado drills shall be practiced monthly, and the provider shall keep documentation evidencing compliance with monthly practice on file for the current year and the previous year.

b. The provider must have procedures in place for the following:

- (1) Evacuation to safely leave the facility.
- (2) Relocation to a common, safe location after evacuation.
- (3) Shelter-in-place to take immediate shelter where the child is when it is unsafe to leave that location due to the emergent issue.
- (4) Lockdown to protect children and providers from an external situation.
- (5) Communication and plans for reunification with families.
- (6) Continuity of operations.
- (7) To address the needs of individual children, including those with functional or access needs.

**110.8(5) *Safe sleep.*** The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Infant sleep shall conform to the following standards:

a. Infants shall always be placed on their backs for sleep.

b. Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission federal standards.

c. Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for sleeping including, but not limited to, an infant seat, car seat, swing, or bouncy seat.

d. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

e. No co-sleeping shall be allowed.

f. Sleeping infants shall be actively observed by sight and sound.

g. If an alternate sleeping position is needed, a signed physician authorization with statement of medical reason is required.

**110.8(6) *Discipline.*** Discipline shall conform to the following standards:

a. Corporal punishment, including spanking, shaking and slapping, shall not be used.

b. Punishment that is humiliating or frightening or that causes pain or discomfort to the child shall not be used.

c. Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.

d. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

*e.* Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

**110.8(7) Meals and snacks.**

*a.* Regular meals and midmorning or midafternoon snacks shall be provided. The meals and snacks shall be well-balanced, nourishing, and in appropriate amounts as defined by the USDA Child and Adult Care Food Program.

*b.* Children may bring food to the child development home for their own consumption but shall not be required to provide their own food.

*c.* Clean, sanitary drinking water shall be readily available to children in indoor and outdoor areas, throughout the day.

**110.8(8) Activity program.** There shall be an activity program which promotes self-esteem and exploration and includes:

*a.* Active play.

*b.* Quiet play.

*c.* Activities for large-muscle development.

*d.* Activities for small-muscle development.

*e.* Play equipment and materials in a safe condition, for both indoor and outdoor activities which are developmentally appropriate for the ages and number of children present.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 3096C, IAB 6/7/17, effective 8/1/17]

**441—110.9(237A) Files.**

**110.9(1)** A provider file shall be maintained and shall contain the following:

*a.* A physical examination report. Providers and all members of a provider's household over the age of 12 shall have good health as evidenced by a preregistration physical examination. Acceptable physical examinations shall be documented on Form 470-5152, Child Care Provider Physical Examination Report. The physical examination shall include any necessary testing for communicable diseases; shall include a discussion regarding current Advisory Committee on Immunization Practices (ACIP)-recommended vaccinations; shall be performed by a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner within six months prior to the provider's registration; and shall be repeated at least every three years. All children residing in the household who are 12 years of age or younger must have the medical documentation outlined in paragraphs 110.9(4) "*d*," "*f*," and "*g*."

*b.* Certificates or other documentation from the department verifying the following:

(1) Required training as set forth in subrule 110.10(1).

(2) Completion of all record checks as required in subrule 110.11(3), at initial application, at each application for change, and at each application for renewal.

**110.9(2)** An individual file for each staff assistant shall be maintained and shall contain the following:

*a.* Documentation from the department which confirms that the record checks required under subrule 110.11(3) have been completed and authorizes or conditionally limits the person's involvement with child care.

*b.* A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.9(1) "*a*."

*c.* Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within three months of employment and every five years thereafter, as required by Iowa Code section 232.69.

**110.9(3)** An individual file for each substitute shall be maintained and shall contain the following:

*a.* Documentation from the department which confirms that the record checks required under subrule 110.11(3) have been completed and authorizes or conditionally limits the person's involvement with child care.

*b.* A completed Form 470-5152, Child Care Provider Physical Examination Report, that meets the requirements of paragraph 110.9(1) "*a*."

c. Certification of a minimum of two hours of approved training relating to the identification and reporting of child abuse, completed within three months of employment and every five years thereafter, as required by Iowa Code section 232.69.

d. Certification in first aid that meets the requirements of paragraph 110.10(1)“c.”

e. Certification or other documentation that minimum health and safety training has been completed in compliance with paragraph 110.10(1) “a” within three months of a substitute’s hiring or before a substitute provides care, whichever occurs first.

**110.9(4) Children’s files.** An individual file for each child shall be maintained and updated annually or when the provider becomes aware of changes. The file shall contain:

a. Identifying information including, at a minimum, the child’s name and birth date; the parent’s name, address and telephone number; special needs of the child; and the parent’s work address and telephone number.

b. Emergency contact information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child’s regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.

c. A signed medical consent from the parent authorizing emergency medical and dental treatment.

d. An admission physical examination report signed by a licensed physician or a designee in a clinic supervised by a licensed physician.

(1) The date of the physical examination shall not be more than 12 months before the child’s first day of attendance at the child development home.

(2) The written report shall include the child’s past health history, status of the child’s present health, allergies and restrictive conditions, and recommendations for continued care when necessary.

(3) For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physical examination report.

(4) The examination report or statement of health status shall be on file before the child’s first day of care.

e. A statement of health condition signed by a physician or designee and submitted annually from the date of the admission physical examination. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.

f. For each school-age child, on the first day of attendance, documentation of a physical examination that was completed at the time of school enrollment or since.

g. A signed and dated immunization certificate provided by the Iowa department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.

h. For any child with allergies, a written emergency plan in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.

i. A list that is signed by the parent and names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.

j. Written permission from the parent for the child to attend activities away from the child development home. The permission shall include:

(1) Times of departure and arrival.

(2) Destination.

(3) Names of persons who will be responsible for the child.

k. Injury report forms documenting injuries requiring first aid or medical care.

l. If the child meets the definition of homelessness as defined by Section 725(2) of the McKinney-Vento Homeless Education Assistance Act, the family shall receive a 60-day grace period to obtain medical documentation.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

#### **441—110.10(237A) Professional development.**

##### **110.10(1) Required training.**

a. Prior to registration and every five years thereafter, the provider shall complete minimum health and safety trainings, approved by the department, in all of the following areas:

- (1) Prevention and control of infectious disease, including immunizations.
- (2) Prevention of sudden infant death syndrome and use of safe sleep practices.
- (3) Administration of medication, consistent with standards for parental consent.
- (4) Prevention of and response to emergencies due to food and allergic reactions.
- (5) Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- (6) Prevention of shaken baby syndrome and abusive head trauma.
- (7) Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- (8) Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- (9) Precautions in transporting children.
- (10) Child development, on or after August 1, 2017.

b. Prior to registration and every five years thereafter, the provider shall complete two hours of Iowa's training for mandatory reporting of child abuse.

c. Prior to registration, the provider shall complete first-aid and cardiopulmonary resuscitation (CPR) training that meets the following requirements:

- (1) Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, the American Safety and Health Institute, or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.
- (2) CPR training shall include certification in infant and child CPR.
- (3) The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.
- (4) The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

d. During each two-year registration period, the provider shall receive a minimum of 24 hours of training from one or more of the following content areas. A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

- (1) Planning a safe, healthy learning environment (includes nutrition).
- (2) Steps to advance children's physical and intellectual development.
- (3) Positive ways to support children's social and emotional development (includes guidance and discipline).
- (4) Strategies to establish productive relationships with families (includes communication skills and cross-cultural competence).
- (5) Strategies to manage an effective program operation (includes business practices).
- (6) Maintaining a commitment to professionalism.
- (7) Observing and recording children's behavior.
- (8) Principles of child growth and development.

e. A provider who submits documentation from a child care resource and referral agency that the provider has completed the Iowa Program for Infant/Toddler Care (IA PITC), ChildNet, or Beyond Business Basics training series may use those hours to fulfill a maximum of two years' training requirements, not including first-aid and mandatory reporter training.

f. Training identified in paragraph 110.10(1)"a" may be counted toward the total 24 hours of required training only at the initial time in which it is received.

g. Minimum health and safety training may be required prior to the five-year period if content has significant changes which warrant that the training be renewed.

**110.10(2) Approved training.**

a. The training must be conducted by a trainer who is employed by or under contract with one of the following entities or who uses curriculum or training materials developed by or obtained with the written permission of one of the following entities:

- (1) An accredited university or college.
  - (2) A community college.
  - (3) Iowa State University Extension.
  - (4) A child care resource and referral agency.
  - (5) An area education agency.
  - (6) The regents' center for early developmental education at the University of Northern Iowa.
  - (7) A hospital (for health and safety, first-aid, and CPR training).
  - (8) The American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute or MEDIC First Aid (for first-aid and CPR training).
  - (9) An Iowa professional association, including the Iowa Association for the Education of Young Children (Iowa AEYC), the Iowa Family Child Care Association (IFCCA), the Iowa After School Alliance, and the Iowa Head Start Association.
  - (10) A national professional association, including the National Association for the Education of Young Children (NAEYC), the National Child Care Association (NCCA), the National Association for Family Child Care (NAFCC), the National After School Association, and the American Academy of Pediatrics.
  - (11) The Child and Adult Care Food Program (CACFP) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).
  - (12) The Iowa department of public health, department of education, or department of human services.
  - (13) Head Start agencies or the Head Start technical assistance system.
  - (14) Organizations that are certified by the International Association for Continuing Education and Training (IACET).
    - b.* Training received in a group setting must follow a presentation format that incorporates a variety of adult learning methods. The material or content of the training must be obtained from one of the entities listed in paragraph 110.10(2)“a” or an entity approved under paragraph 110.10(2)“h.”
    - c.* Approved training shall be made available to Iowa child care providers through the child care provider training registry.
    - d.* Training received in a group setting may include distance learning opportunities, such as training conducted over the Iowa communications network, online courses, or Web conferencing (webinars) if:
      - (1) The training meets the requirements in subrule 110.10(3);
      - (2) The training is taught by an instructor and requires interaction between the instructor and the participants, such as required chats or message boards; and
      - (3) The training organization meets the requirements listed in this subrule or is approved by the department.
    - e.* The department will not approve more than eight hours of training delivered in a single day.
    - f.* The department may randomly monitor any state-approved training for quality control purposes.
    - g.* Training conducted with the provider either during the hours of operation of the facility, provider lunch hours, or while children are resting must not diminish the required ratio coverage. The provider shall not be actively engaged in care and supervision and simultaneously participate in training.
    - h.* A training organization not approved by the department may submit a request for review to the department on Form 470-4528, Request for Child Care Training Approval. All approvals, unless otherwise specified, shall be valid for five years. The department shall issue its decision within 30 business days of receipt of a complete request.
- 110.10(3) Elements of training.** Training provided to Iowa child care providers shall offer:
- a.* Instruction that is consistent with:
    - (1) Iowa child care regulatory standards;
    - (2) The Iowa early learning standards; and
    - (3) The philosophy of developmentally appropriate practice as defined by the National Association for the Education of Young Children, the Program for Infant/Toddler Care, and the National Health and Safety Performance Standards.

- b. Content equal to at least one contact hour of training.
- c. An opportunity for teacher-student interaction and timely feedback, including questions and answers and with evaluation of learning.
- d. For each participant, a certificate of training that includes:
  - (1) The name of the participant.
  - (2) The title of the training.
  - (3) The dates of training.
  - (4) The content area addressed.
  - (5) The name of the training organization.
  - (6) The name of the instructor.
  - (7) The number of contact hours.

[ARC 2647C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

**441—110.11(234) Registration decision.** The department shall issue Form 470-3498, Certificate of Registration, when an applicant meets all requirements for registration. Each local office of the department shall maintain a current list of registered child development homes as a referral service to the community.

**110.11(1)** Registration shall be denied or revoked if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under the health and safety rules. Registration may also be denied or revoked if the department determines that the provider has failed to comply with standards imposed by law and these rules.

**110.11(2)** Record of all denials or revocations of registration and the documentation of reasons for denying or revoking the registration shall be kept in an open file.

**110.11(3)** Record checks.

a. *Applicability.* The department shall conduct Iowa criminal history record and child abuse record checks for each registrant, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each registrant, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Effective July 1, 2013, registration or renewal certificates shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

b. *Authorization.* The person subject to record checks shall complete the Iowa department of human services record check authorization form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; and any other forms required by the department of public safety to authorize the release of records.

c. *Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the registrant becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

d. *National criminal history record checks.* Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be effective on or after July 1, 2013, for an initial application for registration or a renewal application for registration. The national criminal history record check shall be repeated for each person subject to the

check every four years and when the department or registrant becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The registrant is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the fingerprints to the department so that the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

*e. Mandatory prohibition.* A person with any of the following convictions or founded abuse reports is prohibited from involvement with child care:

- (1) Founded child or dependent adult abuse that was determined to be sexual abuse.
- (2) Placement on the sex offender registry.
- (3) Felony child endangerment or neglect or abandonment of a dependent person.
- (4) Felony domestic abuse.
- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.
- (6) Forcible felony.

*f. Mandatory time-limited prohibition.*

(1) A person with the following conviction or founded abuse report is prohibited from involvement with child care for five years from the date of the conviction or founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.
2. Founded abuse that was determined to be physical abuse.

(2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 110.11(3)"f"(1), the person may request the department to perform an evaluation under paragraph 110.11(3)"g" to determine whether prohibition of the person's involvement with child care continues to be warranted.

*g. Evaluation required.* For all other transgressions, and as requested under subparagraph 110.11(3)"f"(2), the department shall evaluate the transgression and make a decision about the person's involvement with child care.

(1) The person with the transgression shall complete and return the record check evaluation form within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form within ten calendar days of the date on the form shall result in denial or revocation of the registration certificate.

(2) The department may use information from the department's case records in performing the evaluation.

- (3) In an evaluation, the department shall consider all of the following factors:
1. The nature and seriousness of the transgression in relation to the position sought or held.
  2. The time elapsed since the commission of the transgression.
  3. The circumstances under which the transgression was committed.
  4. The degree of rehabilitation.
  5. The likelihood that the person will commit the transgression again.
  6. The number of transgressions committed by the person.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is

authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

*h. Evaluation decision.* The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements or corrective action plan.

(1) Within 30 calendar days of receipt of a completed record check evaluation, the department shall make a decision on the person's involvement with child care.

(2) Within 30 calendar days of receipt of a completed record check evaluation, the department shall mail to the person subject to an evaluation a record check decision that explains the decision reached regarding the evaluation of the transgression and a notice of decision: child care.

(3) The department shall issue a notice of decision: child care prohibiting involvement with child care when the person subject to an evaluation fails to complete the record check evaluation within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan, or both. For an employee of a registrant, these conditional requirements shall be developed with the registrant. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the registrant.

*i. Notice to parents of abuse in care.* If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in revocation of registration.

**110.11(4)** If the department has denied or revoked a registration because the provider has continually or repeatedly failed to operate in compliance with Iowa Code chapter 237A and this chapter, the person shall not own or operate a registered facility for a period of 12 months from the date of denial or revocation. The department shall not act on an application for registration submitted by the applicant or provider during the 12-month period. The applicant shall be prohibited from involvement with child care unless the department specifically permits the involvement.

**110.11(5)** Required notifications. If a certificate of registration is revoked, the administrator of the department shall notify the parent, guardian, or legal custodian of each child for whom the facility

provides care. The provider shall cooperate with the department in providing the name and address of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

**110.11(6)** Required notifications to the department.

a. The provider shall, within ten days, notify the department of any of the following:

- (1) Changes in assistants or substitutes;
- (2) Changes in household membership;
- (3) Address changes; and
- (4) Criminal convictions.

b. No assistant, substitute, or coprovider shall be utilized in the care of children and no person shall be permitted to reside in the household until approved by the department.

c. If the provider does not notify the department of changes within ten days, the provider may be subject to revocation of registration or to recoupment of child care assistance provided, or both.

**110.11(7)** Letter of revocation. A letter received by an owner or operator of a child development home initiating action to deny or revoke the home's registration shall be conspicuously posted where it can be read by parents or any member of the public. The letter shall remain posted until resolution of the action to deny or revoke an owner's or operator's certificate of registration.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.12(237A) Complaints.** The department shall conduct an on-site visit when a complaint is received.

**110.12(1)** After each complaint visit, the department shall document whether the child development home was in compliance with registration requirements.

**110.12(2)** The written documentation of the department's conclusion as to whether the child development home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.13(237A) Additional requirements for child development home category A.** In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category A shall meet the following standards:

**110.13(1)** *Limits on number of children in care.*

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than two children who attend school may be present for a period of less than two hours at a time.

d. No more than eight children shall be present at any one time when an emergency school closing is in effect.

**110.13(2)** *Provider qualifications.*

a. The provider shall be at least 18 years old.

b. The provider shall have three written references which attest to character and ability to provide child care.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.14(237A) Additional requirements for child development home category B.** In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category B shall meet the following standards:

**110.14(1)** *Limits on number of children in care.*

a. No more than six children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these six children, no more than four children who are 24 months of age or younger shall be present at any one time. Of these four children, no more than three may be 18 months of age or younger.

c. In addition to the six children not in school, no more than four children who attend school may be present.

d. In addition to these ten children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 12 children shall be present at any one time when an emergency school closing is in effect.

f. If more than eight children are present at any one time for a period of more than two hours, the provider shall be assisted by a department-approved assistant who is at least 14 years old.

**110.14(2) Provider qualifications.**

a. The provider shall be at least 20 years old.

b. The provider shall have a high school diploma, GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.

c. The provider shall either:

(1) Have two years of experience as a registered or nonregistered child care provider, or

(2) Have a child development associate credential or any two-year or four-year degree in a child care-related field and one year of experience as a registered or nonregistered child care home provider.

**110.14(3) Facility requirements.**

a. The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

b. The home shall have a separate quiet area for sick children.

c. The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.15(237A) Additional requirements for child development home category C.** In addition to the requirements in rule 441—110.8(237A), a provider requesting registration in child development home category C shall meet the following standards:

**110.15(1) Limits on number of children in care.**

a. No more than 12 children not attending kindergarten or a higher grade level shall be present at any one time.

b. Of these 12 children, no more than four children who are 24 months of age or younger shall be present at any one time. Whenever four children who are under the age of 18 months are in care, both providers shall be present.

c. In addition to the 12 children not in school, no more than two children who attend school may be present for a period of less than two hours at any one time.

d. In addition to these 14 children, no more than two children who are receiving care on a part-time basis may be present.

e. No more than 16 children shall be present at any one time when an emergency school closing is in effect. If more than eight children are present at any one time due to an emergency school closing exception, the provider shall be assisted by a department-approved assistant who is at least 18 years of age.

*f.* If more than eight children are present, both providers shall be present. Each provider shall meet the provider qualifications for child development home category C.

**110.15(2) Provider qualifications.**

*a.* One provider who meets the following qualifications must always be present:

(1) The provider shall be at least 21 years old.

(2) The provider shall have a high school diploma, GED, or documentation of current or previous enrollment in credit-based coursework from a postsecondary educational institution that is an accredited college or university.

(3) The provider shall either:

1. Have five years of experience as a registered or nonregistered child care provider, or

2. Have a child development associate credential or any two-year or four-year degree in a child care-related field and four years of experience as a registered or nonregistered child care home provider.

*b.* The coprovider shall meet the requirements of subrule 110.14(2).

*c.* No more than two named providers shall be allowed on a registration certificate.

**110.15(3) Facility requirements.**

*a.* The home shall have a minimum of 35 square feet of child-use floor space for each child in care indoors, and a minimum of 50 square feet per child in care outdoors.

*b.* The home shall have a separate quiet area for sick children.

*c.* The home shall have a minimum of two direct exits to the outside from the main floor.

(1) If the second level or the basement of the home is used for the provision of child care, other than the use of a restroom, each additional child-occupied floor shall have at least one direct exit to the outside in addition to one inside stairway.

(2) All exits shall terminate at grade level with permanent steps.

(3) A basement window may be used as an exit if the window can be opened from the inside without the use of tools and it provides a clear opening of not less than 20 inches in width, 24 inches in height, and 5.7 square feet in area. The bottom of the opening shall be not more than 44 inches above the floor, with permanent steps inside leading up to the window.

(4) Occupancy above the second floor shall not be permitted for child care.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.16(237A) Registration actions for nonpayment of child support.** The department shall revoke or deny the issuance or renewal of a child development home registration upon the receipt of a certificate of noncompliance from the child support recovery unit of the department according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

**110.16(1) Service of notice.** The notice required by Iowa Code section 252J.8 shall be served upon the applicant or registrant by restricted certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the applicant or registrant may accept service personally or through authorized counsel.

**110.16(2) Effective date.** The effective date of the revocation or denial of the registration as specified in the notice required by Iowa Code section 252J.8 shall be 60 days following service of the notice upon the applicant or licensee.

**110.16(3) Preparation of notice.** The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or registrant.

**110.16(4) Responsibilities of registrants and applicants.** Registrants and registrant applicants shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in the actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

**110.16(5) District court.** A registrant or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

*a.* The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

*b.* For purposes of determining the effective date of the revocation, or denial of the issuance or renewal of a registration, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

**110.16(6) Procedure for notification.** The department shall notify the applicant or registrant in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the revocation of a registration or the denial of the issuance or renewal of a registration, and shall similarly notify the applicant or registrant when the registration is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

**110.16(7) Appeal rights.** Notwithstanding Iowa Code section 17A.18, the registrant does not have the right to a hearing regarding this issue but may request a court hearing pursuant to Iowa Code section 252J.9.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

**441—110.17(237A) Prohibition from involvement with child care.** If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

[ARC 2647C, IAB 8/3/16, effective 10/1/16]

These rules are intended to implement Iowa Code section 234.6 and chapter 237A.

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CHAPTER 120  
CHILD CARE HOMES

PREAMBLE

This chapter establishes procedures for child care homes that have a child care assistance provider agreement to receive child care assistance funds. Included are application and renewal procedures, standards for providers, and procedures for compliance checks and complaint investigations.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.1(237A) Definitions.**

*“Adult”* means a person 18 years of age or older.

*“Child”* means either of the following:

1. A person 12 years of age or younger.
2. A person 13 years of age or older but younger than 19 years of age who has a developmental disability, as defined under the federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, Public Law No. 106-402, codified in 42 U.S.C. 15002(8).

*“Child care”* means the care, supervision, or guidance of a child by a person other than the child’s parent, guardian, or custodian for periods of less than 24 hours per day per child on a regular basis. *“Child care”* shall not mean special activity programs that meet on a regular basis such as music or dance classes, organized athletics or sports programs, scouting programs, or hobby or craft classes or clubs.

*“Child care facility”* or *“facility”* means a child care center, a preschool, or a registered child development home.

*“Child care home”* means a person or program providing child care to five or fewer children at any one time that is not registered to provide child care under this chapter, as authorized under Iowa Code section 237A.3.

*“Child development home”* means a person or program registered under this chapter that may provide child care to six or more children at any one time.

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

*“Involvement with child care”* means licensed or registered as a child care facility, employed in a child care facility, residing in a child care facility, receiving public funding for providing child care, providing child care as a child care home provider, or residing in a child care home.

*“Parent”* means parent or legal guardian.

*“Person subject to an evaluation”* means a person who has committed a transgression and who is described by any of the following:

1. The person is being considered for registration or is registered.
2. The person is being considered by a child care facility for employment involving direct responsibility for a child or with access to a child when the child is alone, or the person is employed with such responsibilities.
3. The person will reside or resides in a child care facility.
4. The person has applied for or receives public funding for providing child care.
5. The person will reside or resides in a child care home that is not registered but that receives public funding for providing child care.

*“Provider”* means the person or program that applies to receive payment from the child care assistance program to provide child care and is approved as a child care home.

*“School”* means kindergarten or a higher grade level.

*“Transgression”* means the existence of any of the following in a person’s record:

1. Conviction of a crime.
2. A record of having committed founded child or dependent adult abuse.
3. Listing in the sex offender registry established under Iowa Code chapter 692A.
4. A record of having committed a public or civil offense.

5. Department revocation or denial of a child care facility registration or license due to the person's continued or repeated failure to operate the child care facility in compliance with licensing and registration laws and rules.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.2(237A) Application for payment.** A provider shall apply for payment on Form 470-2890, Payment Application for Nonregistered Providers, provided by the department's local office or on the department's Web site. The provider shall also use Form 470-2890 to inform the department of any changes in circumstances that would affect the provider.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.3(237A) Renewal of agreement.** Renewal of the child care assistance provider agreement shall be completed every 24 months. To request renewal, a provider shall submit Form 470-2890, Payment Application for Nonregistered Providers, and copies of certificates of training, which shall be retained in the file. The agreement renewal process shall include completion of child abuse, sex offender, and criminal record checks.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.4(237A) Compliance checks.** An unannounced compliance visit shall be conducted not less than annually to check for compliance with health, safety, and fire standards. Completed evaluation checklists shall be placed in agency files.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.5(237A) Parental access.** Parents shall be afforded unlimited access to their children and to the people caring for their children during the normal hours of operation or whenever their children are in the care of the child care home, unless parental contact is prohibited by court order.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.6(237A) Number of children.** The number of children in a child care home shall conform to the following standards:

**120.6(1) Limit.** No more than five children shall receive care at any one time in the single-family residence.

**120.6(2) Children counted.** To determine the number of children cared for at any one time in a child care home, each child present in the child care home shall be considered to be receiving care unless the child is described by one of the following exceptions:

*a.* The child's parent, guardian, or custodian established or operates the child care home and either the child is attending school or the child receives child care full-time on a regular basis from another person.

*b.* The child has been present in the child care home for more than 72 consecutive hours and meets the requirements of the exception listed above as though the person who established or operates the child care home is the child's parent, guardian, or custodian.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.7(237A) Provider requirements.**

**120.7(1) Provider.** The provider shall:

*a.* Give careful supervision at all times.

*b.* Exchange information with the parent of each child frequently to enhance the quality of care.

*c.* Give consistent, dependable care and be capable of handling emergencies.

*d.* Be present at all times except when emergencies occur or an absence is planned, at which time care shall be provided by a department-approved substitute. When an absence is planned, the provider shall give parents at least 24 hours' prior notice.

*e.* Be free of the use of illegal drugs and shall not be under the influence of alcohol or of any prescription or nonprescription drug that could impair the provider's ability to give careful supervision.

*f.* Be at least 18 years of age.

**120.7(2) *Substitutes.*** The provider shall assume responsibility for providing adequate and appropriate supervision at all times when children are in attendance. Any designated substitute shall have the same responsibility for providing adequate and appropriate supervision. Ultimate responsibility for supervision shall be with the provider.

- a. All standards in this chapter regarding supervision and care of children shall apply to substitutes.
- b. Except in emergency situations, the provider shall inform parents in advance of the planned use of a substitute.
- c. The substitute must be 18 years of age or older.
- d. Use of a substitute shall be limited to:
  - (1) No more than 25 hours per month.
  - (2) An additional period of up to two weeks in a 12-month period.
- e. The provider shall maintain a written record of the number of hours care is provided by a substitute, including the date of the care and the name of the substitute.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.8(237A) Standards.** Conditions in the home shall be safe, sanitary, and free of hazards. The provider shall certify that the child care home meets the following minimum standards.

**120.8(1) *Facility requirements.***

a. The home shall have a nonpay, working landline or mobile telephone with emergency numbers posted for police, fire, ambulance, and the poison information center. The number for each child's parent, for a responsible person who can be reached when the parent cannot, and for the child's physician shall be written on paper and readily accessible by the telephone. The home must prominently display all emergency information, and all travel vehicles must have a paper copy of emergency parent contact information.

b. Electrical wiring shall be maintained, and all accessible electrical outlets shall be tamper-resistant outlets or shall be safely capped. Electrical cords shall be properly used. Improper use includes the running of cords under rugs, over hooks, or through door openings or other use that has been known to be hazardous.

c. Combustible materials shall be kept a minimum of three feet away from furnaces, stoves, water heaters, and gas dryers.

d. Approved safety gates at stairways and doors shall be provided and used as needed.

e. Annual laboratory analysis of a private water supply shall be conducted to show satisfactory bacteriological quality. When children under the age of two are to be cared for, the analysis shall include a nitrate analysis. When private water supplies are determined unsuitable for drinking, commercially bottled water or water treated through a process approved by the health department or designee shall be provided.

f. A safety barrier shall surround any heating stove or heating element, in order to prevent burns.

g. The home shall have at least one 2A 10BC-rated fire extinguisher located in a visible and readily accessible place on each child-occupied floor.

h. The home shall have at least one single-station, battery-operated, UL-approved smoke detector in each child-occupied room and at the top of every stairway. Each smoke detector shall be installed according to manufacturer's recommendations. The provider shall test each smoke detector monthly and keep a record of testing for inspection purposes.

i. Smoking and the use of tobacco products shall be prohibited at all times in the home and in every vehicle in which children receiving care in the home are transported. Smoking and the use of tobacco products shall be prohibited in the outdoor play area during the home's hours of operation. "No smoking" signs shall be posted at every entrance of the child care home and in every vehicle used to transport children. All signs shall include:

(1) The telephone number for reporting of complaints, and

(2) The Internet address of the department of public health ([www.iowasmokefreeair.gov](http://www.iowasmokefreeair.gov)).

j. Homes served by private sewer systems shall be in compliance with discharge restrictions identified at 567—Chapter 69. Discharge of untreated waste water from private sewage disposal systems

is prohibited. Compliance shall be verified by the local board of health at the time of renewal of the child care assistance provider agreement and new application.

*k.* A provider operating in a facility built before 1960 shall assess and control lead hazards before being issued an initial child care assistance provider agreement or a renewal of the provider agreement. To comply with this requirement, the provider shall:

(1) Conduct a visual assessment of the facility for lead hazards that exist in the form of chipping or peeling paint;

(2) Apply interim controls on any chipping or peeling paint found, using lead-safe work methods in accordance with and as defined by department of public health rules at 641—Chapters 69 and 70, unless a certified inspector as defined in 641—Chapter 70 determines that the paint is not lead-based paint; and

(3) Submit Form 470-4755, Lead Assessment and Control, as verification of the visual assessment and completion of interim controls, if necessary.

*l.* The child care home shall be located in a single-family residence that is owned, rented, or leased by the provider.

*m.* Any driver who transports children for any purpose shall have a valid driver's license and adequate motor vehicle insurance that authorizes the driver to operate the type of vehicle being driven. Child restraint devices shall be utilized in compliance with Iowa Code section 321.446.

*n.* Providers shall inform parents of the presence of any pet in the home.

(1) Each dog or cat in the household shall undergo an annual health examination by a licensed veterinarian. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. This examination shall verify that the animal's routine immunizations, particularly rabies, are current and that the animal shows no evidence of endoparasites (roundworms, hookworms, whipworms) and ectoparasites (fleas, mites, ticks, lice).

(2) Each pet bird in the household shall be purchased from a dealer licensed by the Iowa department of agriculture and land stewardship and shall be examined by a veterinarian to verify that the bird is free of infectious diseases. Acceptable veterinary examinations shall be documented on Form 470-5153, Veterinary Health Certificate. Children shall not handle pet birds.

(3) Aquariums shall be well maintained and installed in a manner that prevents children from accessing the water or pulling over a tank.

(4) All animal waste shall be immediately removed from the children's areas and properly disposed of. Children shall not perform any feeding or care of pets or cleanup of pet waste.

(5) No animals shall be allowed in the food preparation, food storage, or serving areas during food preparation and serving times.

*o.* Using an injury report form, the provider shall document all injuries that require first aid or medical care. The form shall be completed on the date of occurrence, shared with the parent, and maintained in the child's file.

*p.* Serious injuries.

(1) Serious injuries, as defined in Iowa Code section 702.18, that occur in a child care home or when a child is in the care of child care home staff shall be reported to the department within 24 hours of the incident.

(2) Serious injuries shall be documented and information maintained in the child's file as required by subrule 120.9(2).

**120.8(2)** *Use of outdoor space.*

*a.* A safe outdoor play area shall be maintained in good condition throughout the year. The play area shall be fenced off when located on a busy thoroughfare or near a hazard which may be injurious to a child and shall have both sunshine and shade areas. The play area shall be kept free from litter, rubbish, and flammable materials and shall be free from contamination by the drainage or ponding of sewage, household waste, or storm water.

*b.* When there is a swimming or wading pool on the premises:

(1) The wading pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high.

(4) An uncovered in-ground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high and flush with the ground.

c. If children are allowed to use an aboveground or in-ground swimming pool:

(1) Written permission from parents shall be available for review.

(2) Equipment needed to rescue a child or adult shall be readily accessible.

(3) The child care provider shall accompany the children and provide constant supervision while the children use the pool.

(4) The child care provider shall complete training in cardiopulmonary resuscitation for infants, toddlers, and children, according to the criteria of the American Red Cross or the American Heart Association.

**120.8(3) Medications and hazardous materials.**

a. All medicines and poisonous, toxic, or otherwise unsafe materials shall be secured from access by a child.

b. A first-aid kit shall be available and easily accessible whenever children are in the child care home, in the outdoor play area, in vehicles used to transport children, and on field trips. The kit shall be sufficient to address first aid related to minor injury or trauma and shall be stored in an area inaccessible to children. The kit shall, at a minimum, include adhesive bandages, bottled water, disposable tweezers, and disposable plastic gloves.

c. Medications shall be given only with the parent's or doctor's written authorization. Each prescribed medication shall be accompanied by a physician's or pharmacist's direction. Both nonprescription and prescription medications shall be in the original container with directions intact and labeled with the child's name. All medications shall be stored properly and, when refrigeration is required, shall be stored in a separate, covered container so as to prevent contamination of food or other medications. All medications shall be stored so they are inaccessible to children. Any medication administered to a child shall be recorded, and the record shall indicate the name of the medication, the date and time of administration, and the amount administered.

d. Medications shall not be provided to a child if the provider has not completed preservice/orientation training that includes medication administration.

**120.8(4) Emergency plans.** Emergency plans in case of man-made or natural disaster shall be written and posted by the primary and secondary exits. The plans shall clearly map building evacuation routes and tornado and flood shelter areas.

a. Fire and tornado drills shall be practiced monthly, and the provider shall keep documentation evidencing compliance with monthly practice on file.

b. The provider must have procedures in place for the following:

(1) Evacuation to safely leave the facility.

(2) Relocation to a common, safe location after evacuation.

(3) Shelter-in-place to take immediate shelter where the child is when it is unsafe to leave that location due to the emergent issue.

(4) Lockdown to protect children and providers from an external situation.

(5) Communication and plans for reunification with families.

(6) Continuity of operations.

(7) To address the needs of individual children, including those with functional or access needs.

**120.8(5) Safe sleep.** The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Infant sleep shall conform to the following standards:

a. Infants shall always be placed on their backs for sleep.

*b.* Infants shall be placed on a firm mattress with a tight fitted sheet that meets U.S. Consumer Product Safety Commission federal standards.

*c.* Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for sleeping including, but not limited to, an infant seat, car seat, swing, or bouncy seat.

*d.* No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

*e.* No co-sleeping shall be allowed.

*f.* Sleeping infants shall be actively observed by sight and sound.

*g.* If an alternate sleeping position is needed, a signed physician authorization with statement of medical reason is required.

**120.8(6) Discipline.** Discipline shall conform to the following standards:

*a.* Corporal punishment, including spanking, shaking and slapping, shall not be used.

*b.* Punishment that is humiliating or frightening or that causes pain or discomfort to the child shall not be used.

*c.* Punishment shall not be administered because of a child's illness, or progress or lack of progress in toilet training, nor shall punishment or threat of punishment be associated with food or rest.

*d.* No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

*e.* Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

**120.8(7) Meals and snacks.**

*a.* Regular meals and snacks that are well-balanced and nourishing shall be provided.

*b.* Children may bring food to the child care home for their own consumption but shall not be required to provide their own food.

*c.* Clean, sanitary drinking water shall be readily available to children in indoor and outdoor areas, throughout the day.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3096C, IAB 6/7/17, effective 8/1/17]

#### **441—120.9(237A) Children's files.**

**120.9(1)** An individual file for each child shall be maintained and updated annually or when the provider becomes aware of changes.

**120.9(2)** The file shall contain:

*a.* Identifying information including, at a minimum, the child's name and birth date; the parent's name, address and telephone number; the special needs of the child; and the parent's work address and telephone number.

*b.* Emergency contact information including, at a minimum, where the parent can be reached, the name, street address, city and telephone number of the child's regular source of health care, and the name, telephone number, and relationship to the child of another adult available in case of emergency.

*c.* A signed medical consent from the parent authorizing emergency medical and dental treatment.

*d.* An admission physical examination report signed by a licensed physician or the designee in a clinic supervised by a licensed physician.

*e.* A statement of health condition signed by a physician or designee submitted annually from the date of the admission physical examination. For a child who is five years of age or older and enrolled in school, a statement of health status signed by the parent or legal guardian may be substituted for the physician statement.

*f.* A list that is signed by the parent and names persons authorized to pick up the child. The authorization shall include the name, telephone number, and relationship of the authorized person to the child.

*g.* A signed and dated immunization certificate provided by the Iowa department of public health. For the school-age child, a copy of the most recent immunization record shall be acceptable.

*h.* For any child with allergies, a written emergency plan in case of an allergic reaction. A copy of this information shall accompany the child if the child leaves the premises.

*i.* Written permission from the parent for the child to attend activities away from the child care home. The permission shall include:

- (1) Times of departure and arrival.
- (2) Destination.
- (3) Names of persons who will be responsible for the child.

*j.* If the child meets the definition of homelessness as defined by Section 725(2) of the McKinney Vento Homeless Education Assistance Act, the family shall receive a 60-day grace period to obtain medical documentation.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

#### **441—120.10(237A) Professional development.**

**120.10(1)** Prior to the issuance of a provider agreement and every five years thereafter, the provider shall complete minimum health and safety trainings, approved by the department, in all of the following content areas:

- a.* Prevention and control of infectious disease, including immunizations.
- b.* Prevention of sudden infant death syndrome and use of safe sleep practices.
- c.* Administration of medication, consistent with standards for parental consent.
- d.* Prevention of and response to emergencies due to food and allergic reactions.
- e.* Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- f.* Prevention of shaken baby syndrome and abusive head trauma.
- g.* Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- h.* Handling and storage of hazardous materials and the appropriate disposal of biocontaminants.
- i.* Precautions in transporting children.
- j.* Child development, on or after August 1, 2017.

**120.10(2)** Prior to issuance of a provider agreement and every five years thereafter, the provider shall complete two hours of Iowa's training for mandatory reporting of child abuse.

**120.10(3)** Prior to issuance of a provider agreement, the provider shall complete first-aid and cardiopulmonary resuscitation (CPR) training that meets the following requirements:

- a.* Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.
- b.* CPR training shall include certification in infant and child CPR.
- c.* The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.
- d.* The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

**120.10(4)** Minimum health and safety training may be required prior to the five-year period if content has significant changes which warrant that the training be renewed.

**120.10(5)** Approved substitutes must have certification or other documentation that minimum health and safety training has been completed in compliance with 441—subrule 110.10(1) within three months of a substitute's hiring or before a substitute provides care, whichever occurs first.

[ARC 2648C, IAB 8/3/16, effective 10/1/16; ARC 3095C, IAB 6/7/17, effective 8/1/17]

**441—120.11(237A) Child care assistance provider agreement decision.** The department shall issue Form 470-3871, Child Care Assistance Provider Agreement, when an applicant meets all requirements for a child care home. The department shall maintain a current list of child care homes as a referral service to the community.

**120.11(1)** A provider agreement shall be denied or canceled if the department finds a hazard to the safety and well-being of a child and the provider cannot correct or refuses to correct the hazard, even though the hazard may not have been specifically listed under these rules. The provider agreement may also be denied or canceled if the department determines that the provider has failed to comply with standards imposed by law and rules found in this chapter or at 441—Chapter 170.

**120.11(2)** Record of all denials or cancellations of provider agreements and the documentation of reasons for denying or canceling the agreement shall be kept in an open file.

**120.11(3)** Record checks.

*a. Applicability.* The department shall conduct Iowa criminal history record and child abuse record checks for each provider, substitute or staff member, anyone living in the home who is 14 years of age or older, and anyone having access to a child when the child is alone. The department shall conduct national criminal history record checks, based on fingerprints, for each provider, substitute or staff member, anyone living in the home who is 18 years of age or older, and anyone 18 years of age or older having access to a child when the child is alone. In accordance with Iowa Code section 726.23, minors under the age of 18 will not be subject to the fingerprint requirement.

(1) The purpose of these record checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal history record and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or other states.

(3) Child care assistance provider agreements shall not be issued until the results of all state and national record checks have been received and, when necessary, evaluated.

*b. Authorization.* The person subject to record checks shall complete the Iowa department of human services record check authorization form; Form DCI-45, Waiver Agreement; Form FD-258, Federal Fingerprint Card; and any other forms required by the department of public safety to authorize the release of records.

*c. Iowa records checks.* Checks and evaluations of Iowa child abuse and criminal history records shall be completed before the person's involvement with child care. Iowa records checks shall be repeated at a minimum of every two years and when the department or the provider becomes aware of any possible transgressions. The department is responsible for the cost of conducting the Iowa records checks.

*d. National criminal history record checks.* Fingerprint-based checks of national criminal history records shall also be completed before a person's involvement with child care. This requirement shall be required for an initial application or a renewal application. The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state. The department is responsible for the cost of conducting the national criminal history record check.

(1) The provider is responsible for any costs associated with the taking (rolling) of fingerprints of all persons subject to record checks and for submitting the fingerprints to the department so the national criminal history record check can be completed. Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking (rolling) fingerprints.

(2) The department shall provide fingerprints to the department of public safety no later than ten business days after receipt of the fingerprint cards. The department shall submit the fingerprints on forms or in a manner allowed by the department of public safety.

(3) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child development home or child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

*e. Mandatory prohibition.* A person with any of the following convictions or founded abuse reports is prohibited from involvement with child care:

(1) Founded child or dependent adult abuse that was determined to be sexual abuse.

- (2) Placement on the sex offender registry.
- (3) Felony child endangerment or neglect or abandonment of a dependent person.
- (4) Felony domestic abuse.
- (5) Felony crime against a child including, but not limited to, sexual exploitation of a minor.
- (6) Forcible felony.

*f. Mandatory time-limited prohibition.*

(1) A person with the following conviction or founded abuse report is prohibited from involvement with child care for five years from the date of the conviction or the founded abuse report:

1. Conviction of a controlled substance offense under Iowa Code chapter 124.
2. Founded abuse that was determined to be physical abuse.

(2) After the five-year prohibition period (from the date of the conviction or the founded abuse report) as defined in subparagraph 120.11(3) "f"(1), the person may request the department to perform an evaluation under paragraph 120.11(3) "g" to determine whether prohibition of the person's involvement with child care continues to be warranted.

*g. Evaluation required.* For all other transgressions, and as requested under subparagraph 120.11(3) "f"(2), the department shall evaluate the transgression and make a decision about the person's involvement with child care.

(1) The person with the transgression shall complete and return the record check evaluation form within ten calendar days of the date on the form. The department shall use the information the person with the transgression provides on this form to assist in the evaluation. Failure of the person with the transgression to complete and return this form within ten calendar days of the date on the form shall result in denial or revocation of the child care assistance provider agreement.

(2) The department may use information from the department's case records in performing the evaluation.

(3) In an evaluation, the department shall consider all of the following factors:

1. The nature and seriousness of the transgression in relation to the position sought or held.
2. The time elapsed since the commission of the transgression.
3. The circumstances under which the transgression was committed.
4. The degree of rehabilitation.
5. The likelihood that the person will commit the transgression again.
6. The number of transgressions committed by the person.

(4) When a person subject to a record check has a transgression that has been determined in a previous evaluation not to warrant prohibition of the person's involvement with child care and the person has no subsequent transgressions, an exemption from reevaluation of the latest record check is authorized. The person may commence employment with another child care facility in accordance with the department's previous evaluation. The exemption is subject to all of the following conditions:

1. The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

2. Any restrictions placed on the person's employment by the department in the previous evaluation shall remain applicable in the person's subsequent employment.

3. The person subject to the record check has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer or the previous employer provides to the subsequent employer the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, the record check shall be reevaluated.

4. The subsequent employer may request a reevaluation of the record check and may employ the person while the reevaluation is being performed.

*h. Evaluation decision.* The department has final authority in determining whether prohibition of the person's involvement with child care is warranted and in developing any conditional requirements or corrective action plan.

(1) Within 30 calendar days of receipt of a completed record check evaluation, the department shall make a decision on the person's involvement with child care.

(2) Within 30 calendar days of receipt of a completed record check evaluation, the department shall mail to the person subject to an evaluation a record check decision that explains the decision reached regarding the evaluation of the transgression and a notice of decision: child care.

(3) The department shall issue a notice of decision: child care prohibiting involvement with child care when the person subject to an evaluation fails to complete the record check evaluation within the ten-calendar-day time frame.

(4) If the department determines, through the record check evaluation process, that the person's prohibition of involvement with child care is warranted, the person shall be prohibited from involvement with child care. The department may identify a period of time after which the person may request that another record check and evaluation be performed.

(5) The department may permit a person who is evaluated to maintain involvement with child care if the person complies with the department's conditions relating to the person's involvement with child care, which may include completion of additional training or an individually designed corrective action plan, or both. For an employee of a provider, these conditional requirements shall be developed with the provider. All conditions placed on a person's involvement with child care shall be communicated, in writing, to both the person subject to the evaluation and the provider.

*i. Notice to parents of abuse in care.* If there has been founded child abuse committed by an owner, director, or staff member of the child care facility or child care home, the department's administrator shall notify the parents, guardians, and legal custodians of each child for whom the facility or child care home provides care.

(1) The child care facility or child care home shall cooperate with the department in providing the names and addresses of the parent, guardian, or custodian of each child for whom the facility provides child care.

(2) This information shall be provided to the department within ten calendar days from the date of the initial request.

(3) Failure or refusal to provide the requested information may result in cancellation of the provider agreement.

**120.11(4) Required notifications to the department.**

*a.* The provider shall, within ten days, notify the department of any of the following:

- (1) Changes in substitutes;
- (2) Changes in household membership;
- (3) Address changes; and
- (4) Criminal convictions.

*b.* No substitute shall be utilized in the care of children and no person shall be permitted to reside in the household until approved by the department.

*c.* If the provider does not notify the department of changes within ten days, the provider may be subject to revocation of the provider's child care assistance provider agreement or to recoupment of child care assistance provided, or both.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.12(237A) Complaints.** The department shall conduct an on-site visit when a complaint is received.

**120.12(1)** After each complaint visit, the department shall document whether the child care home was in compliance with requirements.

**120.12(2)** The written documentation of the department's conclusion as to whether the child care home was in compliance with requirements shall be available to the public. However, the identity of all complainants shall be confidential, unless expressly waived by the complainant.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

**441—120.13(237A) Prohibition from involvement with child care.** If the department has prohibited a person or program from involvement with child care, that person or program shall not provide child care as a nonregistered child care home provider.

[ARC 2648C, IAB 8/3/16, effective 10/1/16]

These rules are intended to implement Iowa Code section 237A.12.

[Filed ARC 2648C (Notice ARC 2552C, IAB 5/25/16), IAB 8/3/16, effective 10/1/16]

[Filed ARC 3095C (Notice ARC 2998C, IAB 3/29/17), IAB 6/7/17, effective 8/1/17]

[Filed ARC 3096C (Notice ARC 2997C, IAB 3/29/17), IAB 6/7/17, effective 8/1/17]



TITLE XV  
*INDIVIDUAL AND FAMILY SUPPORT  
AND PROTECTIVE SERVICES*

CHAPTER 170  
CHILD CARE SERVICES  
[Prior to 7/1/83, Social Services[770] Ch 132]  
[Previously appeared as Ch 132—renumbered IAB 2/29/84]  
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The intent of this chapter is to establish requirements for the payment of child care services. Child care services are for children of low-income parents who are in academic or vocational training; or employed or looking for employment; or for a limited period of time, unable to care for children due to physical or mental illness; or needing protective services to prevent or alleviate child abuse or neglect. Services may be provided in a licensed child care center, a registered child development home, the home of a relative, the child's own home, or a nonregistered family child care home.  
[ARC 2169C, IAB 9/30/15, effective 1/1/16]

**441—170.1(237A) Definitions.**

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

1. Loss or misfiling of forms or documents.
2. Errors in typing or copying.
3. Computer input errors.
4. Mathematical errors.
5. Failure to determine eligibility correctly or to certify assistance in the correct amount when all essential information was available to the department.
6. Failure to make timely changes in assistance following amendments of policies that require the changes by a specific date.

*“Child care”* means a service that provides child care in the absence of parents for a portion of the day, but less than 24 hours. Child care supplements parental care by providing care and protection for children who need care in or outside their homes for part of the day. Child care provides experiences for each child's social, emotional, intellectual, and physical development. Child care may involve comprehensive child development care or it may include special services for a child with special needs. Components of this service shall include supervision, food services, program and activities, and may include transportation.

*“Child with protective needs”* means a child who is not in foster care and has a case file that identifies child care as a safety or well-being need to prevent or alleviate the effects of child abuse or neglect. Child care is provided as part of a safety plan during a child abuse or child in need of assistance assessment or as part of the service plan established in the family's case plan. The child must have:

1. An open child abuse assessment;
2. An open child in need of assistance assessment;
3. An open child welfare case as a result of a child abuse assessment;
4. A petition on file for a child in need of assistance adjudication; or
5. Adjudication as a child in need of assistance.

*“Child with special needs”* means a child with one or more of the following conditions:

1. The child has been diagnosed by a physician or by a person endorsed for service as a school psychologist by the Iowa department of education to have a developmental disability which substantially limits one or more major life activities, and the child requires professional treatment, assistance in self-care, or the purchase of special adaptive equipment.
2. The child has been determined by a qualified intellectual disability professional to have a condition which impairs the child's intellectual and social functioning.

3. The child has been diagnosed by a mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior which deviates substantially from behavior appropriate to the child's age, or which significantly interferes with the child's intellectual, social, or personal adjustment.

*"Client"* means a current or former recipient of the child care assistance program.

*"Client error"* means and may result from:

1. False or misleading statements, oral or written, regarding the client's income, resources, or other circumstances which affect eligibility or the amount of assistance received;
2. Failure to timely report changes in income, resources, or other circumstances which affect eligibility or the amount of assistance received;
3. Failure to timely report the receipt of child care units in excess of the number approved by the department;
4. Failure to comply with the need for service requirements.

*"Department"* means the Iowa department of human services.

*"Food services"* means the preparation and serving of nutritionally balanced meals and snacks.

*"Fraudulent means"* means knowingly making or causing to be made a false statement or a misrepresentation of a material fact, knowingly failing to disclose a material fact, or committing a fraudulent practice.

*"In-home"* means care which is provided within the child's own home.

*"Migrant seasonal farm worker"* means a person to whom all of the following conditions apply:

1. The person performs seasonal agricultural work which requires travel so that the person is unable to return to the person's permanent residence within the same day.
2. Most of the person's income is derived from seasonal agricultural work performed during the months of July through October. Most shall mean the simple majority of the income.
3. The person generally performs seasonal agricultural work in Iowa during the months of July through October.

*"On-line or distance learning"* means training such as, but not limited to, training conducted over the Iowa communications network, on-line courses, or Web conferencing. The training includes:

1. Interaction between the instructor and the student, such as required chats or message boards;
2. Mechanisms for evaluation and measurement of student achievement.

*"Overpayment"* means any benefit or payment received in an amount greater than the amount the client or provider is entitled to receive.

*"Parent"* means the parent or the person who serves in the capacity of the parent of the child receiving child care assistance services.

*"Program and activities"* means the daily schedule of experiences in a child care setting.

*"PROMISE JOBS"* means the department's training program, promoting independence and self-sufficiency through employment job opportunities and basic skills, as described in 441—Chapter 93.

*"Provider"* means a licensed child care center, a registered child development home, a relative who provides care in the relative's own home solely for a related child, a caretaker who provides care for a child in the child's home, or a nonregistered child care home.

*"Provider error"* means and may result from:

1. Presentation for payment of any false or fraudulent claim for services or merchandise;
2. Submittal of false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;
3. Failure to report the receipt of a child care assistance payment in excess of that approved by the department;
4. Charging the department an amount for services rendered over and above what is charged private pay clients for the same services;
5. Failure to maintain a copy of Form 470-4535, Child Care Assistance Billing/Attendance Provider Record, signed by the parent and the provider.

“*Recoupment*” means the repayment of an overpayment by a payment from the client or provider or both.

“*Relative*” means an adult aged 18 or older who is a grandparent, aunt or uncle to the child being provided child care.

“*Supervision*” means the care, protection, and guidance of a child.

“*Transportation*” means the movement of children in a four or more wheeled vehicle designed to carry passengers, such as a car, van, or bus, between home and facility.

“*Unit of service*” means a half day which shall be up to 5 hours of service per 24-hour period.

“*Vocational training or education*” means a training plan which includes a specific goal, that is, high school completion, improved English skills, or development of specific academic or vocational skills.

Training may be approved for high school completion activities, high school equivalency, adult basic education, English as a second language, or postsecondary education, up to and including an associate or a baccalaureate degree program.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1525C, IAB 7/9/14, effective 7/1/14; ARC 1606C, IAB 9/3/14, effective 10/8/14; ARC 2169C, IAB 9/30/15, effective 1/1/16; ARC 2555C, IAB 6/8/16, effective 7/1/16]

**441—170.2(237A,239B) Eligibility requirements.** A person deemed eligible for benefits under this chapter is subject to all other state child care assistance requirements including, but not limited to, provider requirements under Iowa Code chapter 237A and provider reimbursement methodology. The department shall determine the number of units of service to be approved.

**170.2(1) Financial eligibility.** Financial eligibility for child care assistance shall be based on federal poverty levels as determined by the Office of Management and Budget and on Iowa’s median family income as determined by the U.S. Census Bureau. Poverty guidelines and median family income amounts are updated annually. Changes shall go into effect for the child care assistance program on July 1 of each year.

*a. Income limits.* For initial and ongoing eligibility, an applicant family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” cannot exceed the amounts in subparagraphs 170.2(1)“a”(1) to (3). If, at the time of eligibility redetermination as described in subrule 170.3(5), a family’s nonexempt gross monthly income exceeds the limits established in 170.2(1)“a”(1) or (2) but not (3), the family shall remain eligible for an additional 12-month period or until their income exceeds that stated in (3), whichever comes first.

(1) 145 percent of the federal poverty level applicable to the family size for children needing basic care, or

(2) 200 percent of the federal poverty level applicable to the family size for children needing special-needs care, or

(3) 85 percent of Iowa’s median family income, if that figure is lower than the standard in subparagraph (1) or (2).

*b. Exceptions to income limits.*

(1) A person who is participating in activities approved under the PROMISE JOBS program is eligible for child care assistance without regard to income if there is a need for child care services.

(2) A person who is part of the family investment program or whose earned income was taken into account in determining the needs of a family investment program recipient is eligible for child care assistance without regard to income if there is a need for child care services.

(3) Protective child care services are provided without regard to income.

(4) In certain cases, the department will provide child care services directed in a court order.

*c. Determining gross income.* Eligibility shall be determined using a projection of income based on the best estimate of future income. In determining a family’s gross monthly income, the department shall consider all income received by a family member from sources identified by the U.S. Census Bureau in computing median income, unless excluded under paragraph 170.2(1)“d.”

(1) Income considered shall include wages or salary, net profit from farm or nonfarm self-employment, social security, dividends, interest, income from estates or trusts, net rental income and royalties, public assistance or welfare payments, pensions and annuities, unemployment compensation,

workers' compensation, alimony, child support, veterans pensions, cash payments, casino profits, railroad retirement, permanent disability insurance, strike pay and living allowance payments made to participants of the AmeriCorps program. "Net profit from self-employment" means gross income less the costs of producing the income other than depreciation. A net loss in self-employment income cannot be offset from other earned or unearned income.

(2) For migrant seasonal farm workers, the monthly gross income shall be determined by calculating the total amount of income earned in a 12-month period preceding the date of application and dividing the total amount by 12.

(3) When income received weekly or once every two weeks is projected for future months, income shall be projected by adding all income received in the period being used for the projection and dividing the result by the number of instances of income received in that period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

*d. Income exclusions.* The following sources are excluded from the computation of monthly gross income:

(1) Per capita payments from or funds held in trust in satisfaction of a judgment of the Indian Claims Commission or the court of claims.

(2) Payments made pursuant to the Alaska Claims Settlement Act, to the extent the payments are exempt from taxation under Section 21(a) of the Act.

(3) Money received from the sale of property, unless the person was engaged in the business of selling property.

(4) Withdrawals of bank deposits.

(5) Money borrowed.

(6) Tax refunds.

(7) Gifts.

(8) Lump-sum inheritances or insurance payments or settlements.

(9) Capital gains.

(10) The value of the food assistance allotment under the Food and Nutrition Act of 2008.

(11) The value of USDA donated foods.

(12) The value of supplemental food assistance under the Child Nutrition Act of 1966 and the special food program for children under the National School Lunch Act.

(13) Earnings of a child 14 years of age or younger.

(14) Loans and grants obtained and used under conditions that preclude their use for current living expenses.

(15) Any grant or loan to any undergraduate student for educational purposes made or insured under the Higher Education Act.

(16) Home produce used for household consumption.

(17) Earnings received by any youth under the Workforce Investment Act (WIA).

(18) Stipends received for participating in the foster grandparent program.

(19) The first \$65 plus 50 percent of the remainder of income earned in a sheltered workshop or work activity setting.

(20) Payments from the Low-Income Home Energy Assistance Program.

(21) Agent Orange settlement payments.

(22) The income of the parents with whom a teen parent resides.

(23) For children with special needs, income spent on any regular ongoing cost that is specific to that child's disability.

(24) Moneys received under the federal Social Security Persons Achieving Self-Sufficiency (PASS) program or the Income-Related Work Expense (IRWE) program.

(25) Income received by a Supplemental Security Income recipient if the recipient's earned income was considered in determining the needs of a family investment program recipient.

(26) The income of a child who would be in the family investment program eligible group except for the receipt of Supplemental Security Income.

- (27) Any adoption subsidy payments received from the department.
- (28) Federal or state earned income tax credit.
- (29) Payments from the Iowa individual assistance grant program (IIAGP).
- (30) Payments from the transition to independence program (TIP).
- (31) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

EXCEPTION: This exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteer is serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the laws of the state where the volunteer is serving, whichever is greater.

- (32) Reimbursement from the employer for job-related expenses.
- (33) Stipends from the preparation for adult living (PAL) program.
- (34) Payments from the subsidized guardianship waiver program.
- (35) The earnings of a child aged 18 or under who is a full-time student.
- (36) Census earnings received by temporary workers from the Bureau of the Census.
- (37) Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

*e. Family size.* The following people shall be included in the family size for the determination of eligibility:

- (1) Legal spouses (including common law) who reside in the same household.
- (2) Natural mother or father, adoptive mother or father, or stepmother or stepfather, and children who reside in the same household.
- (3) A child or children who live with a person or persons not legally responsible for the child's support.

*f. Effect of temporary absence.* The composition of the family does not change when a family member is temporarily absent from the household. "Temporary absence" means:

- (1) An absence for the purpose of education or employment.
- (2) An absence due to medical reasons that is anticipated to last less than three months.
- (3) Any absence when the person intends to return home within three months.

*g. Resource limits.* For initial and ongoing eligibility, family resources may not exceed \$1 million.

**170.2(2) General eligibility requirements.** In addition to meeting financial requirements, the child needing services must meet age, citizenship, and residency requirements. Each parent in the household must have at least one need for service and shall cooperate with the department's quality control review and with investigations conducted by the department of inspections and appeals.

*a. Age.* Child care shall be provided only to children up to age 13, unless they are children with special needs, in which case child care shall be provided up to age 19. When a child reaches the age of 13, or, as applicable, the age of 19, during the certification period, eligibility shall continue until the end of the approved certification period.

*b. Need for service.* Except for assistance provided under subparagraph 170.2(2)"b"(3), assistance shall be provided to a two-parent family only during the parents' coinciding hours of participation in training, employment, or job search. Each parent in the household shall meet one or more of the following requirements:

(1) The parent is in academic or vocational training. Training shall be on a full-time basis. The training facility shall define what is considered as full-time. Part-time training may be approved only if the number of credit hours to complete training is less than that required for full-time status, the required prerequisite credits or remedial course work is less than that required for full-time status, or training is not offered on a full-time basis. Child care services may be provided for the parent's hours of participation in the academic or vocational training and for actual travel time between the child care location and the training facility.

1. Child care provided while the parent participates in postsecondary education leading up to and including a baccalaureate degree program or vocational training shall be limited to a 24-month lifetime limit. A month is defined as a fiscal month or part thereof and shall generally have starting and ending

dates that fall within two adjacent calendar months but shall only count as one month. Time spent in high school completion, adult basic education, high school equivalency, or English as a second language does not count toward the 24-month limit. PROMISE JOBS child care allowances provided while the parent is a recipient of the family investment program and participating in PROMISE JOBS components in postsecondary education or training shall count toward the 24-month lifetime limit.

2. Payment shall not be approved for child-care during training in the following circumstances:

- Labor market statistics for a local area indicate low employment potential for workers with that training. Exceptions may be made when the parent has a job offer before entering the training or if a parent is willing to relocate after training to an area where there is employment potential. Parents willing to relocate must provide documentation from the department of workforce development, private employment agencies, or employers that jobs paying at least minimum wage for which training is being requested are available in the locale specified by the parent.

- The training is for jobs paying less than minimum wage.

- A parent who possesses a baccalaureate degree wants to take additional college coursework unless the coursework is to obtain a teaching certificate or complete continuing education units.

- The course or training is one that the parent has previously completed.

- The parent was previously unable to maintain the cumulative grade point average required by the training or academic facility in the same training for which application is now being made. This does not apply to parents under the age of 18 who are enrolled in high school completion activities.

- The education is in a field in which the parent will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.

- The parent wants to participate in on-line or distance learning from the parent's own home, and the training facility does not require specified hours of attendance.

(2) The parent is employed 28 or more hours per week or an average of 28 or more hours per week during the month. Child care services may be provided for the hours of employment and for actual travel time between the child care location and the place of employment. If the parent works a shift consisting of at least six hours of employment between the hours of 8 p.m. and 6 a.m. and needs to sleep during daytime hours, child care services may also be provided to allow the parent to sleep during daytime hours.

(3) The parent has a child with protective needs for child care.

(4) The parent is absent from the home due to inpatient hospitalization or outpatient treatment because of physical or mental illness, or is present but due to medical incapacity is unable to care for the child or participate in work or training, as verified by a physician.

1. Eligibility under this paragraph is limited to parents who become medically incapacitated while eligible for child care assistance based on the need criteria in subparagraph 170.2(2) "b"(1) or 170.2(2) "b"(2).

2. Child care assistance shall continue to be available for up to 90 consecutive days after the parent becomes medically incapacitated. Assistance beyond 90 days may be approved by the service area manager or designee if extenuating circumstances are verified by a physician.

3. The number of units of service authorized shall be determined as follows:

- For a single-parent family or for a two-parent family where both parents are incapacitated, the number of units authorized for the period of incapacity shall not exceed the number of units authorized for the family before the onset of incapacity.

- For a two-parent family where only one parent is incapacitated, the units of service authorized shall be based on the need of the parent who is not incapacitated.

(5) The parent is looking for employment. Child care for job search hours shall be limited to only those hours the parent is actually looking for employment, including travel time. Job search shall be limited to a maximum of 90 consecutive calendar days.

1. For applicants, job search shall be approved for a maximum of 90 consecutive calendar days. If the parent has not started employment within 90 days, assistance shall be canceled.

2. For ongoing participants, job search shall be limited to a maximum of 90 consecutive calendar days and will be treated the same as a temporary lapse in need as described at 170.2(2) "b"(9) and (10).

(6) The parent needs child care services due to participation in activities approved under the PROMISE JOBS program.

(7) The family is part of the family investment program and there is a need for child care services due to employment or participation in vocational training or education. A family who meets this requirement due to employment is not required to work a minimum number of hours. If a parent in a family investment program household remains in the home, child care assistance can be paid if that parent receives Supplemental Security Income.

(8) The parent is employed and participating in academic or vocational training for 28 or more hours per week or an average of 28 or more hours per week in the aggregate, during the month. Child care services may be provided for the hours of employment, the hours of participation in academic or vocational training and for actual travel time between the child care location and the place of employment or training. All of the requirements relating to academic or vocational training found at subparagraph 170.2(2)“b”(1), except for the requirement to be enrolled full-time, apply to the part-time training in this subparagraph.

(9) Family eligibility shall continue during an approved certification period when a temporary lapse in need for service for a parent established under this subparagraph occurs. A temporary lapse is defined as a period of not more than 3 consecutive months, and the lapse is due to one or more of the following reasons:

1. Maternity leave.
2. Family Medical Leave Act (FMLA) situations for household members.
3. Participation in a treatment/rehabilitation program.
4. Employment or education/training hours fall below the minimum number required at 170.2(2)“b”(1), (2) or (8).
5. Normal breaks between school terms.

(10) Family eligibility shall be canceled if the lapse in need is not temporary because the lapse will continue for more than 3 consecutive months.

*c. Residency.* To be eligible for child care services, the person must be living in the state of Iowa. “Living in the state” shall include those persons living in Iowa for a temporary period, other than for the purpose of vacation.

*d. Citizenship.* As a condition of eligibility, the applicant shall attest to the child’s citizenship or alien status by signing Form 470-3624 or 470-3624(S), Child Care Assistance Application, or Form 470-0462 or 470-0462(S), Health and Financial Support Application. Child care assistance payments may be made only for a child who:

- (1) Is a citizen or national of the United States; or
- (2) Is a qualified alien as defined at 8 U.S.C. Section 1641. The applicant shall furnish documentation of the alien status of any child declared to be a qualified alien. A child who is a qualified alien is not eligible for child care assistance for a period of five years beginning on the date of the child’s entry into the United States with qualified alien status.

EXCEPTION: The five-year prohibition from receiving assistance does not apply to:

1. Qualified aliens described at 8 U.S.C. Section 1613; or
2. Qualified aliens as defined at 8 U.S.C. Section 1641 who entered the United States before August 22, 1996.

*e. Cooperation.* Parents shall cooperate with the department when the department selects the family’s case for quality control review to verify eligibility. Parents shall also cooperate with investigations conducted by the department of inspections and appeals to determine whether information supplied by the parent regarding eligibility for child care assistance is complete and correct. (See 481—Chapter 72.)

(1) Failure to cooperate shall serve as a basis for cancellation or denial of the family’s child care assistance.

(2) Once denied or canceled for failure to cooperate, the family may reapply but shall not be considered for approval until cooperation occurs.

**170.2(3) Priority for assistance.** Child care services shall be provided only when funds are available. Funds available for child care assistance shall first be used to continue assistance to families currently receiving child care assistance and to families with protective child care needs. When funds are insufficient, families applying for services must meet the specific requirements in this subrule.

*a. Priority groups.* As funds are determined available, families shall be served on a statewide basis from a service-area-wide waiting list as specified in subrule 170.3(4) based on the following schedule in descending order of prioritization.

(1) Families with an income at or below 100 percent of the federal poverty level whose members, for at least 28 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program, and parents with a family income at or below 100 percent of the federal poverty level who are under the age of 21 and are participating in an educational program leading to a high school diploma or equivalent.

(2) Parents under the age of 21 with a family income at or below 100 percent of the federal poverty guidelines who are participating, at a satisfactory level, in an approved training program or in an education program.

(3) Families with an income of more than 100 percent but not more than 145 percent of the federal poverty guidelines whose members, for at least 28 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

*b. Exceptions to priority groups.* The following are eligible for child care assistance notwithstanding waiting lists for child care services:

(1) Families with protective child care needs.

(2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.

(3) Families that receive a state adoption subsidy for a child.

*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.

*c.* Exception: Changes in income do not need to be reported during the approved certification period unless the family's gross monthly income exceeds 85 percent of Iowa's median family income. [ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1525C, IAB 7/9/14, effective 7/1/14; ARC 1606C, IAB 9/3/14, effective 10/8/14; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17]

#### **441—170.3(237A,239B) Application and determination of eligibility.**

##### **170.3(1) Application process.**

*a.* Application for child care assistance may be made at any local office of the department on:

(1) Form 470-3624 or 470-3624(S), Child Care Assistance Application,

(2) Form 470-0462 or 470-0462(S), Health and Financial Support Application, or

(3) Form 470-4377 or 470-4377(S), Child Care Assistance Review, when returned after the end of the certification period.

*b.* The application may be filed by the applicant, by the applicant's authorized representative or, when the applicant is incompetent or incapacitated, by a responsible person acting on behalf of the applicant.

*c.* The date of application is the date a signed application form containing a legible name and address is received in the department office. An electronic or paper application delivered to a closed

office is considered to be received on the first day following the day the office was last open that is not a weekend or state holiday.

*d.* Families who are determined eligible for child care assistance shall be approved for a certification period of at least 12 months. Families who fail to complete the review and redetermination process as described at subrule 170.3(5) will lose eligibility at the end of the certification period.

**170.3(2) Exceptions to application requirement.** An application is not required for:

*a.* A person who is participating in activities approved under the PROMISE JOBS program.  
*b.* Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients. The date of application is the date the family requests child care assistance from the department.

*c.* Children with protective needs.

*d.* Child care services provided under a court order.

*e.* Families whose application has been denied for failure to provide requested information who have provided all necessary information to determine eligibility within 14 days of the denial of the application, or by the next working day if the fourteenth day falls on a weekend or state holiday.

**170.3(3) Application processing.** The department shall approve or deny an application as soon as possible, but no later than 30 days following the date the application was received. This time limit shall apply except in unusual circumstances, such as when the department and the applicant have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expires, or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

*a.* The department worker or PROMISE JOBS worker shall determine the number of units of service authorized for each eligible family and shall:

(1) Inform the family through the notice of decision; and

(2) Inform the family's provider through the notice of decision or through Form 470-4444, Certificate of Enrollment.

*b.* The department shall issue a written notice of decision to the applicant by the next working day following a determination of eligibility.

*c.* The effective date of assistance shall be the date of application or the date the need for service began, whichever is later. When an application is not required as described under subrule 170.3(2), the effective date shall be as follows:

(1) For a person participating in activities under the PROMISE JOBS program, the effective date of child care assistance shall be the date the person becomes a PROMISE JOBS participant as defined in rule 441—93.1(239B) or the date the person has a need for child care assistance to participate in an approved PROMISE JOBS activity as described in 441—Chapter 93, whichever is later.

(2) For a family receiving family investment program benefits, the effective date of child care assistance shall be no earlier than the effective date of family investment program benefits, or 30 days before the date of application for child care assistance, or the date the need for service began, whichever is the latest.

(3) For a family with protective service needs, the effective date of assistance shall be the date the family signs Form 470-0615 or 470-0615(S), Application for All Social Services.

(4) When child care services are provided under a court order, the effective date of assistance shall be the date specified in the court order or the date of the court order if no date is specified.

(5) For a family whose application was denied for failure to provide requested information but who provides all information necessary to determine eligibility, including verification of all changes in circumstances, within 14 days of the denial, the effective date of assistance shall be the date that all information required to establish eligibility is provided. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information.

**170.3(4) Waiting lists for child care services.** When the department has determined that there may be insufficient funding, applications for child care assistance shall be taken only for the priority groups for which funds have been determined available according to subrule 170.2(3).

*a.* The department shall maintain a log of families applying for child care services that meet the requirements within the priority groups for which funds may be available.

(1) Each family shall be entered on the logs according to their eligibility priority group and in sequence of their date of application.

(2) If more than one application is received on the same day for the same priority group, families shall be entered on the log based on the day of the month of the birthday of the oldest eligible child. The lowest numbered day shall be first on the log. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

*b.* When the department determines that there is adequate funding, the department shall notify the public regarding the availability of funds.

**170.3(5) Review and redetermination.** The department shall redetermine a family's financial and general eligibility for child care assistance at least every 12 months. EXCEPTION: The department shall redetermine only general eligibility for recipients of the family investment program (FIP), persons whose earned income was taken into account in determining the needs of FIP recipients, and parents who have children with protective needs, because these families are deemed financially eligible so long as the FIP eligibility or need for protective services continues.

*a.* If FIP or protective services eligibility ends, the department shall redetermine financial and general eligibility for child care assistance according to the requirements in rule 441—170.2(237A,239B). The redetermination of eligibility shall be completed within 30 days.

*b.* The department shall use information gathered on Form 470-4377 or 470-4377(S), Child Care Assistance Review, to redetermine eligibility, except when the family is not required to complete a review form as provided in paragraph 170.3(5)“c.”

(1) The department shall issue a notice of expiration for the child care assistance certification period on Form 470-4377 or 470-4377(S).

(2) If the family does not return a complete review form to the department by the end of the certification period, the family must reapply for benefits, except as provided in paragraph 170.3(6)“b.” A complete review form is Form 470-4377 or 470-4377(S) with all items answered that is signed and dated by the applicant and is accompanied by all verification needed to determine continued eligibility.

*c.* Families who have children with protective needs and families who are receiving child care assistance because the parent is participating in activities under the PROMISE JOBS program are not required to complete Form 470-4377 or 470-4377(S).

(1) The department shall issue a notice of expiration for the child care assistance certification period on the notice of decision when the department approves the family's certification period.

(2) The department shall gather information needed to redetermine general eligibility. If the department needs information from the family, the department will send a written request to the family. If the family does not return the requested information by the due date, the family must reapply for child care assistance, except as provided in paragraph 170.3(6)“b.”

*d.* Families who apply for child care assistance because the parent is seeking employment are not subject to review requirements because eligibility is limited to 90 consecutive calendar days. This waiver of the review requirement applies only when the parent who is seeking employment does not have another need for service.

**170.3(6) Reinstatement.**

*a.* Assistance shall be reinstated without a new application when all necessary information is provided before the effective date of cancellation and eligibility can be reestablished. If there is a change in circumstances, the change must be verified before the case will be reinstated.

*b.* Assistance shall be reinstated without a new application when the case was canceled for failure to provide requested information but all information necessary to determine eligibility, including verification of all changes in circumstances, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the family shall have until the next business day to provide the information. The effective

date of child care assistance shall be the date that all information required to establish eligibility is provided.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17]

**441—170.4(237A) Elements of service provision.**

**170.4(1) Case file.** The child welfare case file shall document the eligibility for service under 170.2(2) “b”(3).

**170.4(2) Fees.** Fees for services received shall be charged to clients according to the schedules in this subrule, except that fees shall not be charged to clients receiving services without regard to income. The fee is a per-unit charge that is applied to the child in the family who receives the largest number of units of service. The fee shall be charged for only one child in the family, regardless of how many children receive assistance.

*a. Sliding fee schedule.*

(1) The fee schedule shown in the following table is effective for eligibility determinations made on or after July 1, 2017:

Level	Monthly Income According to Family Size													Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	11	12	13+	1	2	3 or more
A	\$955	\$1,286	\$1,617	\$1,948	\$2,279	\$2,610	\$2,940	\$3,272	\$3,602	\$3,933	\$4,265	\$4,595	\$4,926	\$0.00	\$0.00	\$0.00
B	\$1,005	\$1,354	\$1,702	\$2,050	\$2,399	\$2,747	\$3,095	\$3,444	\$3,792	\$4,140	\$4,489	\$4,837	\$5,185	\$0.20	\$0.45	\$0.70
C	\$1,033	\$1,392	\$1,750	\$2,107	\$2,466	\$2,824	\$3,182	\$3,540	\$3,898	\$4,256	\$4,615	\$4,972	\$5,330	\$0.45	\$0.70	\$0.95
D	\$1,061	\$1,430	\$1,797	\$2,165	\$2,533	\$2,901	\$3,268	\$3,637	\$4,004	\$4,372	\$4,740	\$5,108	\$5,475	\$0.70	\$0.95	\$1.20
E	\$1,091	\$1,470	\$1,848	\$2,225	\$2,604	\$2,982	\$3,360	\$3,739	\$4,116	\$4,494	\$4,873	\$5,251	\$5,629	\$0.95	\$1.20	\$1.45
F	\$1,121	\$1,510	\$1,898	\$2,286	\$2,675	\$3,063	\$3,451	\$3,841	\$4,229	\$4,617	\$5,006	\$5,394	\$5,782	\$1.20	\$1.45	\$1.70
G	\$1,152	\$1,552	\$1,951	\$2,350	\$2,750	\$3,149	\$3,548	\$3,948	\$4,347	\$4,746	\$5,146	\$5,545	\$5,944	\$1.45	\$1.70	\$1.95
H	\$1,183	\$1,594	\$2,004	\$2,414	\$2,825	\$3,235	\$3,645	\$4,056	\$4,465	\$4,875	\$5,286	\$5,696	\$6,106	\$1.70	\$1.95	\$2.20
I	\$1,217	\$1,639	\$2,060	\$2,482	\$2,904	\$3,325	\$3,747	\$4,169	\$4,590	\$5,012	\$5,434	\$5,855	\$6,277	\$1.95	\$2.20	\$2.45
J	\$1,250	\$1,684	\$2,116	\$2,549	\$2,983	\$3,416	\$3,849	\$4,283	\$4,715	\$5,148	\$5,582	\$6,015	\$6,448	\$2.20	\$2.45	\$2.70
K	\$1,285	\$1,731	\$2,176	\$2,621	\$3,067	\$3,512	\$3,956	\$4,403	\$4,847	\$5,292	\$5,739	\$6,183	\$6,628	\$2.45	\$2.70	\$2.95
L	\$1,320	\$1,778	\$2,235	\$2,692	\$3,150	\$3,607	\$4,064	\$4,523	\$4,980	\$5,437	\$5,895	\$6,352	\$6,809	\$2.70	\$2.95	\$3.20
M	\$1,357	\$1,828	\$2,298	\$2,767	\$3,238	\$3,708	\$4,178	\$4,649	\$5,119	\$5,589	\$6,060	\$6,530	\$6,999	\$2.95	\$3.20	\$3.45
N	\$1,394	\$1,878	\$2,360	\$2,843	\$3,327	\$3,809	\$4,292	\$4,776	\$5,258	\$5,741	\$6,225	\$6,707	\$7,190	\$3.20	\$3.45	\$3.70
O	\$1,433	\$1,930	\$2,426	\$2,922	\$3,420	\$3,916	\$4,412	\$4,910	\$5,406	\$5,902	\$6,399	\$6,895	\$7,391	\$3.45	\$3.70	\$3.95
P	\$1,472	\$1,983	\$2,492	\$3,002	\$3,513	\$4,023	\$4,532	\$5,043	\$5,553	\$6,062	\$6,574	\$7,083	\$7,593	\$3.70	\$3.95	\$4.20
Q	\$1,513	\$2,038	\$2,562	\$3,086	\$3,611	\$4,135	\$4,659	\$5,184	\$5,708	\$6,232	\$6,758	\$7,281	\$7,805	\$3.95	\$4.20	\$4.45
R	\$1,554	\$2,094	\$2,632	\$3,170	\$3,710	\$4,248	\$4,786	\$5,326	\$5,864	\$6,402	\$6,942	\$7,480	\$8,018	\$4.20	\$4.45	\$4.70
S	\$1,598	\$2,152	\$2,706	\$3,259	\$3,814	\$4,367	\$4,920	\$5,475	\$6,028	\$6,581	\$7,136	\$7,689	\$8,242	\$4.45	\$4.70	\$4.95
T	\$1,641	\$2,211	\$2,779	\$3,348	\$3,917	\$4,486	\$5,054	\$5,624	\$6,192	\$6,760	\$7,330	\$7,899	\$8,467	\$4.70	\$4.95	\$5.20
U	\$1,687	\$2,273	\$2,857	\$3,441	\$4,027	\$4,611	\$5,196	\$5,781	\$6,366	\$6,950	\$7,536	\$8,120	\$8,704	\$4.95	\$5.20	\$5.45
V	\$1,733	\$2,335	\$2,935	\$3,535	\$4,137	\$4,737	\$5,337	\$5,939	\$6,539	\$7,139	\$7,741	\$8,341	\$8,941	\$5.20	\$5.45	\$5.70

Level	Monthly Income According to Family Size													Unit Fee Based on Number of Children in Care		
	1	2	3	4	5	6	7	8	9	10	11	12	13+	1	2	3 or more
W	\$1,782	\$2,400	\$3,017	\$3,634	\$4,253	\$4,870	\$5,486	\$6,105	\$6,722	\$7,339	\$7,958	\$8,574	\$9,191	\$5.45	\$5.70	\$5.95
X	\$1,830	\$2,466	\$3,099	\$3,733	\$4,369	\$5,002	\$5,636	\$6,271	\$6,905	\$7,539	\$8,174	\$8,808	\$9,442	\$5.70	\$5.95	\$6.20
Y	\$1,881	\$2,535	\$3,186	\$3,838	\$4,491	\$5,142	\$5,794	\$6,447	\$7,098	\$7,750	\$8,403	\$9,055	\$9,706	\$5.95	\$6.20	\$6.45
Z	\$1,933	\$2,604	\$3,273	\$3,942	\$4,613	\$5,282	\$5,952	\$6,623	\$7,292	\$7,961	\$8,632	\$9,301	\$9,970	\$6.20	\$6.45	\$6.70
AA	\$1,987	\$2,677	\$3,364	\$4,052	\$4,742	\$5,430	\$6,118	\$6,808	\$7,496	\$8,184	\$8,874	\$9,562	\$10,250	\$6.45	\$6.70	\$6.95
BB	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000	\$9,000	\$9,000	\$9,000	\$9,000	\$9,500	\$10,000	\$10,500	\$11,500	\$6.70	\$6.95	\$7.20

- (2) To use the chart:
1. Find the family size used in determining income eligibility for service.
  2. Move across the monthly income table to the column headed by that number.
  3. Move down the column for the applicable family size to the highest figure that is equal to or less than the family's gross monthly income. Income at or above that amount (but less than the amount in the next row) corresponds to the fees in the last three columns of that row.
  4. Choose the fee that corresponds to the number of children in the family who receive child care assistance.

*b. Collection.* The provider shall collect fees from clients.

(1) The provider shall maintain records of fees collected. These records shall be available for audit by the department or its representative.

(2) When a client does not pay the fee, the provider shall demonstrate that a reasonable effort has been made to collect the fee. "Reasonable effort to collect" means an original billing and two follow-up notices of nonpayment.

*c. Inability of client to pay fees.* Child care assistance may be continued without a fee, or with a reduced fee, when a client reports in writing the inability to pay the assessed fee due to the existence of one or more of the conditions set forth below. Before reducing the fee, the worker shall assess the case to verify that the condition exists and to determine whether a reduced fee can be charged. The reduced fee shall then be charged until the condition justifying the reduced fee no longer exists. Reduced fees may be justified by:

(1) Extensive medical bills for which there is no payment through insurance coverage or other assistance.

(2) Shelter costs that exceed 30 percent of the household income.

(3) Utility costs not including the cost of a telephone that exceed 15 percent of the household income.

(4) Additional expenses for food resulting from diets prescribed by a physician.

**170.4(3) Method of provision.** Parents shall be allowed to exercise their choice for in-home care, except when the parent meets the need for service under subparagraph 170.2(2)"b"(3), as long as the conditions in paragraph 170.4(7)"d" are met. When the child meets the need for service under 170.2(2)"b"(3), parents shall be allowed to exercise their choice of licensed, registered, or nonregistered child care provider except when the department service worker determines it is not in the best interest of the child. The provider must meet one of the applicable requirements set forth below.

*a. Licensed child care center.* A child care center shall be licensed by the department to meet the requirements set forth in 441—Chapter 109 and shall have a current Certificate of License, Form 470-0618.

*b. Registered child development home.* A child development home shall meet the requirements for registration set forth in 441—Chapter 110 and shall have a current Certificate of Registration, Form 470-3498.

*c. Out-of-state provider.* A child care provider who is not located in Iowa may be selected by the parent so long as the out-of-state child care provider verifies that the provider meets all of the requirements to be a provider in the state in which the provider operates.

*d. Relative care.* Rescinded IAB 2/6/02, effective 4/1/02.

*e. In-home care.* The adult caretaker selected by the parent to provide care in the child's own home shall be sent Form 470-2890 or 470-2890(S), Payment Application for Nonregistered Providers. The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider's understanding of and compliance with the conditions and requirements for nonregistered in-home care providers that include:

(1) Professional development. The provider shall complete:

1. Prior to provider agreement and every five years thereafter, minimum health and safety trainings, approved by the department, in the following content areas:

- Prevention and control of infectious disease, including immunizations.

- Prevention of sudden infant death syndrome and use of safe sleep practices.
- Administration of medication, consistent with standards for parental consent.
- Prevention of and response to emergencies due to food and allergic reactions.
- Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- Prevention of shaken baby syndrome and abusive head trauma.
- Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- Handling and storage of hazardous materials and appropriate disposal of biocontaminants.
- Precautions in transporting children.

Minimum health and safety training may be required prior to the five-year period if content has significant changes which warrant that the training be renewed.

2. Prior to provider agreement, two hours of Iowa's training for mandatory reporting of child abuse.

3. Prior to provider agreement, first-aid and cardiopulmonary resuscitation (CPR) training meeting the following requirements:

- Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.

- First-aid training shall include certification in infant and child first aid.

- The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

- The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

(2) Limits on the number of children for whom care may be provided.

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order.

(4) Conditions that warrant nonpayment.

*f. Nonregistered family child care home.* A nonregistered child care home shall meet the requirements set forth in 441—Chapter 120.

*g. Iowa records checks for in-home care.* If a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete and submit to the department Form 470-5143, Iowa Department of Human Services Record Check Authorization Form. The department shall use this form to conduct Iowa criminal history record and child abuse record checks.

(1) The purpose of these checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or in other states.

(3) Records checks shall be repeated every two years and when the department or provider becomes aware of any new transgressions.

*h. National criminal history record checks for in-home care.* If a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form DCI-45, Waiver Agreement, and Form FD-258, Federal Fingerprint Card.

(1) The provider subject to this check shall submit any other forms required by the department of public safety to authorize the release of records.

(2) The provider subject to this check is responsible for any costs associated with obtaining the fingerprints and for submitting the prints to the department.

(3) Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints.

(4) The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state.

(5) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

*i. Transgressions.* If any person subject to the record checks in paragraph 170.4(3)“g” or 170.4(3)“h” has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall follow the process for prohibition or evaluation defined at 441—subrule 110.7(3).

(1) If any person would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant.

(2) A person who continues to provide child care in violation of this rule is subject to penalty and injunction under Iowa Code chapter 237A.

**170.4(4) Components of service program.** Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

**170.4(5) Levels of service according to age.** Rescinded IAB 9/30/92, effective 10/1/92.

**170.4(6) Provider's individual program plan.** Rescinded IAB 2/10/10, effective 3/1/10.

**170.4(7) Payment.** The department shall make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has a completed Form 470-3871 or 470-3871(S), Child Care Assistance Provider Agreement, on file with the department. Both the child care provider and the department worker shall sign this form.

*a. Rate of payment.* The rate of payment for child care services, except for in-home care which shall be paid in accordance with 170.4(7)“d,” shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider's declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider's declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider 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
	Basic	QRS 5	Basic	QRS 5	Basic	QRS 5	
Infant and Toddler	\$16.78	\$20.50	\$12.98	\$13.75	\$12.44	\$15.00	\$8.19
Preschool	\$13.53	\$17.50	\$12.18	\$13.50	\$12.18	\$13.75	\$7.19
School Age	\$12.18	\$14.75	\$10.82	\$12.50	\$10.82	\$13.00	\$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	\$51.94	\$17.05	\$13.40	\$10.24
Preschool	\$30.43	\$15.83	\$13.40	\$ 8.99
School Age	\$30.34	\$14.61	\$12.18	\$ 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.” “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 441—Chapter 120.

(2) Under age group, “infant and toddler” shall mean age two weeks to two years; “preschool” shall mean two years to school age; “school age” shall mean a child in attendance in full-day or half-day classes.

(3) “QRS 5” shall mean a provider who has achieved a rating of Level 5 under the quality rating system.

*b. Payment for days of absence.* Payment may be made to a child care provider defined in subrule 170.4(3) for an individual child not in attendance at a child care facility not to exceed four days per calendar month providing that the child is regularly scheduled on those days and the provider also charges a private individual for days of absence.

*c. Payment for multiple children in a family.* When a provider reduces the charges for the second and any subsequent children in a family with multiple children whose care is unsubsidized, the rate of payment made by the department for a family with multiple children shall be similarly reduced.

*d. Payment for in-home care.* Payment may be made for in-home care when there are three or more children in a family who require child care services. The rate of payment for in-home care shall be the minimum wage amount.

*e. Limitations on payment.* Payment shall not be made for therapeutic services that are provided in the care setting and include, but are not limited to, services such as speech, hearing, physical and other therapies, individual or group counseling, therapeutic recreation, and crisis intervention.

*f. Review of the calculation of the rate of payment.* Maximum rate ceilings are not appealable. A provider who is in disagreement with the calculation of the half-day rate as set forth in 170.4(7)“a” may request a review. The procedure for review is as follows:

(1) Within 15 calendar days of notification of the rate in question, the provider shall send a written request for review to the service area manager. The request shall identify the specific rate in question and the methodology used to calculate the rate. The service manager shall provide a written response within 15 calendar days of receipt of the request for review.

(2) When dissatisfied with the response, the provider may, within 15 calendar days of the response, request a review by the chief of the bureau of financial support. The provider shall submit to the bureau chief the original request, the response received, and any additional information desired. The bureau chief shall render a decision in writing within 15 calendar days of receipt of the request.

(3) The provider may appeal the decision to the director of the department or the director’s designee within 15 calendar days of the decision. The director or director’s designee shall issue the final department decision within 15 calendar days of receipt of the request.

*g. Submission of claims.* The department shall issue payment when the provider submits correctly completed documentation of attendance and charges. The department shall pay for no more than the number of units of service authorized in the notice of decision issued pursuant to subrule 170.3(3). Providers shall submit a claim in one of the following ways:

(1) Using Form 470-4534, Child Care Assistance Billing/Attendance; or

(2) Using an electronic request for payment submitted through the KinderTrack system. Providers using this method shall print Form 470-4535, Child Care Assistance Billing/Attendance Provider Record,

to be signed by the provider and the parent. The provider shall keep the signed Form 470-4535 for a period of five years after the billing date.

[ARC 7837B, IAB 6/3/09, effective 7/1/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9490B, IAB 5/4/11, effective 7/1/11; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 0152C, IAB 6/13/12, effective 7/18/12; ARC 0546C, IAB 1/9/13, effective 1/1/13; ARC 0715C, IAB 5/1/13, effective 7/1/13; ARC 0825C, IAB 7/10/13, effective 7/1/13; ARC 0854C, IAB 7/24/13, effective 7/1/13; ARC 1063C, IAB 10/2/13, effective 11/6/13; ARC 1446C, IAB 4/30/14, effective 7/1/14; ARC 1978C, IAB 4/29/15, effective 7/1/15; ARC 2169C, IAB 9/30/15, effective 1/1/16; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 2556C, IAB 6/8/16, effective 7/1/16; ARC 2649C, IAB 8/3/16, effective 10/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17]

#### **441—170.5(237A) Adverse actions.**

**170.5(1) Provider agreement.** The department may refuse to enter into or may revoke the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), if any of the following occur:

- a. The department finds a hazard to the safety and well-being of a child, and the provider cannot or refuses to correct the hazard.
- b. The provider has submitted claims for payment for which the provider is not entitled.
- c. The provider fails to cooperate with an investigation conducted by the department of inspections and appeals to determine whether information the provider supplied to the department regarding payment for child care services is complete and correct. Once the agreement is revoked for failure to cooperate, the department shall not enter into a new agreement with the provider until cooperation occurs.
- d. The provider does not meet one of the applicable requirements set forth in subrule 170.4(3).
- e. The provider fails to comply with any of the terms and conditions of the Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S).
- f. The provider submits attendance documentation for payment and the provider knows or should have known that the documentation is false or inaccurate.
- g. An overpayment of CCA funds with a balance of \$3,000 or more exists for a provider and that provider fails to enter into a repayment agreement with the department of inspections and appeals (DIA) or does not make payments according to the repayment agreement on file with DIA.
- h. The provider is found to have more children in care at one time than allowed for the provider type as found at rule 441—110.6(237A) and 441—subrules 110.13(1), 110.14(1), 110.15(1), 120.6(1) and 170.4(3).

**170.5(2) Denial.** Child care assistance shall be denied when the department determines that:

- a. The client is not in need of service; or
- b. The client is not financially eligible; or
- c. There is another resource available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or
- d. An application is required and the client or representative refuses or fails to sign the application form; or
- e. Funding is not available; or
- f. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or
- g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

**170.5(3) Termination.** Child care assistance may be terminated when the department determines that:

- a. The client no longer meets the eligibility criteria in subrule 170.2(2); or
- b. The client's income exceeds the financial guidelines; or
- c. The client refuses or fails to supply information or verification requested or to request assistance and authorize the department to secure the required information or verification from other sources (signing a general authorization for release of information to the department does not meet this responsibility); or
- d. No payment or only partial payment of client fees has been received within 30 days following the issuance of the last billing; or

- e. Another resource is available to provide the service or a similar service free of charge that allows parents to select from the full range of eligible providers; or
- f. Funding is not available; or
- g. The client fails to cooperate with a quality control review or with an investigation conducted by the department of inspections and appeals.

**170.5(4) Reduction.** Authorized units of service may be reduced when the department determines that:

- a. Continued provision of service at the current level is not necessary to meet the client's service needs; or
- b. Another resource is available to provide the same or similar service free of charge that will meet the client's needs and allow parents to select from the full range of eligible providers; or
- c. Funding is not available to continue the service at the current level. When funding is not available, the department may limit on a statewide basis the number of units of child care services for which payment will be made.

**170.5(5) Provider agreement sanction.** If a Child Care Assistance Provider Agreement, Form 470-3871 or 470-3871(S), is terminated for any of the reasons in subrule 170.5(1), the agreement shall remain terminated for the time periods set forth below:

- a. The first time the agreement is terminated, the provider may reapply for another agreement at any time.
- b. The second time the agreement is terminated, the provider may not reapply for another agreement for 12 months from the effective date of termination.
- c. The third or subsequent time the agreement is terminated, the provider may not reapply for another agreement for 36 months from the effective date of termination.
- d. The department shall not act on an application for a child care assistance provider agreement submitted by a provider during the sanction period.

[ARC 7740B, IAB 5/6/09, effective 6/10/09; ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1893C, IAB 3/4/15, effective 7/1/15; ARC 3092C, IAB 6/7/17, effective 7/1/17]

**441—170.6(237A) Appeals.** Notice of adverse actions and the right of appeal shall be given in accordance with 441—Chapter 7.

**441—170.7(237A) Provider fraud.**

**170.7(1) Fraud.** The department shall consider a child care provider to have committed fraud when:

- a. The department of inspections and appeals, in an administrative or judicial proceeding, has found the provider to have obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000; or
- b. The provider has agreed to entry of a civil judgment or judgment by confession that includes a conclusion of law that the provider has obtained by fraudulent means child care assistance payment in an amount in excess of \$1,000.

**170.7(2) Potential sanctions.** Providers found to have committed fraud shall be subject to one or more of the following sanctions, as determined by the department:

- a. Special review of the provider's claims for child care assistance.
- b. Suspension from receipt of child care assistance payment for six months.
- c. Ineligibility to receive payment under child care assistance.

**170.7(3) Factors considered in determining level of sanction.** The department shall evaluate the following factors in determining the sanction to be imposed:

- a. *History of prior violations.*
  - (1) If the provider has no prior violations, the sanction imposed shall be a special review of provider claims.
  - (2) If the provider has one prior violation, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.
  - (3) If the provider has more than one prior violation, the sanction imposed shall be ineligibility to receive payment under child care assistance.

*b. Prior imposition of sanctions.*

(1) If the provider has not been sanctioned before, the sanction imposed shall be a special review of the provider's claims for child care assistance.

(2) If the provider has been sanctioned once before, the sanction imposed shall be a suspension from receipt of child care assistance payment for six months as well as a special review of provider claims.

(3) If the provider has been sanctioned more than once before, the sanction imposed shall be ineligibility to receive payment under child care assistance.

*c. Seriousness of the violation.*

(1) If the amount fraudulently received is less than \$5,000, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs "a" and "b" is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the amount fraudulently received is \$5,000 or more, and the sanction determined according to paragraphs "a" and "b" is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

*d. Extent of the violation.*

(1) If the fraudulent claims involve five invoices or less or five months or less, the sanction level shall be determined according to paragraphs "a" and "b."

(2) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs "a" and "b" is review of provider claims, the sanction imposed shall be suspension from receipt of child care assistance payment.

(3) If the fraudulent claims involve at least six invoices or six months, and the sanction determined according to paragraphs "a" and "b" is suspension from receipt of child care assistance payment, the sanction imposed shall be ineligibility to receive payment under child care assistance.

**170.7(4) Mitigating factors.**

*a.* If the sanction determined according to subrule 170.7(3) is suspension from or ineligibility for receipt of child care assistance payment, the department shall determine whether it is appropriate to reduce the level of a sanction for the particular case, considering:

(1) Prior provision of provider education.

(2) Provider willingness to obey program rules.

*b.* If the sanction determined according to subrule 170.7(3) is ineligibility for receipt of child care assistance payment, but consideration of the two factors in paragraph "a" indicates that a lesser sanction will resolve the violation, the sanction imposed shall be:

(1) Suspension from receipt of child care assistance payment for six months; and

(2) A special review of provider claims.

*c.* If the sanction determined according to subrule 170.7(3) is suspension from receipt of child care assistance payment, but consideration of the two factors in paragraph "a" indicates that a lesser sanction will resolve the violation, the sanction imposed shall be a special review of provider claims.

**441—170.8(234) Allocation of funds.** Rescinded IAB 2/6/02, effective 4/1/02.

**441—170.9(237A) Child care assistance overpayments.** All child care assistance overpayments shall be subject to recoupment.

**170.9(1) Notification and appeals.** All clients or providers shall be notified as described at subrule 170.9(6), when it is determined that an overpayment exists. Notification shall include the amount, date and reason for the overpayment. The department shall provide additional information regarding the computation of the overpayment upon the client's or provider's request. The client or provider may appeal the computation of the overpayment and any action to recover the overpayment in accordance with 441—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 on Form 470-4530, Notice of Child Care Assistance Overpayment.

*c.* When financial circumstances change, the department of inspections and appeals has the authority to revise the recoupment plan.

*d.* Recoupment for overpayments due to client error or due to an agency error that affected eligibility shall be made from the parent who received child care assistance at the time the overpayment occurred. When two parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

*e.* Recoupment for overpayments due to provider error or due to an agency error that affected benefits shall be made from the provider.

*f.* Recoupment for overpayments caused by both the provider and client shall be collected from both the provider and client equally, 50 percent from the client and 50 percent from the provider.

**170.9(7) Suspension and waiver.** Recoupment will be suspended on nonfraud overpayments when the amount of the overpayment is less than \$35. Recoupment will be waived on nonfraud overpayments of less than \$35 which have been held in suspense for three years.

[ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1893C, IAB 3/4/15, effective 7/1/15]

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CHAPTER 64  
INTERMEDIATE CARE FACILITIES FOR THE  
INTELLECTUALLY DISABLED\*

**481—64.1** Rescinded IAB 7/26/89, effective 7/7/89.

**481—64.2(135C) Variances.** Variances from these rules may be granted by the director of the department of inspections and appeals for good and sufficient reason when the need for variance has been established; no danger to the health, safety, or welfare of any resident results; alternate means are employed or compensating circumstances exist and the variance will apply only to an individual intermediate care facility for the intellectually disabled. Variances will be reviewed at the discretion of the director of the department of inspections and appeals.

**64.2(1)** To request a variance, the licensee must:

- a. Apply for variance in writing on a form provided by the department;
- b. Cite the rule or rules from which a variance is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the variance;
- e. Demonstrate that the requested variance will not endanger the health, safety, or welfare of any resident.

**64.2(2)** Upon receipt of a request for variance, the director of the department of inspections and appeals will:

- a. Examine the rule from which variance is requested to determine that the request is necessary and reasonable;
- b. If the request meets the above criteria, evaluate the alternate arrangements or compensating circumstances against the requirement of the rules;
- c. Examine the effect of the requested variance on the health, safety, or welfare of the residents;
- d. Consult with the applicant if additional information is required.

**64.2(3)** Based upon these studies, approval of the variance will be either granted or denied within 120 days of receipt.

[ARC 0764C, IAB 5/29/13, effective 7/3/13]

**481—64.3(135C) Application for license.**

**64.3(1)** Initial application. In order to obtain an initial intermediate care facility for the intellectually disabled license for an intermediate care facility for the intellectually disabled which is currently licensed, the applicant must:

- a. Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;
- b. Make application at least 30 days prior to the change of ownership of the facility on forms provided by the department;
- c. Submit a floor plan of each floor of the intermediate care facility, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which room will be put and window and door location;
- d. Submit a photograph of the front and side elevation of the intermediate care facility for the intellectually disabled;
- e. Submit the statutory fee for an intermediate care facility for the intellectually disabled license;
- f. Meet all of the rules, regulations and standards contained in 481—Chapter 64.
- g. Comply with federal, state, and local laws, codes, and regulations pertaining to health and safety, including procurement, dispensing, administration, safeguarding and disposal of medications and controlled substances; building, construction, maintenance and equipment standards; sanitation; communicable and reportable diseases; and postmortem procedures;

\*See Interpretive Guidelines at end hereof

*h.* Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**64.3(2)** In order to obtain an initial intermediate care facility for the intellectually disabled license for a facility not currently licensed as an intermediate care facility for the intellectually disabled, the applicant must:

*\*a.* Meet all of the rules, regulations, and standards contained in 481—Chapters 61 and 64; exceptions noted in 481—subrule 61.1(2) shall not apply;

\*Nullified by 1989 Iowa Acts, SJR 10

*b.* Submit a letter of intent and a written résumé of the resident care program and other services provided for departmental review and approval;

*c.* Make application at least 30 days prior to the proposed opening date of the facility on forms provided by the department;

*d.* Submit a floor plan of each floor of the intermediate care facility for the intellectually disabled, drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, and designation of the use to which the rooms will be put and window and door locations;

*e.* Submit a photograph of the front and side elevation of the intermediate care facility for the intellectually disabled;

*f.* Submit the statutory fee for an intermediate care facility for the intellectually disabled;

*g.* Comply with federal, state, and local laws, codes, and regulations pertaining to health and safety, including procurement, dispensing, administration, safeguarding and disposal of medications and controlled substances; building, construction, maintenance and equipment standards; sanitation; communicable and reportable diseases; and postmortem procedures;

*h.* Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

**64.3(3)** Renewal application. In order to obtain a renewal of the intermediate care facility for the intellectually disabled license, the applicant must:

*a.* Submit the completed application form 30 days prior to annual license renewal date of intermediate care facility for the intellectually disabled license;

*b.* Submit the statutory license fee for an intermediate care facility for the intellectually disabled with the application for renewal;

*c.* Have an approved current certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations;

*d.* Submit appropriate changes in the résumé to reflect any changes in the resident care program or other services.

**64.3(4)** Licenses are issued to the person or governmental unit which has responsibility for the operation of the facility and authority to comply with all applicable statutes, rules or regulations.

The person or governmental unit must be the owner of the facility or, if the facility is leased, the lessee.

[ARC 0764C, IAB 5/29/13, effective 7/3/13]

#### **481—64.4(135C) General requirements.**

**64.4(1)** The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

**64.4(2)** The license shall be valid only in the possession of the licensee to whom it is issued.

**64.4(3)** The posted license shall accurately reflect the current status of the intermediate care facility for the intellectually disabled. (III)

**64.4(4)** Licenses expire one year after the date of issuance or as indicated on the license.

**64.4(5)** Each citation or a copy of each citation issued by the department for a Class I or Class II violation shall be prominently posted by the facility in plain view of the residents, visitors, and persons inquiring about placement in the facility. The citation or copy of the citation shall remain posted until the violation is corrected to the satisfaction of the department. (III)

**64.4(6)** The facility shall have in effect a transfer agreement with one or more hospitals sufficiently close to the facility to make feasible the transfer between them of residents and their records. (III) Any facility which does not have such an agreement in effect but has attempted in good faith to enter into such an agreement with a hospital shall be considered to have such an agreement so long as it is in the public interest and essential to ensuring intermediate care facility for the intellectually disabled services for eligible persons in the community.

**64.4(7)** A resident's personal funds and property shall not be used without the written consent of the resident or the resident's guardian. (II)

**64.4(8)** A resident's personal funds and property shall be returned to the resident when the funds or property have been used without the written consent of the resident or the resident's guardian. The department may report findings that funds or property have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

**64.4(9)** A properly trained person shall be charged with the responsibility of administering non-parenteral medications.

*a.* The individual shall have knowledge of the purpose of the drugs, their dangers, and contraindications.

*b.* This person shall be a licensed nurse or physician or shall have successfully completed a department-approved medication aide course or passed a department-approved medication aide challenge examination administered by an area community college.

*c.* A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. This individual shall do all of the following before taking the medication aide challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination;

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination;

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating the individual is competent in medication administration.

(4) Successfully complete a department-approved nurse aide competency evaluation.

*d.* A person who has written documentation of certification as a medication aide in another state may become a medication aide in Iowa by successfully completing a department-approved nurse aide competency examination and a medication aide challenge examination.

[ARC 0764C, IAB 5/29/13, effective 7/3/13]

**481—64.5(135C) Notifications required by the department.** The department shall be notified:

**64.5(1)** Within 48 hours, by letter, any reduction or loss of direct care professional or dietary staff lasting more than seven days which places the staffing ratio of the intermediate care facility for the intellectually disabled below that required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

**64.5(2)** Of any proposed change in the intermediate care facility for the intellectually disabled's functional operation or addition or deletion of required services; (III)

**64.5(3)** Thirty days before addition, alteration, or new construction is begun in the intermediate care facility for the intellectually disabled, or on the premises; (III)

**64.5(4)** Thirty days in advance of closure of the intermediate care facility for the intellectually disabled; (III)

**64.5(5)** Within two weeks of any change in administrator; (III)

**64.5(6)** When any change in the category of license is sought; (III)

**64.5(7)** Prior to the purchase, transfer, assignment, or lease of an intermediate care facility for the intellectually disabled, the licensee shall:

*a.* Inform the department of the pending sale, transfer, assignment, or lease of the facility; (III)

*b.* Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee at least 30 days before the sale, transfer, assignment, or lease is completed; (III)

c. Submit a written authorization to the department permitting the department to release all information of whatever kind from the department's files concerning the licensee's intermediate care facility for the intellectually disabled to the named prospective purchaser, transferee, assignee, or lessee. (III)

**64.5(8)** Pursuant to the authorization submitted to the department by the licensee prior to the purchase, transfer, assignment, or lease of an intermediate care facility for the intellectually disabled, the department shall, upon request, send or give copies of all recent licensure surveys and of any other pertinent information relating to the facility's licensure status to the prospective purchaser, transferee, assignee, or lessee; costs for such copies shall be paid by the prospective purchaser.

[ARC 0764C, IAB 5/29/13, effective 7/3/13]

**481—64.6(135C) Veteran eligibility.**

**64.6(1)** Within 30 days of a resident's admission to a health care facility receiving reimbursement through the medical assistance program under Iowa Code chapter 249A, the facility shall ask the resident or the resident's personal representative whether the resident is a veteran and shall document the response. If the facility determines that the resident is a potential veteran, the facility shall report the resident's name along with the names of the resident's spouse and any dependent children, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. Where appropriate, the facility may also report such information to the Iowa department of human services.

**64.6(2)** If a resident is eligible for benefits through the United States Department of Veterans Affairs or other third-party payor, the facility first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

**64.6(3)** The provisions of this rule shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care. (II, III)

**481—64.7(135C) Licenses for distinct parts.**

**64.7(1)** Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, containing contiguous rooms in a separate wing or building or on a separate floor of the facility and which provide care and services of separate categories.

**64.7(2)** The following requirements shall be met for a separate licensing of a distinct part:

a. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part; (III)

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. The distinct part must be operationally and financially feasible;

d. A separate staff with qualifications appropriate to the care and services being rendered must be regularly assigned and working in the distinct part under responsible management; (III)

e. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry, and dietary in common with each other.

**481—64.8 to 64.16** Rescinded IAB 7/26/89, effective 7/7/89.

**481—64.17(135C) Contracts.** Each party shall receive a copy of the signed contract. (III) Each contract for residents shall:

**64.17(1)** State the rate or scale per day or per month for services included in the rate or scale and method of payment; (III)

**64.17(2)** Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the contract shall:

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in this subrule; (III)

b. State the method of payment of additional charges; (III)

*c.* Contain an explanation of the method of assessment of such additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

*d.* State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

**64.17(3)** Contain an itemized list of those services, with the specific fee the resident will be charged and method of payment, as related to the resident's current condition, based on a preadmission evaluation assessment which is determined in consultation with the administrator; (III)

**64.17(4)** Include the total fee per day to be charged to the resident; (III)

**64.17(5)** State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

*a.* Written notification to the resident, or responsible party when appropriate, of changes in the overall rates of both base and additional charges, at least 30 days prior to effective date of such changes; (III)

*b.* Notification to the resident, or responsible party when appropriate, of changes in charges, based on a change in the resident's condition. Notification must occur prior to the date such revised charges begin. If notification is given orally, subsequent written notification must also be given within a reasonable time, not to exceed one week, listing specifically the adjustments made; (III)

**64.17(6)** State the terms of agreement in regard to refund of all advance payments in the event of transfer, death, voluntary or involuntary discharge; (III)

**64.17(7)** State the terms of agreement concerning the holding and charging for a bed in the event of temporary absence of the resident; such terms shall include, at a minimum, the following provisions:

*a.* If a resident has a temporary absence from a facility for medical treatment, the facility shall ask the resident or responsible party if they wish the bed held open. This shall be documented in the resident's record including the response. Upon request of the resident/responsible party, the facility shall hold the bed open for at least ten days during the resident's absence and the facility shall receive payment for the absent period in accordance with provisions of the contract. (II)

*b.* If a resident has a temporary absence from a facility for therapeutic reasons as approved by a physician or qualified intellectual disabilities professional, the facility shall ask if the resident or responsible party wishes that the bed be held open. This request shall be documented in the resident's record, including the response. The bed shall be held open at least 30 days per year, and the facility shall receive payment for the absent periods in accordance with the provisions of the contract. The required holding during temporary absences for therapeutic reasons is limited to 30 days per year. (II)

*c.* For Title XIX residents the department of social services shall continue funding for the temporary absence as provided under paragraphs "a" and "b" and in accordance with department of social services guidelines.

*d.* Private pay residents shall have a negotiated rate stated in the signed contract relating to these provisions. (II)

**64.17(8)** State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

**64.17(9)** State the conditions of voluntary discharge or transfer; (III)

**64.17(10)** Set forth any other matters deemed appropriate by the parties to the contract. No contract or any provision thereof shall be drawn or construed so as to relieve any facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)  
[ARC 0764C, IAB 5/29/13, effective 7/3/13]

#### **481—64.18(135C) Records.**

**64.18(1)** *Resident record.* The licensee shall keep a permanent record about each resident, with all entries current, dated, and signed. (II) The record shall include:

*a.* Name and previous address of resident; (III)

*b.* Birth date, sex, and marital status of resident; (III)

- c. Church affiliation of resident; (III)
- d. Physician's name, telephone number, and address; (III)
- e. Dentist's name, telephone number, and address; (III)
- f. Name, address, and telephone number of resident's next of kin or legal representative; (III)
- g. Name, address, and telephone number of the person to be notified in case of emergency; (III)
- h. Funeral director's telephone number and address; (III)
- i. Pharmacy's name, telephone number and address; (III)
- j. Certification by the physician that the resident requires no higher level of care than the facility is licensed to provide; (III)
- k. Physician's orders for medication and treatments in writing, which shall be signed by the physician quarterly, and diet orders, which shall be renewed yearly; (III)
- l. A notation of the resident's yearly or other visits to physician or other professionals and all consultation reports and progress notes; (III)
- m. Documentation describing any change in the resident's condition; (II, III)
- n. A notation describing the resident's condition on admission, transfer, and discharge; (III)
- o. In the event of a resident's death, notations in the resident's record shall include the date and time of the resident's death, the circumstances of the resident's death, the disposition of the resident's body, and the date and time that the resident's family and physician were notified of the resident's death; (III)
- p. A copy of instructions given to the resident, the resident's legal representative, or receiving facility in the event of the resident's discharge or transfer; (III) and
- q. Disposition of personal property. (III)

**64.18(2) Confidentiality of resident records.** The facility shall have policies and procedures providing that each resident shall be ensured confidential treatment of all information, including information contained in an automated data bank. The resident's or the resident's legal guardian's written informed consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

A release of information form shall be used which includes to whom the information shall be released, the reason for the release of the information, how the information is to be used, and the period of time for which the release is in effect. A third party not requesting the release shall witness the signing of the release of information form. (II)

a. The facility shall limit access to any resident records to staff and consultants providing professional service to the resident. Information shall be made available to staff only to the extent that the information is relevant to the staff person's responsibilities and duties. (II)

Only those personnel concerned with financial affairs of the residents may have access to the financial information. This paragraph is not meant to preclude access by representatives of state or federal regulatory agencies. (II)

b. The resident, or the resident's legal guardian, shall be entitled to examine all information and shall have the right to secure full copies of the record at reasonable cost upon request, unless the physician or qualified mental health professional determines the disclosure of the record or certain information contained in the record is contraindicated in which case the information will be deleted before the record is made available to the resident. This determination and the reasons for it must be documented in the resident's record by the physician or qualified mental health professional in collaboration with the resident's interdisciplinary team. (II)

**64.18(3) Incident records.** Each facility shall maintain an incident record report and shall have available incident report forms. (II, III)

- a. The report of every incident shall be in detail on a printed incident report form. (II, III)
- b. The person in charge at the time of the incident shall oversee the preparation of the report and sign the report. (III)
- c. The facility shall maintain a copy of the incident report as part of the facility's administrative records and shall make the record available for review. (III)

**64.18(4) Retention of records.** A resident's records shall be retained in the facility for five years following termination of services to the resident even when there is a change of ownership of the facility. (III)

When the facility ceases to operate, the resident's records shall be released to the receiving facility. If no transfer occurs, the records shall be released to the resident's physician. (III)

**481—64.19 to 64.32** Reserved.

**481—64.33(135C) Allegations of dependent adult abuse.**

**64.33(1) Allegations of dependent adult abuse.** Allegations of dependent adult abuse shall be reported and investigated pursuant to Iowa Code chapter 235E and 481—Chapter 52. (I, II, III)

**64.33(2) Separation of accused abuser and victim.** Upon a claim of dependent adult abuse of a resident being reported, the administrator of the facility shall separate the victim and accused abuser immediately and maintain the separation until the department's abuse investigation is completed and an abuse determination is made. (I, II)

[ARC 1204C, IAB 12/11/13, effective 1/15/14]

**481—64.34(135C) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse.** The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2013 Iowa Acts, Senate File 347, and rule 481—50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I, II, III)

[ARC 0903C, IAB 8/7/13, effective 9/11/13]

**481—64.35(135C) Care review committee.** Rescinded ARC 1205C, IAB 12/11/13, effective 1/15/14.

**481—64.36(135C) Involuntary discharge or transfer.**

**64.36(1) Involuntary discharge or transfer permitted.** A facility may involuntarily discharge or transfer a resident for only one of the following reasons:

- a. Medical reasons;
- b. The resident's welfare or that of other residents;
- c. Nonpayment for the resident's stay, as described in the contract for the resident's stay;
- d. Due to action pursuant to Iowa Code chapter 229;
- e. By reason of negative action by the Iowa department of human services; or
- f. By reason of negative action by the quality improvement organization (QIO). (I, II, III)

**64.36(2) Medical reasons.** Medical reasons for transfer or discharge shall be based on the resident's needs and shall be determined and documented in the resident's record by the primary care provider. Transfer or discharge may be required in order to provide a different level of care to the resident. (II)

**64.36(3) Welfare of a resident.** Welfare of a resident or that of other residents refers to a resident's social, emotional, or physical well-being. A resident may be transferred or discharged because the resident's behavior poses a continuing threat to the resident (e.g., suicidal) or to the well-being of other residents or staff (e.g., the resident's behavior is incompatible with other residents' needs and rights). Written documentation that the resident's continued presence in the facility would adversely affect the resident's own welfare or that of other residents shall be made by the administrator or designee and shall include specific information to support this determination. (II)

**64.36(4) Involuntary discharge or transfer prohibited—payment source.** A resident shall not be transferred or discharged solely because the cost of the resident's care is being paid under Iowa Code chapter 249A or because the resident's source of payment is changing from private support to payment under Iowa Code chapter 249A. (I, II)

**64.36(5) Notice.** Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident and the responsible party. (II, III)

- a. The notice shall contain all of the following information:

- (1) The stated reason for the proposed transfer or discharge. (II)
- (2) The effective date of the proposed transfer or discharge. (II)
- (3) A statement, in not less than 12-point type, that reads as follows:

You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request and you will not be transferred before a final decision is rendered. Extension of the 14-day requirement may be permitted in emergency circumstances upon request to the department's designee. If you lose the hearing, you will not be transferred before the expiration of either (1) 30 days following your receipt of the original notice of the discharge or transfer, or (2) no sooner than 5 days following final decision of such hearing, including the exhaustion of all appeals, whichever occurs later. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. (II)

*b.* The notice shall be personally delivered to the resident, and a copy shall be placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

*c.* The notice required by paragraph 64.36(5) "a" shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs:

(1) An emergency transfer or discharge is mandated by the resident's health care needs and is in accordance with the written orders and medical justification of the primary care provider. Emergency transfers or discharges may also be mandated in order to protect the health, safety, or well-being of other residents and staff from the resident being transferred. (II)

(2) The transfer or discharge is subsequently agreed to by the resident or the resident's responsible party, and notification is given to the responsible party, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility.

(3) The discharge or transfer is the result of a final, nonappealable decision by the department of human services or the QIO.

*d.* A hearing requested pursuant to this subrule shall be held in accordance with subrule 64.36(7).

**64.36(6) *Emergency transfer or discharge.*** In the case of an emergency transfer or discharge, the resident must be given a written notice prior to or within 48 hours following the transfer or discharge. (II, III)

*a.* A copy of this notice shall be placed in the resident's file. The notice shall contain all of the following information:

- (1) The stated reason for the transfer or discharge. (II)
- (2) The effective date of the transfer or discharge. (II)
- (3) A statement, in not less than 12-point type, that reads as follows:

You have a right to appeal the facility's decision to transfer or discharge you on an emergency basis. If you think you should not have to leave this facility, you may request a hearing, in writing or verbally, with the Iowa department of inspections and appeals (hereinafter referred to as "department") within 7 days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held no later than 14 days after the department's receipt of your request. You may be transferred or discharged before the hearing is held or before a final decision is rendered. If you win the hearing, you have the right to be transferred back into the facility. To request a hearing or receive further information, call the department at (515)281-4115, or write to the department to the attention of: Administrator, Division of Health Facilities, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. (II)

*b.* The notice shall be personally delivered to the resident, and a copy shall be placed in the resident's record. A copy shall also be transmitted to the department, the resident's responsible party, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. The notice shall indicate that copies have been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent.

*c.* A hearing requested pursuant to this subrule shall be held in accordance with subrule 64.36(7).  
**64.36(7) Hearing.**

*a.* Request for hearing.

(1) The resident must request a hearing within 7 days of receipt of written notice.

(2) The request must be made to the department, either in writing or verbally.

*b.* The hearing shall be held no later than 14 days after the department's receipt of the request unless either party requests an extension due to emergency circumstances.

*c.* Except in the case of an emergency discharge or transfer, a request for a hearing shall stay a transfer or discharge pending a final decision, including the exhaustion of all appeals. (II)

*d.* The hearing shall be heard by a department of inspections and appeals administrative law judge pursuant to Iowa Code chapter 17A and 481—Chapter 10. The hearing shall be public unless the resident or representative requests in writing that the hearing be closed. In a determination as to whether a transfer or discharge is authorized, the burden of proof by a preponderance of the evidence rests on the party requesting the transfer or discharge.

*e.* Notice of the date, time, and place of the hearing shall be sent by certified mail or delivered in person to the facility, the resident, and the responsible party not later than five full business days after the department's receipt of the request. The notice shall also inform the facility and the resident or the responsible party that they have a right to appear at the hearing in person or be represented by an attorney or other individual. The appeal shall be dismissed if neither party is present or represented at the hearing. If only one party appears or is represented, the hearing shall proceed with one party present.

*f.* The administrative law judge's written decision shall be sent by certified mail to the facility, resident, and responsible party within 10 working days after the hearing has been concluded.

*g.* If the basis for an involuntary transfer or discharge is the result of a negative action by the Iowa department of human services or the QIO, an appeal shall be filed with those entities as appropriate. Continued payment shall be consistent with rules of those entities.

**64.36(8) Nonpayment.** If nonpayment is the basis for involuntary transfer or discharge, the resident shall have the right to make full payment up to the date that the discharge or transfer is to be made and then shall have the right to remain in the facility. (II)

**64.36(9) Discussion of involuntary transfer or discharge.** Within 48 hours after notice of involuntary transfer or discharge has been received by the resident, the facility shall discuss the involuntary transfer or discharge with the resident, the resident's responsible party, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

a. The facility administrator or other appropriate facility representative serving as the administrator's designee shall provide an explanation and discussion of the reasons for the resident's involuntary transfer or discharge. (II)

b. The content of the explanation and discussion shall be summarized in writing, shall include the names of the individuals involved in the discussion, and shall be made part of the resident's record. (II)

c. The provisions of this subrule do not apply if the involuntary transfer or discharge has already occurred pursuant to subrule 64.36(6) and emergency notice is provided within 48 hours.

**64.36(10) *Transfer or discharge planning.***

a. The facility shall develop a plan to provide for the orderly and safe transfer or discharge of each resident to be transferred or discharged. (II)

b. To minimize the possible adverse effects of the involuntary transfer, the resident shall receive counseling services by the sending facility before the involuntary transfer and by the receiving facility after the involuntary transfer. Counseling shall be documented in the resident's record. (II)

c. The counseling requirement in paragraph 64.36(10) "b" does not apply if the discharge has already occurred pursuant to subrule 64.36(6) and emergency notice is provided within 48 hours.

d. Counseling, if required, shall be provided by a licensed mental health professional as defined in Iowa Code section 228.1(6). (II)

e. The health care facility that receives a resident who has been involuntarily transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

**64.36(11) *Transfer upon revocation of license or voluntary closure.*** Residents shall not have the right to a hearing to contest an involuntary discharge or transfer resulting from the revocation of the facility's license by the department of inspections and appeals. In the case of the voluntary closure of a facility, a period of 30 days must be allowed for an orderly transfer of residents to other facilities.

**64.36(12) *Intrafacility transfer.***

a. Residents shall not be arbitrarily relocated from room to room within a licensed health care facility. (I, II) Involuntary relocation may occur only in the following situations, which shall be documented in the resident's record: (II)

(1) A resident's incompatibility with or disturbance to other roommates.

(2) For the welfare of the resident or other residents of the facility.

(3) For medical, nursing or psychosocial reasons, as judged by the primary care provider, nurse or social worker in the case of a facility which groups residents by medical, nursing or psychosocial needs.

(4) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.

(5) In the case of a resident whose source of payment was previously private, but who now is eligible for Title XIX (Medicaid) assistance, the resident may be transferred from a private room to a semiprivate room or from one semiprivate room to another.

(6) Reasonable and necessary administrative decisions regarding the use and functioning of the building.

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or responsible party include:

(1) Change from private pay status to Title XIX, except as outlined in subparagraph 64.36(12) "a" (5). (II)

(2) As punishment or behavior modification, except as specified in subparagraph 64.36(12) "a" (1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph 64.36(12) "a," the resident shall be notified at least 48 hours prior to the transfer and the reason therefor shall be explained. The responsible party shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or responsible party. (II)

d. If emergency relocation is required in order to protect the safety or health of the resident or other residents, the notification requirements may be waived. The conditions of the emergency shall be

documented. The family or responsible party shall be notified immediately or as soon as possible of the condition that necessitates emergency relocation, and such notification shall be documented. (II)

*e.* A transfer to a part of a facility that has a different license must be handled the same way as a transfer to another facility and not as an intrafacility transfer. (II, III)

[ARC 1205C, IAB 12/11/13, effective 1/15/14; ARC 1752C, IAB 12/10/14, effective 1/14/15]

**481—64.37 to 64.58** Rescinded IAB 7/26/89, effective 7/7/89.

**481—64.59(135C) County care facilities.** Rescinded ARC 0764C, IAB 5/29/13, effective 7/3/13.

**481—64.60(135C) Federal regulations adopted—conditions of participation.** Regulations in 42 CFR Part 483, Subpart D, Sections 410 to 480 effective October 3, 1988, are adopted by reference and incorporated as part of these rules. A copy of these regulations is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

Classification of violations is I, II, and III, determined by the division using the provisions in 481—Chapter 56, “Fining and Citations,” to enforce a fine to cite a facility.

This rule is intended to implement Iowa Code section 135C.2(3).

**481—64.61(135C) Federal regulations adopted—rights.** Regulations in 42 CFR Part 483, Subpart B, Sections 10, 12, 13, and 15 effective August 1, 1989, are adopted by reference and incorporated as part of these rules. Section 10 governs resident rights; Section 12, admission, transfer or discharge rights; Section 13, resident behavior and facility practices; and Section 15, quality of life. Classification of violations for all of these regulations is I and II. A copy is available on request from the Health Facilities Division, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

NOTE: The federal interpretive guidelines are printed immediately following 481—Chapter 64.

This rule is intended to implement Iowa Code section 135C.14(8).

**481—64.62(135C) Another business or activity in a facility.** A facility is allowed to have another business or activity in a health care facility or in the same physical structure of the facility, if the other business or activity is under the control of and is directly related to and incidental to the operation of the health care facility, or the business or activity is approved by the department and the state fire marshal.

To obtain the approval of the department and the state fire marshal, the facility must submit to the department a written request for approval which identifies the service(s) to be offered by the business and addresses the factors outlined in paragraphs “a” through “j” of this rule. (I, II, III)

**64.62(1)** The following factors will be considered by the department in determining whether a business or activity will interfere with the use of the facility by residents, interfere with services provided to residents, or be disturbing to residents:

- a.* Health and safety risks for residents;
- b.* Compatibility of the proposed business or activity with the facility program;
- c.* Noise created by the proposed business or activity;
- d.* Odors created by the proposed business or activity;
- e.* Use of entrances and exits for the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- f.* Use of the facility’s corridors or rooms as thoroughfares to the business or activity in regard to safety and disturbance of residents and interference with delivery of services;
- g.* Proposed staffing for the business or activity;
- h.* Sharing of services and staff between the proposed business or activity and the facility;
- i.* Facility layout and design; and
- j.* Parking area utilized by the business or activity.

**64.62(2)** Approval of the state fire marshal shall be obtained before approval of the department will be considered.

**64.62(3)** A business or activity conducted in a health care facility or in the same physical structure as a health care facility shall not reduce space, services or staff available to residents below minimums required in these rules. (I, II, III)

**481—64.63(135C) Respite care services.** Respite care services means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person. A facility which chooses to provide respite care services must meet the following requirements related to respite care services and must be licensed as a health care facility.

**64.63(1)** A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

**64.63(2)** Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

**64.63(3)** The facility shall have a contract with each resident in the facility. When the resident is there for respite care services, the contract shall specify the time period during which the resident will be considered to be receiving respite care services. At the end of that period, the contract may be amended to extend that period of time. The contract shall specifically state the resident may be involuntarily discharged while being considered as a respite care resident. The contract shall meet other requirements for contracts between a health care facility and resident, except the requirements concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons.

**64.63(4)** Respite care services shall not be provided by a facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

These rules are intended to implement Iowa Code sections 10A.202, 10A.402, 135C.2(6), 135C.6(1), 135C.14, 135C.14(8), 135C.25, 135C.25(3), 135C.32, 135C.36, 227.4, 235B.1(6), and 235B.3(11).

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<sup>◇</sup> Two or more ARCs

<sup>1</sup> See IAB, Inspections and Appeals Department.

**Interpretive Guidelines\*\*****§440.150 Intermediate Care Facility Services, Other Than in Institutions for Mental Diseases****W101**

W101 is reassigned to §483.410(e). Section 442.251, the standard which requires that facilities meet the requirement for a State license, is redesignated to §483.410(e) and W101 is reassigned as well to afford a sense of continuity.

**W102**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410 Condition of participation: Governing body and management (a) Standard: Governing body**

**W103**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(a) The facility must identify an individual or individuals to constitute the governing body of the facility.**

**Guidance §483.410(a)**

If concerns are noted regarding the governing body, written documentation verifies that the facility has designated the individual or individuals to constitute the governing body and their titles.

**W104**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.**

**Guidance §483.410(a)(1)**

The governing body develops, monitors, and revises, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to provide clients with active treatment and to provide for their health and safety.

Direction by the Governing Body includes areas such as health, safety, sanitation, maintenance and repair, and utilization and management of staff.

Condition level operational deficiencies may be associated with a failure by the Governing Body to exercise general direction of the facility.

**W105**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(a)(2) The governing body must set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility.**

**Guidance §483.410(a)(2)**

The policies of the facility must include the qualifications of the administrator, and the qualifications are stated in the job description of the administrator.

**W106**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(a)(3) The governing body must appoint the administrator of the facility.**

**Guidance §483.410(a)(3)**

This appointment must be in writing.

**(b) Standard: Compliance with Federal, State and local laws**

**§483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to:**

**Guidance §483.410(b)**

The facility has no final adverse action by a Federal, State, or local authority. Such adverse actions include, but are not limited to fines, limitation on services that may be provided, or loss of licensure.

\*\*Editor's Note: Verbatim from federal regulations. Neither the Department nor the Iowa Administrative Code editors have changed the content of the guidelines.

The facility must be able to provide for review, current licenses and permits as well as applicable reports of inspections by State or local health authorities.

If a situation is identified indicating the provider may not be in compliance with Federal, State, or local law, refer that information to the authority having jurisdiction (AHJ) for follow-up actions. See W107, W108, or W109.

**W107**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(b) health,****Guidance §483.410(b)**

Reference the specific law, regulation, or code not met.

**W108**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(b) safety, and****Guidance §483.410(b)**

Reference the specific law, regulation, or code not met.

**W109**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(b) sanitation.****Guidance §483.410(b)**

Reference the specific law, regulation, or code not met.

**(c) Standard: Client Records**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**W110**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(c)(1) The facility must develop and maintain a record keeping system that includes a separate record for each client and;**

**W111**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(c)(1) that documents the client's health care, active treatment, social information, and protection of the client's rights.**

**Guidance §483.410(c)(1)**

The structure and content of a client's record must be an accurate, functional representation of the actual experience of the client in the facility.

The record should contain an accurate account of all information relevant to the client's health care, active treatment, social information and protection of the client's rights, such as communications, correspondence, program plans (to include both in-house and outside service programs), progress summaries, activity plans and activity participation, incidents, consent forms and all medical information.

If the records are maintained electronically, the facility staff should be able to access various parts of the record without difficulty. If they are unable to access components of the record upon request, then this may indicate a lack of training by the facility.

**W112**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(c)(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.**

**Guidance §483.410(c)(2)**

"Keep confidential" means safeguarding the content of information including video, audio, and/or computer stored information from unauthorized disclosure without the specific informed consent of the client, parent of a minor child, or legal guardian, and consistent with the advocate's right of access. Facility staff and consultants, hired to provide services to the client, sign confidentiality agreements before having access to client records and should have access to only that portion of information that is necessary to provide effective responsive services to the client.

These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

The facility has in place safeguards to ensure that access to all information regarding clients is limited to those clients designated by Health Insurance Portability and Accountability Act (HIPAA) requirements, the Developmental Disabilities Act, State law and facility policy.

The facility should prevent any instances of unauthorized access or dissemination. For example, the staff is observed to leave the client record (hard copy or electronic version) in the living room of the house when visitors or persons not authorized to access client records are present. Client records must be secured when staff is not present.

The facility must develop and follow procedures for maintaining the confidentiality of client information during transport to medical appointments or to other locations outside the facility.

Confidentiality applies to both central records and information kept at dispersed locations. If there is information considered too confidential to place in the record used by all staff (e.g., identification of the family's financial assets, sensitive medical data), it may be retained in a companion record located in a secure location in the facility with a notation made in the primary record as to the location of confidential information. The facility must ensure that any client information provided to day services programs is maintained confidential.

The sharing of client specific information with members of the "specially constituted committee" required by §483.440(f)(3), who are not affiliated with the agency, does not violate a client's right to have information about him or her kept confidential. The committee must have relevant information to function properly.

Facility confidentiality safeguards include the development and implementation of written policies to assure that members of the specially constituted team maintain confidentiality. Such processes may include signed confidentiality agreements. These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

#### **W113**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(c)(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.**

#### **Guidance §483.410(c)(3)**

The facility develops and follows written policies governing the release of client information.

Release of any personally identifiable information does not occur unless consent(s) is obtained prior to the release.

These policies must address at a minimum who must give consent for the release of information from records. The policy and procedures should account for other situations involving the release of client information, such as:

- who should be notified when records have been released;
- procedures to be followed with subpoenas;
- time frames for providing requested information; and
- information regarding a client's HIV status may not be released without specific consent and may not be in the record if that consent has not been given.

#### **W114**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(c)(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.**

#### **Guidance §483.410(c)(4)**

Illegible writing in hard copy records can contribute to communication deficits among staff. Illegible writing which cannot be easily interpreted by facility staff upon surveyor request may constitute a safety issue.

Electronic signatures are acceptable in the electronic record system.

**W115**

**§483.410(c)(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.**

**W116**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(c)(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.**

**Guidance §483.410(c)(6)**

“Appropriate” means those parts of each client's record are most likely (or known) to be needed by the residential staff to carry out the client's active treatment program in the unit; to alert staff to health risks and other aspects of medical treatment; to support the psychosocial needs of the client; to contact family or emergency contacts, and to provide anything else necessary to the staff's ability to work on behalf of the client.

The staff of the residential living unit has, and can access, all information which is relevant to implementing client program plans, appropriate care of, interaction with, and provision of services for the client.

**(d) Standard: Services provided under agreements with outside sources****W117**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(d)(1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.**

**Guidance §483.410(d)(1)**

If a service is not provided directly, there must be a written agreement for such services.

Written agreements are required for emergency services such as dentists and pharmacies. For those services that require a visit to a hospital, the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) typically utilizes services from an emergency department of the hospital, thus no written contract is required.

Federal statute (P.L. 94-142) requires all school-aged children to receive a free and appropriate school education. Therefore, a written agreement between ICF/IIDs and public schools is not necessary.

**W118**

**(d)(2)(i) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and**

**W119**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(d)(2)(ii) Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.**

**W120**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(d)(3) The facility must assure that outside services meet the needs of each client.**

**Guidance §483.410(d)(3)**

Outside services are any services needed by the clients and not provided directly by the facility (hospital visits, dental visits, day program services, etc.).

Programs and services must be coordinated between the facility and the outside service, and foster consistency of implementation across settings of teaching strategies and behavior management.

The facility monitors outside services on an ongoing basis to ensure that services provided are consistent with the needs of each client as identified in the Individual Program Plan (IPP). For example, if the facility is implementing a behavior management or a communication program for the client, it is shared with the outside program and implemented by the outside program (workshop, day program, etc.) and the outside program agrees to incorporate it into their day program. At periodic intervals, the facility staff visit or communicate with the outside program to verify consistency across the two settings.

With outside resources, it is the responsibility of the facility to assure that the services are provided in a safe clean environment, by appropriately qualified professions, and any untoward outcome of services are promptly addressed. If, in spite of attempts by the facility to assure compliance, the outside program does not implement the program for the client, then the facility remains responsible for the lack of active treatment.

**W121**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(d)(4) If living quarters are not provided in a facility owned by the ICF/IID, the ICF/IID remains directly responsible for the standards relating to physical environment that are specified in §483.470(a) through (g), (j) and (k).**

**Guidance §483.410(d)(4)**

Even though the facility's premises may be rented from a landlord, the facility must ensure that the requirements for physical environment are met, either through arrangement with the landlord or through the facility's own services.

**(e) Standard: Licensure**

**§483.420(a) Standard: Protection of Clients' Rights**

**The facility must ensure the rights of all clients. Therefore, the facility must**

**Guidelines §483.420(a)**

"Ensure" means that the facility actively asserts the individual's rights and does not wait for him or her to claim a right. This obligation exists even when the individual is less than fully competent and requires that the facility is actively engaged in activities which result in the pro-active assertion of the individual's rights, e.g., guardianship, advocacy, training programs, use of specially constituted committee, etc.

**§483.410(e) Standard: Licensure**

**W101**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.410(e) The facility must be licensed under applicable State and local law.**

**Guidance §483.410(e)**

The facility has a current, valid State license when required under State law.

**W122**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420 Condition of participation: Client protections**

**(a) Standard: Protection of clients' rights**

**§483.420(a) The facility must ensure the rights of all clients. Therefore the facility must**

**Guidance §483.420(a)**

The facility must ensure the client's rights and does not wait for him or her to claim a right. This obligation exists even when the client is less than fully competent and requires that the facility is actively engaged in activities which result in the protection of the client's rights, advocacy for individual clients who have no family or an inactive family, and training programs for clients and staff on the understanding and protection of client rights.

**W123**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;**

**Guidance §483.420(a)(1)**

The obligation to inform requires that the facility presents information on rights to the client, his or her family or his or her legal guardian in a manner and form which they can understand. In most instances, family means parent. However, in those instances where parents are deceased or choose not to be active in the client's life and there is another family member who does wish to be active, but is not the legal guardian, this family member should be informed of the client's rights. Printed materials should be provided in understandable terms and provided in the language necessary to ensure understanding. Specialized methods, as indicated, should be provided for communication with clients, families or legal guardians with hearing or vision impairment.

Pro-active assertion of client rights includes, but is not limited to:

- Signed evidence that the client, his or her family and/or his or her legal guardian have been informed of the client's rights, and
- Evidence that the communication of these rights were provided at the client's level of comprehension, and in the language understandable to the client.

The obligation to inform also requires that the facility make some determination of whether the client and his or her family, or legal guardian understood the rights presented and made additional efforts to communicate the rights if the rights were not understood.

If the facility has written "rules of the facility", these rules must be communicated to the client, their family and or legal guardians at the time of admission and must not be in conflict with any of the rights listed in 42 CFR 483.420 (a) (1-13).

#### **W124**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;**

#### **Guidance §483.420(a)(2)**

Clients, their families or legal guardians are promptly informed of any change in the client's medical or behavioral needs that requires immediate alteration to programmatic or medical intervention. Promptly is defined by the level of severity of the alteration. In each case, they must also be informed of the attendant risks of any recommended treatments or interventions and of their right to refuse treatment, training or services.

If parents or legal guardians wish for other members of the client's family to be informed of such changes, they must put this permission in writing.

The communication of this information must be provided in the manner and language understood by the client or their family or legal guardian (language boards, sign language, etc.).

The term "attendant risks of treatment" describes the risk vs. risk and risk vs. benefit associated with the treatment. These risks include possible side effects, other complications from treatments including medical and drug therapy, unintended consequences of treatment, other behavioral or psychological ramifications arising from treatment, etc.

The facility actively attempts to engage clients who refuse to participate in active treatment. While the regulation recognizes the client's right to refuse treatment, persistent refusal that impacts the health and safety of the client and/or others, or the ability to provide overall active treatment, may result in facility's consideration of alternative placements for the client. It is expected, however, that the facility has assessed the reason for refusal, and developed and implemented all possible interventions to engage the client in active treatment programs prior to referring the client to another therapeutic setting.

A client, his or her family member, or legal guardian who refuses a particular treatment (e.g., a behavior control, seizure control medication or a particular intervention strategy) must be offered information about acceptable alternatives to the treatment, if acceptable alternatives are available. The client's preference about alternatives should be elicited and considered in deciding on the course of treatment. If the client, family member, or legal guardian also refuses the alternative treatment, or if no alternative exists to the treatment refused, the facility must consider the effect this refusal may have on other clients, the client himself or herself, and if they can continue to provide services to the client consistent with these regulations.

If the facility is unable to provide services to a client due to consistent refusal to participate, they must weigh all options including an involuntary discharge. Involuntary discharge must be for good cause (see 483.440(b)(4)(i)).

When a client is considered for participation in experimental research the client, his/her family and/or legal guardian must be fully informed of the nature of the experiment (e.g., what medications or physical interventions will be utilized, the length of the research, any possible side effects and how the information from the research will be utilized). Information regarding the possible consequences of participating or not participating must be provided to the client, family member or legal guardian. The written consent

of the client, his/her family or legal guardian must be received prior to participation. For a client who is a minor or who has been adjudicated as incompetent, the written informed consent of the parents of the minor or the legal guardian is required. The signed, informed consent documentation must be in compliance with HHS Guidelines for Research Involving Human Subjects. The signed consent must also include a clear discussion of what treatments will be included in the research, the time limits for the research and should clearly inform the client, family member or legal guardian that the client may end participation at any time without fear of recrimination. If the research protocol indicates that clients receive compensation, then clients are compensated per the protocol.

Any research must be reviewed and approved by the Specially Constituted Committee. See W263.

#### **W125**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;**

**Guidance §483.420(a)(3)**

To the extent that a client is able, choices are made on his/her own. Each client has autonomy of decision making and choice.

They are free to move about without limitations imposed due to staff preferences or staff convenience.

Clients are not restricted without due cause or due process.

To the extent that the client is able to make decisions for him or herself, it is inappropriate to delegate the person's right to others (e.g. parents, family members, etc.).

The facility has an obligation to assure client health and safety and must balance that obligation with the rights of clients.

If the facility has implemented a restriction, the following should be in place:

- An assessment supporting the need for the restriction;
- An individualized behavior plan to reduce the need for the restriction has been developed and implemented;
- A written informed consent for the behavior plan which includes the restriction;
- Approval of the Specially Constituted Committee; and
- Monitoring by the Committee of the progress of the training program, designed to reduce and eventually eliminate the restriction.

Clients, families, and legal guardians have the right to register a complaint with the facility and the State Survey Agency. If so, the facility must respond promptly and appropriately. The facility must ensure protection of the client from any form of reprisal or intimidation as a result of a complaint or grievance reported by the client, family, or legal guardian.

Issues involving the exercise of constitutional rights such as voting should be addressed as a component of the IPP when the Interdisciplinary Team (IDT) determines a need for training. Clients who have been adjudged to need guardianship or have been assessed as needing assistance to advocate for themselves should receive assistance or support so they may exercise their rights as citizens of the United States.

#### **W126**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;**

**Guidance §483.420(a)(4)**

The regulation is clear that in those cases where a client already possesses the skills necessary to independently manage their own financial affairs, the facility will allow the client to continue to do so. Formal training in financial management must be provided for all other clients in the facility to the extent of their capabilities. The regulation places the responsibility for determining the extent of the client's capabilities in this matter upon an assessment and interdisciplinary process within the facility.

To reach a determination as to whether a money management program is appropriate, the facility IDT uses the comprehensive functional assessment (CFA) to evaluate the ability of each client to participate in such a program. Under 42 C.F.R. 483.440(c)(3), the team evaluation must establish, through

documentation, that the IDT considers all of the objective data within the assessment in reaching their determination, especially the identification of client skills which can be used across training programs. Examples of assessment findings that may be considered by the IDT include skills that can be cross-utilized in training programs such as:

1. Fine motor coordination;
2. The ability to make choices;
3. The ability to identify preferences; and
4. Cognitive abilities including tracking, attention span, communication, and the client's ability to understand the cause and effect. (The client understands of cause and effect is significant in the determination.)

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.

The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

The determination of the appropriateness of a formal money management program is made by the IDT and must be based upon a CFA. The IDT discussions resulting in that determination must be established through documentation in the client's IPP.

#### **W127**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;**

#### **Guidance §483.420(a)(5)**

Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment.

a. The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.

b. The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence.

c. The facility must be organized in such a manner as to proactively assure clients are free from any threat to their physical and psychological health and safety.

d. The facility must act to prevent physical, verbal, sexual or psychological abuse. If the facility fails to implement appropriate corrective action, the potential of additional threats to the clients remain at the facility.

“Threat”, for the purposes of this guideline, is considered any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of clients, or in their death.

“Abuse”, for the purposes of this guideline, is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.

Physical abuse refers to any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

Verbal abuse refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client. Psychological abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

#### **W128**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;**

#### **Guidance §483.420(a)(6)**

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unnecessary" if there is evidence the drugs are being used:

- In excessive dose (duplicate therapy);
- For excessive duration;
- Not monitored adequately;
- Without adequate indications for its use;
- With adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the reasons listed above.

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
- Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
- Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

#### **W129**

**(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)**

**§483.420(a)(7) Provide each client with the opportunity for personal privacy and**

#### **Guidance §483.420(a)(7)**

The facility must provide areas within the living area in which the client can have time to be alone, when appropriate, and to have privacy (their conversations cannot be overheard) for personal

interactions/activities. There should be a location where the client can meet privately with family and/or friends and a telephone available where he/she can hold private telephone conversations.

Personal privacy for clients also includes the right to have certain personal information about them kept confidential. Staff should not discuss one client in front of others (clients, parents, legal guardians, visitors, etc.) and should not post personal information about clients in areas where other clients, families and the public can read the information.

Video/audio taping or live feed must not be used in place of or for the convenience of staff. The facility may install video/audio equipment for purposes of observing client/staff interactions. Video/audio equipment may only be installed in common areas (in no case may videotaping or live feed be done in bathrooms or areas where private visits are conducted). The clients, families and/or legal guardians of the clients residing in the areas where videotaping or live feed will occur must give informed consent for the installation and must be assured that no personal privacy will be jeopardized. The use of the equipment must be presented at and approved by the specially constituted committee for the facility prior to the installation of video or audio devices.

Motion sensors should not be considered cameras.

#### **W130**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(7) ensure privacy during treatment and care of personal needs;**

**Guidance §483.420(a)(7)**

Clients must be provided privacy during personal hygiene activities (e.g., toileting, bathing, dressing) and during medical/nursing treatments that require exposure of one's body.

People not involved in the care of the client should not be present without their consent while they are being examined or treated.

Whenever possible, the facility should be sensitive to clients' preferences for same sex care in private situations.

#### **W131**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(8) Ensure that clients are not compelled to perform services for the facility and**

**Guidance §483.420(a)(8)**

Clients are not required or expected to be a source of labor for a facility. The client must not be required or expected to do productive work for the facility, other than appropriate care of one's own personal space or shared responsibilities for common areas.

#### **W132**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(8) ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;**

**Guidance §483.420(a)(8)**

“Work”, as used in the regulation, means any directed activity, or series of related activities which results in a benefit to the economy of the facility or in a contribution to its maintenance, or in the production of a salable product. In deciding whether a particular activity constitutes “work” as defined above, the key determinant is whether the facility would be required to hire additional full or part-time staff (or pay overtime to existing staff) to perform the service the client is asked to perform.

Clients volunteering to do real work that benefits the facility should give informed consent for such practices and understand that by providing employable services they are able to be compensated. This does not preclude a client from helping out a friend or being kind to others. Self-care activities related to the care of one's own person or property are not considered “work” for purposes of compensation.

In general, participation in any household task which promotes greater independent functioning and assists the client to prepare for less restrictive setting (and which the client has not yet learned) is permitted as long as tasks are included in the IPP in written behavioral and measurable terms. This participation must be supervised, and indices of performance should be available. No task may be performed for the convenience of staff (e.g., supervising clients, running personal errands).

“Compensated” means the client is provided with money or other forms of negotiable compensation for work (including work performed in an occupational training program) and such compensation is to be used at the client’s discretion.

Prevailing wage refers to the wage paid to non-disabled workers in nearby industry or the surrounding community for essentially the same type, quality and quantity of work or work requiring comparable skills. A client who works in the facility must be paid at least the prevailing minimum wage, unless an appropriate certificate has been obtained by the facility in accordance with current regulations and guidelines issued under the Fair Labor Standards Act, as amended.

Any client performing “work”, as defined above, must be compensated in direct proportion to his or her output. The facility should utilize Department of Labor and/or Department of Vocational Rehabilitation formulas and techniques for determining rate of pay. A client’s pay is not dependent on the production of other clients when he or she works in a group.

When the client’s active treatment program includes assignment to occupational or vocational training or work, specific work objectives of anticipated progress should be included in the IPP along with reasons for the assignments. If the training of clients on particular occupational activities or functions involves “real work” to be accomplished for the facility, the clients must be compensated based on ability. For example, if in the process of work training activities which involve learning to clean a floor, the floor for a particular building is cleaned and does not require further janitorial cleanup, then the client must be compensated for this activity at the prevailing wage.

#### **W133**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice,**

**Guidance §483.420(a)(9)**

Privacy must be provided for both face-to-face interactions and electronic interactions.

The facility must provide opportunities for the client to communicate, through regular mail, telephone and/or electronic mail and meet in private with persons of their choice (e.g., friends from the community, family members, and advocates). There may be instances where legal guardians override the wishes of the client. In these instances, the facility should be actively working with the legal guardian and the client to reach the maximum agreeable level of interaction for the client.

Space must be provided for clients to receive visitors in reasonable comfort and privacy.

#### **W134**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(9) and to send and receive unopened mail;**

**Guidance §483.420(a)(9)**

Clients must be provided the opportunity to send/receive all types of mail unopened and read the contents themselves if able. If the staff has to open and read mail to the client, this should be done in a private place allowing the client as much participation as possible.

Clients who have their own electronic equipment must be provided the opportunity to send, receive, and read electronic mail with privacy.

#### **W135**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;**

**Guidance §483.420(a)(10)**

Any restriction of telephone access must be explained in the IPP with a plan to advance the client’s access. For persons with hearing loss who could benefit, Text Telephone (TTY) services or other accommodations should be provided.

As with any other rights restriction, the restriction must be addressed in the IPP, written informed consent obtained, and the plan must be reviewed and approved by the specially constituted committee.

#### **W136**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(11) Ensure clients the opportunity to participate in social, religious, and community group activities;**

**Guidance §483.420(a)(11)**

Clients should be offered the opportunity to participate in various types of activities in the community (e.g., going to grocery stores, hair salons, restaurants, places of worship, pharmacies, community meetings and events) based on their interests and choices. The facility must make accommodations for physical issues such as hearing impairment and mobility limitations. In addition, clients should be taught the applicable skills to participate in their choice of activities to the fullest extent of their abilities. It is not acceptable for all client activities to be provided in the facility.

When a client is identified to be on restriction from community integration opportunities, interview clients, families, legal guardians and staff to determine if due process was afforded for this restriction and whether the restriction is included in the IPP.

In the event of a court placement that restricts community access, due process does not apply.

There should be evidence that the facility assists and encourages all clients, regardless of functioning levels, to have input into the decisions on community integration activities.

It is not acceptable to require clients to attend unwanted activities due to staffing considerations.

**W137**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and**

**Guidance §483.420(a)(12)**

Clients should have personal possessions and clothing which meet their needs, interests and choices.

Clients should have free access to their own possessions and clothing. When considering whether a client has free access to their personal possessions and clothing, ensure that physical limitations have been addressed.

Clients who are unable to access and use personal possessions and clothing appropriately are involved in programs to learn the necessary skills to do so.

In situations where the behavior of one or more clients in a living area prevents free access to personal possessions for each client, the facility must develop IPPs for the client with disruptive behavior. The facility must also ensure that during the implementation of this program plan that none of the other clients have their rights infringed upon. Clients should not be without personal possessions because of the behavior of others with whom they live.

All client possessions, regardless of their apparent value to others are treated with respect for what they may represent to the client. Where those choices include socially stigmatizing materials, the facility should provide learning opportunities to make more socially appropriate choices. The facility should encourage clients to use or display possessions of his or her choice in a culturally normative manner.

If a method for identifying personal effects is used, it should be inconspicuous and in a manner that will assist the client to identify them.

“Appropriate” clothing means a supply of clothing that is sufficient, in good repair, accounts for a variety of occasions and seasons, and appropriate to age, size, gender, and level of activity. Modification or adaptation of clothing fasteners should be considered based on the needs of a client with a physical disability to become more independent.

As appropriate, each client’s active treatment program maximizes opportunities for choice and self-direction with regard to choosing and shopping for clothing which enhances his or her appearance, and selecting daily clothing in accordance with age, sex and cultural norms.

Clients are permitted to keep personal clothing and possessions for their use while in the facility. Determine how the facility both ensures the safety of personal possessions while at the same time providing client access to them when the client chooses.

Clients are provided the opportunity, encouraged, and trained to use age-appropriate materials. The term “age-appropriate” refers to anything that reinforces recognition of the client as a person of a certain chronological age. Clients who choose to keep items traditionally used by children such as dolls or

model cars are not an automatic citation. There must be evidence the facility is encouraging the client to use these possessions in a socially appropriate, non-stigmatizing manner. The facility's environment must be furnished with materials and activities that will enhance opportunities for growth.

**W138**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(a)(12) ensure that each client is dressed in his or her own clothing each day; and**

**Guidance §483.420(a)(12)**

Clothing such as pajamas, underwear, socks, hats, mittens/gloves, and coats should be the personal property of the client and not considered "*stock*" items. There should be no communal clothes. If clients are unable to do their own personal laundry the facility must ensure that clothing is properly laundered and returned to the appropriate client.

The staff of the facility should ensure that clients dress appropriately for the season and the occasion by implementing training programs or guidance for the client as indicated.

**W139**

**§483.420(a)(13) Permit a husband and wife who both reside in the facility to share a room.**

**§483.420(b) Standard: Client Finances**

**(b)(1) The facility must establish and maintain a system that**

**W140**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(b)(1)(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and**

**Guidance §483.420(b)(1)(i)**

All purchases made using client personal funds must be itemized in the accounting record with the exception of pocket money. Pocket money given to the client does not need to be itemized. Pocket money should be considered a nominal amount of five dollars or less at a time. Funds provided by the facility and dispensed to a client as part of a program to train the client in money management, and funds that are not entrusted to the facility (e.g., funds paid directly to the client's representative payee) do not require accounting.

In those instances where a legal guardian or the individual client is in control of their personal funds, no accounting is necessary by the facility.

**W141**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(b)(1)(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.**

**Guidance §483.420(b)(1)(ii)**

If the facility elects to pool clients' funds in an interest-bearing account, including common trust accounts, it is expected to know the interest separately accrued by each client, as part of its required accounting of funds. Interest accumulated to a client's account belongs to the client, not the facility.

**W142**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(b)(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.**

**Guidance §483.420(b)(2)**

Those persons having legal authority to access the accounting records for personal funds such as the client, parent, or legal guardians should be afforded access upon request unless there is documented rationale for withholding the information.

It is not necessary that a facility furnish an annual financial statement to the client, or the client's parent or legal guardian, since the facility is already required to make the financial record available at any time upon request. The client, parent, and/or legal guardian, in turn, is free to choose to make the financial record available to anyone else.

**(c) Standard: Communication with clients, parents, and guardians.**

**§483.420(c)**

**The Facility must –  
W143**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(c)(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;**

**Guidance §483.420(c)(1)**

The facility must maintain an on-going effort to communicate with parents, family members and/or legal guardians regarding the implementation of active treatment programs for the client. The facility encourages and engages parents, family members and legal guardians in the continued implementation of active treatment programs even while spending time outside of the facility setting.

“Unobtainable”, for the purposes of this guideline, means that the facility has made a good faith effort to seek parental or legal guardian participation in the process, even though the effort may ultimately be unsuccessful (for example, the parent may be impossible to locate or may prove unwilling or unable to participate).

“Inappropriate”, for the purposes of this guideline, means that behavior of the parent or legal guardian could be disruptive or detrimental to the client’s program outcome. In this case, determine what the facility has done to bring effective resolution to the problem.

**W144**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(c)(2) Answer communications from clients’ families and friends promptly and appropriately;**

**Guidance §483.420(c)(2)**

It is reasonable to expect that the facility will provide at least an interim response to inquiries from the client’s families and friends within 48 hours.

**W145**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(c)(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client’s and other clients’ privacy, unless the interdisciplinary team determines that the visit would not be appropriate;**

**Guidance §483.420(c)(3)**

Any limitations on visitors must be implemented as a result of IDT evaluation and discussion and be documented. This documentation should include evidence of approval from the specially constituted committee. Decisions to restrict a visitor for an individual client must be reviewed and re-evaluated each time the IPP is reviewed or at the client’s request. Broad restrictions on visitors such as times of the day or certain days of the week are a violation of this requirement.

**W146**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(c)(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client’s and other clients’ privacy;**

**W147**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(c)(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and**

**Guidance §483.420(c)(5)**

The facility should assist and encourage the client to communicate with their families or legal guardians concerning possible outside visits and vacations as frequently as possible. When the client does schedule a trip or vacation, the facility must ensure that all necessary preparation is completed to facilitate the departure.

The facility should not sponsor or allow clients to take a particular type of trip that would jeopardize their safety or health without consultation with parents/legal guardians and/or the IDT.

**W148****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.420(c)(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.****Guidance §483.420(c)(6)**

“Significant” incidents or changes in the client's condition include serious injury, unusual seizure activity, hospitalization, serious illness, accident, death, allegations of abuse, neglect, or mistreatment, unauthorized absence, or any notifications the parent or legal guardian's requests.

It is reasonable to expect the facility to contact the family or legal guardian of a client as soon as possible after an incident occurs, but no later than 24 hours after the incident. If notification is done via electronic mail, the facility must request a response from the e- mail recipient to confirm notification. Telephone notification must be accomplished by talking to the person directly. If a message is left, the facility must request a call back to confirm receipt of the notification.

Contact by letter may be utilized as follow up confirmation, but not be the initial, primary or sole mode of communication with the family or legal guardian.

If unable to contact the family or legal guardian, there should be evidence that the facility attempted to reach alternate emergency contacts.

Requests from clients who are their own guardian to limit notifications to their families must be honored.

**(d) Standard: Staff treatment of clients.****W149****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.****Guidance §483.420(d)(1)**

The facility, through implementation of its policies, must set up a structure that screens and trains employees, protects clients and prevents, identifies, investigates and reports abuse, neglect and mistreatment of clients.

The policies must designate who (either by name or title) has the authority to act in the Administrator's absence and take any immediate corrective actions necessary to assure a client's safety such as removing a staff person from direct client contact.

“Mistreatment”, for the purposes of this guideline, includes behavior or facility practices that result in any type of client exploitation such as financial, physical, sexual, or criminal. Mistreatment also refers to the use of behavioral management techniques outside of their use as approved by the specially constituted committee and facility policies and procedures.

“Neglect” means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self- injurious behavior may constitute neglect. Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect.

Refer to W127 for definitions of abuse.

**W150****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.420(d)(1)(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.****W151****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.420(d)(1)(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.****W152****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.420(d)(1)(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.**

**Guidance §483.420(d)(1)(iii)**

The facility is required to screen potential employees for a prior employment history of child or client abuse, neglect or mistreatment, as well as for any conviction based on those offenses. The abuse, neglect or mistreatment must have been directed toward a child or a client/resident/patient of a health care facility in order for the prohibition of employment to apply.

No one with a conviction or substantiated allegation of child or client abuse, neglect or mistreatment regardless of employment date, is employed by the facility. This requirement also applies to acts of abuse, neglect or mistreatment committed by a current ICF/IID employee outside the jurisdiction of the ICF/IID (e.g., in the community or in another health care facility). The facility must follow state guidelines or requirements for background checks to assure that they make every effort to check new employee's background.

Where the facility has terminated an employee based upon confirmation that abuse, neglect or mistreatment occurred during the employee's performance, and the termination decision was overturned by either arbitration finding or a court finding, the employee must be returned to a position which does not involve direct contact between that employee and clients of the facility.

A person who abused a resident in a nursing facility, and as a result, is barred from employment in the nursing home setting would also be prohibited from employment in the ICF/IID. While facilities are not required to periodically screen existing employees, if the facility becomes aware that such action has been taken against an employee, the facility is required to prohibit continued employment. This is also true of any conviction in a court of law for child, elder, or client (resident, patient) abuse, neglect or mistreatment. Therefore, conviction for abusing one's own child is also a reason employment would be prohibited.

**W153**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.**

**Guidance §483.420(d)(2)**

Injuries of unknown source that give rise to a suspicion that they may be the result of abuse or neglect, should be reported immediately.

An injury should be reported as an "injury of unknown source" when:

- The source of the injury was not witnessed by any person and the source of the injury could not be explained by the client; and
- The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

It is important to note that members of the ICF/IID population are a mobile population and lead active lives. Therefore, they experience normal day-to-day bumps and minor abrasions as they go about their lives. These minor occurrences which are not of serious consequence to the individual and do not present as a suspicious or repetitive injury (as discussed above) should be recorded by the facility staff once they are aware of them and follow-up should be conducted as indicated. For injuries that do not rise to the level of reportable "injuries of unknown source", the facility should follow its policies and procedures for incident recording, investigation, and tracking.

The facility must immediately report any suspicious injuries of unknown source and all allegations of mistreatment, neglect or abuse to a client residing in the facility regardless of who is the alleged perpetrator (e.g., facility staff, parents, legal guardians, volunteer staff from outside agencies serving the client, neighbors, or other clients, etc.).

If state law requires reporting to an agency or entity other than the administrator, the Centers for Medicare & Medicaid Services (CMS) expects the administrator to be notified as well, in order to ensure facility response to promptly safeguard the client(s).

For the purposes of this regulation "immediately" means there should be no delay between staff awareness of the occurrence and reporting to the administrator or other officials in accordance with

State law unless the situation is unstable in which case reporting should occur as soon as the safety of all clients is assured.

**W154**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated and**

**Guidance §483.420(d)(3)**

In the absence of any pre-survey information that would indicate the need for a more thorough review of reports of investigation, review 5 percent of the total client investigations for the last three (3) months (but no less than 10).

A thorough investigation includes at a minimum:

- The collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams;
- Review of all information;
- Resolution of any discrepancies;
- Summary of conclusions; and
- Recommendations for action both to safeguard all the clients during the investigation and after the completion of the report.

If patterns of possible abuse, mistreatment or neglect are identified, or the incident report logs for the past three (3) months indicate an extremely high incident rate, then a full review of the incidents for the past three (3) months should be completed.

**W155**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(d)(3) must prevent further potential abuse while the investigation is in progress.**

**Guidance §483.420(d)(3)**

The facility must take all measures necessary to protect the client, including removal of the staff from working with the client if indicated. See W154.

**W156**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and,**

**Guidance §483.420(d)(4)**

Some states require that allegations of abuse must be reported to the police. A police investigation may take longer than five (5) working days. Their investigation does not change the requirement that the facility must complete an internal investigation report of findings within the five day timeframe. When outside authorities are involved, the facility will still be required to complete their investigation within five days to the extent authorized by such entities. "Working days" means Monday through Friday, excluding state and Federal holidays.

**W157**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.420(d)(4) if the alleged violation is verified, appropriate corrective action must be taken.**

**Guidance §483.420(d)(4)**

The facility is required to ensure that clients residing in the facility are not subjected to physical, verbal, sexual or psychological abuse or punishment.

Appropriate corrective action is required for findings of abuse, neglect or mistreatment by other clients residing in the facility, staff of outside agencies, parents or any other person, and for injuries to clients resulting from controllable environmental factors.

If the facility receives allegations of abuse, neglect, or mistreatment of a client during out of facility visits with their family, they must report these allegations to the appropriate state authority for investigation. The facility does not have to conduct an internal investigation regarding the alleged violation.

Appropriate corrective action is defined as that action which is reasonably likely to prevent the abuse, neglect, mistreatment or injury from recurring.

This regulation does not require staff termination as the only appropriate corrective action.

The corrective action imposed by the facility is commensurate with the violation.

When a facility is forced to re-hire a staff person, determined by the facility investigation to have been responsible for abuse, neglect, or mistreatment, the facility continues to be responsible for ensuring the health and safety of the clients, and ensures that those staff members do not work directly with clients.

#### **W158**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430 Condition of participation: Facility staffing.**

**(a) Standard: Qualified intellectual disability professional**

#### **W159**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who –**

**Guidance §483.430(a)**

The position of qualified intellectual disability professional (QIDP) is unique to the ICF/IID program. This position can be central to the overall responsiveness and effectiveness of an active treatment program. Whether a supervisory or non-supervisory position, the QIDP is responsible to:

- Orchestrate all facets of the active treatment effort, including the IDT creation of relevant IPPs tailored to meet individual client needs;
- Effectively coordinate internal and external program services and supports to facilitate the acquisition of client skills and adaptive behaviors; and
- Promote competent interactions of residential staff with clients in program implementation and behavior management.

Breakdowns in the provision of needed services does not automatically equate with deficient practice with QIDP regulations. Non-compliance with QIDP regulations exist where the facility has failed to provide a QIDP or sufficient numbers of QIDPs to effectively perform these required functions or the QIDP(s) has failed to assertively attempt to integrate, coordinate and/or monitor each client's active treatment program.

Elements of integrating, coordinating and monitoring active treatment programs include:

- Routinely observing clients across settings in program areas to assess effectiveness of program implementation and consistency of training effort to determine effectiveness of IPPs and making timely modifications to facilitate achieving desired skills or goals.
- Routinely interacting with program staff across settings to assist in determining the effectiveness and continued relevance of program plans in meeting identified client needs.
- Determining the need for program revision based on client performance.
- Identifying inconsistencies in training approaches or programs not being implemented as written and facilitating the resolution of these inconsistencies.
- Assures follow-up occurs for any recommendation for services, equipment or programs so that needed services and supplies are provided in a timely manner to meet the client's needs.

The number of QIDPs will vary depending on such factors as the number of clients the facility serves, the complexity of needs manifested by these clients, the number, qualifications and competencies of additional professional staff members, and whether or not other duties are assigned to the QIDP function. The QIDP function may not be delegated to other employees even though the QIDP co-signs their work.

#### **W160**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(a)(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and**

**Guidance §483.430(a)(1)**

“Experience” means providing professional or direct services, either paid or volunteer, in a setting that serves persons with intellectual disabilities. The experience working directly with persons with

intellectual or other developmental disabilities can be obtained prior to or after obtaining the qualifying degree or credentials.

**§483.430(a)(2) Is one of the following:**

**W161**

**(a)(2)(i) A doctor of medicine osteopathy.**

**W162**

**(a)(2)(ii) A registered nurse.**

**W163**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(a)(2)(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section**

**Guidance §483.430(a)(2)(iii)**

The individual must have at least a bachelor's degree in one of the professions listed in §483.430(b)(5)(i-xi)

**(b) Standard: Professional program services**

**W164**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430 (b)(1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.**

**Guidance §483.430 (b)(1)**

The effectiveness of the active treatment effort is dependent on a facility's assembly of a competent team of professional program staff, with knowledge of contemporary care practices in intellectual disabilities specific to their field of expertise, that work cooperatively as members of an IDT. The facility is responsible for the acquisition of professional staff necessary to provide direct and indirect professional services to meet client needs.

Professional program services are those services that meet the needs identified by a client's CFA that must be provided by a member of a vocation founded upon specialized education/training.

Professional staff services also include on-going monitoring of the effectiveness of programs and plans developed by professional staff but implemented by non -professional staff.

Indirect professional staff services also include on-going, technical support to staff implementing these programs as well as timely assessment of the need for modification of the program with appropriate communication to the QIDP and IDT.

The needs identified in the initial CFA, as required in §483.440(c)(3)(v), should guide the team in deciding if a particular professional's involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis.

Since such needed professional expertise may fall within the purview of multiple professional disciplines, based on overlapping training and experience, determine if the facility's delivery of professional services is adequate by the extent to which clients' needs are aggressively and competently addressed. Some examples in which professional expertise may overlap include, but are not limited to:

- Physical development and health: nurse, dietitian, pharmacist.
- Nutritional status: nurse, nutritionist or dietitian.
- Sensorimotor development: educators, recreation therapists, and occupational therapist, physical therapist.
- Affective (emotional) development: special educators, social workers, psychologists, psychiatrists, mental health counselors, rehabilitation counselors, behavior therapists, behavior management specialists, behavior analyst, and medical staff.
- Speech and language (communication) development: speech-language pathologists, special educators for people who are deaf or hearing impaired, and medical staff.
- Auditory functioning: audiologists (basic or comprehensive audiologic assessment and use of amplification equipment); speech-language pathologists (like audiologists, may perform aural rehabilitation); special educators for clients who are hearing impaired and medical staff.

- Cognitive development: teachers (if required by law, e.g., school aged children, or if pursuit of GED is indicated), behavior analysts, psychologists, speech-language pathologists.
- Vocational development: occupational therapists, vocational rehabilitation counselors, or other work specialists (if development of specific vocational skills or work placement is indicated).
- Social Development: teachers, professional recreation staff, social workers, behavior analysts, psychologists (specialized training needs for social skill development).
- Adaptive behaviors or independent living skills: special educators, occupational therapists, behavior analysts, and medical staff.

**W165**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(1) Professional program staff must work directly with clients**

**Guidance §483.430(b)(1)**

Examples of professional staff working directly with clients include: performing professional assessments of clients, provision of direct support and services and periodic monitoring by the professional of the client working on the program. The amount and degree of direct care that professionals must provide will depend on the needs of the client and the ability of other staff to effectively work with clients on a day-to-day basis.

For those services that must be provided by a professional due to either law, licensure or registration, the client receives the services directly from the professional. Professionals may deliver services through the supervision and direction of subordinates where provided by law.

**W166**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(1) and with paraprofessional, nonprofessional and other professional program staff who work with clients.**

**Guidance §483.430(b)(1)**

Paraprofessionals are persons in various occupational fields who are trained to assist professionals but are themselves not licensed at the professional level.

Examples of “working with” these other staff may include, but not be limited to:

- Modeling the correct technique for interacting with clients or implementing a specific program objective.
- Designing residential activity programs and teaching staff how to implement them.
- Conducting classes on discipline specific topics.
- Answering questions of staff related to program implementation or specific behavioral management issues.
- Monitoring active treatment areas to identify program implementation or staff-client interaction issues.

**W167**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.**

**Guidance §483.430(b)(2)**

There should be sufficient professional staff in the facility to ensure that:

- needed assessments by professionals are completed timely;
- direct professional services are provided when indicated;
- clients are receiving interventions as specified in the IPP;
- client outcomes are being monitored by the professional;
- assessments and outcomes are being communicated to the IDT; and
- professional staff are available to consult with team members when needed.

**W168**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.**

**Guidance §483.430(b)(3)**

When a professional does an assessment and determines there are client needs which become incorporated into the IPP, with a current prioritized objective, the professional should actively participate on the IDT. This participation may be through written reports or verbally while attending the IPP meeting or participating via telephone or other electronic means, to provide team members with the opportunity to review and discuss information and recommendations relevant to the client's needs, and to reach decisions as a team, rather than individually, on how best to address those needs.

**W169**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.**

**Guidance §483.430(b)(4)**

Professional program staff provides various types of training to staff as indicated by the IPP and IDT. Formal training: a specific training done at the time a program is implemented or updated by the professional, with all staff who works with the client.

Informal training: when the professional observes the staff not correctly implementing a program, the professional provides informal guidance on correct implementation.

Training on programs that apply to multiple clients: when a particular program applies to several clients in a facility, a professional may provide training to several staff on a particular topic that applies to multiple clients (such as safe transfer techniques).

Professional staff of the facility should participate in ongoing training such as conferences and workshops to maintain current standards of practice in the field of intellectual and developmental disabilities as required by their professional licensure or certification.

**W170**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in §483.410(b), must meet the following qualifications:**

**W171**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.**

**Guidance §483.430(b)(5)(i)**

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in the state they are practicing in, and are registered or certified nationally as applicable.

**W172**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.**

**Guidance §483.430(b)(5)(ii)**

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no “other comparable body.”

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

**W173**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.**

**Guidance §483.430(b)(5)(iii)**

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

**W174**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.**

**Guidance §483.430(b)(5)(iv)**

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in State they are practicing in, and are registered or certified nationally as applicable.

**W175**

**§483.430(b)(5)(v) To be designated as a psychologist, an individual must have at least a master’s degree in psychology from an accredited school.**

**§483.430(b)(5)(vi) To be designated as a social worker, an individual must—**

**W176**

**§483.430(b)(5)(vi)(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or**

**§483.430(b)(5)(vi)(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.**

**§483.430(b)(5)(vii) To be designated as a speech-language pathologist or audiologist, an individual must—**

**W177**

**§483.430(b)(5)(vii)(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or**

**§483.430(b)(5)(vii)(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.**

**W178**

**§483.430(b)(5)(viii) To be designated as a professional recreation staff member an individual must have a bachelor’s degree in recreation or in a specialty area such as art, dance, music or physical education.**

**W179**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.**

**Guidance §483.430(b)(5)(ix)**

If a professional is not nationally registered as a dietitian, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

**W180**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).**

**Guidance §483.430(b)(5)(x)**

Human Services is a diverse field focused on improving the quality of life of clients in communities in which the professional serves. A human services professional works directly with the population being served. Surveyors should see evidence that a human service professional has a bachelor's degree at a minimum.

**W181**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(b)(5)(xi) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5)(i) through (x) of this section are not required-**

**(A) Except for qualified intellectual disability professionals;**

**(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and**

**(C) Unless otherwise specified by State licensure and certification requirements.**

**Guidance §483.430(b)(5)(xi)**

An individual client program may not require that professional staff perform all of the services as outlined by the IPP (e.g. the direct support staff may be trained by the professional to safely and effectively carry out the designed program), however, any specialized therapy must involve evaluation, program development, and re-assessment by the appropriate professional at periodic intervals.

**(c) Standard: Facility staffing**

**W182**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(c)(1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.**

**Guidance §483.430(c)(1)**

The facility must have sufficient staff to provide needed care and services without the use of volunteers or enlisting the help of clients residing in the facility to perform the duties normally performed by facility staff.

The facility may not rely on volunteers in lieu of paid staff to fill required staff positions and perform direct care services. Volunteers are permissible, but must be in addition to the number of paid staff required to carry out a function. Volunteers should have an orientation to the policies and procedures of the facility and oversight is required by facility staff.

**W183**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(c)(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing- -**

**(i) Clients for whom a physician has ordered a medical care plan;**

**(ii) Clients who are aggressive, assaultive or security risks;**

**(iii) More than 16 clients; or**

**(iv) Fewer than 16 clients within a multi-unit building.**

**Guidance §483.430(c)(2)**

Indicators of staff not being awake in relation to the occurrence of incidents, accidents, and injuries may include, but are not limited to:

- incidents of unplanned client absences;
- untimely reaction to a medical emergency;
- injuries from client to client aggression; or
- a pattern of injuries of unknown origin.

If even one client meets 483.430(c)(2)(i-ii) then staff must be awake on a 24-hour basis.

A client has a medical care plan when an acute or chronic occurrence requires clinical assessment and monitoring on a scheduled basis.

**W184**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(c)(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing- -**

**(i) Clients for whom a physician has not ordered a medical care plan;**

**(ii) Clients who are not aggressive, assaultive or security risks; and**

**(iii) Sixteen or fewer clients.**

**Guidance §483.430(c)(3)**

At all times, there must be at least one staff person on-duty in the facility if even one client is present. For purposes of this provision, “on duty” staff need not be awake during normal sleeping hours, but do need to respond to injuries, illness, and emergencies promptly.

**W185**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(c)(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.**

**Guidance §483.430(c)(4)**

Direct care staff should not be performing support services (e.g., making beds, cooking, cleaning, etc.) independently which takes them away from client interaction and teaching. If support services in the house cannot be done jointly as chores between clients, as part of their training program, and the support staff, additional staff should be added to perform the chores. This does not include any staff chores done during client’s sleeping hours.

“Support staff” include all personnel hired by the facility that are not either direct care staff or professional staff. For example, support staff includes, but are not limited to, secretaries, clerks, housekeepers, maintenance and laundry personnel.

**(d) Standard: Direct care residential living unit staff**

**W186**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.430(d)(1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.**

**Guidance §483.430(d)(1)**

“Sufficient” means enough direct care staff to effectively implement the active treatment programs as defined in the IPP, to meet client needs, and to respond to emergencies, illness, or injuries.

Even though minimum ratios are defined at §483.430(d)(3), active treatment may require more staff than the minimums required ratios, therefore compliance should not be based on staffing ratios alone.

**§483.430(d)(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.**

**Guidance §483.430(d)(2)**

“Direct care staff” are those personnel who are assigned to work directly with the clients providing support during activities of daily living and active treatment programs.

Professional staff who work with clients in a living unit on a periodic basis are not included in direct care staff ratios.

Supervisors of direct care staff can be counted only if they share in the actual work of the direct care of clients on a continuous basis (e.g. take client assignment).

Direct care supervisors whose principle assigned function is to supervise direct care staff may not be included in direct care staff ratios although they may occasionally provide direct services to clients.

Non-direct care staff supervisors whose principle assigned function is to supervise non- direct care staff may not be included in direct care staff ratios.

#### W187

*(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)*

**§483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:**

**(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2.**

**(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4.**

**(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.**

#### **Guidance §483.430(d)(3)**

*The minimum ratios in this standard indicate the **minimum** number of direct-care staff that must be present and on duty, 24 hours a day, 365 days a year, for each discrete living unit. For example, to calculate the minimum number of living unit staff that must be present and on duty in a discrete living unit serving 16 individuals with multiple disabilities: divide the number of individuals "16," by the number corresponding to the regulation "3.2," the result equals "5." Therefore, the facility must determine how many staff it must hire to ensure that at least 5 staff will be able to be present and on duty during the 24 hour period in which those individuals are present.*

*Using the living unit described above, "calculated over all shifts in a 24-hour period" means that there are present and on duty every day of the year: one direct care staff for each eight individuals on the first shift (1:8), one direct care staff for each eight individuals on the second shift (1:8), and one direct care staff for each 16 individuals on the third shift (1:16). Therefore, there are five (5) direct care staff present and on duty for each twenty-four hour day, for 16 individuals. The same calculations are made for the other ratios, whichever applies. Determine if absences of staff for breaks and meals results in a pattern of prolonged periods in which present and on-duty staff do not meet the ratios.*

#### W188

**§483.420(d)(4) When there are no clients present in the living unit, a responsible staff member must be available by telephone.**

#### **§483.430(e) Standard: Staff Training Program**

#### W189

*(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)*

**§483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.**

#### **Guidance §483.430(e)(1)**

Newly employed staff receive a supported orientation program (mentor or ongoing supervision) during their early employment. All staff receive continuing education on such issues as abuse and neglect, handling emergency situations, behavior management, and treating people with respect and dignity, etc. The primary evidence of an effective staff training program is the observed competent interaction between staff and clients.

**§483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients'**

#### W190

*(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)*

**§483.430(e)(2) developmental,**

**Guidance §483.430(e)(2)**

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems;
- and
- effective recordkeeping procedures.

**W191**

*(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)*

**§483.430(e)(2) behavioral,**

**Guidance §483.430(e)(2)**

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;
- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

**W192**

*(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)*

**§483.430(e)(2) and health needs**

**Guidance §483.430(e)(2)**

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

**W193**

*(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)*

**§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.**

**Guidance §483.430(e)(3)**

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

Inadequate training is evident when staff do not correctly implement behavioral programs, use inappropriate management techniques, cannot explain what intervention is to be used and how it is to be implemented.

**W194**

*(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)*

**§483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.**

**Guidance §483.430(e)(4)**

Staff are observed in various settings during the day correctly and consistently implementing the specific IPPs of the clients with whom they are working.

**W195**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440 Condition of participation: Active treatment services**

**(a) Standard: Active treatment**

**W196**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward-**

**(i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and**

**(ii) The prevention or deceleration of regression or loss of current optimal functional status.**

Active treatment embodies an individually- tailored series of daily life and living experiences that serve as the primary opportunity for the acquisition, development and expression of functional skills and adaptive behaviors necessary for the client to experience optimal independence and promote purposeful “self-expression”.

The uniqueness of each client is a core consideration in the design of active treatment programs. It is expected that individual clients are given the opportunity to provide input into the content of their day-to-day living experiences.

An active treatment program includes the following elements as substantiated through observation, interview and record review:

*a) Each client’s needs and strengths have been accurately assessed and relevant input has been obtained from team members; (Observations and interviews with the client by the surveyor should be consistent with the current assessment information. Interview the QIDP regarding any needs observed but not addressed through assessment/programming by the facility).*

*b) Each client’s IPP is based on assessed needs and strengths, and addresses major life areas such as personal skills, home living skills, community living skills, employment skills, etc., essential to increasing independence and ensuring rights;*

*c) Needs identified as a priority are addressed formally and through activities which are relevant and responsive to client need, interest and choice;*

*d) Active treatment is consistently implemented in all relevant settings both formally and informally as the need arises or opportunities present themselves. It should not be limited to specific periods of time during the day or environments. Each client should receive aggressive and consistent training, treatments and supports in accordance with their needs and IPP. New skills and appropriate behaviors are encouraged and reinforced across environments and times of day. Each client has the adaptive equipment and environmental adaptations necessary for him/her to progress toward heightened independence as recommended and contained in their IPP. Active treatment means taking advantage of opportunities for the practice of new skills and the use of other skills during the normal rhythm of each client’s day.*

*e) Each client’s performance related to IPP objectives is accurately and consistently measured and documented and programs are modified on an ongoing basis based on data and major life changes; and*

*i. Clients with degenerative conditions receive training, treatment and services designed to retain skills and functioning and to prevent further regression to the extent possible.*

*ii. Clients may need adjustments to their active treatment programs as functional or endurance limitations are identified associated with the aging process. In such cases, there may be more of an emphasis on the retention of skills already attained and reducing the rate of loss of skills, than on the acquisition of new skills.*

In large part, it is this pervasive and continuous reinforcement of “formal” training through “informal” routine daily living experiences and interactions with staff and others that makes active treatment programs effective. Formal settings are those that are planned and specifically structured for training on objectives and interventions. Informal settings are times that are not anticipated or planned but that offer the opportunity for training.

Active treatment programs mirror normal living experiences such as leisure activities and social conversation at the dinner table. It must be clear that active treatment programs are far more than

implementation of discreet formal training sessions or programs that are conducted at prescribed times by defined personnel. Learning occurs in the process of the normal rhythm of life and life experiences.

**W197**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(a)(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.**

**Guidance §483.440(a)(2)**

All active treatment programs must be based upon assessed developmental needs which are prohibiting the client from living in a more independent setting.

Active treatment moves clients to a more independent setting.

- When a client is in the facility simply for protective oversight and is not in need of training for developmental deficits, this does not constitute active treatment (e.g. a court placement to protect the community or the client from the client's behavior).

- Programs that are simply being provided to maintain a client's independence would not be considered active treatment since the client is not actively being trained to live in a more independent setting. If a client already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support and resources that services that only an ICF/IID can provide, they can be considered generally independent.

For example, a client is admitted to the ICF/IID for the primary purpose of competency determination for a court hearing. This client lived independently prior to admission. The active treatment programs they are receiving are focused on maintaining that independence and do not address specific developmental deficits that inhibit independent living. This would not be considered active treatment.

**(b) Standard: Admissions, transfers, and discharge****W198**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(1) Clients who are admitted by the facility must be in need of and receiving active treatment services.**

**Guidance §483.440(b)(1)**

All client admissions must be based upon assessed developmental deficits which are prohibiting the client from living in a more independent setting and which require those intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The individual components of the provision of active treatment include CFA, IPP, program implementation, program documentation, and program monitoring and change. When any of these individual components of active treatment are not in place, resulting in the clients not receiving active treatment, this regulation this not met.

**W199**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.**

**Guidance §483.440(b)(2)**

Preliminary evaluations should support the need for an admission to an ICF/IID (e.g., deficits in functional skills or adaptive behaviors). The information from the preliminary evaluation must be used by the facility to make an admission decision.

Occasionally, emergency admissions of clients may occur without benefit of a preliminary evaluation having been conducted prior to admission. When situational emergencies necessitate admission before a preliminary evaluation can be conducted, or when pre-admission information is incomplete, the completion of the preliminary admission evaluation within seven (7) calendar days after admission will satisfy compliance with this requirement.

**W200**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.**

**Guidance §483.440(b)(3)**

The preliminary evaluation contains specific information useful to determine if the facility can meet the client's needs and if the client can benefit from placement.

The facility makes every reasonable effort to gather all available data to assist in their determination.

Background information would include information that gives insight into the clients' previous living environments and programming efforts.

The assessment must include a consideration as to whether reasonable accommodation as required by the Americans with Disabilities Act would enable the client to benefit from placement in facility.

**§483.440(b)(4) If a client is to be either transferred or discharged, the facility must –**  
**W201**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(4)(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and**

**Guidance §483.440(b)(4)(i)**

Transfer or discharge occurs only when the facility cannot meet the client's needs, the client no longer requires an active treatment program in an ICF/IID setting; the individual/guardian chooses to reside elsewhere, or when a determination is made that another level of service or living situation would be more beneficial to the client.

"Transfer" means the temporary movement of a client to another facility (e.g. another ICF/IID, psychiatric hospital, medical hospital) with the intention of return to the original site.

"Discharge" means the permanent movement of a client to another facility or setting which operates independently from the ICF/IID (e.g. the facility is not under the jurisdiction of the facility's governing body).

Documentation includes evidence of an assessment that evaluated the pros and cons of the transfer or discharge and the rationale for the final decision.

**W202**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(4)(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).**

**Guidance §483.440(b)(4)(ii)**

The client and their family or the client and their legal guardian are involved in planning for any transfer or discharge and receive the services necessary to assist in preparing for movement, unless an emergency (medical) situation prevents that involvement. If the client has an advocate, the advocate should participate in the decision-making process.

Orderly, planned transfers and discharges usually take place over an extended period of time. The IPP should reflect objectives or interventions which prepare the client for transfer or discharge. Transfers or discharges executed on short timeframes (e.g. less than 30 days) without "good cause" would not comply with the "reasonable" intent of the regulations.

"Reasonable" time is the time required to provide clients and their families with planned steps and established timeframes to facilitate the successful transition. Time frames are modified based on client needs and emergent situations.

Preparation of the client for transfer may include orientation or trial visits to the new location. Staff should take steps to minimize potential anxiety or any behavioral reactions which could result from the client's transfer.

**§483.440(b)(5) At the time of the discharge, the facility must-**

**W203**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(5)(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status****Guidance §483.440(b)(5)(i)**

The final summary should be useful for continued services in the client's new setting. The final discharge summary should be entered into the client's record, provide a summary of the client's course of stay in the ICF/IID, provide a final summary of the client's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the client's IPP.

The status should address whether or not a clients' skills have been maintained, deteriorated, or improved during their stay.

**W204**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(5)(i) and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and****Guidance §483.440(b)(5)(i)**

When the client is discharged, the receiving entity (another ICF/IID, waiver home, family home, nursing home, etc.) is provided a copy of the discharge summary. The ICF/IID should obtain written consent to share this information with the persons who will be providing services to the client in the future and their parents/or legal guardians. Sharing the discharge summary with State Agencies as applicable is determined by state requirements.

**W205**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(b)(5)(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.****Guidance §483.440(b)(5)(ii)**

The post discharge plan of care is a component of the discharge summary.

The facility utilizes the information from the discharge summary to prepare the discharge plan of care. The post-discharge plan of care identifies the essential supports and services necessary for the client to successfully adjust to the new living environment and describe necessary coordination of services. It should incorporate the client's preferences. It should identify specific client needs after discharge such as personal care, physical therapy, client/caregiver education needs, and the ability of the client or caregiver to meet those needs after discharge.

**(c) Standard: Individual program plan****W206**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to- -**

**i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and**

**ii) Designing programs that meet the client's needs.**

**Guidance §483.440(c)(1)**

If a need is identified in the CFA, the professional associated with that need will conduct an initial evaluation for the development of the IPP.

The needs identified in the CFA determine the professional, paraprofessional, direct support staff, disciplines or service areas that must participate in the development of the IPP.

**W207**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(2) Appropriate facility staff must participate in interdisciplinary team meetings.****Guidance §483.440(c)(2)**

While there is no correct number of individuals that comprise the IDT, the team should include appropriate facility staff (professional and paraprofessional staff), that are responsible for designing, developing, and/or implementing the client's IPP and direct support staff who work closely with the clients.

For any prioritized objective, the paraprofessional or professional personnel responsible for the development and monitoring of that program should participate on the team, either through actual attendance or written or verbal input.

Members of the IDT may change as the assessed needs of the client change (e.g. medical issues, nutritional issues, communication needs, fine motor skill needs, gross motor skill needs, social issues or behavioral concerns).

**W208**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(2) Participation by other agencies serving the client is encouraged.**

**Guidance §483.440(c)(2)**

The facility must make every effort to coordinate the Individual Education Plan (IEP) from the school or the client's program plan from outside program, work site or workshop with the IPP. This may result in a single document, but there is no requirement for a single combined document. There must be evidence that all applicable plans were coordinated (evidence of discussion across the plans and observation would confirm integration of the IPP across the various settings). The QIDP is responsible for the coordination of the plans.

The facility should communicate changes in the IPP or in the clients' life situation with teachers and workplace representatives either directly or through written communication.

**W209**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(2) Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.**

**Guidance §483.440(c)(2)**

The facility should make every effort to schedule team meetings at a time that enables the client parent or legal guardian, to attend without having to forfeit work time or pay.

The facility should make every effort to schedule team meetings at a time that enables the client parent or legal guardian, to attend without having to forfeit work time or pay.

It is expected that the client will routinely attend team meetings unless their participation is unobtainable. Examples of when client participation is not available include, but are not limited to: 1) the client is away from the facility for medical reasons or hospitalization; or 2) although the facility has documented repeated attempts to engage the client, the client refuses to participate.

If families/legal guardians are unable to attend a program planning meeting, the facility provides them information regarding the meeting outcome and gives them an opportunity to discuss the plan with the facility staff.

"Unobtainable", for the purposes of this guideline, means that the facility has made a good faith effort to seek parental or legal guardian participation in the process, even though the effort may ultimately be unsuccessful (for example, the parent may be impossible to locate or may prove unwilling or unable to participate).

"Inappropriate", for the purposes of this guideline, means that the parent or legal guardian's behavior is so disruptive or uncooperative that others cannot effectively participate; the client does not wish his or her parent to participate, and the client is competent to make this decision; or there is strong and documented evidence that the parent or legal guardian is not acting on the client's behalf or in the client's best interest. In the case of the latter, determine what the facility has done to bring effective resolution to the problem.

Instances when it is not appropriate for the client, parent or legal guardian, to attend the team discussion are rare. If the client does not attend the meeting, the facility must document the reason for his/her non-participation.

There may also be instances where a parent or legal guardian is considered unobtainable for a team meeting, such as being out of the country. In these instances, the parent or legal guardian should still be notified of the meeting, provided with information concerning the outcome of the meeting and documentation in the client record should describe why the parent or legal guardian could not attend and what information was provided to them.

If the client is an adult who is competent to make decisions and who is not adjudicated, parents may not participate in the process if their participation is opposed by the client.

In the event that a non-adjudicated adult chooses not to have their family involved in the active treatment process, the surveyor should see evidence in the record of efforts made by the facility to understand why the client has declined family participation. If the client continues to decline family involvement after the facility has held discussions with him/her about the importance of this issue, the facility should honor the wishes of the client.

In general, the more involvement and communication among the team members, the client and the parent or legal guardian the more likely the plan will be successful. The facility goal should be to routinely include these parties unless rare circumstances exist.

#### **W210**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.**

#### **Guidance §483.440(c)(3)**

For new admissions, the CFA is completed within 30 days after admission and is utilized as the basis for the IPP.

New, revised or updated assessments completed within the first 30 days of admission, accurately identify the functional abilities of the client.

“Accurate” assessments refer to assessment data that are current, relevant and valid, and the skills, abilities, and training needs identified by the assessment correspond to the client’s actual, observed status. Assessments must be administered with appropriate adaptations such as specialized equipment, use of an interpreter, use of manual communication and tests designed to measure performance in the presence of visual disability.

The content of or format of the assessments or the particular assessment tools which are to be used for the CFA are not specified. Assessments must include identification of those functional life skills in which the client needs to be more independent and those services needed for the client to become more community integrated.

#### **W211**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3) The comprehensive functional assessment must take into consideration the client’s age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must -**

#### **Guidance §483.440(c)(3)**

During assessment, the client is given opportunities to participate in age-appropriate activities to assess the person’s functioning in those activities or settings. For example, the use of baby toys during the assessment of an adult would not be appropriate.

#### **W212**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(i) Identify the presenting problems and disabilities and where possible, their causes;**

#### **Guidance §483.440(c)(3)(i)**

The CFA includes:

- all diagnoses and developmental deficits for the client;
- the supporting information for each; and
- each evaluation should include conclusions and recommendations which go into the development of an active treatment program for the client.

#### **W213**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(ii) Identify the client’s specific developmental strengths;**

#### **Guidance §483.440(c)(3)(ii)**

The client's identified developmental strengths, preferences, methods of coping/compensation, community use and awareness, friendships and positive attributes and capabilities are clearly described in functional terms in the assessments.

Identified strengths are consistent with the client's observed functional status.

#### **W214**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

#### **§483.440(c)(3)(iii) Identify the client's specific developmental and behavioral management needs; Guidance §483.440(c)(3)(iii)**

The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture.

"Behavioral management needs" include those behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities (e.g. spitting, pica, self-injurious behavior, aggressive behavior toward others or self-injurious behavior).

A functional behavioral assessment is a problem-solving process for evaluating client inappropriate behavior. It relies on a variety of techniques and strategies to identify the purpose of the specific behavior(s) and to help the IDT select interventions to directly address the behavior(s). A functional behavior assessment looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant client-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non-occurrence) of specific behaviors.

The CFA must identify the specific accommodations that address the client's needs to ensure better opportunity for the client's success. The identified accommodations may be assistive technology which can help a person learn, play, complete tasks, get around, communicate, hear or see better, control their own environment and take care of their personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.).

#### **W215**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

#### **§483.440(c)(3)(iv) Identify the client's needs for services without regard to the actual availability of the services needed; and**

#### **Guidance §483.440(c)(3)(iv)**

Identification of needed services is based on the CFA.

In the presence of significant developmental deficits, it is not acceptable for the facility to say that a particular professional therapy or treatment is not needed or not available if the CFA identifies a deficit. The assessment must identify the course of specific interventions recommended to meet the client's needs, both through direct professional services and non-professional services. For example, a client's communication skill development may not require the intensive services of a speech-language pathologist however, the direct care staff will need to work with the client and use a pre-determined communication system.

#### **§483.440(c)(3)(v) Include**

#### **Guidance §483.440(c)(3)(v)**

The CFA should include an assessment of each of the areas listed below. Assessments should include specific information about the person's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

If assessments are done separately by professional disciplines, there should be evidence that the assessments are brought together in an interdisciplinary approach to address the client's various developmental areas.

The CFA must be completed upon admission and annually as indicated. While the assessment may not have the specific titles of the areas listed below, the surveyor must be able to identify information within assessments from each of the areas below.

#### **W216**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) physical development and health,**

**Guidance §483.440(c)(3)(v)**

Physical development and health: This portion of the CFA includes the client's developmental history, results of the physical examination conducted by a licensed physician, physician assistant, or nurse practitioner, health assessment data (including a medication and immunization history); a review and summary of all laboratory reports since the last comprehensive evaluation, a summary of all required medical interventions since the last CFA; skills of the client normally associated with the monitoring and supervision of one's own health status, and administration and/or scheduling of one's own medical treatments. Reports of all specialist consultations should be included in the assessment as indicated by physical examination results.

IDT reviews any current advanced directives that the client may have in place as part of the CFA.

**W217**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) nutritional status,**

**Guidance §483.440(c)(3)(v)**

Nutritional status: Nutritional status includes height and weight, the client's eating habits and preferences, favorite foods, determination of appropriateness of diet, adequacy of total food intake, bowel habits, means through which the client receives nutrition (e.g. feeding tube) and the skills associated with eating (including chewing, sucking and swallowing disorders).

**W218**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) sensorimotor development,**

**Guidance §483.440(c)(3)(v)**

Sensorimotor development: Sensorimotor development includes the development of perceptual skills that are involved in observing the environment and making sense of it. Identified sensory deficits should be evaluated in conjunction with the impact they will have on the client's life. A sensory deficit in eye contact may not have a detrimental effect on the client's life if it will not hold the client back from further accomplishments or skill acquisitions. Motor development includes those behaviors that primarily involve: muscular, neuromuscular, or physical skills and varying degrees of physical dexterity. Because sensory and motor development are intimately related and because activities in these areas are functionally inseparable, attention to these two aspects of bodily activity is often combined in the concept of sensorimotor development. For those motor areas that are identified by the assessment as limited, the assessment should specify the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status and the extent of time the device is to be used throughout the day.

**W219**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) affective development,**

**Guidance §483.440(c)(3)(v)**

Affective (Emotional) development: Affective or emotional development includes the development of behaviors that relate to one's interests, attitudes, values, morals, emotional feelings and emotional expressions.

**W220**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) speech and language development**

**Guidance §483.440(c)(3)(v)**

Speech and language (communication) development: One of the most contributable causes of behaviors, frustration by the clients, etc. is lack of effective communication. It is imperative that the CFA identifies how the client communicates, what barriers are present, what services are available and what programs and services will be provided to assist the client to go out into and participate fully in the world. Observed client communication skills match the evaluation results and that training programs are in place to address needs.

Communication development refers to the development of both verbal and nonverbal and receptive and expressive communication skills. Assessment data identify the appropriate intervention strategy to be applied, and which, if any, augmentative or assistive devices will improve communication and functional status. These intervention strategies should provide the client with a viable means of communication which is appropriate to their sensory, cognitive and physical abilities.

**W221**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) and auditory functioning,****Guidance §483.440(c)(3)(v)**

Auditory functioning: Auditory functioning refers to the extent to which a person can hear, to the maximum use of residual hearing if a hearing loss exists, and whether or not the client will benefit from the use of amplification, including a hearing aid or a program of amplification.

**W222**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) cognitive development,****Guidance §483.440(c)(3)(v)**

Cognitive development: Cognitive development refers to the development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving. It is also the identification of different learning styles the client has and those best used by the trainers. It is critical that the CFA address the individual learning style of the client in order to best direct the way the trainers will teach formal and informal programs.

**W223**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) social development,****Guidance §483.440(c)(3)(v)**

Social Development: Social development refers to the formation of those self-help, recreation and leisure, and interpersonal skills that enable a client to establish and maintain appropriate roles and fulfilling relationships with others. Assessments may address family supports and relationships, sexual awareness and sexuality, friendships, social awareness, social skills and social interests.

**W224**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) adaptive behaviors or independent living skills necessary for the client to be able to function in the community,****Guidance §483.440(c)(3)(v)**

Adaptive behaviors or independent living skills: Adaptive behavior refers to the effectiveness or degree with which clients meet the standards of personal independence and social responsibility and community orientation and integration expected of their age and cultural group. Adaptive behaviors are those behaviors that are developed to cope with deficits in order to be able to perform every day skills as independently as possible. Independent living skills include, but are not limited to, such things as food shopping, meal preparation, housekeeping and kitchen chores, laundry, bed making, and budgeting. Assessment may be performed by anyone trained to do so. Standardized tests are not required. Standardized adaptive behavior scales which identify all or predominantly all “developmental needs” are not sufficient to meet this requirement, but can serve as a basis for screening.

**W225**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(3)(v) and as applicable, vocational skills.****Guidance §483.440(c)(3)(v)**

Vocational development, “as applicable”: Vocational development refers to work interests, work skills, work attitudes, work-related behaviors, and present and future employment options. The determination of whether or not a vocational assessment is “applicable” is typically based on age (adolescents or adults more than likely require this type of assessment). The vocational assessment for each client may address

job sampling, job development, on-site job training and long term follow-up, as appropriate to the client and determined by the IDT.

Vocational assessments should describe, for all domains, what clients can and cannot do in terms of skills needed within the context of their daily lives and jobs.

Assessments should be individualized and based on:

- Actual performance of the client against objective criteria;
- Reports by staff/parents/legal guardians; and
- Observed performance in a variety of settings.

#### **W226**

**§483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan**

#### **W227**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4) that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section,**

**Guidance §483.440(c)(4)**

Objectives are developed for those needs that are identified by the CFA and which are considered to be most likely to improve the client's ability to independently function in his/her daily life, as determined by the IDT.

There is a clear link between the specific objectives and the functional assessment data and recommendations.

Objectives are developed for those needs that are observed to most likely impact the client's ability to function in daily life. Training objectives should be developed to address client needs rather than staff oriented objectives.

Clients are expected to have training objectives in the areas of activities of daily living, based on the client's assessed needs and as prioritized by the IDT. If clients have eyeglasses, dentures and/or other assistive devices it is expected that the team considers objectives, based upon the assessment of client needs, addressing the care and use of such devices. However, in the area of programs to teach the clients' money management it is not expected that every client will automatically have a formal training objective to participate in such a program. The decision to prioritize such a program and to what level the program is developed is decided by the IDT based upon the results of the CFA and in consideration of such factors as, transferable skills, the ability to make choices, the ability to identify preferences and cognitive abilities such as attention span and an understanding of the principle of cause and effect.

Similarly, the decision to prioritize and develop a training objective for a client to participate in a self-administration program for medications must be made by the IDT and be based upon information from the CFA. Formal self administration programs should not be confused with informal efforts to include the client in the administration process such as allowing them to hold a glass of water, identify the box where his/her medications are stored or put a pill into their own mouth themselves under the supervision of a person who is qualified to administer medications.

#### **W228**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4) and the planned sequence for dealing with those objectives.**

**Guidance §483.440(c)(4)**

The objectives identified in W227 are organized in a logical sequence, determined by the team that will assist the client toward the attainment of skills resulting in greater self- choice, independence, and community integration. The logical sequencing of objectives means there is a completion of one objective that serves as the building block for the next with relevance to the client's functional status. Where objectives are logically ordered but do not have relevance to the client's functional status, refer to 483.440(c)(4).

If the IPP is organized in a logical sequence, this requirement is met. For example, if the long term goal is to travel independently in the community, the objective sequencing may involve training the client to

recognize traffic signs, cross the street safely, and to obtain help when needed if lost or an emergency arises.

**These objectives must –  
W229**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4)(i) Be stated separately, in terms of a single behavioral outcome;**

**Guidance §483.440(c)(4)(i)**

Each objective clearly states one expected learning result.

“Single” behavioral outcome means that there is a separate objective assigned for each discrete behavior that the team intends the client to learn. For example, “Mary will bake a cake and clean the oven” are two separate behaviors and, therefore, should be stated in two separate objectives. Completion of the morning hygiene routine includes programs for performance of face washing, tooth brushing and hair combing which are three separate objectives; however, the behavioral outcome for each would be the same (e.g. completion of the morning hygiene routine).

**W230**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4)(ii) Be assigned projected completion dates;**

**Guidance §483.440(c)(4)(ii)**

Completion dates are based on the client’s rate of learning.

Completion dates are assigned to each objective on which the client is currently working. Completion dates are individualized (e.g. not all the same for all clients and all objectives).

The “projected date of completion” for an IPP objective is not the same as a “review” date. For each objective assigned a priority, the team should assign a projected date (month and year) by which it believes the client will have learned the new skill, based on all of the assessment data. This date triggers the team to evaluate continuously whether or not the client’s progress or learning curve is sufficient to warrant a revision to the training program.

**W231**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4)(iii) Be expressed in behavioral terms that provide measurable indices of performance;**

**Guidance §483.440(c)(4)(iii)**

The desired learning outcome is stated in a manner which enables all staff working with the client to consistently identify the target behavior and to clearly identify when it is being displayed.

The objective is stated in a manner which permits it to be measured with quantifiable data.

“Behavioral” terms include only those behaviors which are “client” rather than staff oriented and those that any person would agree can be seen or heard. Determine if all staff who work with the client can define the exact same outcome on which to measure the client’s performance.

“Measurable indices of performance” are the quantifiable criteria to use in determining successful achievement of the objective. Quantifiable criteria include various measurements of intensity and duration. For example, “Client X will walk ten feet, with the use of her tripod walker, on each of five (5) consecutive days.”

**W232**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4)(iv) Be organized to reflect a developmental progression appropriate to the individual; and**

**Guidance §483.440(c)(4)(iv)**

Objectives must be relevant to the client’s current skill sets and abilities as identified in the CFA.

The ICF/IID must consider the person’s current functional abilities and project what steps, methods, and strategies are likely to be effective in achieving the objective.

**W233**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(4)(v) Be assigned priorities.**

**Guidance §483.440(c)(4)(v)**

Priorities are established based on the needs and in consideration of the desires of the client and emphasize the development of greater independence, self-choice, and community integration.

The team determines which objectives are the highest priority to be addressed, either because the client has an immediate need or the priority objectives must be accomplished before other priorities are addressed.

**§483.440(c)(5) Each written training program designed to implement the objectives in the individual program plan must specify:****Guidance §483.440(c)(5)**

The following regulations (5) (i-iv) apply to formal training programs developed for current implementation.

**W234**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(5)(i) The methods to be used;****Guidance §483.440(c)(5)(i)**

The training program provides clear directions to any staff person working with the client on how to implement the teaching strategies. To comply with this requirement the methodologies must be written in a clear enough manner that a substitute staff person will be able to read the methodologies and implement them without substantial differences from a regularly assigned staff person. Methodologies should be consistent across settings, such as when the client is in the day program.

**W235**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(5)(ii) The schedule for use of the method;****Guidance §483.440(c)(5)(ii)**

Active treatment (the implementation of training programs pursuant to objectives) should be provided in formal and informal settings throughout the rhythm of the client's day. While there may be structured episodes when the client works intensively and singularly on one or more objectives (schedule), the provision of active treatment is not adequate when confined solely to these types of formal settings but should be incorporated into all activities when appropriate (client's routine). For example, objectives on grasping may be as effectively carried out during the client's use of a toothbrush and a spoon as in an isolated session.

**W236**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(5)(iii) The person responsible for the program;****Guidance §483.440(c)(4)(v)**

The IPP should include the actual name of the staff person who is responsible for the ongoing monitoring of the client's program to ensure it is being implemented appropriately, as well as the designated position which will implement the program.

The QIDP should be familiar with the assessment and recording requirements for each client for each formal objective, including who is responsible for making these observations and completing the recording, and demonstrate a familiarity with the current data recorded for each client.

**W237**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(5)(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;****Guidance §483.440(c)(5)(iv)**

The IDT must determine the type of data necessary to judge a client's progress on an objective, and describe the data collection method in the written training program. The facility determines what data to collect, but whatever system is chosen for collection must yield accurate measurement of the criteria stated in the client's IPP objectives. For example, if the criteria in the client's IPP objective specified a behavior to be measured by "accuracy," or "successes out of opportunities," then it would not be acceptable for the prescribed data collection method to record "level of prompt".

Examples of a few data collection systems include, but are not limited to:

- level of prompt;
- successful trials completed out of opportunities given;
- frequency counts; and
- frequency sampling.

The IDT must consider and select the type and frequency of data collection for each objective based upon the need to measure appropriately the client's performance toward the targeted IPP skill development. The facility should collect data with enough frequency and content to be able to appropriately measure the client's performance toward the targeted IPP skill development. The frequency of data collection may vary with the objective but must be made at sufficient intervals to allow analysis of the progress of the client.

#### **W238**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(5)(v) The inappropriate client behavior(s), if applicable; and The inappropriate client behavior(s), if applicable; and**

**Guidance §483.440(c)(5)(v)**

Any specific behaviors which would interfere with the client's ability to function in, or benefit from the training program are identified (e.g. a fear of water could interfere with the client's bathing program).

#### **W239**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(5)(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.**

**Guidance §483.440(c)(5)(vi)**

The training program provides specific information as to how to elicit or strengthen appropriate behavior and what behaviors to teach reinforce or encourage which would reduce or replace the inappropriate behavior.

If a client is exhibiting an inappropriate behavior, the CFA should discover why the behavior is occurring and the team should develop associated training objectives to help the client develop more appropriate behaviors. The objective for decelerating targeted inappropriate behaviors is not solely the reduction of these behaviors. The objective should also include the positive functional replacement behavior (adaptive behavior).

A replacement behavior allows a client to substitute an unconstructive or disruptive behavior with something more constructive and functionally equivalent. For example, instead of throwing work materials as a way to get a break from vocational task demands, teach the client to say or sign for 'break'.

**§483.440(c)(6) The individual program plan must also:**

#### **W240**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(6)(i) Describe relevant interventions to support the individual toward independence.**

**Guidance §483.440(c)(6)(i)**

Appropriate materials, adaptations and modifications to equipment and the environment are available in order to promote and support individual training programs. Examples may include, but are not limited, to built-up toilet seats, adaptive eating utensils, extended reach devices, and modification to the facility van to accommodate a wheelchair.

The IPP describes supports and services, in addition to the individual goals and objectives that will be provided by the facility to assist the client to function with greater independence.

#### **W241**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(6)(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.**

**Guidance §483.440(c)(6)(ii)**

This requirement refers to the training program plans, objectives, descriptions of staff interventions and data collection tools which must be readily accessible to any staff in order for the programs to be consistently and effectively carried out and data collected.

#### W242

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(6)(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.**

#### **Guidance §483.440(c)(6)(iii)**

All clients who lack the skills listed within this standard have associated training programs developed to meet their needs according to prioritization. These programs are consistently implemented in both formal and informal settings.

“Developmentally incapable” is a decision made by the IDT that means a client does not have the capacity to acquire certain skill sets. The decision must be based on an assessment of the client’s strengths, needs, and functional limitations.

The determination of developmental incapability must be accompanied by written evidence supporting this determination.

Such evidence may include training programs which failed after many different strategies were tried, or physical limitations that preclude the acquisition of the skill. Examples are:

- 1) Eye contact program was attempted using seven different methods over a two year period;
- 2) An client has two frozen elbow joints which do not allow her to get her hands to her mouth and consequently she will not be trained on any hand to mouth skills; and
- 3) Some clients may have insufficient neuromuscular and sensory control to ever be totally independent in toileting skills.

Toilet scheduling alone without any plan to progress would not be considered a toilet training program. The components of functional skills “training” as used in this regulation means aggressive implementation of a systematic program of formal and informal techniques, which are:

- targeted toward assisting the client achieving the measurable behavioral level of skill competency specified in IPP objectives;
- implemented at natural occurrences of activity and training programs; ( e.g.: an objective for a client to increase grasping may be implemented as easily in the workshop with a built up tool as in the bathroom with a toothbrush);
- conducted by all personnel involved with the client including those outside the home such as in day programs; and
- carried out in conversation and interaction with the client appropriate to the situation.

**§483.440(c)(6)(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify**

#### **Guidance §483.440(c)(6)(iv)**

The use of mechanical supports are based upon an individual assessment and fitting. Mechanical devices are used to support a client’s proper body position or alignment and may be essential to prevent contractures or deformities. However, mechanical supports restrict movement and the client should be released from the support periodically for exercise and free movement. Mechanical supports may not be used as a substitute for programs or therapy. For example, the use of a bolster to position a client upright in a sitting position without any indication there has been an assessment for the need for muscle re-training may be an indication of a mechanical device in lieu of programming. Some supports allow movement and provide opportunity for more increased functioning. Some examples of devices used as mechanical supports include splints, wedges, bolsters, lap trays, etc.

Wheelchairs are not generally used to position or align the body and would not alone constitute a mechanical support. However, adaptations to a wheelchair which facilitate correct body alignment by inhibiting reflexive, involuntary motor activity are mechanical supports and should be included in the plan for the client.

**W243****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(c)(6)(iv) the reason for each support,****W244****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(c)(6)(iv) the situations in which each is to be applied,****W245****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(c)(6)(iv) and a schedule for the use of each support.****W246****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(c)(6)(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.****Guidance §483.440(c)(6)(v)**

Clients with sensory or physical difficulties should be given the same opportunities to move around in their environments as clients who do not have those difficulties. Even clients who use specialized wheelchairs should be given the opportunity to utilize other devices such as walkers, wagons and scooters to move about and/or change their positions.

With the exception of those clients who are acutely ill (such as those who are hospitalized or incapacitated by a “short term” illness), all clients should be out of bed and outside their bedroom area as long as possible each day, and in proper body alignment at all times. This is a necessity in order to prevent regression, contractures, and deformities and to provide sensory stimulation.

Bed rest is a temporary situation associated most usually with a medical condition and must be ordered by the medical staff of the facility. The term implies that the client will remain in his/her bed for most of any 24-hour period. Although active treatment programs may be carried out to some extent while the client is on bed rest, the client’s program cannot be completed in its entirety. While there may be situations where continuous bed rest may be necessary, these situations are rare.

For those rare instances where out-of-bed activity is a threat to a client’s health and safety (e.g., blood clot in the leg), active treatment adapted to the medical capacity of the client must be continued.

**W247****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(c)(6)(vi) Include opportunities for client choice and self-management.****Guidance §483.440(c)(6)(vi)**

Choice and self-management are integral components of becoming independent. Clients should be given opportunities for choice and self-management in both formal and informal settings through the IPP process, leisure activities, and other life choices.

The ICF/IID must incorporate opportunities into daily life experiences that promote choice making and decision making by clients. Examples of some activities leading toward responsibility for one’s own self-management include, but are not limited to:

- 1) choosing housing or roommates;
- 2) choosing clothing to purchase or wear;
- 3) choosing what, where, and how to eat (e.g., the use of family style dining, access to condiments and second helpings).

Choices can be made by all clients. The type of choices the person makes may vary from simple to complex, dependent upon client abilities.

Clients are provided opportunities for choice and self-management and the facility does not limit choices by making decisions for the people being served without their input. Clients are provided the opportunity to demonstrate skills to the degree they are capable and only assisted by staff as indicated in their IPP. A lack of facility staffing or staff convenience must not result in a limitation of choices of self-management for the clients.

**W248**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.**

**Guidance §483.440(c)(7)**

The client or legal representative, as well as the facility staff, and staff from outside agencies, with appropriate consent, have, or can access, a copy of the IPP.

**(d) Standard: Program implementation**

**W249**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.**

**Guidance §483.440(d)(1)**

There should be no delay in the development and implementation of the IPP. To promote a team process and meaningful discussion, IPP development should take place during IDT meetings. Any IPP objective or modification that is critical to the health and safety of any client should be implemented immediately following IDT discussion.”

Each individual receives training and services consistent with the current IPP.

The time period between admission and the 30 day IDT meeting is primarily to assist the client to become adjusted and acclimated to his or her new living environment and to enable the facility to complete the CFA. During this time period the facility should also be providing those services and activities determined during the pre-admission assessment as essential to the client's daily functioning.

The active treatment program for the client is consistently implemented in all relevant settings both formally and informally as opportunities present themselves. It should not be limited to specific periods of time during the day or specific environments.

Each client should receive aggressive and continuous training, treatments and supports in accordance with their needs and IPP. New skills and appropriate behaviors are encouraged and reinforced across environments and times of day.

- During observations confirm that the client activities relate directly to the strengths, needs and objectives in the IPP for each client and are not “busy work,” generalized or non-developmental time fillers. For example, screwing nuts on bolts and then unscrewing them repeatedly with no goal or transferable skills is “busy work.” Screwing nuts on bolts that will be part of a product is functional reinforcement of skill acquisition.

- Clients use adaptive equipment, assistive devices, environmental supports, materials, supplies, etc., as specified in each client's IPP to assist the client to accomplish stated objectives.

There is no specific number or frequency of interventions that meets this requirement. The surveyors should see that the facility capitalizes on all opportunities throughout the course of the day that promote progress toward the achievement of goals and objectives.

Informal opportunities (“teachable moments”) should be utilized to reinforce learning or appropriate skill development and needs are addressed as they present.

Although a client may not be able to reach complete independence in a functional skill, it is crucial that retention of their current skills be supported.

Clients may have defined periods of time where they may engage in leisure activities of their choice which are not necessarily directly associated with their IPP goals and objectives.

**W250**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.**

**Guidance §483.440(d)(2)**

The schedule is individualized, consistent with the client's objectives, and reflects normal daily routines.

The staff working with individual clients are familiar with their daily schedules and can produce the schedule upon request.

The active treatment schedule allows flexibility and is adjusted to the needs and preferences of the client, as necessary. It's a schedule of the client's general daily plans, but can be changed.

The active treatment schedule is a functional schedule which enables client and staff to be in the right location in order to participate in the training as scheduled by the IPP.

#### W251

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.**

#### **Guidance §483.440(d)(3)**

All disciplines, including direct care staff, interacting with the client work together to provide a uniform, consistent approach to implementation of the IPP.

#### **(e) Standard: Program documentation**

#### W252

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.**

#### **Guidance §483.440(e)(1)**

"Data" are defined to be performance information collected and reported in numerical or quantifiable form for each training objective assigned priority in the IPP.

Data are those performance measurements collected at the time the treatment, procedure, intervention or interaction occurs with the client and recorded as soon as possible. The data should be located in a place accessible to staff who conduct training.

Data should be collected in a form and frequency as required by the plan to enable quantitative (frequency or numbers) analysis of the client's progress.

Data are accurate (e.g., reflective of actual client performance.)

**§483.440(e)(2) The facility must document significant events that**

#### W253

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(e)(2) are related to the client's individual program plan and assessments and**

#### **Guidance §483.440(e)(2)**

Significant events are those events which would cause a reasonable person to be affected and which impact a normal routine. Such events include changes in the client's functional status, emotional health, physical health, accomplishments, activities or needs which impact the CFA and IPP, as well as instances of abuse, neglect or mistreatment.

The client record should contain documentation that such events are evaluated and monitored.

#### W254

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(e)(2) that contribute to an overall understanding of the client's ongoing level and quality of functioning.**

#### **(f) Standard: Program monitoring and change**

**§483.440(f)(1) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client-**

#### **Guidance §483.440(f)(1)**

Program implementation is a critical piece of each client's active treatment program. The QIDP must review or revise client programs according to 483.440(f)(1)(i-iv) and at such an interval that any of the requirements are promptly identified and addressed.

#### W255

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(1)(i) Has successfully completed an objective or objectives identified in the individual program plan;**

**Guidance §483.440(f)(1)(i)**

The QIDP ensures the program has been modified or changed in response to the client's specific accomplishments or need for new program.

**W256**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(1)(ii) Is regressing or losing skills already gained;**

**W257**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(1)(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or**

**Guidance §483.440(f)(1)(iii)**

There should be evidence that the QIDP has reviewed and revised the IPP in those situations when the client's IPP has been consistently implemented yet the client fails to achieve their objectives.

**W258**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(1)(iv) Is being considered for training towards new objectives.**

**§483.440(f)(2) At least annually,**

**Guidance §483.440(f)(2)**

For the "annual" review to meet this requirement, it must be completed by at least the 365th day following the previous review, unless in an isolated or rare instance a client or the client's family is not available for a projected period of time and the subsequent delay is a minimal number of days.

**W259**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(2) the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed;**

**Guidance §483.440(f)(2)**

The CFA is reviewed at least annually.

The review of the CFA occurs sooner than annually if:

- indicated by the needs of the client;
- reflects any changes in the client since their last evaluation; and
- incorporates information about the client's progress or regression with objectives.

The review of the CFA applies to all evaluations conducted for a client. It is not required that each assessment be completely redone each year, except the physical examination. It is required that at least annually the assessment(s) be updated when changes occur so as to accurately reflect the client's current status.

**W260**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(2) and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.**

**Guidance §483.440(f)(2)**

The IPP reflects the functional changes for the client which occurred since the last IPP. It is unlikely that an active treatment program will have no changes from year to year without documentation to support not changing the plan. Question an IPP that is a duplication of the prior year's plan without explanation.

**W261**

**(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)**

**§483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to-**

**Guidance §483.440(f)(3)**

The facility must have a specially constituted committee whose primary function is to proactively protect client rights by monitoring facility practices and programs. The purpose of the committee is to assure that each client's rights are protected utilizing a group of both internal staff and *external participants who have no vested interest in the facility as well as clients as appropriate*. There should be evidence that the committee members have been trained annually on the rights of the clients, what constitutes a restriction of a right and the difference between punishment and training.

Depending on size, complexity and available resources, the ICF/IID may establish more than one specially constituted committee. However, each committee must contain the required membership and participate regularly and perform the functions of the committee according to the requirements. Participation on the specially constituted committee(s) must be in real time allowing all membership to speak and discuss in an interactive mode.

The regulation does not specify the professional credentials of the "qualified persons" (who have either experience or training in contemporary practices to change inappropriate client behavior). There is no requirement that any specific discipline, such as nurse, physician or pharmacist be a member of the committee.

The intent of including "persons with no ownership or controlling interest" on the committee is to assure that, in addition to having no financial interest in the facility, at least one member of each constituted committee is an impartial outsider in that he/she would not have an "interest" represented by any other of the required members or the facility itself. Staff and consultants employed by the facility or at another facility under the same governing body, cannot fulfill the role of person with no ownership or controlling interest.

Although occasional absences from committee meetings are understandable, patterns of absence by the required membership of the committee is not acceptable. At least a quorum of committee members (as defined by the facility) must review, approve and monitor the programs which involve risk to client rights and protections and that quorum must include one person from each of the required categories.

#### **W262**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;**

#### **Guidance §483.440(f)(3)(i)**

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

**W263****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(f)(3)(ii) Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and****Guidance §483.440(f)(3)(ii)**

The committee must ensure that written informed consent must be obtained prior to implementation of any restrictive or intrusive program. In the event of an emergency, the facility may obtain a verbal consent, which must be authenticated in writing as soon as possible and subsequently submitted to the committee as verification.

The consent is required for the entire behavior management program not just the specific restrictive technique.

Consent is informed when the person giving consent is fully aware of the:

- specific treatment;
- reason for treatment or procedure;;
- the attendant risks vs. benefits;
- alternatives;
- right to refuse; and
- the consequences associated with consent or refusal of the program.

Informed consent must be in writing and must be specific to the program and restrictive practice and reflect a specific time frame. Blanket consents are not allowed. In the case of unplanned events such as assault and property destruction requiring immediate action, verbal consent may be obtained. However, it should be authenticated in writing as soon as reasonably possible (within 30 days).

For clients up to the age of 18, their parent or legally appointed guardian must give consent for him or her. At the age of 18, however, clients become adults and are assumed to be competent unless otherwise determined by a court.

For clients who are adults and have not been adjudicated incompetent and have not been assigned a legal guardian who may not fully understand the consequences of the program, informed consent for use of restrictive programs, practices or procedures should be obtained from a person or an entity in accordance with state law, to act as the representative or advocate of the client's interests.

The specially constituted committee must ensure that the informed and voluntary consent of the client, parent of a minor, legal guardian, or the person or organization designated by the state is obtained prior to each of the following circumstances:

- The involvement of the client in research activities; or
- Implementation of programs or practices that could abridge or involve risks to client protections or rights.

**W264****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.440(f)(3)(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.****Guidance §483.440(f)(3)(iii)**

The committee has been made aware of and reviewed:

- facility policies and procedures;
- facility services;
- programs; and
- practices which may restrict or violate the rights of client.

The committee has established and uses a mechanism for monitoring clients' rights issues and informs the governing body of any issues of concern in a timely manner. This process is at the discretion of the committee. There is no requirement for periodic review of the policies by the committee.

The function of the committee is not limited to the review, approval and monitoring of restrictive behavior management practices. Examples of issues involving client rights that might be reviewed by the committee, in addition to behavior management, include, but are not limited to:

- 1) Research proposals involving clients;
- 2) Abuse, neglect and mistreatment of clients;
- 3) Allegations dealing with theft of a client's personal property or funds;
- 4) Damage to a client's goods or denial of other client rights;
- 5) Client grievances;
- 6) Visitation procedures;
- 7) Guardianship/advocacy issues;
- 8) Rights training programs;
- 9) Confidentiality issues;
- 10) Advance directives/DNR orders;
- 11) Practices which restrict clients (e.g., locked doors, fenced in yards); and
- 12) Video monitoring.

#### **W265**

**§483.440(f)(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.**

#### **W266**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450 Condition of participation: Client behavior and facility practices**

**(a) Standard: Facility practices– Conduct toward clients**

#### **W267**

**(Rev.135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.**

**Guidance §483.450(a)(1)**

The primary survey emphasis is on the implementation of the policies and procedures developed by the facility.

Conduct between staff and clients refers to language, actions, discipline, rules, order and other types of interactions exchanged between staff and clients or imposed upon clients by the staff during a client's daily experiences that affect the quality of a client's life.

**§483.450(a)(1) These policies and procedures must –**

#### **W268**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(1)(i) Promote the growth, development and independence of the client;**

**Guidance §483.450(a)(1)(i)**

Consistent with facility policies, staff is observed to be engaged in activities which promote the client's growth, development and independence.

1) IPPs and data support the fact that from the time of admission, clients are learning new adaptive and functional skills while becoming more independent.

2) Interactions between clients and staff are consistent and positive.

3) Staff teach and encourage clients to interact with each other in a manner that promotes social integration both in the facility and out in the community.

4) All opportunities to teach and reinforce skill acquisition are utilized.

5) Staff identify and remove impediments in the learning environment (e.g. client is unable to concentrate in a room with a television because when they see the television, they want to watch their favorite show. Staff must identify this learning impediment and train in an environment without a television).

6) Staff encourage clients to complete tasks with as much independence as possible.

7) Staff encourage clients to take risks while providing reasonable safeguards to prevent injury.

8) Encourage clients to make choices during their daily activities.

**W269**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(1)(ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;**

**Guidance §483.450(a)(1)(ii)**

Written facility policies describe how the facility will offer choice to the clients during the course of their day.

Written policies describe how self-determination, as defined by free choice of one's own acts and decisions without external coercion or direction, to the extent possible and self-management, as defined by control of one's own routine and daily responsibilities, to the extent possible, are incorporated into the development of program plans and daily routines.

**W270**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(1)(iii) Specify client conduct to be allowed or not allowed; and**

**Guidance §483.450(a)(1)(iii)**

"Client conduct" refers to any behavior, choice, action, or activity in which a client may choose to engage alone or with others.

Written policies and procedures which may be in the form of "house rules", must not impinge on individual client rights and must not be used as a substitute for the development of individualized programs and plans.

**W271**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(1)(iv) Be available to all staff, clients, parents of minor children, and legal guardians.**

**Guidance §483.450(a)(1)(iv)**

Policies and procedures for management of conduct between staff and clients (483.450(a)(1)) should be provided to clients, parents of minor children, and legal guardians at admission and upon request. Policies and procedures are available on the residential and program areas if these are in separate buildings.

**W272**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(2) To the extent possible, clients must participate in the formulation of these policies and procedures.**

**Guidance §483.450(a)(2)**

"To the extent possible" does not mean that the clients are excluded due to the clients' schedule or intellectual or developmental level. Facilities should be able to provide documentation that substantiates that clients were offered the opportunity and participated in the development of the policies. This could be accomplished through client committees or in house meetings. There should be documentation of these discussions between the client representatives and the facility.

**W273**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(a)(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.**

**Guidance §483.450(a)(3)**

Staff will promptly intervene when any clients tries to independently impose discipline upon another client. For example, a client who is serving dessert to the group withholds dessert from another client based upon their own evaluation of that client's behavior.

**(b) Standard: Management of inappropriate client behavior**

**W274**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior**

**Guidance §483.450(b)(1)**

At a minimum, the facility must have written policies and procedures regarding the management of maladaptive behaviors addressing the following:

483.450(b)(1) (W 275 – W284).

- the use of a functional behavior assessment in the development of behavior management programs;
- a hierarchy of least to most intrusive measures; and
- incorporation of behavior management programs into the IPP.

**§483.450(b)(1) These policies and procedures must be**

**W275**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1) consistent with the provisions of paragraph (a) of this section.**

**§483.450(b)(1) These procedures must**

**W276**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;**

**Guidance §483.450(b)(1)(i)**

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

**W277**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;**

**Guidance §483.450(b)(1)(ii)**

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

**W278**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and**

**Guidance §483.450(b)(1)(iii)**

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

**§483.450(b)(1)(iv) Address the following:**

**W279**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iv)(A) The use of time-out rooms;**

**Guidance §483.450(b)(1)(iv)(A)**

“Time-out room” is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

**W280**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iv)(B) The use of physical restraints;**

**Guidance §483.450(b)(1)(iv)(B)**

“Physical restraint” is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client’s body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

**W281**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;**

**Guidance §483.450(b)(1)(iv)(C)**

Applicable policies may include a discussion of:

- When a drug can be used to manage inappropriate behavior;
- Consistency with diagnosis;
- Alternatives tried before a drug is used;
- Precautions that must be followed prior to and during the use (lab values, monitoring of side effects);
- Implementation of a plan to address the behaviors for which the drug was prescribed; and
- Plan to reduce the medication as appropriate.

Drugs to manage inappropriate behavior are defined as any medication prescribed and administered for purposes of modifying the maladaptive behavior of a client.

**W282**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iv)(D) The application of painful or noxious stimuli;**

**Guidance §483.450(b)(1)(iv)(D)**

“Application of painful or noxious stimuli” is defined as any procedure by which staff apply, contingent upon the exhibition of maladaptive behavior, startling, unpleasant, or painful stimuli, or stimuli that have a potentially noxious effect.

While the regulation permits the use of painful or noxious stimuli these techniques are the last resort and can only be utilized for behaviors that are causing significant harm and have not responded to competently administered interventions of less intrusive nature.

Facility policies must state that:

- The use of noxious stimuli is only permitted when the client exhibits behaviors so severe that they present a potential risk for significant or even life-threatening circumstances;
- the IDT and facility must weigh the potential risk of the behavior against the risk involved in the use of the painful or noxious techniques to manage behavior;

- that safeguards and strict oversight must be in place for consideration to use techniques that may be painful or even unpleasant;
- techniques that may be painful or noxious must be time limited;
- the proposed use of these techniques requires scrutiny of clinical effectiveness and specially constituted committee review; and
- on-going monitoring and safeguards must be in place during implementation of the technique.

**W283**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iv)(E) The staff members who may authorize the use of specified interventions;**

**Guidance §483.450(b)(1)(iv)(E)**

**W284**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(1)(iv)(F) A mechanism for monitoring and controlling the use of interventions.**

**Guidance §483.450(b)(1)(iv)(F)**

Facility policies must address what supervisory oversight is provided during the application of the intervention in order to ensure that procedures were followed correctly. Procedures should also address what retrospective analysis is done on each intervention to ensure that procedures are being consistently followed.

**W285**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.**

**§483.450(b)(3) Techniques to manage inappropriate client behavior must never be used**

**W286**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(3) for disciplinary purposes,**

**Guidance §483.450(b)(3)**

No intervention, whether as a part of a formal program or in emergency situations (see W289) may be used as punishment, retaliation or retribution. A staff member cannot employ a behavior management technique simply because a client refuses to follow a staff request.

The implementation of all interventions, except in emergency situations, must be administered consistent with the IPP and the specific behaviors identified in the IPP requiring the intervention. Instances where an intervention is done as a punishment because the client did not comply with staff instructions and not associated with the IPP include:

- Personal property confiscated for behavior at staff discretion;
- Rights restricted without approved plans; and
- Punitive house rules, such as prohibiting reentry into the kitchen for snacks if a meal is not eaten completely.

**W287**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(3) for the convenience of staff**

**Guidance §483.450(b)(3)**

Inadequate numbers of staff, inefficient deployment of staff, and insufficient training of staff can lead to restrictive practices used for staff convenience.

Examples of techniques used to manage client behavior for staff convenience including, but are not limited to:

- Clients allowed to discipline other clients;
- Clients restricted to one area of the home; and
- Unauthorized use of restraints (e.g., lap trays, bean bags, gait belt, and merry walkers for the purpose of restricting movement)

**W288**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(3) or as a substitute for an active treatment program.**

**Guidance §483.450(b)(3)**

Substitutions for active treatment programming occur when the staff utilizes interventions and restrictive techniques on their own, either because there is not a formal behavioral program to address the client's behaviors or because the staff do not follow the plan as written.

**W289**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.**

**Guidance §483.450(b)(4)**

The use of behavior interventions are expected to be incorporated into the IPP and be based upon the results of the functional behavioral assessment.

However, there may be isolated and rare instances when a client exhibits unexpected behavior that requires immediate intervention on the part of the staff. In these instances, the least restrictive intervention must be employed and removed as soon as the client is no longer an immediate threat to self or others. The IPP team must then discuss the need for adding a behavioral plan into the clients program.

**W290**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(b)(5) Standing or as needed programs to control inappropriate behavior are not permitted.**

**Guidance §483.450(b)(5)**

The staff of the facility may not maintain or use, outside of the IPPs, any list of "as needed" interventions that can be used with any client at any time. With the exception of isolated and rare emergency situations, all restrictive behavior interventions must be incorporated into the formal IPP and individualized for the client.

**(c) Standard: Time-out rooms**

**W291**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(c)(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:**

**(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)**

**(ii) The client is under the direct constant visual supervision of designated staff.**

**(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.**

**Guidance §483.450(c)(1)**

Seclusion, defined as the placement of a client alone in a locked room, is never allowed.

Time out procedures allows a client to be alone in a room, but do not allow that room to be locked. During a time out procedure, egress can only be prevented by a person standing in the door way, or holding the door closed, but as soon as the staff move from the door way or let go of the door the client can come out.

Use of the timeout room or procedure must be part of an approved behavioral plan and may involve the separation of a client from a group or a particular situation, in a non- locked setting for the purpose of calming or removing the client from the reinforcing stimuli that are sustaining an identified maladaptive behavior.

Designated time out rooms must be set up so that the staff has continuous, direct observation of the client at all times. Because of the danger that staff can get distracted by other events or duties, this cannot be accomplished by a camera in lieu of the staff having direct visual of the client.

Key locks, latch locks, and doors that open inward without an inside doorknob are not permitted by the regulations for use in time out rooms as they do not require constant physical pressure from a staff member to keep the door shut. In each instance where a time out room is used, the client's IPP must include:

- The functional behavioral assessment which resulted in a recommendation for the use of time out procedures; and
- Instructions on how often data is to be collected during the time out period and the criteria for release from time out.

The use of a time out room must be approved by the Specially constituted committee as part of an approved program.

#### **W292**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(c)(2) Placement of a client in a time-out room must not exceed one hour.**

#### **W293**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.**

#### **Guidance §483.450(c)(3)**

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

#### **W294**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(c)(4) A record of time-out activities must be kept.**

#### **Guidance §483.450(c)(4)**

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

#### **(d) Standard: Physical restraints**

**§483.450(d)(1) The facility may employ physical restraint only- -**

#### **W295**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;**

#### **Guidance §483.450(d)(1)(i)**

The use of physical restraint is specified within the IPP. The plan must address:

- 1) The specific type of client behavior to be managed by this plan;
- 2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
- 3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
- 4) The type of physical restraint;
- 5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
- 6) The replacement behavior being taught to the client to reduce the need for future restraints.

#### **W296**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or**

#### **Guidance §483.450(d)(1)(ii)**

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

- 1) the client has not exhibited before;
- 2) were not identified in the functional analysis of behavior; or
- 3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

#### **W297**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.**

#### **Guidance §483.450(d)(1)(iii)**

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

**§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:**

#### **Guidance §483.450(d)(2)**

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

#### **W298**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and**

#### **Guidance §483.450(d)(2)(i)**

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

#### **W299**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.**

#### **Guidance §483.450(d)(2)(ii)**

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other

clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

**W300**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.**

**Guidance §483.450(d)(3)**

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

**W301**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,**

**Guidance §483.450(d)(4)**

The frequency of monitoring will vary according to the type and design of the device and the psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

**W302**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(4) released from the restraint as quickly as possible, and**

**Guidance §483.450(d)(4)**

“As quickly as possible” means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

**W303**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(4) a record of these checks and usage must be kept.**

**§483.450(d)(5) Restraints must be designed and used**

**W304**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(5) so as not to cause physical injury to the client**

**Guidance §483.450(d)(5)**

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer’s directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

**W305**

**§483.450(d)(5) and so as to cause the least possible discomfort.**

**§483.450(d)(6) Opportunity for motion and exercise must be provided**

**W306**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,**

**Guidance §483.450(d)(6)**

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint).

See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints. However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the restraint is still properly applied and the client appears comfortable.

**W307**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(6) and a record of such activity must be kept.**

**§483.450(d)(7) Barred enclosures**

**Guidance §483.450(d)(7)**

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

**W308**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(7) must not be more than three feet in height and**

**W309**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(d)(7) must not have tops.**

**(e) Standard: Drug usage**

**§483.450(e) Standard: Drug Usage**

**W310**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.**

**Guidance §483.450(e)(1)**

Clients are alert and available for participation in daily living activities.

Some medications administered for medical reasons or to manage behavior may cause drowsiness as a side effect or due to an accumulation of the drug in the client's system. For clients who are observed to be sleeping in chairs during their work day, their programs or recreational times, there should be evidence that the facility staff notified the medical staff and an assessment was performed of the client including their medication regimen. Medical staff should make adjustments to address the issue if indicated.

**§483.450(e)(2) Drugs used for control of inappropriate behavior must**

**W311**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(2) be approved by the interdisciplinary team and**

**Guidance §483.450(e)(2)**

The physician and other team members discuss the risks and benefits of the medication to address the target behavior/symptoms, and approve the use of the drug as being consistent with the active treatment program. Decisions about the necessity of the use of drugs to manage inappropriate behavior should be made by the IDT. It is the responsibility of the IDT members to provide the physician with sufficient information regarding the need for a client to receive a drug for inappropriate behavior. The physician will make the ultimate decision to order the use of the drug. The IDT should document any disagreement with the physician's order.

In those instances where a client returns from a physician's visit with an order for an unsolicited drug to manage client's inappropriate behaviors, there must be evidence (e.g. IDT meeting notes or clients record) that the team concurred with the necessity for the order without trying less restrictive measures first and discussed any concerns with the physician.

### **W312**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.**

#### **Guidance §483.450(e)(2)**

All medications to manage behavior must be integrated into the IPP and the IPP must specify how the specific target behavior for which the medication is prescribed will be reduced or eliminated. This includes medications which are typically used for medical conditions that may be used to manage behavior (e.g. 1. propranolol (Inderal), an antihypertensive used for self-injurious behavior, and 2. carbamazepine (Tegretol), an anticonvulsant, used for aggression).

Drugs for behavior management must not be ordered on a PRN basis for a client. The facility staff must contact the physician to obtain a one-time order if the situation necessitates the use of medication. The facility policy must address the maximum number of times a medication can be used as an emergency prior to being incorporated in the IPP, side effects of such medications, and the frequency of re-evaluation of ongoing behavior and its treatment.

Clients or their legal guardian have the right to choose sedation for medical and dental procedures. However, the facility cannot do routine administration of medication for sedation for medical and dental procedures without the agreement/consent of the client or their parent/legal guardian and they must follow the specific orders of the healthcare practitioner who will be providing services to the client. Decisions to order medications prior to medical and dental procedures must be made on an individual basis. Clients who demonstrate severe anxiety around these procedures should be considered for desensitization programs.

### **W313**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.**

#### **Guidance §483.450(e)(3)**

The risk(s) associated with the drug being used is consistent with the type and severity of the behavior/symptoms it is intended to affect.

At the time the drug was started and incorporated into the IPP, the behaviors were discussed and presented to team members. It was the documented decision of the team that the behaviors were of such a severity that pharmacological intervention was required and the physician was provided with the team information to assist him in his decision to prescribe the medication.

**§483.450(e)(4) Drugs used for control of inappropriate behavior must be - -**

**§483.450(e)(4)(i) Monitored closely,**

### **W314**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(4) in conjunction with the physician and the drug regimen review requirement at §483.460(j),**

#### **Guidance §483.450(e)(4)**

The physician and pharmacist must regularly review use of drugs for control of inappropriate behavior for their effectiveness in changing the targeted behavior/symptoms, untoward side effects, contraindications for continued use, and communicate this information to relevant staff.

### **W315**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(4) for desired responses and adverse consequences by facility staff; and**

**Guidance §483.450(e)(4)**

Direct support staff members are the people who most closely and most frequently observe and record client behaviors. There should be evidence that the direct support staff receive information via the IPP as to the behaviors to be observed, the side effects associated with the medication, the amount and types of documentation required and the communication with clinical staff which is indicated. See 483.430 (e)(1) for training on observations, documentation and communication related to behavior management.

**§483.450(e)(4)(ii) Gradually withdrawn****W316**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(4) at least annually****Guidance §483.450(e)(4)**

Clients receiving medications to control behavior must be evaluated at least annually for a possible reduction of the medication progressing the client toward final elimination of the drug or lowest possible therapeutic level of the drug. However, evaluation should be done earlier than annually if observations indicate that the client's behavior has improved to the point that reduction may be considered as determined by the IPP, unless otherwise ordered by the client's physician.

**W317**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.450(e)(4) in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.****Guidance §483.450(e)(4)**

The IDT is aware of and involved in planning the drug reduction program and participates in its implementation and monitoring.

Progress or regression of the client is monitored and taken into consideration in determining the rate of withdrawal and whether to continue withdrawal.

In determining whether there is clinical contraindication to the annual drug withdrawal, the physician and IDT should consider the client's clinical history, diagnostic/behavioral status, previous reduction/discontinuation attempts, and current regimen effectiveness.

If a client also has a diagnosis of a psychiatric condition that requires a stable level of a psychiatric medication in order to control the symptoms associated with the psychiatric diagnosis, the annual evaluation for reduction of that particular medication for the symptoms of the psychiatric diagnosis would not apply. Documentation in the client's record from their psychiatrist or physician that medication reduction would be contraindicated or that the current level of medications is therapeutic meets the intent of this regulation.

**W318**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460 Condition of participation: Health care services****(a) Standard: Physician services****W319**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(1) The facility must ensure the availability of physician services 24 hours a day.****Guidance §483.460(a)(1)**

A designated physician must be available via telephone, pager, e-mail or on-site in the facility on a 24 hour per day basis for consultation regarding both emergency and non-emergency medical issues. If the facility employs a fulltime physician, there must be procedures in place for coverage in the absence of the physician from the facility.

If the facility contracts with a community-based physician for 24 hour per day coverage, there must be written arrangements in place to detail the responsibilities of the contract physician regarding direct services to the clients, interactions with the direct support staff and the interactions between the nursing staff of the facility and the contract physician. The contract with the contract physician must delineate the process for coverage when he/she is not available.

Upon interview, the staff should be aware of the procedures they are to follow to contact a physician in the event of an illness or injury. Routinely sending clients to emergent care or the emergency room of a hospital because there are no facility physicians available for consultation is not consistent with the regulations.

Interview and record review verify that the physician is available and responsive 24 hours a day.

**W320**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care.**

**Guidance §483.460(a)(2)**

A medical care plan of treatment is developed for those clients who are either acutely ill and require licensed nursing care and monitoring temporarily on a 24 hour basis or clients whose chronic medical conditions require or indicate 24 hour licensed nursing care and monitoring. The physician determines when 24 hour nursing care is required.

The medical care plan is based upon the orders from the physician for treatments and care and nursing standards of practice. There is evidence in the client's record that the physician and the nursing staff at the facility work together to ensure that the medical care plan is current and appropriate (e.g. changes in physician written orders for care pursuant to observations from the nursing staff and/or direct observations and interactions with the client, and nursing documentation of care).

The fact that a client has a medical care plan in place should not preclude him/her from an active treatment program, except in instances of acute illness where the active treatment program is temporarily suspended. For clients with chronic medical conditions, it may be necessary for their active treatment program to be modified due to the tolerance level of the client or adapted to accommodate medical limitations. However, active treatment must be provided on a continuous basis.

**W321**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(2) This plan must be integrated in the individual program plan.**

**Guidance §483.460(a)(2)**

Although the medical care plan can be a separate document, it is always an integral part of the IPP process. There should be evidence that the plans are shared and discussed at the time of all interdisciplinary discussions and the information from the medical care plan is utilized in the development of the IPP objectives.

**§483.460(a)(3) The facility must provide or obtain**

**W322**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(3) preventive and general care**

**Guidance §483.460(a)(3)**

The facility has procedures in place to ensure that the clients receive general health care services to assure optimal levels of wellness. General health care services include assessment and treatment of acute and chronic complaints or situations; teaching relevant health care principles to staff and clients; and periodic surveillance of the health status of the clients.

As a result of clinical assessment, referrals are made for specialized assessment and tests. Facility health care staff follow-up to ensure the assessments are done and the findings incorporated into the medical care plan and/or the IPP.

The facility must have arrangements in place to provide routine or episodic laboratory, and radiology services for the clients if not provided in-house or through the clients physician. There must be a written agreement that specifies the responsibilities of the facility and outside provider. (See §483.410(a)).

Preventive health care services include screening procedures designed to identify health concerns and initiate treatment as early as possible. The facility should have a health prevention program in place and follow the plan to address those screenings that the facility will perform periodically that are relevant to all clients, and those screenings associated with a particular gender or age or vulnerability.

Physician refusal to perform a test, such as a pap smear, must be consistent with guidelines for clients, per the local standard in the community.

If the facility has a physician that refuses to provide preventative healthcare based on the client's level of functioning, medical staff at the facility should meet with and consult with this physician in order to ensure that clients receive the same health services as persons living in the local community.

Refer to these websites for current recommended screenings: Agency for Healthcare Research and Quality (AHRQ)

For men: <http://www.ahrq.gov/ppip/healthymen.htm>  
Centers for Disease Control (CDC)

For women: <http://www.cdc.gov/women/pubs/cancer.htm>

**§483.460(a)(3) as well as annual physical examinations of each client that at a minimum include the following:**

**W323**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(3)(i) Evaluation of vision and hearing;**

**Guidance §483.460(a)(3)(i)**

Information relevant to the client's ability to see and hear is a critical component in the development of appropriate active treatment strategies.

All clients, including clients who are non-verbal, should have evidence in his/her record that they receive an annual evaluation of their vision and hearing which includes a screening as a minimum, follow-up examination as indicated by the screen and timely referrals as indicated by the examination. Screening is a gross assessment of the client's vision and hearing and usually does not include a measurement of acuity. Examinations are conducted to follow-up on issues noted in the screening and are conducted by qualified professionals.

Clients who appear to have vision or hearing problems or the staff indicate that they have vision or hearing problems and no accommodations have been made. The annual vision and hearing evaluation verifies that clients appearing to have vision/hearing issues or if staff indicate that a client has vision/hearing issues that these issues have been/are being addressed.

If a client's vision or hearing can only be assessed through examinations conducted by specialists (e.g., comprehensive ophthalmological examinations and evoked response audiometry (ERA)), these tests need not be conducted yearly, but rather upon the specialist's expressed recommendations. During discussions at the annual IPP review the team reviews information from the health professional, speech and hearing professional, and direct support staff and makes referrals back to the specialist if indicated.

**W324**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(3)(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;**

**Guidance §483.460(a)(3)(ii)**

These immunization guides may be obtained from: American Academy of Pediatrics

[www.aap.org/healthtopics/immunizations.cfm](http://www.aap.org/healthtopics/immunizations.cfm)

Centers for Disease Control (CDC)

[www.cdc.gov/vaccines/recs/schedule/default.htm](http://www.cdc.gov/vaccines/recs/schedule/default.htm).

**W325**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(a)(3)(iii) Routine screening laboratory examinations as determined necessary by the physician,**

**Guidance §483.460(a)(3)(iii)**

The facility may have a set of routine laboratory tests which are to be done on every client annually which is developed and approved by the facility physician. However, such a list is not required. The physician may write orders individually for the clients based upon their medical history, age, gender or medical vulnerabilities.

**W326****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(a)(3)(iii) and special studies when needed;****W327****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(a)(3)(iv) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.****Guidance §483.460(a)(3)(iv)**

The facility should have in place a system for the identification, reporting, investigation, and control of Tuberculosis (TB) in order to prevent its transmission within the facility. This system should include:

- 1) Policies and procedures for screening new employees, new clients, and other people who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility (such as volunteers and contract professional staff);
- 2) Policies and procedures for subsequent screening for clients and for employees, and other people (such as volunteers and contract professional staff) who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility per State Health Department requirements;
- 3) Policies and procedures for reporting positive TB test results to the appropriate State authorities;
- 4) Policies for the investigative procedures, per the local health department, that would be put in place should a client or staff person test positive for TB;
- 5) Policies and procedures for treatment and precautions to be used with clients who display TB symptoms, as substantiated by positive skin testing or x-ray results; and
- 6) Policies and procedures for the evaluation of the effectiveness of the surveillance system.

When one or more clients or staff display TB symptoms, as substantiated by positive skin testing or x-ray results, they do not return to work until a physician has cleared them to return to work.

**W328****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(a)(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.****Guidance §483.460(a)(4)**

Refer to the applicable State Nurse Practice Act or applicable Board of Medicine Practice Act to determine the extent that the nurse practitioner or physician assistant may provide physician services.

**(b) Standard: Physician participation in the individual program plan****§483.460(b) A physician must participate in-****W329****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(b)(1) The establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs; and****Guidance §483.460(b)(1)**

During the admission process, which takes place from the time the client is admitted to the facility to the time the initial IPP is completed, a physician is required to ensure that an assessment of the client's medical status is thoroughly considered and incorporated into the IPP planning process by the team as it develops the IPP. The physician's input may be by means of written reports, evaluations, and recommendations.

The physician (consistent with Medicaid Utilization Control regulations at §456.380) must evaluate the client at the time of admission to identify all diagnoses and complaints, provide orders for all medications and treatments and provide recommendations for restorative and rehabilitative services.

§456.380 requires that a physician conduct this initial assessment therefore, it may not be done by a physician extender (e.g., Physician assistant or Advanced Practice Registered Nurse).

**W330****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(b)(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.**

**Guidance §483.460(b)(2)**

The need for physician participation on an individual client's IPP team is determined by the medical needs of the client. How the physician participates (whether through written report, telephone consultation, attendance at the meeting, etc.) is to be left to the discretion of the facility. In instances where a client has no overriding medical issues, the nurse of the facility can represent the medical component on the IDT process or consult with the appropriate physician and share the information with the team. However, in situations where a client's medical condition is unstable/fragile to the extent that it impacts the training/work that may be planned, the physician must participate in providing guidance on the types and extent of programs that would be appropriate considering the client's physical/medical limitations. If a client is noted to be having difficulty participating in the objectives set forth in his/her IPP due to serious medical concerns, review the input that was provided by the physician into the development of the plan and whether the IPP team requested such input.

**(c) Standard: Nursing services**

**W331**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c) The facility must provide clients with nursing services in accordance with their needs.**

**Guidance §483.460(c)**

The nurse responds in a timely manner to all medical concerns reported, conducts assessments as indicated, effects timely and appropriate interventions, communicates with the client's physicians and other health care professionals as indicated, provides treatments as ordered, monitors client progress following illness or injury and provides training to clients and/or staff as indicated.

**§483.460(c) These services must include**

**W332**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process;**

**Guidance §483.460(c)(1)**

For those clients who have had an uneventful year medically and have no medical/health concerns at the time of the IPP meeting the facility nurse may submit a summary report to the IDT unless the IDT determines that his/her attendance is necessary. An eventful year medically would include a year which required unplanned hospital admissions or in which medical issues necessitated treatment for a prolonged or continuing period. However when a client has had an eventful year medically or current medical/health concerns, this could have an impact on their objectives and accordingly the nurse should participate in the IDT discussion directly.

**W333**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;**

**Guidance §483.460(c)(2)**

A medical care plan addresses those clinical treatments and observations that are to be done for the client by the medical staff and other staff of the facility in order to either improve an acute medical condition or to maintain a medically fragile client as clinically stable as possible. The medical care plan is an adjunct to the IPP and is not considered a substitution for the IPP.

**§483.460(c)(3) For those clients certified as not needing a medical care plan, a review of their health status which must-**

**W334**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(3)(i) Be by a direct physical examination;**

**Guidance §483.460(c)(3)(i)**

A direct physical examination means a visual review of the body as well as examination/assessment of body systems. This includes observations made through non-verbal communication (including visual, tactile, nonverbal gestures, grimaces, etc.) which may be an indication that there is a potential for further assessment and/or monitoring. A paper review of the client's medical record and health statistics does not meet the intent of the regulation for a direct physical examination.

**W335**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(3)(ii) Be by a licensed nurse;**

**Guidance §483.460(c)(3)(ii)**

The term "licensed nurse", for purposes of these guidelines, means a registered nurse, a licensed practical nurse or a licensed vocational nurse currently licensed by the State in which the facility is located. The nurse must operate consistent with the requirements of the applicable Nurse Practice Act. If this direct physical examination is done by a physician, it is not necessary for the nurse to repeat the exam.

**W336**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(3)(iii) Be on a quarterly or more frequent basis depending on client need;**

**Guidance §483.460(c)(3)(iii)**

"On a quarterly basis" means that the examinations are conducted approximately 90 days apart (e.g. scheduled to be conducted approximately once every 90 days). If during the course of a calendar year, there were three quarterly examinations conducted by a licensed nurse and in the fourth quarter the annual physical examination was performed by a physician, the intent of this requirement is met without the nurse performing an additional examination.

**W337**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(3)(iv) Be recorded in the client's record; and**

**Guidance §483.460(c)(3)(iv)**

The actual findings of each examination and the date conducted must be incorporated into the client's record.

**W338**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(3)(v) Result in any necessary action (including referral to a physician to address client health problems).**

**Guidance §483.460(c)(3)(v)**

The nursing staff document that referrals are made in a timely manner, if indicated, for any concerns identified. Nurses must ensure all concerns they identify are communicated and addressed appropriately, including:

- Need is fully identified in assessment;
- Appropriate referrals are made;
- Revisions are made to IPP/Medical care plan; and
- Follow-up occurs to the new plan.

**W339**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(4) Other nursing care as prescribed by the physician or as identified by client needs; and**

**Guidance §483.460(c)(4)**

Nursing interventions are implemented as indicated by the needs of the client and consistent with either standard nursing practice principles or orders from the attending physician. Health and wellness are actively promoted, problems are attended to before they negatively impact the client's health and wellness, and steps are taken to prevent the recurrence of such problems while responding promptly to client's needs.

Client health care complaints that are reported either directly by the client or by the direct care staff are addressed promptly by the nursing staff. Client health care complaints and response by nursing staff are documented in the client's record.

**§483.460(c)(5) Implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to –**  
**W340**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(5)(i) Training clients and staff as needed in appropriate health and hygiene methods;**  
**Guidance §483.460(c)(5)(i)**

Nursing staff periodically provides training to clients and staff on how to care for health needs or conditions, personal hygiene, health maintenance, and disease prevention. Nursing staff actively participates in periodic discussions with client and staff to promote health habits in the areas of diet, exercise and non-smoking.

Based upon individual training needs, the nursing staff provides training to individuals in areas such as medications, family planning, prevention of sexually transmitted diseases, control of other infectious diseases, self-monitoring of health status and self-prevention of health problems, etc. The nurses may train clients directly on their objectives or train other staff to do this training as appropriate.

**W341**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(5)(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and**

**Guidance §483.460(c)(5)(ii)**

Nursing staff should actively participate in surveillance and reporting of communicable diseases per the Centers for Disease Control (CDC) guidelines and applicable state laws. They should teach and promote infection control techniques such as hand washing by clients and staff and should be making periodic observations to ensure that such good infection control techniques are consistently utilized.

**W342**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(c)(5)(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.**

**Guidance §483.460(c)(5)(iii)**

Nursing staff must train and ensure direct support staff demonstrate competency in detecting signs and symptoms of illness, injury, or change in the client's health baseline (e.g. responsiveness, fatigue, irritability, constipation, diarrhea, dehydration, confusion, unexplained weight loss, changes in endurance and changes in respiratory function).

Staff is responsive to health care needs or injuries of clients and receives instruction and support during temporary illness of clients.

If not, review staff training records to determine whether training was provided periodically to the involved employee. Interview direct care staff to determine their level of understanding regarding the signs and symptoms of illness that are to be reported to the medical staff. The records of clients with recent hospitalizations verify that staff detected and reported relevant symptoms promptly.

**(d) Standard: Nursing staff**

**W343**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(d)(1) Nurses providing services in the facility must have a current license to practice in the State.**

**Guidance §483.460(d)(1)**

The facility should have a procedure in place to ensure that any contract nursing staff members are currently licensed prior to the provision of services. Include any contract nurses used by the facility in the sample of nurses reviewed for licensure.

**W344**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(d)(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.**

**Guidance §483.460(d)(2)**

The facility provides for nursing services based on the health needs and conditions of clients residing there. Examples include:

- 1) physician ordered treatments that require the skills of a licensed nurse;
- 2) preventive screenings;
- 3) assessment and intervention;
- 4) direct physical examination and examination of body systems;
- 5) teaching; and
- 6) advocacy for the medical services needed by the client.

Client health care needs are met in a timely manner (within 24 hours) by the available nursing staff.

If nurses who do not have experience in the care of persons with intellectual disabilities are employed by the facility, they should be provided with a formal orientation period and on-going educational opportunities to increase their understanding of the client population.

When one or more clients in the facility has an active medical care plan, there must be 24 hour nursing services available to come to the facility as needed to make skilled assessments and interventions.

**W345**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(d)(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.**

**Guidance §483.460(d)(3)**

Refer to the applicable State Nurse Practice Act.

**W346**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(d)(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.**

**Guidance §483.460(d)(4)**

The facility must have written arrangements with a registered nurse (RN) to provide consultation in those instances where LPNs/LVNs provide all the direct nursing care for the clients. Verify that the agreement requires the RN to respond promptly to all calls from the LPN/LVN and to come on-site to the facility if necessary. The facility must also ensure registered nurse back-up when the primary registered nurse consultant is unavailable (vacations, etc.). Review documentation in the client records to confirm that the LPNs/LVNs of the facility are consulting the registered nurse consultant when indicated and that she/he responds promptly to such calls.

**W347**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(d)(5) Non- licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons.**

The work of any direct support staff (caring for clients with a medical care plan) is directed by an onsite licensed nurse). The nurse evaluates the care provided by the staff as needed, but at least each shift. If observations of care indicate that direct care staff are not providing care as directed by the medical care plan, then review the supervision provided by the nursing staff.

**(e) Standard: Dental services**

**W348**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.**

**Guidance §483.460(e)(1)**

It is expected that the clients will obtain dental services (both diagnostic and treatment) from community dentists whenever possible. In some instances, there may be clients residing in the facility who are physically unable to travel to the community for services. The facility must secure dental services (both diagnostic and treatment) for these clients either through an in-house program, which is part of the organizational and administrative structure of the facility, or through a written agreement with an outside dental service to come into the facility to provide such services.

**W349**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(e)(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.**

**Guidance §483.460(e)(2)**

Reports of dental care may be submitted to the IDT for inclusion in their discussions surrounding either development of the plan or update to the plan. This includes procedures a client may have had or be having during the plan development period, such as root canal or singular extractions. Actual attendance at the IDT meeting by the dentist may be left to the request of the IDT.

**W350**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(e)(3) The facility must provide education and training in the maintenance of oral health.**

**Guidance §483.460(e)(3)**

Formal or informal training in the maintenance of oral hygiene is provided to clients who require it, and to those staff who are responsible for carrying out such activities. The IPP should include an assessment of the client's ability to perform oral hygiene independently and an associated program if the client is not independent.

**(f) Standard: Comprehensive dental diagnostic services**

**§483.460(f) Comprehensive dental diagnostic services include**

**W351**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(f)(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission);**

**Guidance §483.460(f)(1)**

A "month" is defined as the interval between the date of admission and close of business of the corresponding day in the following month.

A complete intraoral examination includes an oral cancer screen.

**§483.460(f)(2) Periodic examination and diagnosis performed**

**W352**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(f)(2) at least annually,**

**Guidance §483.460(f)(2)**

Dental examinations occur no less frequently than annually. Clients without teeth must receive an annual oral cancer screening examination by a dental professional.

**W353**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(f)(2) including radiographs when indicated and detection of manifestations of systemic disease; and**

**Guidance §483.460(f)(2)**

There should be evidence in dental reports that dentists follow current standards of practice for the performance of x-rays in order to assist in the diagnosis and treatment of the client.

**W354**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(f)(3) A review of the results of examination and entry of the results in the client's dental record.**

**Guidance §483.460(f)(3)**

The entry referenced at this regulation is the dental entry into the dental record. See W359 for requirement of copying this dental record into the facility record.

**(g) Standard: Comprehensive dental treatment**

**§483.460(g) The facility must ensure comprehensive dental treatment services that include- -  
W355**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(g)(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and**

**Guidance §483.460(g)(1)**

The facility should be able to produce upon request, a written contract/agreement between the facility and a licensed dentist for 24/7 guidance/provision of emergency services for the clients. The agreement should also indicate what back-up coverage will be provided when the dentist is not available.

**W356**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(g)(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.**

**(h) Standard: Documentation of dental services**

**§483.460(h)(1) If the facility maintains an in-house dental service, the facility must  
W357**

**keep a permanent dental record for each client,**

**W358**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(h)(1) with a dental summary maintained in the client's living-unit.**

**Guidance §483.460(h)(1)**

The "dental summary" refers to the summary of each visit entered by the dental professional. The note includes any care instructions to be followed up by facility staff as a result of treatment.

**§483.460(h)(2) If the facility does not maintain an in-house dental service, the facility must  
W359**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(h)(2) obtain a dental summary of the results of dental visits**

**Guidance §483.460(h)(2)**

The facility should receive a written report of each dentist visit for inclusion in the client's record at the facility and for reference by the medical and direct support staff.

**W360**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(h)(2) and maintain the summary in the client's living unit.**

See guideline above at W359.

**(i) Standard: Pharmacy services**

**W361**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.**

**Guidance §483.460(i)**

The facility either has an onsite pharmacy or has formal arrangements in place for the provision of routine, unanticipated, or emergency drugs. There are no instances where a client does not receive needed medications due to the unavailability of drugs.

**(j) Standard: Drug regimen review**

**W362**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.**

**Guidance §483.460(j)(1)**

The primary function of the pharmacist during the quarterly drug review is to identify possible drug interactions, check for evidence of any side effects associated with the drug usage, determine if laboratory results associated with the drug are within normal limits and verify that the facility is administering the medication appropriately and to comment upon the efficacy of the drug use (e.g. blood sugar controlled, blood pressure within normal limits). In the case of drugs used to manage behavior, the pharmacist may need information from the IDT to determine efficacy. See Appendix PP, Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews, to the State Operations Manual (Pharmaceutical Service Requirements in Long Term Care Facilities).

**W363**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.**

**Guidance §483.460(j)(2)**

The physician and IDT members must discuss, document and take necessary follow-up action for any irregularities noted.

**W364**

**§483.460(j)(3) The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.**

**W365**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(j)(4) An individual medication administration record must be maintained for each client.**

**W366**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(j)(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.**

**Guidance §483.460(j)(5)**

Pharmacist participation on the IDT is at the request of the team. It would not be necessary for the pharmacist to routinely attend all team meetings when the client is on a stable drug regimen that does not appear to be influencing his/her active treatment programs. Pharmacist participation may be appropriate, in situations such as assisting the IDT develop the most effective training programs for when the client is in an evolving situation with their medication.

For example:

- A client begins a new or more complex drug regimen;
- The physician orders off-label use of a medication;
- Frequent changes in the drug regimen are affecting IPP implementation.

**(k) Standard: Drug administration**

**W367**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(k) The facility must have an organized system for drug administration that identifies each drug up to the point of administration.**

**§483.460(k) The system must assure that**

**W368**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(k)(1) All drugs are administered in compliance with the physician's orders;**

**Guidance §483.460(k)(1)**

Administration errors identified in previous medication administration records qualify as non-compliance with physician's orders.

**W369****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(2) All drugs, including those that are self-administered, are administered without error;****Guidance §483.460(k)(2)**

A medication error is an observed discrepancy during the medication pass between what is ordered and what is administered.

This also applies to self-administered medications.

For small facilities (16 beds or less), the medication administration pass will encompass a total of eight (8) drug doses. The observations should be split between two separate drug passes 4/4 (one in the morning and one in the late afternoon or early evening). The medications observed during the observations may or may not be for clients in the survey sample. Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

For large facilities (17 or more beds) with either single or multiple buildings, the medication administration pass will encompass a total of 12 doses. The observations should be split between two separate passes 6/6 (one in the morning and one in late afternoon or early evening). Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

**W370****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(3) Unlicensed personnel are allowed to administer drugs only if State law permits;****Guidance §483.460(k)(3)**

Unlicensed personnel administer only those forms of medication which state law permits. Licensed nurse(s) in the facility oversee any administration of medications by unlicensed persons and periodically evaluate their performance.

**W371****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(4) Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;****Guidance §483.460(k)(4)**

The IDT decision that a self-administration program is appropriate, as is the case for all formal training objectives, must be based upon accurate, current, valid assessment of the client's skills and potential. The determination as to the appropriateness of a self-administration program must never be made singularly on the client's diagnosis or current functional abilities.

For clients assessed to be inappropriate for a self-administration program, but determined by the IDT to possess the capacity to functionally, cognitively, emotionally or developmentally benefit from participation in the drug administration process, it is expected that the facility will provide opportunities for the client to participate in the medication administration process under direct supervision. This participation can include but is not limited to, identifying the medication taken, reaching/grasping a cup of water during the process and placing oral medications in the mouth, etc.

**W372****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client;****Guidance §483.460(k)(5)**

While the IDT may set an objective of self administration of medication for a client, they are required to notify the client's physician of this proposed objective. If the client's physician objects on medical grounds, the team must not proceed with the objective until such time as a discussion is held with the physician and he/she agrees to proceed after receiving additional information.

**W373****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(6) No client self-administers medication until he or she demonstrates the competency to do so;****Guidance §483.460(k)(6)**

The written self-administration program for a client must detail the criteria that will be employed by the facility staff to verify that the client successfully completes all phases of the program and continues to comply with all necessary requirements for self administration. Clients who self-administer medications must secure all medications in such a manner as to protect access by other clients or visitors.

**W374****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law;****Guidance §483.460(k)(7)**

When clients go out of the facility for home visits, or to attend work or school, drugs they are taking must be packaged and labeled in accordance with state law by a person authorized by state law to package and label.

**§483.460(k)(8) Drug administration errors and adverse drug reactions are****Guidance §483.460(k)(8)**

Documentation of any medication error should be entered into the client's record and should include what error was made, who was notified of the error, the response of the medical person notified, the physical condition of the client at the time of the notification and subsequent observations of the clients physical condition related to the error.

**W375****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(8) recorded****Guidance §483.460(k)(8)**

Documentation of adverse drug reactions must be entered into the client's record and should include all complaints made by the client or observations made by the staff following the drug administration, the notification of medical personnel, and the response of the medical personnel, any emergency actions that were required and all subsequent observations of the client's condition related to the reaction.

**W376****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(k)(8) and reported immediately to a physician.****Guidance §483.460(k)(8)**

"Immediately" means at the time the error or reaction is identified.

**(l) Standard: Drug storage and recordkeeping****§483.460(l)(1) The facility must store drugs under proper conditions of****Guidance §483.460(l)(1)**

Drugs are stored according to manufacturer's recommendations.

**W377****sanitation,****W378****temperature,****W379****light,****W380****humidity,****W381****and security.****W382**

**§483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.**

**W383**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area.**

**Guidance §483.460(l)(2)**

“Authorized persons” is restricted to those who administer the drugs (as allowed by state law) and nursing supervisors (if any). No other personnel should have access to these keys.

**W384**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(l)(2) Clients who have been trained to self-administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.**

**Guidance §483.460(l)(2)**

Drugs that are self-administered do not have to be double locked. The purpose for the double locking is to limit access to scheduled drugs. Since the client is generally the only one who has access to his/her drug supply (with perhaps the exception of a licensed nurse or whoever has overall responsibility for medication administration at the facility and a facility’s Director of Nursing Services, who may have access to all of the facility’s drug supplies), there is no need to further limit access.

**W385**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(l)(3) The facility must maintain records of the receipt and disposition of all controlled drugs.**

**Guidance §483.460(l)(3)**

The facility must follow state requirements for the control and disposition of controlled drugs.

**W386**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(l)(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).**

**Guidance §483.460(l)(4)**

The facility should follow state requirements for the reconciliation of controlled drugs.

**W387**

**§483.460(l)(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs**

**§483.460(m) Standard: Drug Labeling**

**§483.460(m)(1) Labeling of drugs and biologicals must**

**W388**

**§483.460(m)(1)(i) Be based on currently accepted professional principles and practices; and**

**W389**

**§483.460(m)(1)(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.**

**§483.460(m)(2) The facility must remove from use—**

**W390**

**§483.460(m)(2)(i) Outdated drugs; and**

**W391**

**§483.460(m)(2)(ii) Drug containers with worn, illegible, or missing labels.**

**W392**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.460(m)(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client’s current medication supply if discontinued by the physician.**

**(n) Standard: Laboratory services****W393****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(n)(1) If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.****Guidance §483.460(n)(1)**

If the facility performs laboratory services, it must have a current, valid Clinical Laboratory Improvement Amendment (CLIA) certificate for the types of tests it is performing.

For the purposes of this regulation, a “laboratory service or test” is defined as any examination or analysis of materials derived from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings.

**W394****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.460(n)(1) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.****Guidance §483.460(n)(1)**

A facility performing any laboratory service or test must have applied to CMS, and received a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. An application for a Certificate of Waiver may be made if the facility performs only those tests on the waived list. A complete list of waived tests can be found at: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>.

If the facility performs any test, not appearing on the waived list, a Certificate of Compliance or Certificate of Accreditation is required. An appropriate CLIA certificate is required regardless of the frequency with which the laboratory services or tests are conducted. When no tests are performed, a CLIA certificate is not needed. Facilities only collecting specimens and not performing testing do not need a certificate.

A not-for-profit, a state, or local government organization may have one certificate covering all the facilities it operates (e.g., all the separately certified residences which fall under its governing body), if no more than a total of 15 types of waived or moderately complex laboratory tests are used. This exception applies only to laboratories performing limited public health testing. See State Operations Manual (SOM) 6008. Each location where a laboratory tests are performed must file a separate application to be separately certified unless the laboratory meets one of the exceptions outlined at 42CFR493.35(b), 493.443(b), or 493.55(b).

Any laboratory located in a state that has a CMS-approved laboratory program is exempt from CLIA certification. Currently there are two states with approved programs: Washington and New York. New York has a partial exemption; therefore, if the laboratory is located in New York, contact the New York State Agency to determine if the exemption applies.

**W406****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****§483.470 Condition of participation: Physical environment. (a) Standard: Client living environment.****W407****(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)****(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.****Guidance §§483.470(a)(1)**

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation supports the placement:

- Assessment;
- Client program plan;

- Staff documentation of client response to training programs; and
- QIDP notes.

**W408**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with others of comparable social and intellectual development.**

**(b) Standard: Client bedrooms.**

**(1) Bedrooms must- -**

**W409**

**§483.470(b)(1)(i) Be rooms that have at least one outside wall**

**W410**

**§483.470(b)(1)(ii) Be equipped with or located near toilet and bathing facilities;**

**W411**

**§483.470(b)(1)(iii) Accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section;**

**§483.470(b)(1)(iv) measure**

**W412**

**At least 60 square feet per client in multiple client bedrooms**

**W413**

**And at least 80 square feet in single client bedrooms; and**

**W414**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.**

**Guidance §483.470(b)(1)(v)**

If a facility was initially certified on or after October 3, 1988 and/or is under renovations or conversions, they must have walls that extend floor to ceiling.

**W415**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) If a bedroom is below grade level, it must have a window that–**

**(i) Is usable as a second means of escape by client(s) occupying the room; and**

**(ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.**

**Guidance §483.470(b)(2)**

The intent of the regulation is to prohibit the housing of clients in basements that are entirely below grade. Clients may be housed on the lower level of housing (e.g. a bi-level house), provided the window height requirements are met and the window is of sufficient size to be used as a means of escape.

**W416**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disabilities professional–**

**(i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and**

**(ii) Documents the reason why housing in a room of only four or fewer persons would not be medically feasible.**

**Guidance §483.470(b)(3)**

The medical care plan for each client housed in a room with more than four clients should indicate the need for continuous monitoring. The medical care plan will include:

- the physician certification that the client is severely medically impaired and requires direct and continuous monitoring during sleeping hours; and
- the reason why this housing arrangement for fewer than four people would not be medically feasible.

**(4) The facility must provide each client with—**  
W417

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(i) A separate bed of proper size and height for the convenience of the client;**

**Guidance §483.470(b)(4)(i)**

The client's preference, chronological age, and physical and medical needs are the determining factors in bed size and height.

W418

**§483.470(b)(4)(ii) A clean, comfortable, mattress;**

W419

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(iii) Bedding appropriate to the weather and climate; and**

W420

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(iv) Functional furniture, appropriate to the client's needs,**

**Guidance §483.470(b)(4)(iv)**

Client preferences and program needs should be considered in furniture selection. For clients with physical disabilities, furniture is adapted to accommodate the client's physical challenges and enable the client to use the furniture with minimal support.

W421

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.**

**Guidance §483.470(b)(4)(iv)**

Closets should have enough space for a reasonable amount of the current season's clothing.

Clients who use wheelchairs or have other physical challenges can reach the racks and shelves in their closets.

The facility is permitted either to provide the client with an individualized closet or with a designated area in a shared closet. The use of central clothing bins in a facility clothing room, in the absence of required client closet space in the bedroom, is not an acceptable practice.

**(c) Standard: Storage space in bedrooms.**

**The facility must provide—**

W422

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(1) Space for equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and**

**Guidance §483.470(c)(1)**

Sufficient space that permits the use of wheelchairs, walkers and other adaptive equipment should be provided within the bedroom.

W423

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.**

**Guidance §483.470(c)(2)**

Each client should have storage in their bedroom for their personal belongings. Clients should have free access to this storage without the assistance of staff. If it is necessary for clients' personal belongings

to be locked due to the behavior of other clients, the client must still be provided free access to his own possessions (See W137 for requirements for locked areas).

**(d) Standard: Client bathrooms**

**The facility must—**

**W424**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;**

**Guidance §483.470(d)(1)**

In a home setting, the toilet facilities need to be of sufficient number to meet the needs of the client without prolonged delay. There must be enough toilets in the living units to meet the program needs of the clients at any given time, as well as provide for intermediate toileting needs of the clients living in the unit.

In a home setting, it may be unrealistic to say a client would never have to wait for a shower or bath or to brush his/her teeth.

Bathrooms and fixtures must be adapted to accommodate clients with physical disabilities.

**W425**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) Provide for individual privacy in toilets, bathtubs, and showers; and**

**Guidance §483.470(d)(2)**

A bathroom containing multiple toilets, showers or bathtubs, must have doors, curtains, or some other means of protecting the client from view when fully or partially unclothed.

Clients should not be able to be seen through the door or window by passersby when they are using the bathrooms.

Client privacy does not preclude the assistance provided by facility staff when necessitated by the client's condition.

**W426**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110° Fahrenheit.**

**(e) Standard: Heating and ventilation.**

**(1) Each client bedroom in the facility must have—**

**W427**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(i) At least one window to the outside; and**

**Guidance §483.470(e)(1)(i)**

(See also W415)

**W428**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.**

**(2) The facility must—**

**W429**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and**

**Guidance §483.470(e)(2)(i)**

A "normal comfort range" in most instances is defined as not going below a temperature of 68 degrees Fahrenheit or exceeding a temperature of 80 degrees Fahrenheit in facilities in most geographic areas of the country.

In extremely hot or extremely cold weather, precautions are taken by the facility to protect the clients, particularly those who are medically compromised, from ill effects of the temperature.

**W430**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.**

**Guidance §483.470(e)(2)(ii)**

Refer to Life Safety Code Chapters 32 and 33

Unvented fuel fired heaters are prohibited. NFPA 101 2000 Edition.

32/33.2.5.23

**(f) Standard: Floors.**

**The facility must have—**

**W431**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.**

**W432**

**§483.470(f) (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and**

**§483.470(f) (3) Exposed floor surfaces and floor coverings that**

**W433**

**promote mobility in areas used by clients,**

**W434**

**and promote maintenance of sanitary conditions.**

**§483.470(g) Standard: Space and Equipment**

**The facility must—**

**W435**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services, as required by this subpart and as identified in each client's individual program plan.**

**Guidance §483.470(g)(1)**

Staff and clients must have the space, materials and equipment needed to implement formal and informal active treatment programs.

There must be sufficient space to accommodate group activities, including groups with clients who use wheelchairs.

Recreational supplies, equipment, and materials are available and reflect the interests, physical abilities and chronological age of the clients.

**W436**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.**

**Guidance §483.470(g)(2)**

The term “furnish” means that the facility is responsible for obtaining or purchasing these items once an assessment has identified the need and is responsible for making any necessary arrangements for the client to receive them. Clients’ personal funds should not be used for these items since this is a covered service under the ICF/IID benefit.

The term “maintain in good repair” means that the facility is responsible for ensuring that these items are kept in good working order, and is responsible for any resulting expense that may be incurred.

Programs must be in place, when identified by assessment and determined by the ID team, to teach clients about the use and care for their equipment to the extent of their capabilities.

**W437**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(3) Provide adequate clean linen and dirty linen storage areas.**

**Guidance §483.470(g)(3)**

Clean linen must be separated from dirty linen and stored in a manner which prevents contamination. Linen soiled with bodily fluids must be stored separately and in a manner which protects clients from exposure to possible infectious sources.

A bedroom hamper can be an acceptable dirty linen storage “area” if kept odor free and consistent with the infection control requirements at §483.470(1).

**(h) Standard: Emergency plan and procedures.**

**W438**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.**

**Guidance §483.470(h)(1)**

These plans may include identification of transportation and alternative shelter needs in cases when the facility must be evacuated and may incorporate state-specific emergency preparedness requirements as applicable.

**W439**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.**

**Guidance §483.470(h)(2)**

“Periodic review” is a judgment made by the facility based on the circumstances of the facility. If the facility changes its physical plant or if changes external to the facility necessitates a review of the disaster plan, then the facility is responsible for carrying out the review.

Interview staff about where emergency plans and procedures are located and what the facility policy is regarding how often, and under what circumstances the plans and procedures are reviewed and updated.

**(i) Standard: Evacuation drills.**

**(1) The facility must hold evacuation drills**

**W440**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**at least quarterly for each shift of personnel**

**Guidance §483.470(i)(1)**

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33 code: Clients have to participate in an evacuation drill each shift at least quarterly.

Chapter 18/19 code: There must be an evacuation drill on each shift at least quarterly. This drill is designed to train staff on evacuation procedures.

Review facility records to verify that evacuations drills are held each shift at least once in each 3-month period.

Refer to (S&C 10-26-LSC)

**W441**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**and under varied conditions to—**

**Guidance §483.470(i)(1)**

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33: Expects that all clients living in that unit are capable of self-evacuation during an emergency. This self evacuation should be practiced under varying conditions including various times of the day or night and in various weather conditions.

Chapter 18/19: Requires drills which simulate emergency situations which familiarize facility staff with emergency actions they may be required to perform. The general emphasis of these sections of the code is upon training of the staff and not upon providing practice for the client. Drills should be practiced under varying conditions including various times of the day or night and in various weather conditions.

**W442**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;**

**Guidance §483.470(i)(1)(i)**

For facilities under Chapter 18/19 of the LSC

Staff should be able to verbalize the proper procedures to be followed during emergency drills. Staff training records should document that all staff have received training on emergency drills and evacuations.

**W443**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and**

**Guidance §483.470(i)(1)(ii)**

Staff on all shifts are able to express familiarity with the use of fire extinguisher, alarms, and any other safety features in the facility.

**W444**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.**

**Guidance §483.470(i)(1)(iii)**

See also W448. The plan(s) must be revised as needed and must be based upon analysis completed under W448.

**The facility must–**

**W445**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(i) Actually evacuate clients during at least one drill each year on each shift;**

**Guidance §483.470(i)(2)(i)**

All clients totally evacuate the building at least once per year per shift, regardless of the occupancy chapter under which the building falls.

All facilities, regardless of their size require actual evacuation. "Actually evacuate", as used in this standard, applies to all clients. The drills are conducted not only to rehearse the clients and staff for a fire emergency (see §483.470(i)(2)(v)), but for other disasters such as hurricanes, tornadoes, floods, etc. Such disasters would require the entire occupancy to be evacuated, and, therefore, the actual evacuation must be practiced, as required.

**W446**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(ii) Make special provisions for the evacuation of clients with physical disabilities;**

**Guidance §483.470(i)(2)(ii)**

Clients with physical or medical disabilities may require special procedures for evacuation, taking into account equipment or staff that must be maintained for the client's care at all times. The facility's evacuation plan should:

- identify such clients;
- clearly delineate any special evacuation procedures for those clients.

Staff should be familiar with the facility's special evacuation procedures when working with clients who are in need of unique provisions.

**W447**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(iii) File a report and evaluation on each evacuation drill;**

**Guidance §483.470(i)(2)(iii)**

There is a written report of each evacuation drill held.

**W448**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(iv) Investigate all problems with evacuation drills, including accidents,**

**Guidance §483.470(i)(2)(iv)**

The documentation for each evacuation drill includes an analysis of:

- The timeliness of the evacuation;

- Any difficulties observed during the drill;
- Investigates the cause of the difficulties; and
- Develops a plan to ensure the difficulties will not reoccur.

**W449**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)  
and take corrective action; and**

**Guidance §483.470(i)(2)(iv)**

When a problem is identified during the evacuation drill and the facility develops a plan to prevent reoccurrence, there is evidence the facility implemented corrective action and follow-up completed to ensure corrective action was successful.

**W450**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.**

**Guidance §483.470(i)(2)(v)**

The Life Safety Code NFPA 101, 2000 Edition at 3.3.167 defines safe location as “a location remote or separated from the effects of a fire so that such effects no longer pose a threat.”

**W451**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(3) Facilities must meet the requirements of paragraph (i)(1) and (2) of this section for any live-in and relief staff they utilize.**

**Guidance §483.470(i)(3)**

In the case of live-in staff, drills must occur quarterly. Typically, live-in staff can be found in facilities that fall under Chapter 32/33 of the LSC code. Drills should be held at varying times of the day and night for clients to practice evacuation including morning, afternoon, evening and the middle of the night.

**(j) Standard: Fire protection.**

**Guidance §483.470(j)**

These standards are covered by the Life Safety Code (LSC) survey. The facility must meet the appropriate chapter of the Life Safety Code, 2000 edition.

When surveying an ICF/IID for compliance with the LSC, it is first necessary to determine whether the facility will be surveyed under Health Care (HC) or Board and Care (BC) occupancy.

- If clients receive nursing services, or if the provider elects to use Health Care, the facility should be surveyed as a Health Care Facility under Chapter 18 or 19 of the LSC, as appropriate.

- If clients receive personal care and protective oversight but not continuing nursing services, the facility is to be surveyed under Board and Care and the following three steps should be followed:

- 1) Determine the size (16 or less = small; 17 or more = large);

- 2) Determine the Evacuation Difficulty (PROMPT, SLOW, or IMPRACTICAL) using Appendix F of the fire safety evaluation system for board and care facilities (FSES/BC); and

- 3) Survey the building using one of two methods:

- a. The prescriptive requirements of Chapters 32 or 33; or

- b. The FSES/BC, Appendix G.

**(1) General. Except as otherwise provided in this section—**

**(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:**

[http://www.archives.gov/federal\\_register/code\\_of\\_federal\\_regulations/ibr\\_locations.html](http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html). Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

**(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.**

**Guidance §483.470(j)(1)(ii)**

Roller latches are prohibited on corridor doors as a latching device.

**(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.**

**(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).**

**Guidance §483.470(j)(3)**

The evacuation capability of residents is determined using Chapter 6 of NFPA 101A, 2001 edition.

**4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.**

**5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.**

**Guidance §483.470(j)(5)**

Battery powered emergency lighting must last at least 90 minutes.

**6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.**

**Guidance §483.470(j)(6)**

Roller latches are prohibited on corridor doors as a latching device.

**(7) Facilities that meet the LSC definition of a health care occupancy.**

**(i) After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:**

**Guidance §483.470(j)(7)(i)**

Waivers may be granted only to facilities that meet the Life Safety Code definition of a Health Care Occupancy. Waivers are not granted to facilities that met the requirements of a Residential Board and Care Occupancy.

Waivers are recommended by the State Survey Agency and approved by the Regional Office.

**(A) The waiver would not adversely affect the health and safety of the clients.**

**B) Rigid application of specific provisions would result in an unreasonable hardship for the facility.**

**ii) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a facility may install alcohol-based hand rub dispensers if—**

**(A) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;**

**(B) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;**

**(C) The dispensers are installed in a manner that adequately protects against inappropriate access;**

**D) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and**

**(E) The dispensers are maintained in accordance with dispenser manufacturer guidelines**

**(k) Standard: Paint.**

**The facility must—**

**W452**

**§483.470(k)(1) Use lead-free paint inside the facility; and**

**W453**

**§483.470(k)(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.**

**§483.470(l) Standard: Infection Control**

**W454**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.**

**Guidance §483.470(l)(1)**

The facility is clean and staff have eliminated opportunities for cross-contamination of infections. Food is stored, prepared, distributed, and served in a sanitary manner to prevent food borne illness.

**W455**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**There must be an active program for the prevention, control, and investigation of infection and communicable diseases.**

**Guidance §483.470(l)(1)**

Facilities maintain an ongoing surveillance program of communicable disease control and investigation of infections and an active training program that ensures the clients served receive adequate prevention of transmission information and skills, according to needs.

The facility's infection control program should include procedures for:

- identification of the extent of infestation or infection;
- protection of clients;
- treatment of clients;
- notification of family or legal guardian;
- reporting to the health department as indicated; and
- continued follow-up to resolution.

Both the Occupational Safety and Health Administration (OSHA) and the CDC have specific requirements regarding human immuno-deficiency virus (HIV), TB, and hepatitis precautions. These requirements should be incorporated into the facility's practices when relevant to the clients residing in the facility. Concerns about OSHA violations should be referred to OSHA.

**W456**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(2) The facility must implement successful corrective action in affected problem areas.**

**W457**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(3) The facility must maintain a record of incidents and corrective actions related to infections.**

**W458**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.**

**Guidance §483.470(l)(4)**

The facility should have and implement a policy that clearly delineates those signs and symptoms for which they will restrict staff access to clients or to clients' food.

**W459**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480 Condition of participation: Dietetic services**

**(a) Standard: Food and nutrition services**

**W460**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(a)(1) Each client must receive a nourishing, well balanced, diet including modified and specially prescribed diets.**

**Guidance §483.480(a)(1)**

“Well balanced diets” are defined as diets that contain a variety of foods from the food groups currently recommended by the Academy of Nutrition and Dietetics (AND).

“Modified and specially-prescribed” diets are defined as diets that are altered in any way to enable the client to eat (e.g. food that is chopped, pureed) or diets that are intended to correct or prevent a nutritional deficiency or health problem.

Refer to W463 and W474 regarding modified and specially prescribed diets.

The following may be indicators of or may lead to compromised nutritional status:

- Unplanned significant weight gain or loss;
- Fever/infection;
- Diarrhea;
- Chronic disease;
- Chewing and Swallowing problems;
- Teeth and gum diseases;
- Excessive use of laxatives;
- Abnormal laboratory values;
- Brittle, dry hair;
- Ridged or spoon shaped nails;
- Dry flaky skin; and
- Unexplained changed in mood such as general fatigue, apathy, irritability, lack of concentration.

If one or more of these indicators are present, determine the facility’s response through observation, interview, and record review.

Surveyors should assure the facility is responsive to client food allergies and the potential for adverse food/drug interactions. If surveyors suspects these may exist, investigate further.

Examples of facility responsiveness to allergies and food/drug interactions include, but are not limited to:

- Clients on long term anticonvulsant drug regimens (e.g., phenobarbital, phenytoin, primidone) are periodically monitored per facility policy for decreased serum levels of folic acid and vitamin D;
- Therapeutic doses of nutrients are provided to decrease the likelihood of anemia and prevent decreased bone density, etc.; and
- Fiber and fluids are increased in the diet of clients to decrease the likelihood of constipation.

**Guidance §483.470(a)(1)**

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation support the placement:

- Assessment;
- Client program plan;
- Staff documentation of client response to training programs; and
- QIDP notes.

**W461**

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

**§483.480(a)(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility’s discretion.**

**Guidance §483.480(a)(2)**

The facility employs a registered dietitian either on a part-time, full-time or on a consultant basis.

**W462**

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

**§483.480(a)(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.**

**Guidance §483.480(a)(3)**

Where the facility does not have a full-time qualified dietitian, verify that the director of food services coordinates with a dietitian to assure the nutritional adequacy of meals and snacks.

The food service director coordinates with the part-time or consultant dietitian to develop client meal plans and monitor client nutritional status.

The qualifications of the food service director may be dictated by facility policy or by state law, if applicable.

In small group home settings where the staff and clients plan and prepare meals cooperatively, there may not be a designated food services director. In these cases, the consultant or part-time dietitian would meet with the available home staff to ensure adequacy of menus and diets.

**§483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe**

**W463**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(a)(4) all modified and special diets**

**W464**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(a)(4) including those used as a part of a program to manage inappropriate client behavior.**

**Guidance §483.480(a)(4)**

Modifying a clients' diet must never be used as punishment.

**W465**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(a)(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.**

**Guidance §483.480(a)(5)**

This regulation addresses the use of food in shaping positive adaptive behavior. Where clients have specialized nutritional needs, these needs must be taken into consideration.

When food is used as a primary reinforcement of behavior for a client who has a dietary restriction, these foods should be consistent with the foods allowed by the prescribed diet.

Food used as a reinforcement must be part of a behavior plan approved by the IDT and consistent with nutritional parameters for that client. For example, a client with diabetes does not receive concentrated sweets as a reinforcement.

**W466**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(a)(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.**

**Guidance §483.480(a)(6)**

For suggested guidelines write to:

U.S. Department of Agriculture

Human Nutrition Information Services

Washington, D.C. 20250

<http://fnic.nal.usda.gov>

**(b) Standard: Meal services**

**W467**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(1) Each client must receive at least three meals daily,**

**Guidance §483.480(b)(1)**

Meal times may be flexible and accommodate a variety of activities (e.g. holiday and weekend activities).

Clients should be offered the opportunity of three meals every day, but may be given the choice of not participating in a meal due to their schedule or preference.

For example, a client wakes up late on a Saturday morning and decides to have brunch.

**W468**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(1) at regular times comparable to normal mealtimes in the community**

**Guidance §483.480(b)(1)**

Generally, meal times conform to the norms of the community, however the clients' schedules and preferences may result in slight variations. Slight variations are acceptable, but gross variations such as breakfast at 3 am would not be acceptable.

**§483.480(b)(1) with –**

**W469**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(1)(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day,**

**Guidance §483.480(b)(1)(i)**

A "substantial evening meal" is defined as an offering of three or more items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements.

**W470**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(1)(i) except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may lapse between a substantial evening meal and breakfast; and**

**Guidance §483.480(b)(1)(i)**

A "nourishing snack" is an offering of items, single or in combination, from the basic food groups. Snack supplies are available in the facility and are accessible to clients. Interview staff and clients about their access to snacks.

**W471**

**§483.480(b)(1)(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i).**

**§483.480(b)(2) Food must be served–**

**Facility Practices §483.480(b)(2)(i)**

Portions served, either by staff or by the individuals themselves, closely match designated serving sizes on menus. Slight variations are not significant enough or frequent enough to affect individual's health.

**W472**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(2)(i) In appropriate quantity;**

**Guidance §483.480(b)(2)(i)**

Meal observations verify that portions served, either by staff or by the clients, match the designated serving sizes on menus.

**W473**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(2)(ii) At appropriate temperature;**

**Guidance §483.480(b)(2)(ii)**

Hot foods are served hot and cold foods are served cold, according to facility policy specific to the type of food or as desired by the client. The facility follows current state requirements for safe food temperatures.

**W474**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(2)(iii) In a form consistent with the developmental level of the client; and**

**Guidance §483.480(b)(2)(iii)**

The term "form", as used in this requirement, refers to food consistency (e.g., pureed, chopped, ground, etc.). Food that is ground, chopped or pureed is based on assessed client need, and only to the extent required.

Food consistency modifications due to an acute medical or dental condition are temporary and; client's food consistency is upgraded at the soonest possible time. Clients with chronic medical or dental conditions are periodically reviewed and at least annually for the possibility of an upgrade in food consistency.

Client assessments must document the justification for modified texture of the client's diet.

**W475**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(2)(iv) With appropriate utensils.**

**Guidance §483.480(b)(2)(iv)**

“Appropriate utensils” refers to eating utensils and adaptive eating equipment that enable clients to eat as independently as possible in accordance with their highest functional level.

Commonly used utensils (fork, knife, and spoon) appropriate to the food being consumed are provided to all clients except those using adaptive equipment instead. Clients should be afforded the opportunity to use forks, spoons, and knives as indicated by the food served.

Utensils must be in good condition, clean, allow portion sizes appropriate to the client's prescribed diet and meet the client's needs.

**W476**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(b)(3) Food served to clients individually and uneaten must be discarded.**

**Guidance §483.480(b)(3)**

This standard does not apply to food served in family-style dishes, unless the length of time the food is on the table or other considerations (such as clients fingering or drooling in the food) compromise the safety and nutritive value for later consumption of the food.

**(c) Standard: Menus**

**W477**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(c)(1)(i) Be prepared in advance;**

**Guidance §483.480(c)(1)(i)**

The facility should be able to produce a copy of client menus prospectively to verify that meal planning is done in advance.

**W478**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(c)(1)(ii) Provide a variety of foods at each meal;**

**Guidance §483.480(c)(1)(ii)**

A “variety” of food at each meal includes offerings from each of the food groups.

**W479**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(c)(1)(iii) Be different for the same days of each week and adjusted for seasonal changes; and**

**Guidance §483.480(c)(1)(iii)**

Menus should make use of seasonal foods in order to capitalize on the availability of fresher more vitamin enriched foods.

In certain portions of the country, there may be cultural preferences that influence the frequency with which a food appears on the menu. This is acceptable in the facility if it is acceptable in the community.

**W480**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(c)(1)(iv) Include the average portion sizes for menu items.**

**Guidance §483.480(c)(1)(iv)**

Verify the menu lists client portion sizes and observe that the portions served correspond to the clients prescribed diet.

**W481**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(c)(2) Menus for food actually served must be kept on file for 30 days.**

**(d) Standard: Dining areas and service**

**§483.480(d) The facility must –**  
**W482**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;**

**Guidance §483.480(d)(1)**

For purposes of this standard, “dining areas” mean discrete eating areas located outside of bedrooms, established, furnished, and equipped for the purpose of eating meals.

When a client is not eating in a designated dining area, there must be either a medical rationale or this must be an isolated instance when the client has a personal reason to eat in another area, such as a television area to watch his or her favorite program.

Interview with the client should confirm that this is not routine, but is for a particular isolated reason.

**W483**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;**

**Guidance §483.480(d)(2)**

Clients must have the opportunity to participate in the normal dining experience with their companions in the dining room.

Clients in wheelchairs are included in dining groupings of their peers without physical disabilities.

Clients in wheelchairs eat at the table and not with lap trays/hospital trays unless medically contraindicated.

**W484**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;**

**Guidance §483.480(d)(3)**

Clients use adaptive equipment or are being trained to use such equipment when the need is identified in the IPP.

Examples of adaptive equipment that may be needed are:

- Double suction cups or other devices to anchor dishes on a table or tray for clients with major coordination problems;
- Rocking one-handed knife-fork or knife-spoon for a client with the use of only one hand;
- Built-up or extended handles or silverware for those with problems of grasp or range of motion;
- Plate guards or plates with raised rims to provide a surface against which the client with a physical disability can push food onto a fork or a spoon;
- Flexible drinking straws;
- Spoon bent to a 90 degree angle at the bowl or a swivel spoon to assist a client without normal wrist motions; and
- Any other adaptive device deemed by the team as needed by the client to eat more independently.

**W485**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(4) Supervise and staff dining rooms adequately**

**Guidance §483.480(d)(4)**

There should be sufficient staff to implement eating programs for clients who require them and to provide necessary intervention and supervision for normalization including normal meal time behavior.

Client mealtime should not be inadequately delayed due to insufficient staff assistance.

**W486**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(4) to direct self-help dining procedures,****Guidance §483.480(d)(4)**

Staff is present during meal times to monitor clients who are able to eat independently, promoting, supporting, reinforcing and encouraging them to eat in an appropriate and normalized manner (e.g., manners, social behaviors, etc.)

**W487**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(4) to assure that each client receives enough food and****Guidance §483.480(d)(4)**

Clients can request and receive second helpings unless contraindicated by a prescribed diet.

For clients on restrictive diets that prefer not to be on these diets or seek seconds, the facility resolves the personal choice issues vs. health risks.

**W488**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(4) to assure that each client eats in a manner consistent with his or her developmental level; and****Guidance §483.480(d)(4)**

The intent of this regulation is to promote the acquisition of skills that lead to greater independence in eating.

Clients should be actively encouraged to eat independently to the extent possible and in accordance with their assessed abilities.

Clients should receive training to develop independent eating skills consistent with their developmental potential as identified through the CFA.

Clients learn skills in accordance with their functional levels. Skills may include:

- Use of utensils;
- Meal preparation;
- Socialization during meals;
- Family style dining; and
- Ordering food in restaurants.

Clients' eating programs are implemented in accordance with their training objectives.

To the maximum extent possible, staff model appropriate mealtime behavior and conversation by sitting at the table with clients, and when possible, eating meals with clients.

**W489**

**(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)**

**§483.480(d)(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.****Guidance §483.480(d)(5)**

If a client eats in any position other than an upright position, the physician should document the medical necessity for the position, and/or the IPP should include the program plan to teach the client the physical skill necessary for eating upright.

This applies to all clients, including those fed by nasogastric tube or gastrostomy tube. The IPP should identify the most appropriate position for the client to be positioned during mealtime, in relation to the placement of the food contents.

[ARC 3109C, IAB 6/7/17, effective 7/12/17]

CHAPTER 106  
DEER HUNTING BY RESIDENTS  
[Prior to 12/31/86, Conservation Commission[290] Ch 106]

**571—106.1(481A) Licenses.** When hunting deer, all hunters must have in their possession a valid deer hunting license and a valid resident hunting license and must have paid the habitat fee (if normally required to have a hunting license and to pay the habitat fee to hunt). No person while hunting deer shall carry or have in possession any license or transportation tag issued to another person. No one who is issued a deer hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while that person is deer hunting or tagging a deer.

**106.1(1) Type of license.**

*a. General deer licenses.* General deer licenses shall be valid for taking deer in one season selected at the time the license is purchased. General deer licenses shall be valid for taking deer of either sex except in Buena Vista, Calhoun, Cerro Gordo, Cherokee, Clay, Dickinson, Emmet, Franklin, Grundy, Hamilton, Hancock, Hardin, Humboldt, Ida, Kossuth, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Sac, Sioux, Webster, Winnebago, Worth and Wright counties during the early muzzleloader or first regular gun season when the general deer license will be valid for taking deer with at least one forked antler. Paid general deer licenses shall be valid statewide except where prohibited in deer population management zones established under 571—Chapter 105. Free general deer licenses shall be valid for taking deer of either sex only on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

*b. Antlerless-deer-only licenses.* Antlerless-deer-only licenses shall be valid for taking deer that have no forked antler. Paid antlerless-deer-only licenses shall be valid in one county or in one deer population management zone and in one season as selected at the time the license is purchased. Free and reduced-fee antlerless-deer-only licenses shall be valid on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

**106.1(2) Bow season licenses.** General deer and antlerless-deer-only licenses, paid or free, shall be valid in both segments of the bow season.

**106.1(3) Regular gun season licenses.** Paid general deer and antlerless-deer-only licenses shall be valid in either the first or the second regular gun season, as designated on the license. Free general deer licenses and antlerless-deer-only licenses shall be valid in both the first and second regular gun seasons.

**106.1(4) Muzzleloader season licenses.** General deer and antlerless-deer-only licenses, paid or free, shall be valid in either the early or the late muzzleloader season, as designated on the license.

**106.1(5) November antlerless-deer-only licenses.** Rescinded IAB 7/11/12, effective 8/15/12.

**106.1(6) January antlerless-deer-only licenses.** Rescinded IAB 8/6/14, effective 9/10/14.

**106.1(7) Free and reduced-fee deer licenses for landowners and tenants.** A maximum of one free general deer license, two free antlerless-deer-only licenses, and two reduced-fee antlerless-deer-only licenses may be issued to a qualifying landowner or eligible family member and a qualifying tenant or eligible family member. Eligibility for licenses is described in 571—106.12(481A). The free general deer license shall be available for one of the following seasons: the youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, or first and second regular gun seasons. One free antlerless-deer-only license shall be available for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, or first and second regular gun seasons. The second free antlerless-deer-only license shall be valid only for the January antlerless-deer-only season and will be available only if a portion of the farm unit lies within a county where paid antlerless-deer-only licenses are available during that season. Each reduced-fee antlerless-deer-only license shall be valid for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, or January antlerless-deer-only season. January antlerless-deer-only licenses will be available only if a portion of the farm unit is located in a county where paid antlerless-deer-only licenses are available in that season.

**106.1(8) Antlerless-deer-only crossbow licenses for senior citizens.** Persons 70 years old or older may obtain one paid antlerless-deer-only license valid statewide for taking antlerless deer with a crossbow. The license will be valid only during the bow season.

**106.1(9) Nonambulatory deer hunting licenses.** The commission shall issue licenses in conformance with 2009 Iowa Acts, Senate File 187. A person applying for this license must provide a completed form obtained from the department of natural resources. The application shall be certified by the applicant's attending physician with an original signature and declare that the applicant is nonambulatory using the criteria listed in 2009 Iowa Acts, Senate File 187. A medical statement from the applicant's attending physician that specifies criteria met shall be on 8½" × 11" letterhead stationery. The attending physician shall be a currently practicing doctor of medicine, doctor of osteopathy, physician assistant or nurse practitioner.

[ARC 7921B, IAB 7/1/09, effective 8/5/09; ARC 8255B, IAB 11/4/09, effective 12/9/09; ARC 8888B, IAB 6/30/10, effective 8/18/10; ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14]

**571—106.2(481A) Season dates.** Deer may be taken only during the following seasons:

**106.2(1) Bow season.** Deer may be taken in accordance with the type of license issued from October 1 through the Friday before the first Saturday in December and from the Monday following the third Saturday in December through January 10 of the following year.

**106.2(2) Regular gun seasons.** Deer may be taken in accordance with the type, season and zone designated on the license from the first Saturday in December and continuing for five consecutive days (first regular gun season) or from the second Saturday in December and continuing for nine consecutive days (second regular gun season).

**106.2(3) Muzzleloader seasons.** Deer may be taken in accordance with the type, season and zone designated on the license from the Saturday closest to October 14 and continuing for nine consecutive days (early muzzleloader season) or from the Monday following the third Saturday in December through January 10 of the following year (late muzzleloader season).

**106.2(4) November antlerless-deer-only season.** Rescinded IAB 7/11/12, effective 8/15/12.

**106.2(5) January antlerless-deer-only season.** Rescinded IAB 8/6/14, effective 9/10/14.  
[ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14]

**571—106.3(481A) Shooting hours.** Legal shooting hours shall be from one-half hour before sunrise to one-half hour after sunset in all seasons.

**571—106.4(481A) Limits.**

**106.4(1) Bow season.** The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

**106.4(2) Muzzleloader seasons.** The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

**106.4(3) Regular gun seasons.** The bag limit is one deer for each hunter in the party who has a valid deer transportation tag. The possession limit is one deer per license. "Possession" shall mean that the deer is in the possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

**106.4(4) November antlerless-deer-only season.** Rescinded IAB 7/11/12, effective 8/15/12.

**106.4(5) January antlerless-deer-only season.** Rescinded IAB 8/6/14, effective 9/10/14.

**106.4(6) Maximum annual possession limit.** The maximum annual possession limit for a resident deer hunter is one deer for each legal license and transportation tag obtained.

[ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14]

**571—106.5(481A) Areas closed to hunting.** There shall be no open seasons for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth

County, where posted accordingly. There shall be no open seasons for hunting deer on all portions of rights-of-way on Interstate Highways 29, 35, 80 and 380.

**571—106.6(481A) Paid deer license quotas and restrictions.** Paid deer licenses, including antlerless-deer-only licenses, will be restricted in the type and number that may be purchased.

**106.6(1) Paid general deer licenses.** Residents may purchase no more than two paid general deer licenses, one for the bow season and one for one of the following seasons: early muzzleloader season, late muzzleloader season, first regular gun season, or second regular gun season. No more than 7,500 paid statewide general deer licenses will be sold for the early muzzleloader season. Fifty additional paid early muzzleloader season licenses will be sold through and will be valid only for the Iowa Army Ammunition Plant. There will be no quota on the number of paid general deer licenses issued in the bow season, late muzzleloader season, first regular gun season, or second regular gun season.

**106.6(2) Paid antlerless-deer-only licenses.** Paid antlerless-deer-only licenses have quotas for each county and will be sold for each county until quotas are reached.

*a.* Paid antlerless-deer-only licenses may be purchased for any season in counties where licenses are available, except as outlined in 106.6(2)“*b.*” A license must be used in the season, county or deer population management area selected at the time the license is purchased.

*b.* No one may obtain paid licenses for both the first regular gun season and second regular gun season regardless of whether the licenses are valid for any deer or antlerless deer only. Paid antlerless-deer-only licenses for the early muzzleloader season may only be purchased by hunters who have already purchased one of the 7,500 paid statewide general deer licenses. Hunters who purchase one of the 7,500 paid statewide general deer licenses for the early muzzleloader season may not obtain paid antlerless licenses for the first or second regular gun season.

*c.* Prior to September 15, a hunter may purchase one antlerless-deer-only license for any season for which the hunter is eligible. Beginning September 15, a hunter may purchase an unlimited number of antlerless-deer-only licenses for any season for which the hunter is eligible, as set forth in 106.6(2)“*b.*” until the county or population management area quotas are filled. Licenses purchased for deer population management areas will not count in the county quota.

**106.6(3) November antlerless-deer-only season.** Rescinded IAB 7/11/12, effective 8/15/12.

**106.6(4) January antlerless-deer-only licenses.** Rescinded IAB 8/6/14, effective 9/10/14.

**106.6(5) Free landowner/tenant licenses.** A person obtaining a free landowner/tenant license may purchase any combination of paid bow and paid gun licenses available to persons who are not eligible for landowner/tenant licenses as described in 571—106.12(481A).

**106.6(6) Antlerless-deer-only licenses.** Paid antlerless-deer-only licenses will be available by county for the 2017–2018 deer season as follows:

County	Quota	County	Quota	County	Quota
Adair	1025	Floyd	0	Monona	850
Adams	1450	Franklin	0	Monroe	1950
Allamakee	3600	Fremont	400	Montgomery	750
Appanoose	1800	Greene	0	Muscatine	775
Audubon	0	Grundy	0	O’Brien	0
Benton	325	Guthrie	1950	Osceola	0
Black Hawk	0	Hamilton	0	Page	750
Boone	300	Hancock	0	Palo Alto	0
Bremer	650	Hardin	0	Plymouth	0
Buchanan	300	Harrison	850	Pocahontas	0
Buena Vista	0	Henry	925	Polk	1350
Butler	0	Howard	350	Pottawattamie	850
Calhoun	0	Humboldt	0	Poweshiek	300

County	Quota	County	Quota	County	Quota
Carroll	0	Ida	0	Ringgold	1600
Cass	400	Iowa	450	Sac	0
Cedar	775	Jackson	825	Scott	200
Cerro Gordo	0	Jasper	775	Shelby	0
Cherokee	0	Jefferson	1650	Sioux	0
Chickasaw	375	Johnson	850	Story	150
Clarke	2100	Jones	800	Tama	200
Clay	0	Keokuk	450	Taylor	1600
Clayton	3400	Kossuth	0	Union	1500
Clinton	400	Lee	1275	Van Buren	2000
Crawford	0	Linn	850	Wapello	1825
Dallas	1875	Louisa	675	Warren	2200
Davis	1600	Lucas	2200	Washington	750
Decatur	2200	Lyon	0	Wayne	2200
Delaware	800	Madison	2350	Webster	0
Des Moines	800	Mahaska	475	Winnebago	0
Dickinson	0	Marion	1650	Winneshiek	2275
Dubuque	825	Marshall	150	Woodbury	625
Emmet	0	Mills	750	Worth	0
Fayette	1800	Mitchell	0	Wright	0

[ARC 7921B, IAB 7/1/09, effective 8/5/09; ARC 8888B, IAB 6/30/10, effective 8/18/10; ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 0830C, IAB 7/10/13, effective 8/14/13; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 2086C, IAB 8/5/15, effective 9/9/15; ARC 2697C, IAB 8/31/16, effective 8/12/16; ARC 3098C, IAB 6/7/17, effective 7/12/17]

**571—106.7(481A) Method of take.** Permitted weapons and devices vary according to the type of season.

**106.7(1) Bow season.** Only longbow, compound or recurve bows shooting broadhead arrows are permitted during the bow season. Arrows must be at least 18 inches long.

*a.* Crossbows may be used during the bow season in the following two situations:

(1) By persons with certain afflictions of the upper body as provided in 571—15.5(481A); and

(2) By persons over the age of 70 with an antlerless-deer-only license as provided in Iowa Code section 483A.8A.

*b.* No explosive or chemical devices may be attached to the arrow, broadhead or bolt (if used with a crossbow).

**106.7(2) Regular gun seasons.** Only 10-, 12-, 16- and 20-gauge shotguns shooting single slugs, and straight wall cartridge rifles, muzzleloaders, and handguns as described more fully in 106.7(3), will be permitted for taking deer during the regular gun seasons.

**106.7(3) Muzzleloader seasons.** Only muzzleloading rifles and muzzleloading pistols will be permitted for taking deer during the early muzzleloader season. During the late muzzleloader season, deer may be taken with a muzzleloading rifle, muzzleloading pistol, centerfire handgun, crossbow or bow as described in 106.7(1).

*a.* Muzzleloading rifles are defined as flintlock or percussion cap lock muzzleloaded rifles and muskets of not less than .44 and not larger than .775 caliber, shooting single projectiles only.

*b.* Centerfire handguns must be .357 caliber or larger shooting straight wall cartridges propelling an expanding-type bullet (no full-metal jacket) and complying with all other requirements provided in Iowa Code section 481A.48. In addition, centerfire handguns must be designed to be shot with one hand using a pistol grip and have either:

(1) A cylinder of several chambers brought successively into line with the barrel and discharged with the same hammer; or

(2) A magazine feeding a single chamber integral with the barrel and using either the action of a slide or a bolt action to eject the casing, or having a break action capable of only holding one round.

c. Muzzleloading pistols must be .44 caliber or larger, shooting single projectiles only.

d. Crossbow means a weapon consisting of a bow mounted transversely on a stock or frame and designed to fire a bolt, arrow, or quarrel by the release of the bow string, which is controlled by a mechanical trigger and a working safety. Crossbows equipped with pistol grips and designed to be fired with one hand are illegal for taking or attempting to take deer. All projectiles used in conjunction with a crossbow for deer hunting must be equipped with a broadhead.

e. Legal handgun calibers for hunting deer in Iowa are listed in the department of natural resources' hunting and trapping regulations booklet published each summer and adopted by reference herein. Centerfire handguns and black powder handguns must have a 4-inch minimum barrel length, and centerfire handguns shall not have any parts that extend beyond the back of the pistol grip. There can be no shoulder stock or long-barrel modifications to any handgun.

**106.7(4)** *November antlerless-deer-only season.* Rescinded IAB 7/11/12, effective 8/15/12.

**106.7(5)** *January antlerless-deer-only season.* Rescinded IAB 8/6/14, effective 9/10/14.

**106.7(6)** *Prohibited weapons and devices.* The use of dogs, domestic animals, bait, rifles other than muzzleloaded or straight wall cartridge as provided in 106.7(2), 106.7(3) and 106.10(5), handguns except as provided in 106.7(2) and 106.7(3), crossbows except as provided in 106.7(1) and 106.7(3), automobiles, aircraft, or any mechanical conveyance or device, including electronic calls, is prohibited, except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Bait" means grain, fruit, vegetables, nuts, hay, salt, mineral blocks, or any other natural food materials; commercial products containing natural food materials; or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. "Paraplegic" means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease of or injury to the spinal cord. It shall be unlawful for a person, while hunting deer, to carry or have in possession a rifle except as provided in 106.7(2), 106.7(3) and 106.10(5). A person in possession of a valid permit to carry weapons may carry a handgun while hunting. However, only the handguns listed in 106.7(3) shall be used to hunt deer and only when a handgun is a lawful method of take.

**106.7(7)** *Discharge of firearms from roadway.* No person shall discharge a rifle, including a muzzleloading rifle or musket, or a handgun from a highway while deer hunting. In addition, no person shall discharge a shotgun shooting slugs from a highway north of U.S. Highway 30. A "highway" means the way between property lines open to the public for vehicle traffic, including the road ditch, as defined in Iowa Code section 321.1(78).

**106.7(8)** *Hunting from blinds.* No person shall use a blind for hunting deer during the regular gun deer seasons as defined in 106.2(2), unless such blind exhibits a solid blaze orange marking which is a minimum of 144 square inches in size and is visible in all directions. Such blaze orange shall be affixed directly on or directly on top of the blind. For the purposes of this subrule, the term "blind" is defined as an enclosure used for concealment while hunting, constructed either wholly or partially from man-made materials, and used by a person who is hunting for the purpose of hiding from sight. A blind is not a naturally occurring landscape feature or an arrangement of natural or agricultural plant material that a hunter uses for concealment. In addition to the requirements in this subrule, hunters using blinds must also satisfy the requirements of wearing blaze orange as prescribed in Iowa Code section 481A.122.

[ARC 9717B, IAB 9/7/11, effective 10/12/11; ARC 0189C, IAB 7/11/12, effective 8/15/12; ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 2086C, IAB 8/5/15, effective 9/9/15; ARC 3098C, IAB 6/7/17, effective 7/12/17]

**571—106.8(481A) Procedures to obtain licenses.** All resident deer hunting licenses must be obtained using the electronic licensing system for Iowa (ELSI). Licenses may be purchased from ELSI license agents, or online at [www.iowadnr.com](http://www.iowadnr.com), or by calling the ELSI telephone ordering system.

**106.8(1) Licenses with quotas.** All paid deer hunting licenses for which a quota is established may be obtained from the ELSI system on a first-come, first-served basis beginning August 15 until the quota fills, or through the last day of the hunting period for which the license is valid.

**106.8(2) Licenses without quotas.** All deer hunting licenses that have no quota may be obtained from the ELSI system beginning August 15 through the last day of the hunting period for which a license is valid.

**106.8(3) Providing false information.**

*a.* Any person who provides false information about the person's identity or eligibility for any paid or free landowner/tenant deer license and tag and who attests that the information is correct by accepting and signing the license or tag shall have the person's hunting license revoked as a part of the sentencing for such criminal conviction, and the person shall not be issued a hunting license for one year pursuant to the authority of Iowa Code Supplement section 483A.24(2) "f" and rule 571—15.6(483A).

*b.* In addition to any legal penalties that may be imposed, the obtaining of a license in violation of this rule shall invalidate that deer license and transportation tag and any other deer hunting license and transportation tag obtained during the same year.

**571—106.9(481A) Transportation tag.** A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to one leg of each antlerless deer or on the main beam between two points, if present, on one of the antlers of an antlered deer in such a manner that the tag cannot be removed without mutilating or destroying the tag. This tag shall be attached to the carcass of the deer within 15 minutes of the time the deer carcass is located after being taken or before the carcass is moved to be transported by any means from the place where the deer was taken, whichever occurs first. No person shall tag a deer with a transportation tag issued to another person or with a tag that was purchased after the deer was taken. During the youth/disabled hunter season, bow season, early muzzleloader season and late muzzleloader season, the hunter who killed the deer must tag the deer by using the transportation tag issued in that person's name. During the first and second regular gun seasons and the January antlerless-deer-only season, anyone present in the hunting party may tag a deer with a tag issued in that person's name. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to the deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility or until the deer has been processed for consumption.

[ARC 9717B, IAB 9/7/11, effective 10/12/11; ARC 0189C, IAB 7/11/12, effective 8/15/12]

**571—106.10(481A) Youth deer and severely disabled hunts.**

**106.10(1) Licenses.**

*a. Youth deer hunt.* A youth deer license may be issued to any Iowa resident who is not over 15 years old on the day the youth obtains the license. The youth license may be paid or free to persons eligible for free licenses. If the youth obtains a free landowner/tenant license, it will count as the one free general deer license for which the youth's family is eligible.

Each participating youth must be accompanied by an adult who possesses a regular hunting license and has paid the habitat fee (if the adult is normally required to have a hunting license and to pay the habitat fee to hunt). Only one adult may participate for each youth hunter. The accompanying adult must not possess a firearm or bow and must be in the direct company of the youth at all times.

A person may obtain only one youth general deer license but may also obtain any other paid or free general deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner with which other hunters obtain them, as described in 106.6(2).

*b. Severely disabled hunt.* Any severely disabled Iowa resident meeting the requirements of Iowa Code section 321L.1(8) may be issued one general deer license to hunt deer during the youth season. A person applying for this license must either possess a disability parking permit or provide a completed form from the department of natural resources. The form must be signed by a physician verifying

that the person's disability meets the criteria defined in Iowa Code section 321L.1(8). The attending physician shall be currently practicing medicine and shall be a medical doctor, a doctor of osteopathy, a physician assistant, or a nurse practitioner. Forms are available online at [www.iowadnr.gov](http://www.iowadnr.gov), by visiting the DNR office at the Wallace State Office Building, Des Moines, Iowa, or any district office, or by calling (515)725-8200. A person between 16 and 65 years of age must also possess a regular hunting license and have paid the habitat fee to obtain a license (if normally required to have a hunting license and to pay the habitat fee to hunt). A severely disabled person obtaining this license may obtain any other paid and free general deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner by which other hunters obtain them, as described in 106.6(2).

**106.10(2) *Season dates.*** Deer of either sex may be taken statewide for 16 consecutive days beginning on the third Saturday in September. A person who is issued a youth deer hunting license and does not take a deer during the youth deer hunting season may use the deer hunting license and unused tag during the early muzzleloader, late muzzleloader, and one of the shotgun seasons. The license will be valid for the type of deer and in the area specified on the original license. The youth must follow all other rules specified in this chapter for each season. A youth hunting in one of the other seasons must obtain a hunting license and habitat stamp or hunt with a licensed adult if required by Iowa Code section 483A.24. If the tag is filled during one of the seasons, the license will not be valid in subsequent seasons.

**106.10(3) *Shooting hours.*** Legal shooting hours will be one-half hour before sunrise to one-half hour after sunset each day regardless of weapon used.

**106.10(4) *Limits and license quotas.*** An unlimited number of licenses may be issued. The daily and season bag and possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

**106.10(5) *Method of take and other regulations.*** Deer may be taken with shotgun, bow, straight wall cartridge rifles, or muzzleloaded rifles as permitted in 571—106.7(481A). All participants must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122. All other regulations for obtaining licenses or hunting deer shall apply.

**106.10(6) *Procedures for obtaining licenses.*** Paid and free youth season licenses and licenses for severely disabled hunters may be obtained through ELSI beginning August 15 through the last day of the youth season.

[ARC 1562C, IAB 8/6/14, effective 9/10/14; ARC 2086C, IAB 8/5/15, effective 9/9/15; ARC 3098C, IAB 6/7/17, effective 7/12/17]

**571—106.11(481A) Deer depredation management.** The deer depredation management program provides assistance to producers through technical advice and additional deer licenses and permits where the localized reduction of female deer is needed to reduce damage. Upon signing a depredation management agreement with the department, producers of agricultural or high-value horticultural crops may be issued deer depredation permits to shoot deer causing excessive crop damage. If immediate action is necessary to forestall serious damage, depredation permits may be issued before an agreement is signed. Further permits will not be authorized until an agreement is signed.

**106.11(1) *Method of take and other regulations.*** Legal weapons and restrictions will be governed by 571—106.7(481A). For deer shooting permits only, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93. The producer or designee must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122.

**106.11(2) *Eligibility.*** Producers growing typical agricultural crops (such as corn, soybeans, hay and oats and tree farms and other forestlands under a timber management program) and producers of high-value horticultural crops (such as Christmas trees, fruit or vegetable crops, nursery stock, and commercially grown nuts) shall be eligible to enter into depredation management agreements if these crops sustain excessive damage.

- a. The producer may be the landowner or a tenant, whoever has cropping rights to the land.
- b. Excessive damage is defined as crop losses exceeding \$1,000 in a single growing season, or the likelihood that damage will exceed \$1,000 if preventive action is not taken, or a documented history of at least \$1,000 of damage annually in previous years.

c. Producers who lease their deer hunting rights are not eligible for the deer depredation management program.

**106.11(3) Depredation management plans.** Upon request from a producer, field employees of the wildlife bureau will inspect and identify the type and amount of crop damage sustained from deer. If damage is not excessive, technical advice will be given to the producer on methods to reduce or prevent future damage. If damage is excessive and the producer agrees to participate, a written depredation management plan will be developed by depredation biologists in consultation with the producer.

a. The goal of the management plan will be to reduce damage to below excessive levels within a specified time period through a combination of producer-initiated preventive measures and the issuance of deer depredation permits.

(1) Depredation plans written for producers of typical agricultural crops may require preventive measures such as harassment of deer with pyrotechnics and cannons, guard dogs, and temporary fencing, as well as allowing more hunters, increasing the take of antlerless deer, and other measures that may prove effective.

(2) Depredation plans written for producers of high-value horticultural crops may include all of the measures in (1) above, plus permanent fencing where necessary. Fencing will not be required if the cost of a fence exceeds \$1,000.

(3) Depredation permits to shoot deer may be issued to Iowa residents to reduce deer numbers until long-term preventive measures become effective. Depredation permits will not be used as a long-term solution to deer damage problems.

b. Depredation management plans will normally be written for a three-year period with progress reviewed annually by the department and the producer.

(1) The plan will become effective when signed by the depredation biologist and the producer.

(2) Plans may be modified or extended if mutually agreed upon by the department and the producer.

(3) Depredation permits will not be issued after the initial term of the management plan if the producer fails to implement preventive measures outlined in the plan.

**106.11(4) Depredation permits.** Two types of permits may be issued under a depredation management plan.

a. Deer depredation licenses. Deer depredation licenses may be sold to resident hunters only for the regular deer license fee for use during one or more legal hunting seasons. Depredation licenses will be available to producers of agricultural and horticultural crops.

(1) Depredation licenses will be issued up to the number specified in the management plan.

(2) The landowner or an eligible family member, which shall include the landowner's spouse or domestic partner and juvenile children, may obtain one depredation license for each season established by the commission. No other individual may initially obtain more than three depredation licenses per management plan. When a deer is reported harvested on one of these licenses, then another license may be obtained.

(3) Depredation licenses will be valid only for hunting antlerless deer, regardless of restrictions that may be imposed on regular deer hunting licenses in that county.

(4) Hunters may keep any deer legally tagged with a depredation license.

(5) All other regulations for the hunting season specified on the license will apply.

(6) Depredation licenses will be valid only on the land where damage is occurring and the immediately adjacent property unless the land is within a designated block hunt area as described in subparagraph (7). Other parcels of land in the farm unit not adjacent to the parcels receiving damage will not qualify.

(7) Block hunt areas are areas designated and delineated by wildlife biologists of the wildlife bureau to facilitate herd reduction in a given area where all producers may not qualify for the depredation program or in areas of persistent deer depredation. Depredation licenses issued to producers within the block hunt area are valid on all properties within the delineated boundaries. Individual landowner permission is required for hunters utilizing depredation licenses within the block hunt area boundaries. Creation of a given block hunt area does not authorize trespass.

*b.* Deer shooting permits. Permits for shooting deer outside an established hunting season may be issued to producers of high-value horticultural crops when damage cannot be controlled in a timely manner during the hunting seasons (such as late summer buck rubs in an orchard and winter browsing in a Christmas tree plantation) and to other agricultural producers who have an approved DNR deer depredation plan, and on areas such as airports where public safety may be an issue.

(1) Deer shooting permits will be issued at no cost to the applicant.

(2) The applicant or one or more designees approved by the department may take all the deer specified on the permit.

(3) Permits available to producers of high-value horticultural crops or agricultural crops may be valid for taking deer outside of a hunting season depending on the nature of the damage. The number and type of deer to be killed will be determined by a department depredation biologist and will be part of the deer depredation management plan.

(4) Permits issued due to public safety concerns may be used for taking any deer, as necessary, to address unpredictable intrusion which could jeopardize public safety. Permits may be issued for an entire year (January 1 through December 31) if the facility involved signs an agreement with the department.

(5) All deer killed must be recovered and processed for human consumption.

(6) The times, dates, place and other restrictions on the shooting of deer will be specified on the permit.

(7) Antlers from all deer recovered must be turned over to the conservation officer within 48 hours. Antlers will be disposed of according to department rules.

(8) For out-of-season shooting permits, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93.

*c.* Depredation licenses and shooting permits will be issued in addition to any other licenses for which the hunters may be eligible.

*d.* Depredation licenses and shooting permits will not be issued if the producer restricts the legal take of deer from the property sustaining damage by limiting hunter numbers below levels required to control the deer herd. This restriction does not apply in situations where shooting permits are issued for public safety concerns.

*e.* A person who receives a depredation permit pursuant to this paragraph shall pay a \$1 fee for each license that shall be used and is appropriated for the purpose of deer herd population management, including assisting with the cost of processing deer donated to the help us stop hunger (HUSH) program administered by the commission and a \$1 writing fee for each license to the license agent.

**106.11(5) Disposal.** Rescinded IAB 7/16/08, effective 8/20/08.  
[ARC 7921B, IAB 7/1/09, effective 8/5/09]

### **571—106.12(481A) Eligibility for free landowner/tenant deer licenses.**

#### **106.12(1) Who qualifies for free deer hunting licenses.**

*a.* Owners and tenants of a farm unit and the spouse and juvenile child of an owner or tenant who reside with the owner or tenant are eligible for free deer licenses. The owner or tenant does not have to reside on the farm unit but must be actively engaged in farming it. Nonresident landowners do not qualify.

*b.* Juvenile child defined. “Juvenile child” means a person less than 18 years of age or a person who is 18 or 19 years of age and is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma or a high school equivalency diploma. A person 18 years of age or older who has received a high school diploma or high school equivalency diploma does not qualify.

**106.12(2) Who qualifies as a tenant.** A “tenant” is a person other than the landowner who is actively engaged in the operation of the farm. The tenant may be a member of the landowner’s family, including in some circumstances the landowner’s spouse or child, or a third party who is not a family member. The tenant does not have to reside on the farm unit.

**106.12(3) What “actively engaged in farming” means.** Landowners and tenants are “actively engaged in farming” if they personally participate in decisions about farm operations and those decisions, along with external factors such as weather and market prices, determine their profit or loss

for the products they produce. Tenants qualify if they farm land owned by another and pay rent in cash or in kind. A farm manager or other third party who operates a farm for a fee or a laborer who works on the farm for a wage and is not a family member does not qualify as a tenant.

**106.12(4)** *Landowners who qualify as active farmers.* These landowners:

- a. Are the sole operator of a farm unit (along with immediate family members), or
- b. Make all decisions about farm operations, but contract for custom farming or hire labor to do some or all of the work, or
- c. Participate annually in decisions about farm operations such as negotiations with federal farm agencies or negotiations about cropping practices on specific fields that are rented to a tenant, or
- d. Raise specialty crops from operations such as orchards, nurseries, or tree farms that do not necessarily produce annual income but require annual operating decisions about maintenance or improvements, or
- e. May have portions of the farm enrolled in a long-term land retirement program such as the Conservation Reserve Program (CRP) as long as other farm operations occur annually, or
- f. Place their entire cropland in the CRP or other long-term land retirement program with no other active farming operation occurring on the farm.

**106.12(5)** *Landowners who do not qualify.* These landowners:

- a. Use a farm manager or other third party to operate the farm, or
- b. Cash rent the entire farm to a tenant who is responsible for all farm operations including following preapproved operations plans.

**106.12(6)** *Where free licenses are valid.* A free license is valid only on that portion of the farm unit that is in a zone open to deer hunting. “Farm unit” means all parcels of land in tracts of two or more contiguous acres that are operated as a unit for agricultural purposes and are under lawful control of the landowner or tenant regardless of how that land is subdivided for business purposes. Individual parcels of land do not need to be adjacent to one another to be included in the farm unit. “Agricultural purposes” includes but is not limited to field crops, livestock, horticultural crops (e.g., from nurseries, orchards, truck farms, or Christmas tree plantations), and land managed for timber production.

**106.12(7)** *Registration of landowners and tenants.* Landowners and tenants and their eligible family members who want to obtain free deer hunting licenses must register with the department before the free licenses will be issued. Procedures for registering are described in 571—95.2(481A).

**571—106.13(481A) Harvest reporting.** Each hunter who bags a deer must report that kill according to procedures described in 571—95.1(481A).

**571—106.14(481A) Extension to the regular gun seasons.** Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.8, 483A.8B, 483A.8C, 483A.24 and 483A.24B.

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†See HJR 5 of 2003 Session of Eightieth General Assembly.



CHAPTER 41  
SAFETY REQUIREMENTS FOR THE USE OF  
RADIATION MACHINES AND CERTAIN USES  
OF RADIOACTIVE MATERIALS

**641—41.1(136C) X-rays in the healing arts.**

**41.1(1) Scope.** This rule establishes requirements, for which a registrant is responsible, for use of X-ray equipment and imaging systems by or under the supervision of an individual authorized by and licensed in accordance with state statutes to engage in the healing arts or veterinary medicine.

*a.* The provisions of Chapter 41 are in addition to, and not in substitution for, any other applicable portions of 641—Chapters 38 to 42.

*b.* All references to any Code of Federal Regulations (CFR) in this chapter are those in effect as of November 5, 2014.

**41.1(2) Definitions.** For the purpose of this chapter, the definitions of 641—Chapters 38 and 40 may also apply. The following are specific to 641—Chapter 41.

“*Accessible surface*” means the external surface of the enclosure or housing of the radiation producing machine as provided by the manufacturer.

“*Added filtration*” means any filtration which is in addition to the inherent filtration.

“*Aluminum equivalent*” means the thickness of type 1100 aluminum alloy affording the same attenuation, under specified conditions, as the material in question.

“*Attenuation block*” means a block or stack, having dimensions 20 centimeters by 20 centimeters by 3.8 centimeters, of type 1100 aluminum alloy or other materials having equivalent attenuation.

“*Automatic exposure control (AEC)*” means a device which automatically controls one or more technique factors in order to obtain at a preselected location(s) a required quantity of radiation (see also “Phototimer”). (Includes devices such as phototimers and ion chambers.)

“*Base density*” means the optical density due to the supporting base of the film alone. The base density of a film is the optical density that would result if an unexposed film were processed through the fixer, wash, and dryer, without first passing through the developer.

“*Base plus fog density*” means the optical density of a film due to its base density plus any action of the developer on the unexposed silver halide crystals. The base plus fog density can be measured by processing an unexposed film through the entire processing cycle and measuring the resultant optical density.

“*Beam monitoring system*” means a system designed to detect and measure the radiation present in the useful beam.

“*C-arm X-ray system*” means an X-ray system in which the image receptor and X-ray tube housing assembly are connected by a common mechanical support system in order to maintain a desired spatial relationship. This system is designed to allow a change in the projection of the beam through the patient without a change in the position of the patient.

“*Cassette*” means a light-tight case, usually made of thin, low X-ray absorption plastic, for holding X-ray film. One or two intensifying screens for the conversion of X-rays to visible light photons are mounted inside the cassette so that they are in close contact to the film.

“*Cephalometric device*” means a device intended for the radiographic visualization and measurement of the dimensions of the human head.

“*Certified components*” means components of X-ray systems which are subject to regulations promulgated under Public Law 90-602, the “Radiation Control for Health and Safety Act of 1968,” the Food and Drug Administration.

“*Certified system*” means any X-ray system which has one or more certified component(s).

“*Coefficient of variation*” or “*C*” means the ratio of the standard deviation to the mean value of a population of observations. It is estimated using the following equation:

$$c = \frac{s}{\bar{x}} = \frac{1}{\bar{x}} \left[ \sum_{i=1}^n \frac{(x_i - \bar{x})^2}{n-1} \right]^{1/2}$$

where:

$\bar{s}$  = Estimated standard deviation of the population.

$\bar{X}$  = Mean value of observations in sample.

$X_i$  =  $i^{\text{th}}$  observation in sample.

$n$  = Number of observations in sample.

“*Computed tomography*” means the production of a tomogram by the acquisition and computer processing of X-ray transmission data.

“*Control chart*” means a chart used to record (and control) the results of quality control testing as a function of time.

“*Control limit*” means the range of variation on a control chart beyond which action must be taken to correct the results of quality control testing.

“*Control panel*” (see X-ray control panel).

“*Cooling curve*” means the graphical relationship between heat units stored and cooling time.

“*CT*” (see “Computed tomography”).

“*Dead-man switch*” means a switch so constructed that a circuit closing contact can be maintained only by continuous pressure on the switch by the operator.

“*Dedicated mammography equipment*” means X-ray systems designed specifically for breast imaging, providing optimum imaging geometry, a device for breast compression and low dose exposure that can generate reproducible images of high quality.

“*Densitometer*” means an instrument which measures the degree of blackening (or radiographic density) of film due to radiation or light by measuring the ratio of the light intensity incident on the film to the light intensity transmitted by the film.

“*Detents*” means mechanical settings that limit or prevent the motion or rotation of an X-ray tube, cassette assembly, or image receptor system.

“*Developer*” means a chemical solution (alkaline) that changes the latent image (exposed silver halide crystals) on a film to a visible image composed of minute masses of black metallic silver.

“*Developer replenishment*” means the process, occurring as film travels past a certain point in the processor, triggering the activation of a pump, whereby fresh developer is added in small amounts to the solution in the developer tank of the processor. The purpose is to maintain the proper alkalinity, chemical activity, and level of solution in the developer tank.

“*Diagnostic mammography*” means mammography performed on an individual who, by virtue of symptoms or physical findings, is considered to have a substantial likelihood of having breast disease.

“*Diagnostic source assembly*” means the tube housing assembly with a beam-limiting device attached.

“*Direct scattered radiation*” means that scattered radiation which has been deviated in direction only by materials irradiated by the useful beam (see “Scattered radiation”).

“*Entrance exposure rate*” means the exposure free in air per unit time at the point where the center of the useful beam enters the patient.

“*Equipment*” (see “X-ray equipment”).

“*Field emission equipment*” means equipment which uses an X-ray tube in which electron emission from the cathode is due solely to the action of an electric field.

“*Filter*” means material placed in the useful beam to preferentially absorb selected radiations.

“*Fixer*” means a chemical solution (acidic) which removes the unexposed and undeveloped silver halide crystals from film so it will not discolor or darken with age or exposure to light. Fixer also hardens the gelatin containing the black metallic silver so film may be dried and resist damage from abrasions.

“*Fixer retention*” means the inadequate removal of fixer from the film by the water in the wash tank of the processor. Retained fixer causes eventual brown discoloration of the radiograph.

“*Fluoroscopic imaging assembly*” means a subsystem in which X-ray photons produce a visual image. It includes the image receptor(s) such as the image intensifier and spot-film device, electrical

interlocks, if any, and structural material providing linkage between the image receptor and diagnostic source assembly.

*“Focal spot (actual)”* means the area projected on the anode of the X-ray tube bombarded by the electrons accelerated from the cathode and from which the useful beam originates.

*“Focal spot size”* means the area of the target or anode that is bombarded by electrons from the cathode of the X-ray tube to produce X-rays. The smaller the focal spot, the better the limited spatial resolution of the X-ray system, especially in magnification mammography.

*“Fog”* means the density added to a radiograph due to unwanted action of the developer on the unexposed silver halide crystals or by light, radiation, chemical, or heat exposure during storage, handling, and processing.

*“General purpose radiographic X-ray system”* means any radiographic X-ray system which, by design, is not limited to radiographic examination of specific anatomical regions.

*“Gonad shield”* means a protective barrier for the testes or ovaries.

*“Healing arts screening”* means the use of radiation on human beings for the detection or evaluation of health indicators for which the individual is considered at high risk when such tests are not specifically and individually ordered by:

1. An individual authorized under 41.1(3)“a”(7), or
2. An individual licensed as a physician in Iowa and listed as an authorized user on an NRC or agreement state radioactive materials license.

*“Heat unit”* means a unit of energy equal to the product of the peak kilovoltage, milliamperes, and seconds, i.e.,  $kVp \times mA \times \text{second}$ .

*“Image contrast”* means the amount of radiographic density difference between adjacent areas resulting from a fixed amount of attenuation difference or light exposure difference.

*“Image intensifier”* means a device, installed in its housing, which instantaneously converts an X-ray pattern into a corresponding light image of higher energy intensity.

*“Image noise”* See “Radiographic noise.”

*“Image quality”* means the overall clarity and detail of a radiographic image. Limiting spatial resolution (or resolving power), image sharpness, and image contrast are three common measures of image quality.

*“Image receptor”* means any device, such as a fluorescent screen or radiographic film, which transforms incident X-ray photons either into a visible image or into another form which can be made into a visible image by further transformations.

*“Image sharpness”* means the overall impression of detail and clarity in a radiographic image.

*“Inherent filtration”* means the filtration of the useful beam provided by the permanently installed components of the tube housing assembly.

*“Kilovolts peak”* (see “Peak tube potential”).

*“kVp”* (see “Peak tube potential”).

*“kWs”* means kilowatt second.

*“Leakage technique factors”* means the technique factors associated with the diagnostic or therapeutic source assembly which are used in measuring leakage radiation. They are defined as follows:

a. For diagnostic source assemblies intended for capacitor energy storage equipment, the maximum-rated peak tube potential and the maximum-rated number of exposures in an hour for operation at the maximum-rated peak tube potential with the quantity of charge per exposure being 10 millicoulombs, i.e., 10 milliamperere seconds, or the minimum obtainable from the unit, whichever is larger.

b. For diagnostic source assemblies intended for field emission equipment rated for pulsed operation, the maximum-rated peak tube potential and the maximum-rated number of X-ray pulses in an hour for operation at the maximum-rated peak tube potential.

c. For all other diagnostic or therapeutic source assemblies, the maximum-rated peak tube potential and the maximum-rated continuous tube current for the maximum-rated peak tube potential.

“*Linear attenuation coefficient*” or “ $\mu$ ” means the quotient of  $dN/N$  divided by  $dl$  when  $dN/N$  is the fraction of uncharged ionizing radiation that experience interactions in traversing a distance  $dl$  in a specified material.

“*Line-voltage regulation*” means the difference between the no-load and the load line potentials expressed as a percent of the load line potential. It is calculated using the following equation:

$$\text{Percent line-voltage regulation} = 100 (V_n - V_l) / V_l$$

where

$V_n$  = No-load line potential and

$V_l$  = Load line potential.

“*mAs*” means milliamperere second.

“*Maximum line current*” means the root-mean-square current in the supply line of an X-ray machine operating at its maximum rating.

“*Mobile X-ray equipment*” (see “X-ray equipment”).

“*PBL*” (see “Positive beam limitation”).

“*Phototimer*” means a method for controlling radiation exposures to image receptors by the amount of radiation which reaches a radiation-monitoring device(s). The radiation-monitoring device(s) is part of an electronic circuit which controls the duration of time the tube is activated (see “Automatic exposure control”).

“*PID*” (see “Position indicating device”).

“*Portable X-ray equipment*” (see “X-ray equipment”).

“*Position indicating device*” means a device on dental X-ray equipment used to indicate the beam position and to establish a definite source-surface (skin) distance. It may or may not incorporate or serve as a beam-limiting device.

“*Positive beam limitation*” means the automatic or semiautomatic adjustment of an X-ray beam to the size of the selected image receptor, whereby exposures cannot be made without such adjustment.

“*Processor*” means an automated device which transports film in a controlled manner by a system of rollers through specialized sections where developing, fixing, washing, and drying of the film occur.

“*Protective apron*” means an apron made of radiation-absorbing materials used to reduce radiation exposure.

“*Protective glove*” means a glove made of radiation-absorbing materials used to reduce radiation exposure.

“*Quality assurance*” means the overall program of testing and maintaining the highest possible standards of quality in the acquisition and interpretation of radiographic images.

“*Quality control*” means the actual process of testing and maintaining the highest possible standards of quality in equipment performance and the acquisition and interpretation of radiographic images.

“*Radiation therapy simulation system*” means a radiographic or fluoroscopic X-ray system intended for localizing the volume to be exposed during radiation therapy and confirming the position and size of the therapeutic irradiation field.

“*Radiograph*” means an image receptor on which the image is created directly or indirectly by an X-ray pattern and results in a permanent record.

“*Radiographic contrast*” means the magnitude of optical density difference between structures of interest and their surroundings, or between areas of film receiving different amount of X-ray or visible light exposure.

“*Radiographic noise*” means unwanted fluctuations in optical density on the screen-film image.

“*Rating*” means the operating limits as specified by the component manufacturer.

“*Recording*” means producing a permanent form of an image resulting from X-ray photons.

“*Repeat (or reject) analysis*” means a systematic approach to determine the causes for radiographs being discarded or repeated, or both.

“*Replenishment rate*” means the amount of chemicals added in order to maintain the proper chemical activity of developer and fixer solutions.

*“Response time”* means the time required for an instrument system to reach 90 percent of its final reading when the radiation-sensitive volume of the instrument system is exposed to a step change in radiation flux from zero sufficient to provide a steady state midscale reading.

*“Safelight”* means a source of minimal visible light in a darkroom, produced at frequencies (colors) to which the film is insensitive, protecting the film from unwanted exposure (fog) while allowing personnel to function more efficiently and safely.

*“Screen”* means microscopic phosphor crystals on a plastic support used in conjunction with either single or double emulsion film; the screen emits visible light when exposed to X-radiation, creating a latent image on X-ray film.

*“Screen-film combination”* means a particular intensifying screen used with a particular type of film. Care must be taken to match the number of screens (one or two) to the number of emulsions coating the film and to match the light output spectrum of the screen to the light sensitivity of the film.

*“Screen-film contact”* means the close proximity of the intensifying screen to the emulsion of the film, necessary in order to achieve a sharp image on the film.

*“Sensitometer”* means a device used to reproducibly expose a piece of film to a number of different levels of light intensity.

*“Sensitometric strip”* means a sheet of film exposed by a sensitometer, resulting in a gray scale range. Such strips are used to measure the range of densities, from minimum to maximum, resulting from a reproducible set of exposures.

*“Sensitometry”* means a quantitative measurement of the response of film to exposure and development. Sensitometry is used to test the processor setup and stability.

*“SID”* (see “Source-image receptor distance”).

*“Source”* means the focal spot of the X-ray tube.

*“Source-image receptor distance”* means the distance from the source to the center of the input surface of the image receptor.

*“Spot check”* means a procedure which is performed to ensure that a previous calibration continues to be valid.

*“Spot film”* means a radiograph which is made during a fluoroscopic examination to permanently record conditions which exist during that fluoroscopic procedure.

*“Spot-film device”* means a device intended to transport or position a radiographic image receptor between the X-ray source and fluoroscopic image receptor. It includes a device intended to hold a cassette over the input end of an image intensifier for the purpose of making a radiograph.

*“Stationary X-ray equipment”* (see “X-ray equipment”).

*“Technique factors”* means the following conditions of operation:

a. For capacitor energy storage equipment, peak tube potential in kV and quantity of charge in mAs;  
b. For field emission equipment rated for pulsed operation, peak tube potential in kV, and number of X-ray pulses;

c. For CT X-ray systems designed for pulsed operation, peak tube potential in kV, scan time in seconds, and either tube current in mA, X-ray pulse width in seconds, and the number of X-ray pulses per scan, or the product of tube current, X-ray pulse width, and the number of X-ray pulses in mAs;

d. For CT X-ray systems not designed for pulsed operation, peak tube potential in kV, and either tube current in mA and scan time in seconds, or the product of tube current and exposure time in mAs and the scan time when the scan time and exposure time are equivalent; and

e. For all other equipment, peak tube potential in kV, and either tube current in mA and exposure time in seconds, or the product of tube current and exposure time in mAs.

*“Tomogram”* means the depiction of the X-ray attenuation properties of a section through the body.

*“Tube rating chart”* means the set of curves which specify the rated limits of operation of the tube in terms of the technique factors.

*“Useful beam”* means the radiation emanating from the tube housing port or the radiation head and passing through the aperture of the beam-limiting device when the exposure controls are in a mode to cause the system to produce radiation.

*“Variable-aperture beam-limiting device”* means a beam-limiting device which has capacity for stepless adjustment of the X-ray field size at a given SID.

*“Viewbox”* means a device by which a uniform field of white light is transmitted through an X-ray so that the image on the film may be seen.

*“Visible area”* means that portion of the input surface of the image receptor over which incident X-ray photons are producing a visible image.

*“X-ray control panel”* means a device which controls input power to the X-ray high-voltage generator and the X-ray tube. It includes equipment such as timers, phototimers, automatic brightness stabilizers, and similar devices, which control the technique factors of an X-ray exposure.

*“X-ray equipment”* means an X-ray system, subsystem, or component thereof. Types of X-ray equipment are as follows:

a. *“Mobile X-ray equipment”* means X-ray equipment mounted on a permanent base with wheels or casters for moving while completely assembled.

b. *“Portable X-ray equipment”* means X-ray equipment designed to be hand-carried but used with a tripod or other stabilization mechanism so the operator is not holding the equipment during exposure.

c. *“Stationary X-ray equipment”* means X-ray equipment which is installed in a fixed location.

d. *“Handheld X-ray equipment”* means X-ray equipment designed by the manufacturer to be handheld by the operator during the exposure. X-ray equipment designed without a backscatter shield is prohibited.

*“X-ray exposure control”* means a device, switch, button or similar means by which an operator initiates or terminates the radiation exposure. The X-ray exposure control may include such associated equipment as timers and backup timers.

*“X-ray field”* means that area of the intersection of the useful beam and any one of the set of planes parallel to and including the plane of the image receptor, whose perimeter is the locus of points at which the exposure rate is one-fourth of the maximum in the intersection.

*“X-ray high-voltage generator”* means a device which transforms electrical energy from the potential supplied by the X-ray control to the tube operating potential. The device may also include means for transforming alternating current to direct current, filament transformers for the X-ray tube(s), high-voltage switches, electrical protective devices, and other appropriate elements.

*“X-ray system”* means an assemblage of components for the controlled production of X-rays. It includes minimally an X-ray high-voltage generator, an X-ray control, a tube housing assembly, a beam-limiting device, and the necessary supporting structures. Additional components which function with the system are considered integral parts of the system.

*“X-ray table”* means a patient support device with its patient support structure (tabletop) interposed between the patient and the image receptor during radiography or fluoroscopy. This includes, but is not limited to, any stretcher equipped with a radiolucent panel and any table equipped with a cassette tray (or bucky), cassette tunnel, image intensifier, or spot-film device beneath the tabletop.

**41.1(3) Administrative controls.**

a. Registrant. The registrant shall be responsible for maintaining and directing the operation of the X-ray system(s) under the registrant’s administrative control, for ensuring that the requirements of these rules are met in the operation of the X-ray system(s), and for having the following minimum tests performed by a registered service facility according to the following schedule:

1. Medical/chiropractic: timer accuracy, exposure reproducibility, kVp accuracy as set forth in 41.1(6), and light field/X-ray field alignment as set forth in 41.1(6) every two years.

2. Dental/podiatry: timer accuracy, exposure reproducibility and kVp accuracy as set forth in 41.1(7) every four years.

3. Fluoroscopic: entrance exposure rate (41.1(5) “c”), and minimum SSD (41.1(5) “f”) annually.

4. Veterinary systems are exempt from the above testing requirements.

All service and installation shall be performed by persons registered under 641—subrule 39.3(3). The registrant or the registrant’s agent shall ensure that the requirements of these rules are met in the operation of the X-ray system(s).

(1) An X-ray system which does not meet the provisions of these rules shall not be operated for diagnostic or therapeutic purposes unless so directed by the agency. All position locking, holding, and centering devices on X-ray system components and systems shall function as intended. All X-ray systems shall be maintained in good mechanical repair and comply with all state and local electrical code requirements.

(2) Individuals who will be operating the X-ray systems shall be adequately instructed in safe operating procedures and be competent in the safe use of the equipment. In addition:

1. Operators in medical facilities shall meet the requirements of 641—Chapter 42, as applicable, and shall make the permit available at the individual's place of employment. If the permit holder works at more than one facility, a duplicate of the permit shall be kept at each facility.

(3) A chart shall be provided in the vicinity of the diagnostic X-ray system's control panel which specifies, for all examinations performed with that system, the following information:

1. Patient's body part and anatomical size, or body part thickness, or age (for pediatrics), versus technique factors to be utilized unless automatically set by the X-ray system;

2. Type and size of the film or film-screen combination to be used;

3. Type and focal distance of the grid to be used, if any;

4. Source to image receptor distance to be used, except for dental intraoral radiography; and

5. Type and location of placement of human patient shielding to be used (e.g., gonad).

(4) Written safety procedures shall be provided to each individual operating X-ray equipment, including patient holding and any restrictions of the operating technique required for the safe operation of the particular X-ray system. The operator shall be able to demonstrate familiarity with these procedures.

(5) Except for patients who cannot be moved out of the room, only the staff and ancillary personnel required for the medical procedure or training shall be in the room during the radiographic exposure. Other than the patient being examined:

1. All individuals shall be positioned such that no part of the body will be struck by the useful beam unless protected by 0.5 millimeter lead equivalent.

2. The X-ray operator, other staff, ancillary personnel, and other persons required for the medical procedure shall be protected from the scattered primary radiation by protective aprons or whole body protective barriers of not less than 0.25 millimeter lead equivalent.

3. Human patients who cannot be removed from the room shall be protected from the direct scatter radiation by whole body protective barriers of 0.25 millimeter lead equivalent or shall be so positioned that the nearest portion of the body is at least 2 meters from both the tube head and the nearest edge of the image receptor.

(6) Gonad shielding of not less than 0.50 millimeter lead equivalent shall be used for human patients, who have not passed the reproductive age, during radiographic procedures in which the gonads are in the useful beam, except for cases in which this would interfere with the diagnostic procedure.

(7) Individuals shall not be exposed to the useful beam unless (1) the radiation exposure occurs in the context of a previously established professional relationship between a licensed practitioner of the healing arts or a licensed registered nurse who is registered as an advanced registered nurse practitioner pursuant to Iowa Code chapter 152 and a patient, which includes a physical examination by the practitioner of the patient unless such examination is not clinically indicated; and (2) such practitioner issues a written order for the radiation exposure. The written order shall be issued prior to the exposure unless the exposure results from care provided in an emergency or surgery setting. A verbal order may be issued provided the licensed practitioner is supervising the procedure and the order is documented in the patient's record after the procedure is completed. This provision specifically prohibits deliberate exposure for the following purposes:

1. Exposure of an individual for training, demonstration, or other non-healing arts purposes; and

2. Exposure of an individual for the purpose of healing arts screening except as authorized by 41.1(3) "a"(11).

(8) When a patient or film must be provided with auxiliary support during a radiation exposure:

1. Mechanical holding devices shall be used when the technique permits. The written safety procedures, required by 41.1(3)“a”(4), shall list individual projections where holding devices cannot be utilized;

2. Written safety procedures, as required by 41.1(3)“a”(4), shall indicate the requirements for selecting a holder and the procedure the holder shall follow;

3. The human holder shall be instructed in personal radiation safety and protected as required by 41.1(3)“a”(5)“2”;

4. No individual shall be used routinely to hold film or patients; and

5. In those cases where the human patient must hold the film, except during intraoral examinations, any portion of the body other than the area of clinical interest struck by the useful beam shall be protected by not less than 0.5 millimeter lead equivalent material.

6. Each facility shall have leaded aprons and gloves available in sufficient numbers to provide protection to all personnel who are involved with X-ray operations and who are otherwise not shielded.

(9) Procedures and auxiliary equipment designed to minimize patient and personnel exposure commensurate with the needed diagnostic information shall be utilized.

1. The speed of film or screen and film combinations shall be the fastest speed consistent with the diagnostic objective of the examinations. Film cassettes without intensifying screens shall not be used for any routine diagnostic radiological imaging, with the exception of veterinary radiography and standard film packets for intraoral use in dental radiography.

2. The radiation exposure to the patient shall be the minimum exposure required to produce images of good diagnostic quality.

3. Portable or mobile X-ray equipment shall be used only for examinations, excluding intraoral dental imaging, where it is impractical to transfer the patient(s) to a stationary X-ray installation. Handheld mobile X-ray equipment may be used for routine intraoral dental imaging in place of stationary equipment. Handheld X-ray equipment shall be used only for intraoral dental radiography.

4. X-ray systems subject to 41.1(6) shall not be utilized in procedures where the source to human patient distance is less than 30 centimeters.

5. If grids are used between the patient and the image receptor to decrease scatter to the film and improve contrast, the grid shall:

- Be positioned properly, i.e., tube side facing the correct direction, and the grid centered to the central ray;
- If the grid is of the focused type, be at the proper focal distance for the SIDs being used.

(10) All individuals who are associated with the operation of an X-ray system are subject to the requirements of 641—subrule 40.36(4) and rules 641—40.15(136C) and 641—40.37(136C). In addition:

1. When protective clothing or devices are worn on portions of the body and a personnel monitoring device(s) is present, it (they) shall be worn in accordance with the recommendations found in Chapter 4 of the National Council of Radiation Protection and Measurements Report No. 57.

2. Exposure of a personnel monitoring device to deceptively indicate a dose delivered to an individual is prohibited.

(11) Healing arts screening. Any person proposing to conduct a healing arts screening program shall not initiate such a program in the state of Iowa without prior written approval of the agency. When requesting such approval, that person shall submit the information outlined in Appendix C of this chapter. The agency shall not approve a healing arts screening program unless the applicant submits data supporting the efficacy of the screening test in diagnosing the disease or condition being screened. If any information submitted to the agency becomes invalid or outdated, the applicant shall notify the agency in writing within five calendar days.

(12) Rescinded IAB 3/31/04, effective 5/5/04.

*b.* Information and maintenance record and associated information. Records in 41.1(3)“b”(1) and (3) below shall be maintained until the X-ray system is removed from the facility. There shall be two cycles of records on file for items in 41.1(3)“b”(2) below. The registrant shall maintain the following information for each X-ray system for inspection by the agency:

- (1) User’s manual for the X-ray system;

(2) Records of surveys, calibrations, maintenance, and modifications performed on the X-ray system(s) with the names of persons who performed such services;

(3) A copy of all correspondence with this agency regarding that X-ray system.

c. X-ray utilization log. Except for veterinary facilities, each facility shall maintain an X-ray log containing the patient's name, the type of examinations, the dates the examinations were performed, the name of the individual performing the X-ray procedure, and the number of exposures and retakes involved. When the patient or film must be provided with human auxiliary support, the name of the human holder shall be recorded. These records shall be kept until the facility is inspected by this agency or until all films listed on the utilization log have been purged.

d. Plan review.

(1) Prior to construction of all new installations, or modifications of existing installations, or installation of equipment into existing facilities utilizing X-rays for diagnostic or therapeutic purposes, the floor plans and equipment arrangements shall be submitted to the agency for review and verification that national standards have been met. The required information is denoted in Appendices A and B of this chapter.

(2) The agency may require the applicant to utilize the services of a qualified expert to determine the shielding requirements prior to the plan review and approval.

(3) The approval of such plans shall not preclude the requirement of additional modifications should a subsequent analysis of operating conditions indicate the possibility of an individual receiving a dose in excess of the limits prescribed in 641—Chapter 40.

e. Federal performance standards. All X-ray equipment shall comply with the applicable performance standards of 21 CFR 1020.30 to 1020.40 which were in effect at the time the unit was manufactured. All equipment manufactured before the effective date of 21 CFR 1020.30 to 1020.40 shall meet the requirements of the Iowa rules. Persons registered to possess the affected radiation-emitting equipment in Iowa shall be responsible for maintaining the equipment in compliance with the appropriate federal performance standards.

f. X-ray film processing facilities and practices (except for mammography). Each installation using a radiographic X-ray system and using analog image receptors (e.g., radiographic film) shall have available suitable equipment for handling and processing radiographic film in accordance with the following provisions:

(1) Manually developed film.

1. Processing tanks shall be constructed of mechanically rigid, corrosion-resistant material; and

2. Film shall be processed in accordance with the time-temperature relationships recommended by the film developer manufacturer. The specified developer temperature and immersion time shall be posted in the darkroom. Deviations from the manufacturer's recommendations shall be in writing and on file at the facility. Documentation shall include justification for the deviation.

3. Devices shall be utilized which will indicate the actual temperature of the developer and signal the passage of a preset time appropriate to the developing time required.

(2) Automatic processors and other closed processing systems.

1. Film shall be processed in accordance with the time-temperature relationships recommended by the film developer manufacturer.

2. Processing deviations from the requirements of 41.1(3)“f” shall be documented by the registrant in such manner that the requirements are shown to be met or exceeded (e.g., extended processing and special rapid chemistry).

3. All processing equipment shall be in good mechanical working order.

(3) Other requirements.

1. Pass boxes, if provided, shall be so constructed as to exclude light from the darkroom when cassettes are placed in or removed from the boxes, and shall incorporate adequate shielding from stray radiation to prevent exposure of undeveloped film.

2. The darkroom shall be light tight and use proper safelighting such that any film type in use exposed in a cassette to X-radiation sufficient to produce an optical density from 1 to 2 when processed shall not suffer an increase in density greater than 0.1 when exposed out of the cassette in the darkroom

for 2 minutes with all safelights on. If used, daylight film handling boxes shall preclude fogging of the film.

3. Darkrooms typically used by more than one individual shall be provided a method to prevent accidental entry while undeveloped films are being handled or processed.

4. Film shall be stored in a cool, dry place and shall be protected from exposure to stray radiation. Film in open packages shall be stored in a light tight container.

5. Film cassettes and intensifying screens shall be inspected periodically and shall be cleaned and replaced as necessary to best ensure radiographs of good diagnostic quality.

6. Outdated X-ray film shall not be used for diagnostic radiographs, unless the film has been stored in accordance with the manufacturer's recommendations and a sample of the film passes a sensitometric test for normal ranges of base plus fog and speed.

7. Film developing solutions shall be prepared in accordance with the directions given by the manufacturer and shall be maintained in strength by replenishment or renewal so that full development is accomplished within the time specified by the manufacturer.

(4) Records shall be maintained to verify that the items in 41.1(3) "f" are performed according to the requirements. Records may be discarded only after an agency inspection has been completed and the facility determined to be in compliance.

g. Retention of films. Record retention of films shall be seven years for patients 18 years of age or older and seven years plus the difference between the patient's age and 18 for minors.

(1) If the facility is currently utilizing hard-copy film to store images, it may continue to use this method throughout the retention period.

(2) If the facility is currently utilizing computer media and also storing images in a hard-copy format, it may continue to use this method of retention throughout the retention period. If the images are also on computer media, the data should be backed up, or refreshed, at appropriate intervals as defined by the facility.

(3) If the facility is solely utilizing computer media to store study information for which a report is generated, the recording media is to be stored in conditions that will ensure that deterioration will not occur for the period required by this policy. The facility must maintain either retrieval or access or both to the stored images.

(4) If a patient's medical images are identified as being involved in a legal case, the records should immediately be coded appropriately, and maintained for the required time frame defined in this paragraph. At the time the records have reached the end of the appropriate time frame for retention, the previously identified responsible individuals involved in the legal action should be contacted for further instruction.

(5) If records are temporarily transferred to any party, appropriate information relating to location, date of release, and individual having custody of the records should be maintained.

(6) A facility that is ceasing operations must either transfer its film records to another facility or provide the film records to its patients. A certified letter as to the location, or disposition, of the film records must be sent to notify the patients of the transferal.

**41.1(4) General requirements for all diagnostic X-ray systems.** In addition to other requirements of this chapter, all diagnostic X-ray systems shall meet the following requirements:

a. Warning label. The control panel containing the main power switch shall bear the warning statement, legible and accessible to view: "WARNING: This X-ray unit may be dangerous to patient and operator unless safe exposure factors and operating instructions are observed."

b. Battery charge indicator. On battery-powered X-ray generators, visual means shall be provided on the control panel to indicate whether the battery is in a state of charge adequate for proper operation.

c. Leakage radiation from the diagnostic source assembly. The leakage radiation from the diagnostic source assembly measured at a distance of 1 meter in any direction from the source shall not exceed 100 milliroentgens (25.8  $\mu\text{C}/\text{kg}$ ) in one hour when the X-ray tube is operated at its leakage technique factors. Compliance shall be determined by measurements averaged over an area of 100 square centimeters with no linear dimension greater than 20 centimeters.

*d.* Radiation from components other than the diagnostic source assembly. The radiation emitted by a component other than the diagnostic source assembly shall not exceed 2 milliroentgens (0.516  $\mu\text{C}/\text{kg}$ ) in one hour at 5 centimeters from any accessible surface of the component when it is operated in an assembled X-ray system under any conditions for which it was designed. Compliance shall be determined by measurements averaged over an area of 100 square centimeters with no linear dimension greater than 20 centimeters.

*e.* Beam quality.

(1) Half-value layer.

1. The half-value layer of the useful beam for a given X-ray tube potential shall not be less than the values shown in Table I. If it is necessary to determine such half-value layer at an X-ray tube potential which is not listed in Table I, linear interpolation or extrapolation may be made.

Table I

Design operating range (kVp)	Measured potential (kVp)	Half-value layer (mm of aluminum)
Below 50 . . . . .	30	0.3
	40	0.4
	49	0.5
50 to 70 . . . . .	50	1.2
	60	1.3
	70	1.5
Above 70 . . . . .	71	2.1
	80	2.3
	90	2.5
	100	2.7
	110	3.0
	120	3.2
	130	3.5
	140	3.8
	150	4.1

2. and 3. Rescinded IAB 4/8/98, effective 7/1/98.

4. For capacitor energy storage equipment, compliance with the requirements of 41.1(4)“e” shall be determined with the system fully charged and a setting of 10 mAs for each exposure.

5. The required minimal half-value layer of the useful beam shall include the filtration contributed by all materials which are permanently between the source and the patient.

(2) Filtration controls. For X-ray systems which have variable kVp and variable filtration for the useful beam, a device shall link the kVp selector with the filter(s) and shall prevent an exposure unless the minimum amount of filtration required by 41.1(4)“e”(1)“1” is in the useful beam for the given kVp which has been selected.

*f.* Multiple tubes. Where two or more radiographic tubes are controlled by one exposure switch, the tube or tubes which have been selected shall be clearly indicated prior to initiation of the exposure. This indication shall be both on the X-ray control panel and at or near the tube housing assembly which has been selected.

g. Mechanical support of tube head. The tube housing assembly supports shall be adjusted such that the tube housing assembly will remain stable during an exposure unless tube housing movement is a designed function of the X-ray system.

h. Technique indicators.

(1) The technique factors to be used during an exposure shall be indicated before the exposure begins. If automatic exposure controls are used, the technique factors which are set prior to the exposure shall be indicated.

(2) The requirement of 41.1(4)“h”(1) may be met by permanent markings on equipment having fixed technique factors. Indication of technique factors shall be visible from the operator’s position except in the case of spot films made by the fluoroscopist.

(3) The technique indicators shall be accurate to within manufacturer’s standards.

i. Rescinded IAB 3/30/05, effective 5/4/05.

**41.1(5) Fluoroscopic X-ray systems except for computed tomography X-ray systems.** All fluoroscopic X-ray systems shall be image intensified and meet the following requirements:

a. Limitation of useful beam.

(1) Primary barrier.

1. The fluoroscopic imaging assembly shall be provided with a primary protective barrier which intercepts the entire cross section of the useful beam at any SID.

2. The X-ray tube used for fluoroscopy shall not produce X-rays unless the barrier is in position to intercept the entire useful beam.

(2) Fluoroscopic beam limitation.

1. For certified fluoroscopic systems with or without a spot film device, neither the length nor the width of the X-ray field in the plane of the image receptor shall exceed that of the visible area of the image receptor by more than 3 percent of the SID. The sum of the excess length and the excess width shall be no greater than 4 percent of the SID.

2. For uncertified fluoroscopic systems with a spot film device, the X-ray beam with the shutter fully opened (during fluoroscopy or spot filming) shall be no larger than the largest spot film size for which the device is designed. Measurements shall be made at the maximum SID available but at no less than 20 centimeters from the tabletop to the film plane distance.

3. For uncertified fluoroscopic systems without a spot film device, the requirements of 41.1(5)“a”(2)“1” apply.

4. Other requirements for fluoroscopic beam limitation:

- Means shall be provided to permit further limitation of the field. Beam-limiting devices manufactured after May 22, 1979, and incorporated in equipment with a variable SID or a visible area of greater than 300 square centimeters shall be provided with means for stepless adjustment of the X-ray field;

- All equipment with a fixed SID and a visible area of 300 square centimeters or less shall be provided either with stepless adjustment of the X-ray field or with means to further limit the X-ray field size at the plane of the image receptor to 125 square centimeters or less;

- If provided, stepless adjustment shall, at the greatest SID, provide continuous field sizes from the maximum attainable to a field size of 5 centimeters by 5 centimeters or less;

- For equipment manufactured after February 25, 1978, when the angle between the image receptor and beam axis is variable, means shall be provided to indicate when the axis of the X-ray beam is perpendicular to the plane of the image receptor;

- For noncircular X-ray fields used with circular image receptors, the error in alignment shall be determined along the length and width dimensions of the X-ray field which pass through the center of the visible area of the image receptor.

(3) Spot-film beam limitation. Spot-film devices shall meet the following requirements:

1. Means shall be provided between the source and the patient for adjustment of the X-ray field size in the plane of the film to the size of that portion of the film which has been selected on the spot-film selector. Such adjustment shall be automatically accomplished except when the X-ray field size in the plane of the film is smaller than that of the selected portion of the film. For spot-film devices

manufactured after June 21, 1979, if the X-ray field size is less than the size of the selected portion of the film, the means for adjustment of the field size shall be only at the operator's option;

2. Neither the length nor the width of the X-ray field in the plane of the image receptor shall differ from the corresponding dimensions of the selected portion of the image receptor by more than 3 percent of the SID when adjusted for full coverage of the selected portion of the image receptor. The sum, without regard to sign, of the length and width differences shall not exceed 4 percent of the SID;

3. It shall be possible to adjust the X-ray field size in the plane of the film to a size smaller than the selected portion of the film. The minimum field size at the greatest SID shall be equal to, or less than, 5 centimeters by 5 centimeters;

4. The center of the X-ray field in the plane of the film shall be aligned with the center of the selected portion of the film to within 2 percent of the SID; and

5. On spot-film devices manufactured after February 25, 1978, if the angle between the plane of the image receptor and beam axis is variable, means shall be provided to indicate when the axis of the X-ray beam is perpendicular to the plane of the image receptor, and compliance shall be determined with the beam axis indicated to be perpendicular to the plane of the image receptor.

(4) Override. If a means exists to override any of the automatic X-ray field size adjustments required in 41.1(5) "a"(2) and 41.1(5) "a"(3), that means:

1. Shall be designed for use only in the event of system failure;
2. Shall incorporate a signal visible at the fluoroscopist's position which will indicate whenever the automatic field size adjustment is overridden; and
3. Shall have a clear and durable label as follows:

#### FOR X-RAY FIELD LIMITATION SYSTEM FAILURE

b. Activation of the fluoroscopic tube. X-ray production in the fluoroscopic mode shall be controlled by a device which requires continuous pressure by the fluoroscopist for the entire time of any exposure. When recording serial fluoroscopic images, the fluoroscopist shall be able to terminate the X-ray exposure(s) at any time, but means may be provided to permit completion of any single exposure of the series in process.

c. Exposure rate limits.

(1) Entrance exposure rate allowable limits.

1. Fluoroscopic equipment which is provided with automatic exposure rate control shall not be operable at any combination of tube potential and current which will result in an exposure rate in excess of 2.6 mC/kg (10 roentgens) per minute at the point where the center of the useful beam enters the patient, except

- During recording of fluoroscopic images; or
- When an optional high level control is provided. When so provided, the equipment shall not be operable at any combination of tube potential and current which will result in an exposure rate in excess of 5 roentgens (1.3 mC/kg) per minute at the point where the center of the useful beam enters the patient unless the high level control is activated. Special means of activation of high level controls shall be required. The high level control shall only be operable when continuous manual activation is provided by the operator. A continuous signal audible to the fluoroscopist shall indicate that the high level control is being employed.

2. Fluoroscopic equipment which is not provided with automatic exposure rate control shall not be operable at any combination of tube potential and current which will result in an exposure rate in excess of 5 roentgens (1.3 mC/kg) per minute at the point where the center of the useful beam enters the patient, except:

- During recording of fluoroscopic images; or
- When the mode or modes have an optional high level control, in which case the mode or modes shall not be operable at any combination of tube potential and current which shall result in an exposure rate in excess of 5 roentgens (1.3 mC/kg) per minute at the point where the center of the useful beam enters the patient, unless the high level control is activated. Special means of activation of high level controls

shall be required. The high level control shall only be operable when continuous manual activation is provided by the operator. A continuous signal audible to the fluoroscopist shall indicate that the high level control is being employed.

3. Compliance with the requirements of 41.1(5)“c” shall be determined as follows:

- If the source is below the table, exposure rate shall be measured 1 centimeter above the tabletop or cradle;

- If the source is above the table, the exposure rate shall be measured at 30 centimeters above the tabletop with the end of the beam-limiting device or spacer positioned as closely as possible to the point of measurement;

- All C-arm fluoroscopes, both stationary and mobile, shall meet the entrance exposure rate limits at 30 centimeters from the input surface of the fluoroscopic imaging assembly with the source positioned at any available SID provided that the end of the spacer assembly or beam-limiting device is not closer than 30 centimeters from the input surface of the fluoroscopic imaging assembly.

- For a lateral type fluoroscope, the exposure rate shall be measured at a point 15 centimeters from the centerline of the X-ray table and in the direction of the X-ray source with the end of the beam-limiting device or spacer positioned as closely as possible to the point of measurement. If the tabletop is movable, it shall be positioned as closely as possible to the lateral X-ray source, with the end of the beam-limiting device or spacer no closer than 15 centimeters to the centerline of the X-ray table.

4. Fluoroscopic equipment which is provided with both automatic exposure rate control mode and a manual mode shall not be operable at any combination of tube potential and current which shall result in an exposure rate in excess of 10 roentgens (2.6 mC/kg) per minute in either mode at the point where the center of the useful beam enters the patient, except:

- During recording of fluoroscopic images; or

- When the mode or modes have an optional high level control, in which case the mode or modes shall not be operable at any combination of tube potential and current which shall result in an exposure rate in excess of 5 roentgens (1.3 mC/kg) per minute at the point where the center of the useful beam enters the patient, unless the high level control is activated. Special means of activation of high level controls shall be required. The high level control shall only be operable when continuous manual activation is provided by the operator. A continuous signal audible to the fluoroscopist shall indicate that the high level control is being employed.

5. Any fluoroscopic equipment manufactured after May 19, 1995, which can exceed 5 roentgens (1.3 mC/kg) per minute shall be equipped with an automatic exposure rate control. All entrance exposure rate limits shall be 10 roentgens (2.6 mC/kg) per minute with an upper limit of 20 roentgens (5.2 mC/kg) per minute when the high level control is activated.

6. Conditions of periodic measurement of maximum entrance exposure rate are as follows:

- The measurement shall be made under the conditions that satisfy the requirements of 41.1(5)“c”(1)“3”;

- The kVp, mA, or other selectable parameters shall be adjusted to those settings which give the maximum entrance exposure rate;

- The X-ray system(s) that incorporates automatic exposure rate control shall have sufficient attenuative material placed in the useful beam to produce either a milliamperage or kilovoltage or both to satisfy the conditions of 41.1(5)“c”(1)“3.”

(2) Reserved.

d. Barrier transmitted radiation rate limits.

(1) The exposure rate due to transmission through the primary protective barrier with the attenuation block in the useful beam, combined with radiation from the image intensifier, if provided, shall not exceed 2 milliroentgens (0.516  $\mu$ C/kg) per hour at 10 centimeters from any accessible surface of the fluoroscopic imaging assembly beyond the plane of the image receptor for each roentgen per minute of entrance exposure rate.

(2) Measuring compliance of barrier transmission.

1. The exposure rate due to transmission through the primary protective barrier combined with radiation from the image intensifier shall be determined by measurements averaged over an area of 100 square centimeters with no linear dimension greater than 20 centimeters.

2. If the source is below the tabletop, the measurement shall be made with the input surface of the fluoroscopic imaging assembly positioned 30 centimeters above the tabletop.

3. If the source is above the tabletop and the SID is variable, the measurement shall be made with the end of the beam-limiting device or spacer as close to the tabletop as it can be placed, provided that it shall not be closer than 30 centimeters.

4. Movable grids and compression devices shall be removed from the useful beam during the measurement.

*e.* Indication of potential and current. During fluoroscopy and cinefluorography the kV and the mA shall be continuously indicated.

*f.* Source-to-skin distance. The SSD shall not be less than:

(1) 38 centimeters on stationary fluoroscopes installed on or after August 1, 1974,

(2) 35.5 centimeters on stationary fluoroscopes which were in operation prior to August 1, 1974,

(3) 30 centimeters on all mobile fluoroscopes, and

(4) 20 centimeters for mobile fluoroscopes used for specific surgical application.

(5) The written safety procedures must provide precautionary measures to be adhered to during the use of this device in addition to the procedures provided in 41.1(3)“a”(4).

*g.* Fluoroscopic timer.

(1) Means shall be provided to preset the cumulative on-time of the fluoroscopic X-ray tube. The maximum cumulative time of the timing device shall not exceed five minutes without resetting.

(2) A signal audible to the fluoroscopist shall indicate the completion of any preset cumulative on-time. Such signal shall continue to sound while X-rays are produced until the timing device is reset.

*h.* Control of scattered radiation.

(1) Fluoroscopic table designs when combined with procedures utilized shall be such that no unprotected part of any staff or ancillary individual's body shall be exposed to unattenuated scattered radiation which originates from under the table. The attenuation required shall be not less than 0.25 millimeter lead equivalent.

(2) Equipment configuration when combined with procedures shall be such that no portion of any staff or ancillary individual's body, except the extremities, shall be exposed to the unattenuated scattered radiation emanating from above the tabletop unless that individual:

1. Is at least 120 centimeters from the center of the useful beam, or

2. The radiation has passed through not less than 0.25 millimeter lead equivalent material including, but not limited to, drapes, Bucky-slot cover panel, or self-supporting curtains, in addition to any lead equivalency provided by the protective apron referred to in 41.1(3)“a”(5).

(3) The agency may grant exemptions to 41.1(5)“h”(2) where a sterile field will not permit the use of the normal protective barriers. Where the use of prefitted sterilized covers for the barriers is practical, the agency shall not permit such exemption.

*i.* Spot-film exposure reproducibility. Fluoroscopic systems equipped with spot-film (radiographic) mode shall meet the exposure reproducibility requirements of 41.1(6)“d” when operating in the spot-film mode.

*j.* Radiation therapy simulation systems. Radiation therapy simulation systems shall be exempt from all the requirements of 41.1(5)“a,” “c,” “d,” and “g” provided that:

(1) Such systems are designed and used in such a manner that no individual other than the patient is in the X-ray room during periods of time when the system is producing X-rays; and

(2) Systems which do not meet the requirements of 41.1(5)“g” are provided with a means of indicating the cumulative time that an individual patient has been exposed to X-rays. Procedures shall require in such cases that the timer be reset between examinations.

*k.* Dose-area-product monitor requirements.

(1) All fluoroscopic equipment installed after July 1, 2002, and used for special procedures (e.g., pacemaker implantation, diagnostic cardiac procedures (catheterization), and therapeutic cardiac

procedures (angioplasty-balloon; stent; directional coronary atherectomy; rotational atherectomy; laser atherectomy; radio frequency ablation; and intravascular brachytherapy)) shall be equipped with a dose-area-product monitor capable of recording the total radiation dose received by a patient when the fluoroscopic tube is used. Equipment used and installed prior to July 1, 2002, shall be retrofitted with the radiation exposure device by January 1, 2004.

(2) Each facility using fluoroscopic equipment for special procedures shall include in the patient's chart and in a log for agency review the patient radiation exposure received per procedure. Adult doses that exceed 300 rad and doses for children (under the age of 18) that exceed 100 rad must be reviewed by the facility's radiation safety committee. The review must document the reason why a dose exceeded 300 rad for adults or 100 rad for children, and the reason must be documented in the committee's minutes. If a facility does not have a radiation safety committee, the facility must provide the agency, within 30 days of the event, documentation stating why the patient's dose exceeded 300 rad for adults or 100 rad for children. Also, if the patient doses noted above are exceeded, the patient's physician must do a follow-up examination of the patient to determine if there is any evidence of dose recorded reaction and to ensure that proper treatment is rendered.

(3) All fluoroscopic radiation detection devices in this subrule shall be calibrated annually or after repair or replacement.

*l. Equipment operation.*

(1) All imaging formed by the use of fluoroscopic X-ray systems shall be directly viewed and interpreted by a licensed practitioner of the healing arts.

(2) Overhead fluoroscopy shall not be used as a positioning tool for general purpose radiographic examinations.

(3) Facilities that use fluoroscopic X-ray systems shall maintain a record of cumulative fluoroscopic exposure time used and the number of spot films for each examination. This record shall indicate patient identification, type of examination, date of examination, and operator's name.

*m. Additional requirements for stationary fluoroscopic systems used for cardiac catheterization procedures.*

(1) Protective barriers shall be available for use by individuals whose presence is required in the room during activation of the X-ray tube(s). If a protective barrier includes or consists of a transparent viewing panel, the viewing panel shall afford protection of not less than 0.5 millimeter of lead equivalent.

(2) Protective aprons of not less than 0.25 millimeter of lead equivalent shall be worn in the fluoroscopy room by all individuals (except the patient). Any individual required to be in the room for short periods of time may not be required to wear a protective apron if exposure levels below minimum as seen on film badge reports can be verified. Individuals not using protective aprons should follow ALARA by using time and distance to reduce exposure. Any declared pregnant individual must meet the requirements of 641—40.22(136C).

*n. Supervision of fluoroscopy.* The use of fluoroscopy by radiologic technologists and radiologic students shall be performed under the direct supervision of a licensed practitioner or an advanced registered nurse practitioner (ARNP), pursuant to 655—subrule 7.2(2), for the purpose of localization to obtain images for diagnostic or therapeutic purposes. The use of fluoroscopy by radiologist assistants shall be as defined in 641—42.6(136C).

**41.1(6)** *Radiographic systems other than fluoroscopic, dental intraoral, veterinary, or computed tomography X-ray systems.*

*a. Beam limitation.* The useful beam shall be limited to the area of clinical interest. This shall be considered met if a positive beam-limiting device meeting manufacturer's specifications and the requirements of 41.1(6)"h"(2) have been properly used or if evidence of collimation is shown on at least three sides or three corners of the film (for example, projections from the shutters of the collimator, cone cutting at the corners, or borders at the film's edge.)

(1) General purpose stationary and mobile X-ray systems and veterinarian systems (other than portable) installed after July 1, 1998.

1. Only X-ray systems provided with means for independent stepless adjustment of at least two dimensions of the X-ray field shall be used.

2. A method shall be provided for visually defining the perimeter of the X-ray field.
  - Illuminance shall be greater than 7.5 foot-candles or 80.3 LUX at 100 centimeters or maximum SID whichever is less.
  - The total misalignment of the edges of the visually defined field with the respective edges of the X-ray field along either the length or width of the visually defined field shall not exceed 2 percent of the distance from the source to the center of the visually defined field when the surface upon which it appears is perpendicular to the axis of the X-ray beam.
3. The agency may grant an exemption on noncertified X-ray systems to 41.1(6)“a”(1)“1” and “2” provided the registrant makes a written application for such exemption and in that application demonstrates it is impractical to comply with 41.1(6)“a”(1)“1” and “2”; and the purpose of 41.1(6)“a”(1)“1” and “2” will be met by other methods.
  - (2) Additional requirements for stationary general purpose X-ray systems. In addition to the requirements of 41.1(6)“a”(1), stationary general purpose X-ray systems, both certified and noncertified, shall meet the following requirements:
    1. A method shall be provided to indicate when the axis of the X-ray beam is perpendicular to the plane of the image receptor, to align the center of the X-ray field with respect to the center of the image receptor to within 2 percent of the SID, and to indicate the SID to within 2 percent;
    2. The beam-limiting device shall indicate numerically the field size in the plane of the image receptor to which it is adjusted; and
    3. Indication of field size dimensions and SIDs shall be specified in inches or centimeters, and shall be such that aperture adjustments result in X-ray field dimensions in the plane of the image receptor which correspond to those indicated by the beam-limiting device to within 2 percent of the SID when the beam axis is indicated to be perpendicular to the plane of the image receptor.
  - (3) X-ray systems designed for one image receptor size. Radiographic equipment designed for only one image receptor size at a fixed SID shall be provided with means to limit the field at the plane of the image receptor to dimensions no greater than those of the image receptor, and to align the center of the X-ray field with the center of the image receptor to within 2 percent of the SID, or shall be provided with means to both size and align the X-ray field such that the X-ray field at the plane of the image receptor does not extend beyond any edge of the image receptor.
  - (4) Systems designed for or provided with special attachments for mammography. Rescinded IAB 4/8/98, effective 7/1/98.
  - (5) X-ray systems other than those described in 41.1(6)“a”(1), (2), and (3), and veterinary systems installed prior to July 1, 1998, and all portable veterinary X-ray systems.
    1. Means shall be provided to limit the X-ray field in the plane of the image receptor so that such field does not exceed each dimension of the image receptor by more than 2 percent of the SID when the axis of the X-ray beam is perpendicular to the plane of the image receptor.
    2. Means shall be provided to align the center of the X-ray field with the center of the image receptor to within 2 percent of the SID, or means shall be provided to both size and align the X-ray field such that the X-ray field at the plane of the image receptor does not extend beyond any edge of the image receptor. Compliance shall be determined with the axis of the X-ray beam perpendicular to the plane of the image receptor.
    3. 41.1(6)“a”(5)“1” and “2” may be met with a system that meets the requirements for a general purpose X-ray system as specified in 41.1(6)“a”(1) or, when alignment means are also provided, may be met with either:
      - An assortment of removable, fixed-aperture, beam-limiting devices sufficient to meet the requirement for each combination of image receptor size and SID for which the unit is designed with each such device having clear and permanent markings to indicate the image receptor size and SID for which it is designed; or
      - A beam-limiting device having multiple fixed apertures sufficient to meet the requirement for each combination of image receptor size and SID for which the unit is designed. Permanent, clearly legible markings shall indicate the image receptor size and SID for which each aperture is designed and shall indicate which aperture is in position for use.

*b.* Radiation exposure control devices.

(1) Timers.

1. Means shall be provided to initiate the radiation exposure by a deliberate action on the part of the operator, such as the depression of a switch. Radiation exposure shall not be initiated without such an action.

2. Means shall be provided to terminate the exposure at a preset time interval, preset product of current and time, a preset number of pulses, or a preset radiation exposure to the image receptor. In addition, it shall not be possible to make an exposure when the timer is set to a "zero" or "off" position if either position is provided. Except for dental panoramic systems, termination of an exposure shall cause automatic resetting of the timer to its initial setting or to "zero."

(2) X-ray control.

1. Manual exposure control. An X-ray control shall be incorporated into each X-ray system such that an exposure can be terminated by the operator at any time except for exposure of one-half second or less, or during serial radiography when means shall be provided to permit completion of any single exposure of the series in process.

2. Each X-ray control shall be located in such a way as to meet the following requirements: Stationary X-ray systems (except podiatry and veterinary units) shall be required to have the X-ray exposure switch permanently mounted in a protected area so that the operator is required to remain in that protected area during the entire exposure and so that the operator can view the patient while making any exposures; and mobile and portable X-ray systems which are:

- Used for greater than one week in the same location, i.e., a room or suite, shall meet the requirements of 41.1(6) "b"(2)"2"; or

- Used for greater than one hour and less than one week at the same location, i.e., a room or suite, or in a clinical setting for routine extremities only, or where moving the X-ray system from room to room is impractical, shall meet the requirement of the above paragraph or be provided with a 6.5 foot (1.98 m) high protective barrier which is placed at least 2.7 meters (9 feet) from the tube housing assembly. Written procedures must instruct the operator to remain in the protected area during the entire exposure. Stationary podiatric systems which do not meet the above requirements shall be provided with a 9-foot exposure button cord which allows the operator to remain behind a protective barrier during the entire exposure. If the protective barrier is moveable, written procedures must be on file at the facility, which dictate that the operator will remain behind the barrier during the entire exposure.

3. The X-ray control shall provide visual indication observable at or from the operator's protected position whenever X-rays are produced. In addition, a signal audible to the operator shall indicate that the exposure has terminated.

(3) Automatic exposure controls. When an automatic exposure control is provided:

1. Indication shall be made on the control panel when this mode of operation is selected;

2. If the X-ray tube potential is equal to or greater than 50 kVp, the minimum exposure time for field emission equipment rated for pulsed operation shall be equal to or less than a time interval equivalent to 2 pulses;

3. The minimum exposure time for all equipment other than that specified in 41.1(6) "b"(3)"2" shall be equal to or less than one-sixtieth second or a time interval required to deliver 5 mAs, whichever is greater;

4. Either the product of peak X-ray tube potential, current, and exposure time shall be limited to not more than 60 kW per exposure, or the product of X-ray tube current and exposure time shall be limited to not more than 600 mAs per exposure except that, when the X-ray tube potential is less than 50 kVp, the product of X-ray tube current and exposure time shall be limited to not more than 2000 mAs per exposure; and

5. A visible signal shall indicate when an exposure has been terminated at the limits required by 41.1(6) "b"(3)"4," and manual resetting shall be required before further automatically timed exposures can be made.

(4) Reproducibility. With a timer setting of 0.5 seconds or less, the average exposure period ( $T$ ) shall be greater than or equal to five times the maximum exposure period ( $T_{\max}$ ) minus the minimum exposure period ( $T_{\min}$ ) when four timer tests are performed:

$$\bar{T} \geq 5 (T_{\max} - T_{\min})$$

(5) Exposure duration (timer) linearity. For systems having independent selection of exposure time settings, the average ratios ( $X_1$ ) of exposure to the indicated timer setting, in units of  $C \text{ kg}^{-1}\text{s}^{-1}$  (mR/s), obtained at any two clinically used timer settings shall not differ by more than 0.10 times their sum. This is written as:

$$(X_1 - X_2) \leq 0.1 (X_1 + X_2)$$

where  $X_1$  and  $X_2$  are the average  $C \text{ kg}^{-1}\text{s}^{-1}$  (mR/s) values.

c. Source-to-skin distance. All mobile or portable radiographic systems shall be provided with means to limit the source-to-skin distance to equal to or greater than 30 centimeters except for veterinary systems.

d. Exposure reproducibility. When all technique factors are held constant, including control panel selections associated with automatic exposure control systems, the coefficient of variation of exposure for both manual and automatic exposure control systems shall not exceed 0.05. This requirement applies to clinically used techniques.

e. Radiation from capacitor energy storage equipment in standby status. Radiation emitted from the X-ray tube when the system is fully charged and the exposure switch or timer is not activated shall not exceed a rate of 2 milliroentgens ( $0.516 \mu\text{C}/\text{kg}$ ) per hour at 5 centimeters from any accessible surface of the diagnostic source assembly, with the beam-limiting device fully open.

f. Accuracy. Deviation of measured technique factors from indicated values of kVp and exposure time shall not exceed the limits specified for that system by its manufacturer. In the absence of manufacturer's specifications, the deviation shall not exceed 10 percent of the indicated value for kVp and 20 percent for time.

g. mA/mAs linearity. The following requirements apply when the equipment is operated on a power supply as specified by the manufacturer for any fixed X-ray tube potential within the range of 40 percent to 100 percent of the maximum rated:

(1) Equipment having independent selection of X-ray tube current (mA). The average ratios ( $X_i$ ) of exposure to the indicated milliamperere-seconds product ( $C \text{ kg}^{-1}\text{mAs}^{-1}$  (or mR/mAs)) obtained at any two consecutive tube current settings shall not differ by more than 0.10 times their sum:

$$X_1 - X_2 \leq 0.10 (X_1 + X_2)$$

where  $X_1$  and  $X_2$  are the average values obtained at each of two consecutive tube current settings, or at two settings differing by no more than a factor of 2 where the tube current selection is continuous.

(2) Equipment having a combined X-ray tube current-exposure time product (mAs) selector, but not a separate tube current (mA) selector. The average ratios ( $X_i$ ) of exposure to the indicated milliamperere-seconds product, in units of mR/mAs (or  $C \text{ kg}^{-1}\text{mAs}^{-1}$ ), obtained at any two consecutive mAs selector settings shall not differ by more than 0.10 times their sum:

$$X_1 - X_2 \leq 0.10 (X_1 + X_2)$$

where  $X_1$  and  $X_2$  are the average values obtained at any two consecutive mAs selector settings, or at two settings differing by no more than a factor of 2 where the mAs selector provides continuous selection.

(3) Measuring compliance. Determination of compliance shall be based on 10 exposures taken within a time period of one hour, at each of the two settings. These two settings may include any two focal spot sizes except where one is equal to or less than 0.45 millimeters and the other is greater than

0.45 millimeters. For purposes of this requirement, focal spot size is the nominal focal spot size specified by the X-ray tube manufacturer.

*h.* Additional requirements applicable to certified systems only. Diagnostic X-ray systems incorporating one or more certified component(s) shall be required to comply with the following additional requirement(s) which relate to that certified component(s).

(1) Beam limitation for stationary and mobile general purpose X-ray systems.

1. There shall be provided a means of stepless adjustment of the X-ray field. The minimum field size at an SID of 100 centimeters shall be equal to or less than 5 centimeters by 5 centimeters.

2. When a light localizer is used to define the X-ray field, it shall provide an average illumination of not less than 160 lux or 15 foot-candles at 100 centimeters or at the maximum SID, whichever is less. The average illumination shall be based upon measurements made in the approximate center of each quadrant of the light field. Radiation therapy simulation systems manufactured on and after May 27, 1980, are exempt from this requirement.

3. The edge of the light field at 100 centimeters or at the maximum SID, whichever is less, shall have a contrast ratio, corrected for ambient lighting, of not less than 4 in the case of beam-limiting devices designed for use on stationary equipment, and a contrast ratio of not less than 3 in the case of beam-limiting devices designed for use on mobile equipment. The contrast ratio is defined as  $I_1/I_2$  where  $I_1$  is the illumination 3 millimeters from the edge of the light field toward the center of the field; and  $I_2$  is the illumination 3 millimeters from the edge of the light field away from the center of the field. Compliance shall be determined with a measuring instrument aperture of 1 millimeter in diameter.

(2) Beam limitation and alignment on stationary general purpose X-ray systems equipped with PBL. If PBL is being used, the following requirements shall be met:

1. PBL shall prevent the production of X-rays when

- Either the length or width of the X-ray field in the plane of the image receptor differs, except as permitted by 41.1(6) "h"(3), from the corresponding image receptor dimensions by more than 3 percent of the SID; or
- The sum of the length and width differences as stated in 41.1(6) "h"(2)"1" above without regard to sign exceeds 4 percent of the SID;

2. Compliance with 41.1(6) "h"(2)"1" shall be determined when the equipment indicates that the beam axis is perpendicular to the plane of the image receptor. Compliance shall be determined no sooner than 5 seconds after insertion of the image receptor;

3. The PBL system shall be capable of operation, at the discretion of the operator, such that the size of the field may be made smaller than the size of the image receptor through stepless adjustment of the field size. The minimum field size at an SID of 100 centimeters shall be equal to or less than 5 centimeters by 5 centimeters;

4. The PBL system shall be designed such that if a change in image receptor does not cause an automatic return to PBL function as described in 41.1(6) "h"(2)"1," then any change of image receptor size or SID must cause the automatic return.

(3) Beam limitation for portable X-ray systems. Beam limitation for portable X-ray systems shall meet the beam limitation requirements of 41.1(6) "a" or 41.1(6) "h"(2).

*i.* Tube stands for portable X-ray systems. A tube stand or other mechanical support shall be used for portable X-ray systems, so that the X-ray tube housing assembly need not be handheld during exposures.

*j.* Systems used in a clinical (nonsurgical) setting shall be restricted to one room within a location or suite which meets the requirements of 41.1(3) "d."

**41.1(7) Intraoral dental radiographic systems.** In addition to the provisions of 41.1(3) and 41.1(4), the requirements of 41.1(7) apply to X-ray equipment and associated facilities used for dental radiography. Requirements for extraoral dental radiographic systems are covered in 41.1(6). Only systems meeting the requirements of 41.1(7) shall be used. Additional requirements specific to handheld dental X-ray equipment are outlined in 41.1(7) "i."

*a.* *Source-to-skin distance.* X-ray systems designed for use with an intraoral image receptor shall be provided with means to limit source-to-skin distance to not less than:

(1) 18 centimeters if operable above 50 kVp, or

(2) 10 centimeters if not operable above 50 kVp.

*b. Beam limitation.* Radiographic systems designed for use with an intraoral image receptor shall be provided with means to limit the X-ray beam such that:

(1) If the minimum source-to-skin distance (SSD) is 18 centimeters or more, the X-ray field, at the minimum SSD, shall be containable in a circle having a diameter of no more than 7 centimeters; and

(2) If the minimum SSD is less than 18 centimeters, the X-ray field, at the minimum SSD, shall be containable in a circle having a diameter of no more than 6 centimeters.

(3) The position indicating device shall be shielded and open-ended. The shielding shall be equivalent to the requirements of 41.1(4)“c.”

*c. Exposure control.*

(1) Exposure initiation.

1. Means shall be provided to initiate the radiation exposure by a deliberate action on the part of the operator, such as the depression of a switch. Radiation exposure shall not be initiated without such an action; and

2. It shall not be possible to make an exposure when the timer is set to a “zero” or “off” position if either position is provided.

(2) Exposure indication. Means shall be provided for visual indication observable at or from the operator’s protected position whenever X-rays are produced. In addition, a signal audible to the operator shall indicate that the exposure has terminated except in X-ray systems that cannot be altered to meet this requirement.

(3) Exposure termination.

1. Means shall be provided to terminate the exposure at a preset time interval, preset product of current and time, a preset number of pulses, or a preset radiation exposure to the image receptor. In addition:

2. Termination of exposure shall cause automatic resetting of the timer to its initial setting or to “zero.”

3. An X-ray control shall be incorporated into each X-ray system such that an exposure can be terminated by the operator at any time, except for exposures of one-half ( $\frac{1}{2}$ ) second or less.

(4) Exposure duration (timer) linearity. For systems having independent selection of exposure time settings, the average ratios ( $X_1$ ) of exposure to the indicated timer setting, in units of  $C\ kg^{-2}s^{-1}$  (mR/s), obtained at any two clinically used timer settings shall not differ by more than 0.10 times their sum. This is written as:

$$(X_1 - X_2) \leq 0.1 (X_1 + X_2)$$

where  $X_1$  and  $X_2$  are the average values.

(5) Each X-ray exposure switch shall be located in such a way as to meet the following requirements:

1. Stationary X-ray systems shall be required to have the X-ray exposure switch located in a protected area or have an exposure switch cord of sufficient length to permit the operator to activate the equipment while in a protected area, e.g., corridor outside the operator. The procedures required under 41.1(3)“a”(4) must instruct the operator to remain in the protected area during the entire exposure.

2. Mobile and portable X-ray systems which are:

- Used for greater than one week in the same location, i.e., a room or suite, shall meet the requirements of 41.1(7)“c”(5)“1.”

- Used for greater than one hour and less than one week at the same location, i.e., a room or suite, shall meet the requirements of the above paragraph or be provided with a 6.5 foot (1.98 m) high protective barrier or means to allow the operator to be at least 6 feet ( 1.8 meters) from the tube housing assembly while making exposure.

3. Portable dental X-ray systems designed with a backscatter shield may be used without an additional protective barrier, but the operator must stand directly behind the equipment to allow the shield to function as designed.

*d. Reproducibility.* When the equipment is operated on an adequate power supply as specified by the manufacturer, the estimated coefficient of variation of radiation exposures shall be no greater than 0.05, for any specific combination of selected technique factors.

*e. mA/mS linearity.* The following requirements apply when the equipment is operated on a power supply as specified by the manufacturer for any fixed X-ray tube potential within the range of 40 percent to 100 percent of the maximum rated.

(1) Equipment having independent selection of X-ray tube current (mA). The average ratios ( $X_1$ ) of exposure to the indicated milliamperere-seconds product, in units of  $C\text{ kg}^{-1}\text{ mAs}^{-1}$  (or mR/mAs), obtained at any two consecutive tube current settings shall not differ by more than 0.10 times their sum:

$$(X_1 - X_2) \leq 0.1 (X_1 + X_2)$$

where  $X_1$  and  $X_2$  are the average values obtained at each of two consecutive tube current settings, or at two settings differing by no more than a factor of 2 where the tube current selection is continuous.

(2) Equipment having a combined X-ray tube current-exposure time product (mAs) selector, but not a separate tube current (mA) selector. The average ratios ( $X_1$ ) of exposure to the indicated milliamperere-seconds product, in units of  $C\text{ kg}^{-1}\text{ mAs}^{-1}$  (or mR/mAs), obtained at any two consecutive mAs selector settings shall not differ by more than 0.10 times their sum:

$$(X_1 - X_2) \leq 0.1 (X_1 + X_2)$$

where  $X_1$  and  $X_2$  are the average values obtained at any two mAs selector settings, or at two settings differing by no more than a factor of 2 where the mAs selector provides continuous selection.

(3) Measuring compliance. Determination of compliance shall be based on 10 exposures taken within a time period of one hour, at each of the two settings. These two settings may include any two focal spot sizes except where one is equal to or less than 0.45 millimeters and the other is greater than 0.45 millimeters. For purposes of this requirement, focal spot size is the nominal focal spot size specified by the X-ray tube manufacturer.

*f. Accuracy.* Deviation of technique factors from indicated values for kVp and exposure time (if time is independently selectable) shall not exceed the limits specified for that system by its manufacturer. In the absence of manufacturer's specifications the deviation shall not exceed 10 percent of the indicated value for kVp and 20 percent for time.

*g. kVp limitations.* Dental X-ray machine with a nominal fixed kVp of less than 50 kVp shall not be used to make diagnostic dental radiographs of humans.

*h. Administrative controls.*

(1) Patient and film holding devices shall be used when the techniques permit.  
 (2) The tube housing and the PID for stationary or mobile systems shall not be held by the operator during an exposure.  
 (3) The X-ray system shall be operated in such a manner that the useful beam at the patient's skin does not exceed the requirements of 41.1(7) "b"(1).

(4) Dental fluoroscopy without image intensification shall not be used.

*i. Handheld dental X-ray systems.* Only equipment specifically designed by the manufacturer to be held by the operator for intraoral dental X-ray exposures is allowed to be operated pursuant to this subrule.

(1) Operators shall be specifically trained to operate the equipment. Records of training shall be kept at the facility until the operator is no longer an employee or until the equipment is removed from the facility.

(2) Protective aprons of not less than 0.25 millimeter lead equivalent shall be provided for operators to wear while operating the equipment.

(3) Dosimetry shall be provided for operators who are expected to exceed 10 percent of the annual occupational dose limit as outlined in 641—40.84(136C).

(4) Operators shall operate the equipment according to the manufacturer's instructions.

(5) The image receptor used must be digital radiography (DR), computed radiography (CR), or intraoral film with a speed class designated as “E/F” or a film with a faster speed designation than “F” or “E/F.”

(6) No individual except the equipment operator may be within a radius of at least 6 feet from the patient during exposures.

(7) The equipment shall not be operated unless the backscatter shield is in place as designed by the manufacturer.

(8) The equipment shall not be operated in hallways, waiting rooms, or other areas where access for individuals of the general public cannot be controlled.

(9) The equipment shall be held without any motion during a patient examination. If the operator has difficulty in holding the equipment stationary, the operator shall use a tube stand. The equipment shall be operated on a tube stand whenever practicable to avoid unnecessary motion and retakes.

(10) When not in use, the equipment shall be stored in a manner that would prevent inadvertent exposures or use by unauthorized individuals.

**41.1(8)** Rescinded IAB 6/4/97, effective 7/9/97.

**41.1(9)** *Bone densitometry units.*

a. No additional shielding for the room is required.

b. Film badges, OSL devices, or TLDs must be issued for the first six months to all personnel operating the unit. If monitoring indicates no exposure, the IDPH may allow discontinuance of monitoring upon written request. When new procedures are started that have not been previously monitored, monitoring must be reinstated for six months and another request for discontinuance submitted to the agency.

c. Rescinded IAB 2/6/13, effective 3/13/13.

d. Specific operating procedures must be prepared and made available at the operator’s position.

e. Bone densitometry on human patients shall be conducted only under a prescription of a licensed physician, a licensed physician assistant as defined in Iowa Code section 148C.1, subsection 6, or a licensed registered nurse who is registered as an advanced registered nurse practitioner pursuant to Iowa Code chapter 152.

f. During the operation of the bone densitometry system:

(1) The operator, ancillary personnel, and members of the general public shall be positioned at least one meter from the patient and bone densitometry system during the examination.

(2) The operator shall advise the patient that the bone densitometry examination is a type of X-ray procedure.

g. Equipment shall be maintained and operated in accordance with the manufacturer’s specifications. Records of maintenance shall be kept for inspection by the agency.

**41.1(10)** *Veterinary medicine radiographic installations.*

a. *Equipment.*

(1) The protective tube housing shall be equivalent to the requirements of 41.1(4)“c.”

(2) Diaphragms or cones shall be provided for collimating the useful beam to the area of clinical interest and shall provide the same degree of protection as is required of the housing.

(3) The total filtration permanently in the useful beam shall not be less than 0.5 millimeters aluminum equivalent for machines operating up to 50 kVp, 1.5 millimeters aluminum equivalent for machines operating between 50 and 70 kVp, and 2.5 millimeters aluminum equivalent for machines operating above 70 kVp.

b. *Operator protection.*

(1) All wall, ceiling, and floor areas shall be equivalent to or provided with applicable protective barriers to ensure compliance with 641—40.15(136C) and 40.21(136C) and subrule 40.26(1).

(2) All stationary, mobile or portable X-ray systems shall be provided with either a 2 meter (6.5 feet) high protective barrier for operator protections during exposures, or shall be provided with means to allow the operator to be at least 2.7 meters (9 feet) from the tube housing assembly during exposures.

c. *Operating procedures.* Veterinary medicine radiographic installations are exempt from the requirements of 641—41.1(136C) except for 641—subrules 41.1(3) and 41.1(10).

(1) No individual other than the operator shall be in the X-ray room while exposures are being made unless such individual's assistance is required, and

(2) The operator shall stand behind the protective barrier of 9 feet from the useful beam and the animal during radiographic exposures, or

(3) When an animal must be held in position during radiography, mechanical supporting or restraining devices should be used. If the animal must be held by an individual, that individual shall be protected with appropriate shielding devices, such as protective gloves and apron, and shall be so positioned that no part of the holder's body will be struck by the useful beam. The exposure of any individual used for this purpose shall be monitored.

**41.1(11) Computed tomography X-ray systems.**

a. Definitions. In addition to the definitions provided in 641—38.2(136C), 641—40.2(136C), and 41.1(2), the following definitions shall be applicable to 41.1(11):

“*Computed tomography dose index*” means the integral from  $-7T$  to  $+7T$  of the dose profile along a line perpendicular to the tomographic plane divided by the product of the nominal tomographic section thickness and the number of tomograms produced in a single scan, that is:

$$\overline{\text{CTDI}} = \frac{1}{nT} \int_{-7T}^{+7T} D(z) dz$$

where:

$z$  = Position along a line perpendicular to the tomographic plane.

$D(z)$  = Dose at position  $z$ .

$T$  = Nominal tomographic section thickness.

$n$  = Number of tomograms produced in a single scan.

This definition assumes that the dose profile is centered around  $z = 0$  and that, for a multiple tomogram system, the scan increment between adjacent scans is  $nT$ .

“*Contrast scale*” means the change in the linear attenuation coefficient per CTN relative to water, that is:

$$\overline{\text{CS}} = \frac{\mu_x - \mu_w}{\text{CTN}_x - \text{CTN}_w}$$

where:

$\mu_x$  = Linear attenuation coefficient of the material of interest.

$\mu_w$  = Linear attenuation coefficient of water.

$\overline{\text{CTN}}_x$  = of the material of interest.

$\overline{\text{CTN}}_w$  = of water.

“*CS*” (see “*Contrast scale*”).

“*CT conditions of operation*” means all selectable parameters governing the operation of a CT X-ray system including, but not limited to, nominal tomographic section thickness, filtration, and the technique factors as defined in 41.1(2).

“*CTDI*” (see “*Computed tomography dose index*”).

“*CT gantry*” means the tube housing assemblies, beam-limiting devices, detectors, and the supporting structures and frames which hold these components.

“*CTN*” (see “*CT number*”).

“*CT number*” means the number used to represent the X-ray attenuation associated with each elemental area of the CT image.

$$\overline{\text{CTN}} = \frac{k(\mu_x - \mu_w)}{\mu_w}$$

where:

$k$  = A constant. (The constant has a normal value of 1,000 when the Hounsfield scale of CTN is used.)

$\mu_x$  = Linear attenuation coefficient of the material of interest.

$\mu_w$  = Linear attenuation coefficient of water.

“*Dose profile*” means the dose as a function of position along a line.

“*Elemental area*” means the smallest area within a tomogram for which the X-ray attenuation properties of a body are depicted (see also “*Picture element*”).

“*Multiple tomogram system*” means a computed tomography X-ray system which obtains X-ray transmission data simultaneously during a single scan to produce more than one tomogram.

“*Noise*” means the standard deviation of the fluctuation in CTN expressed as a percentage of the attenuation coefficient of water. Its estimate ( $S_n$ ) is calculated using the following expression:

$$S_n = \frac{100 \cdot \overline{\text{CS}} \cdot s}{\mu_w}$$

where:

$\overline{\text{CS}}$  = Linear attenuation coefficient of the material of interest.

$\mu_w$  = Linear attenuation coefficient of water.

$s$  = Estimated standard deviation of the CTN of picture elements in a specified area of the CT image.

“*Nominal tomographic section thickness*” means the full width at half-maximum of the sensitivity profile taken at the center of the cross-sectional volume over which X-ray transmission data are collected.

“*Picture element*” means an elemental area of a tomogram.

“*Reference plane*” means a plane which is displaced from and parallel to the tomographic plane.

“*Scan*” means the complete process of collecting X-ray transmission data for the production of a tomogram. Data can be collected simultaneously during a single scan for the production of one or more tomograms.

“*Scan increment*” means the amount of relative displacement of the patient with respect to the CT X-ray system between successive scans measured along the direction of such displacement.

“*Scan sequence*” means a preselected set of two or more scans performed consecutively under preselected CT conditions of operation.

“*Scan time*” means the period of time between the beginning and end of X-ray transmission data accumulation for a single scan.

“*Single tomogram system*” means a CT X-ray system which obtains X-ray transmission data during a scan to produce a single tomogram.

“*Tomographic plane*” means that geometric plane which is identified as corresponding to the output tomogram.

“*Tomographic section*” means the volume of an object whose X-ray attenuation properties are imaged in a tomogram.

*b.* Requirements for equipment.

(1) Termination of exposure.

1. Means shall be provided to terminate the X-ray exposure automatically by either deenergizing the X-ray source or shuttering the X-ray beam in the event of equipment failure affecting data collection. Such termination shall occur within an interval that limits the total scan time to no more than 110 percent of its preset value through the use of either a backup timer or devices which monitor equipment function.

2. A visible signal shall indicate when the X-ray exposure has been terminated through the means required by 41.1(11)“*b*”(1)“1.”

3. The operator shall be able to terminate the X-ray exposure at any time during a scan, or series of scans under CT X-ray system control, of greater than one-half second duration.

(2) Tomographic plane indication and alignment.

1. For any single tomogram system, means shall be provided to permit visual determination of the tomographic plane or a reference plane offset from the tomographic plane.

2. For any multiple tomogram system, means shall be provided to permit visual determination of the location of a reference plane. This reference plane can be offset from the location of the tomographic planes.

3. If a device using a light source is used to satisfy 41.1(11) "b"(2)"1" or "2," the light source shall provide illumination levels sufficient to permit visual determination of the location of the tomographic plane or reference plane under ambient light conditions of up to 500 lux.

(3) Beam-on and shutter status indicators and control switches.

1. The CT X-ray control and gantry shall provide visual indication whenever X-rays are produced and, if applicable, whether the shutter is open or closed.

2. Each emergency button or switch shall be clearly labeled as to its function.

(4) Indication of CT conditions of operation. The CT X-ray system shall be designed such that the CT conditions of operation to be used during a scan or a scan sequence shall be indicated prior to the initiation of a scan or a scan sequence. On equipment having all or some of these conditions of operation at fixed values, this requirement may be met by permanent markings. Indication of CT conditions of operation shall be visible from any position from which scan initiation is possible.

(5) Extraneous radiation. When data are not being collected for image production, the radiation adjacent to the tube port shall not exceed that permitted by 41.1(4) "c."

(6) Maximum surface CTDI identification. The angular position where the maximum surface CTDI occurs shall be identified to allow for reproducible positioning of a CT dosimetry phantom.

(7) Additional requirements applicable to CT X-ray systems containing a gantry manufactured after September 3, 1985.

1. The total error in the indicated location of the tomographic plane or reference plane shall not exceed 5 millimeters.

2. If the X-ray production period is less than one-half second, the indication of X-ray production shall be actuated for at least one-half second. Indicators at or near the gantry shall be discernible from any point external to the patient opening where insertion of any part of the human body into the primary beam is possible.

3. The deviation of indicated scan increment versus actual increment shall not exceed plus or minus 1 millimeter with any mass from 0 to 100 kilograms resting on the support device. The patient support device shall be incremented from a typical starting position to the maximum incremented distance or 30 centimeters, whichever is less, and then returned to the starting position. Measurement of actual versus indicated scan increment may be taken anywhere along this travel.

4. Premature termination of the X-ray exposure by the operator shall necessitate resetting of the CT conditions of operation prior to the initiation of another scan.

c. Facility design requirements.

(1) Aural communication. Provision shall be made for two-way aural communication between the patient and the operator at the control panel.

(2) Viewing systems.

1. Windows, mirrors, closed-circuit television, or an equivalent shall be provided to permit continuous observation of the patient during irradiation and shall be so located that the operator can observe the patient from the control panel.

2. When the primary viewing system is by electronic means, an alternate viewing system (which may be electronic) shall be available for use in the event of failure of the primary viewing system.

d. Surveys, calibrations, spot checks, and operating procedures.

(1) Surveys.

1. All CT X-ray systems shall have a survey made by, or under the direction of, a qualified expert. In addition, such surveys shall be done after any change in the facility or equipment which might cause a significant increase in radiation hazard.

2. The registrant shall obtain a written report of the survey from the qualified expert, and a copy of the report shall be made available to the agency upon request.

(2) Radiation calibrations.

1. The calibration of the radiation output of the CT X-ray system shall be performed by, or under the direction of, a qualified expert who is physically present at the facility during such calibration.

2. The calibration of a CT X-ray system shall be performed at intervals specified by a qualified expert and after any change or replacement of components which, in the opinion of the qualified expert, could cause a change in the radiation output.

3. The calibration of the radiation output of a CT X-ray system shall be performed with a calibrated dosimetry system. The calibration of such system shall be traceable to a national standard. The dosimetry system shall have been calibrated within the preceding two years.

4. CT dosimetry phantom(s) shall be used in determining the radiation output of a CT X-ray system. Such phantom(s) shall meet the following specifications and conditions of use: CT dosimetry phantom(s) shall be right circular cylinders of polymethyl methacrylate of density 1.19 plus or minus 0.01 grams per cubic centimeter. The phantom(s) shall be at least 14 centimeters in length and shall have diameters of 32.0 centimeters for testing CT X-ray systems designed to image any section of the body and 16.0 centimeters for systems designed to image the head or for whole body scanners operated in the head scanning mode; CT dosimetry phantom(s) shall provide means for the placement of a dosimeter(s) along the axis of rotation and along a line parallel to the axis of rotation 1.0 centimeter from the outer surface and within the phantom. Means for the placement of dosimeters or alignment devices at other locations may be provided; any effects on the doses measured due to the removal of phantom material to accommodate dosimeters shall be accounted for through appropriate corrections to the reported data or included in the statement of maximum deviation for the values obtained using the phantom; and all dose measurements shall be performed with the CT dosimetry phantom placed on the patient couch or support device without additional attenuation materials present.

5. The calibration shall be required for each type of head, body, or whole-body scan performed at the facility.

6. Calibration shall meet the following requirements: The dose profile along the center axis of the CT dosimetry phantom for the minimum, maximum, and midrange values of the nominal tomographic section thickness used by the registrant shall be measurable. Where less than three nominal tomographic thicknesses can be selected, the dose profile determination shall be performed for each available nominal tomographic section thickness; the CTDI<sup>3/4</sup> along the two axes specified in 41.1(11)“d”(2)“4” shall be measured. (For the purpose of determining the CTDI, the manufacturer’s statement as to the nominal tomographic section thickness for that particular system may be utilized.) The CT dosimetry phantom shall be oriented so that the measurement point 1.0 centimeter from the outer surface and within the phantom is in the same angular position within the gantry as the point of maximum surface CTDI identified. The CT conditions of operation shall correspond to typical values used by the registrant; and the spot checks specified in 41.1(11)“d”(3) shall be made.

7. Calibration procedures shall be in writing. Records of calibrations performed shall be maintained for inspection by the agency.

(3) Spot checks.

1. The spot-check procedures shall be in writing and shall have been developed by a qualified expert.

2. The spot-check procedures shall incorporate the use of a CT dosimetry phantom which has a capability of providing an indication of contrast scale, noise, nominal tomographic section thickness, the resolution capability of the system for low and high contrast objects, and measuring the mean CTN for water or other reference material.

3. All spot checks shall be included in the calibration required by 41.1(11)“d”(2) and at time intervals and under system conditions specified by a qualified expert.

4. Spot checks shall include acquisition of images obtained with the CT dosimetry phantom(s) using the same processing mode and CT conditions of operation as are used to perform calibrations required by 41.1(11)“d”(2). The images shall be retained, until a new calibration is performed, in two forms as follows: photographic copies of the images obtained from the image display device; and images stored in digital form on a storage medium compatible with the CT X-ray system.

5. Written records of the spot checks performed shall be maintained for inspection by the agency.

(4) Operating procedures.

1. The CT X-ray system shall not be operated except by a licensed practitioner or an individual who has been specifically trained in its operation and holds a current permit to practice as a general radiologic technologist as defined under the provisions of 641—Chapter 42.

**41.1(12) X-ray machines used for mammography.** Rescinded IAB 4/8/98, effective 7/1/98.  
[ARC 8659B, IAB 4/7/10, effective 5/12/10; ARC 0577C, IAB 2/6/13, effective 3/13/13; ARC 1639C, IAB 10/1/14, effective 11/5/14; ARC 3103C, IAB 6/7/17, effective 7/12/17]

#### **641—41.2(136C) Use of radionuclides in the healing arts.**

**41.2(1) Purpose and scope.**

a. This rule establishes requirements and provisions for the use of radionuclides in the healing arts and for issuance of licenses authorizing the medical use of this material. These requirements and provisions provide for the protection of the public health and safety. The requirements and provisions of this rule are in addition to, and not in substitution for, the applicable portions of 641—Chapters 38 to 40. The requirements and provisions of these rules apply to applicants and licensees subject to this rule unless specifically exempted.

b. All references to any Code of Federal Regulations (CFR) in this chapter are those in effect as of November 5, 2014.

**41.2(2) Definitions.** For the purpose of this chapter, the definitions of 641—Chapters 38 to 40 may also apply. As used in 41.2(136C), the following definitions apply:

“*Area of use*” means a portion of a physical structure that has been set aside for the purpose of receiving, using, or storing radioactive material.

“*Authorized medical physicist*” means an individual who:

- a. Meets the requirements of 41.2(74) and 41.2(77); or
- b. Is identified as an authorized medical physicist or teletherapy physicist on:
  1. A specific medical use license issued by this agency, the NRC, or an agreement state;
  2. A medical use permit issued by an NRC master material licensee;
  3. A permit issued by an NRC or agreement state broad scope medical use licensee; or
  4. A permit issued by an NRC master material license broad scope medical use permittee.

“*Authorized nuclear pharmacist*” means a pharmacist who:

a. Has met the appropriate requirements of 41.2(77) and 41.2(78), or before May 3, 2006, meets the requirements in 10 CFR 35.980(a) and 10 CFR 35.59; or:

b. Is identified as an authorized nuclear pharmacist on:

1. A specific license issued by the agency, NRC or agreement state that authorizes medical use or the practice of nuclear pharmacy;
2. A permit issued by an NRC master material licensee that authorizes medical use or the practice of nuclear pharmacy;
3. A permit issued by the NRC or agreement state broad scope medical use licensee that authorizes medical use or the practice of nuclear pharmacy; or
4. A permit issued by an NRC master material license broad scope medical use permittee that authorizes medical use or the practice of nuclear pharmacy; or

c. Is identified as an authorized nuclear pharmacist by a commercial nuclear pharmacy that has been authorized to identify authorized nuclear pharmacists; or

d. Is designated as an authorized nuclear pharmacist in accordance with 641—39.4(29)“j”(2)“3.”

“*Authorized user*” means a physician, dentist, or podiatrist who has met the appropriate requirements of 41.2(67)“a,”41.2(68)“a,”41.2(69)“a,”41.2(70)“a,”41.2(72)“a,”41.2(73)“a,”41.2(81)“a,” or

41.2(82) “a,” or before May 3, 2006, meets the requirements in 10 CFR 35.910(a), 35.920(a), 35.930(c), 35.940(a), 35.950(a), or 35.960(a) and 10 CFR 35.59; or who is identified on:

1. A current Iowa, NRC, or agreement state license that authorizes the medical use of radioactive material;
2. A permit issued by an NRC master material licensee that is authorized to permit the medical use of radioactive material;
3. A permit issued by an NRC, agreement state, or Iowa-specific licensee of broad scope that is authorized to permit medical use of radioactive material; or
4. A permit issued by an NRC master material license broad scope permittee that is authorized to permit medical use of radioactive material.

“*Dedicated check source*” means a radioactive source that is used to ensure the constant operation of a radiation detection or measurement device over several months or years. This source may also be used for other purposes.

“*Management*” means the chief executive officer or that individual’s designee.

“*Medical institution*” means an organization in which several medical disciplines are practiced.

“*Mobile nuclear medicine service*” means the transportation and medical use of radioactive material.

“*Output*” means the exposure rate, dose rate, or a quantity related in a known manner to these rates from a teletherapy unit for a specified set of exposure conditions.

“*Pharmacist*” means an individual licensed by a state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico to practice pharmacy.

“*Radiation safety officer*” means an individual who, in addition to the definition in 641—38.2(136C), meets the requirements of 41.2(77) and 41.2(65)“a,” or 41.2(65)“c”(1), or before May 3, 2006, meets the requirements in 10 CFR 35.900(a) and 10 CFR 35.59; or is identified as a radiation safety officer on a specific medical use license issued by Iowa, the NRC, or agreement state or a medical use permit issued by an NRC master material licensee.

“*Teletherapy physicist*” means an individual identified as the qualified teletherapy physicist on an agency license.

“*Unit dosage*” means a dosage prepared for medical use for administration as a single dosage to a patient or human research subject without any further manipulation of the dosage after it is initially prepared.

“*Visiting authorized user*” means an authorized user who is not identified on the license of the licensee being visited.

**41.2(3) License required.**

a. No person shall manufacture, produce, acquire, receive, possess, use, or transfer radioactive material for medical use except in accordance with a specific license issued pursuant to these rules.

b. Unless prohibited by license condition, an individual may receive, possess, use, or transfer radioactive material in accordance with these rules under the supervision of an authorized user as provided in 41.2(11).

c. An individual may prepare unsealed radioactive material for medical use in accordance with these rules under the supervision of an authorized nuclear pharmacist or authorized user as provided in 41.2(11) unless prohibited by license condition.

d. A licensee may conduct research involving human subjects using radioactive material provided that the research is conducted, funded, supported, or regulated by another federal agency which has implemented the Federal Policy for the Protection of Human Subjects. Otherwise, a licensee shall apply for and receive approval of a specific amendment to its license before conducting such research. Both types of licensees shall, at a minimum, obtain informed consent from the human subjects and obtain prior review and approval of the research activities by an Institutional Review Board in accordance with the meaning of these terms as defined and described in the Federal Policy for the Protection of Human Subjects.

Nothing in this subrule relieves the licensee from complying with applicable FDA, federal, and other state requirements governing radioactive drugs or devices.

*e.* An applicant that satisfies the requirements of 641—paragraph 39.4(28) “*b*” may apply for a Type A specific license of broad scope.

**41.2(4) License amendments.** A licensee shall apply for and receive a license amendment:

*a.* Before using radioactive material for a method or type of medical use not permitted by the license issued under this rule;

*b.* Before permitting anyone, except a visiting authorized user or visiting authorized nuclear pharmacist described in 41.2(12), to work as an authorized user or authorized nuclear pharmacist under the license;

*c.* Before changing a radiation safety officer, teletherapy physicist or authorized medical physicist;

*d.* Before receiving radioactive material in excess of the amount authorized on the license;

*e.* Before adding to or changing the address or addresses of use identified in the application or on the license; and

*f.* Before changing statements, representations, and procedures which are incorporated into the license.

**41.2(5) Notifications.**

*a.* A licensee shall provide to the agency a copy of the board certification, the NRC or agreement state license, or the permit issued by a licensee of broad scope for each individual no later than 30 days after the date that the licensee permits the individual to work as a visiting authorized user or a visiting authorized nuclear pharmacist.

*b.* A licensee shall notify the agency by letter no later than 30 days after:

(1) An authorized user, an authorized nuclear pharmacist, radiation safety officer, or teletherapy physicist permanently discontinues performance of duties under the license or has a name change; or

(2) The licensee’s mailing address changes.

*c.* The licensee shall mail the documents required in this subrule to the Iowa Department of Public Health, Des Moines, Iowa.

*d.* Exemptions regarding Type A specific licenses of broad scope. A licensee possessing a Type A specific license of broad scope for medical use is exempt from the following:

(1) The provision of 41.2(4) “*b*”;

(2) The provisions of 41.2(4) “*e*” regarding additions to or changes in the areas of use only at the addresses specified in the license;

(3) The provision of 41.2(5) “*a*”;

(4) The provisions of 41.2(5) “*b*”(1) for authorized user or an authorized nuclear pharmacist.

**41.2(6) Maintenance of records.**

*a.* Each record required by this rule must be legible throughout the retention period specified by each subrule. The record may be original or reproduced copy or a microform, provided that the copy or microform is authenticated by authorized personnel and that the microform is capable of producing a clear copy throughout the required retention period.

*b.* The record may also be stored on electronic media with the capability for producing legible, accurate, and complete records during the required retention period. Records such as letters, drawings, and specifications must include all pertinent information such as stamps, initials, and signatures.

*c.* The licensee shall maintain adequate safeguards against tampering with and loss of records specified in 41.2(6) “*a*” and “*b*.”

**41.2(7) ALARA program.**

*a.* Each licensee shall develop and implement a written program to maintain radiation doses and releases of radioactive material in effluents to unrestricted areas as low as reasonably achievable in accordance with 641—subrule 40.1(3).

*b.* To satisfy the requirement of 41.2(7) “*a*”:

(1) The management, radiation safety officer, and all authorized users shall participate in the establishment, implementation, and operation of the program as required by these rules or the radiation safety committee; or

(2) For licensees that are not medical institutions, management and all authorized users shall participate in the program as required by the radiation safety officer.

c. The ALARA program shall include an annual review by the radiation safety committee for licensees that are medical institutions, or management and the radiation safety officer for licensees that are not medical institutions, of summaries of the types and amounts of radioactive material used, occupational dose reports, and continuing education and training for all personnel who work with or in the vicinity of radioactive material. The purpose of the review is to ensure that individuals make every reasonable effort to maintain occupational doses, doses to the general public, and releases of radioactive material as low as reasonably achievable, taking into account the state of technology, and the cost of improvements in relation to benefits.

d. The licensee shall retain a current written description of the ALARA program for the duration of the license. The written description shall include:

- (1) A commitment by management to keep occupational doses as low as reasonably achievable;
- (2) A requirement that the radiation safety officer brief management once each year on the radiation safety program;
- (3) Personnel exposure investigational levels as established in accordance with 41.2(9) "b"(8) that, when exceeded, will initiate an investigation by the radiation safety officer of the cause of the exposure; and
- (4) Personnel exposure investigational levels that, when exceeded, will initiate a prompt investigation by the radiation safety officer of the cause of the exposure and a consideration of actions that might be taken to reduce the probability of recurrence.

**41.2(8) Radiation safety officer.**

a. A licensee shall appoint a radiation safety officer responsible for implementing the radiation safety program. The licensee, through the radiation safety officer, shall ensure that radiation safety activities are being performed in accordance with approved procedures and regulatory requirements in the daily operation of the licensee's radioactive material program.

b. The radiation safety officer shall:

- (1) Investigate overexposures, accidents, spills, losses, thefts, unauthorized receipts, uses, transfers, and disposals, and other deviations from approved radiation safety practice and implement corrective actions as necessary;
- (2) Implement written policy and procedures for:
  1. Authorizing the purchase of radioactive material;
  2. Receiving and opening packages of radioactive material;
  3. Storing radioactive material;
  4. Keeping an inventory record of radioactive material;
  5. Using radioactive material safely;
  6. Taking emergency action if control of radioactive material is lost;
  7. Performing periodic radiation surveys;
  8. Performing checks and calibrations of survey instruments and other safety equipment;
  9. Disposing of radioactive material;
  10. Training personnel who work in or frequent areas where radioactive material is used or stored;

and

11. Keeping a copy of all records and reports required by the agency rules, a copy of these rules, a copy of each licensing request and license and amendments, and the written policy and procedures required by the rules; and

- (3) For medical use not sited at a medical institution, approve or disapprove radiation safety program changes with the advice and consent of management prior to submittal to the agency for licensing action; or

- (4) For medical use sited at a medical institution, assist the radiation safety committee in the performance of its duties.

**41.2(9) Radiation safety committee.** Each medical institution licensee shall establish a radiation safety committee to oversee the use of radioactive material.

a. The committee shall meet the following administrative requirements:

(1) Membership must consist of at least three individuals and shall include an authorized user of each type of use permitted by the license, the radiation safety officer, a representative of the nursing service, and a representative of management who is neither an authorized user nor a radiation safety officer. Other members may be included as the licensee deems appropriate.

(2) The committee shall meet at least once each calendar quarter.

(3) Rescinded IAB 10/1/14, effective 11/5/14.

(4) The minutes of each radiation safety committee meeting shall include:

1. The date of the meeting;

2. Members present;

3. Members absent;

4. Summary of deliberations and discussions;

5. Recommended actions and the numerical results of all ballots; and

6. Document any reviews required in 41.2(7) "c" and 41.2(9) "b."

(5) The committee shall provide each member with a copy of the meeting minutes and retain one copy until the agency authorizes its disposition.

b. To oversee the use of licensed material, the committee shall:

(1) Be responsible for monitoring the institutional program to maintain occupational doses as low as reasonably achievable;

(2) Review:

1. Review, on the basis of safety and with regard to the training and experience standards of this rule, and approve or disapprove any individual who is to be listed as an authorized user, an authorized nuclear pharmacist, the radiation safety officer, or teletherapy physicist before submitting a license application or request for amendment or renewal;

2. Review on the basis of the board certification, the license, or the permit identifying an individual, and approve or disapprove any individual prior to allowing that individual to work as an authorized user or authorized nuclear pharmacist.

(3) Review on the basis of safety and approve or disapprove each proposed method of use of radioactive material;

(4) Review on the basis of safety, and approve with the advice and consent of the radiation safety officer and the management representative, or disapprove procedures and radiation safety program changes prior to submittal to the agency for licensing action;

(5) Review quarterly, with the assistance of the radiation safety officer, occupational radiation exposure records of all personnel working with radioactive material;

(6) Review quarterly, with the assistance of the radiation safety officer, all incidents involving radioactive material with respect to cause and subsequent actions taken;

(7) Review annually, with the assistance of the radiation safety officer, the radioactive material program; and

(8) Establish a table of investigational levels for occupational dose that, when exceeded, will initiate investigations and considerations of action by the radiation safety officer.

**41.2(10) Authority and responsibilities for the radiation protection program.**

a. In addition to the radiation protection program requirements of 641—40.10(136C), a licensee's management shall approve in writing:

(1) Requests for a license application, renewal, or amendment before submittal to this agency;

(2) Any individual before allowing that individual to work as an authorized user, authorized nuclear pharmacist, or authorized medical physicist; and

(3) Radiation protection program changes that do not require a license amendment.

b. A licensee's management shall appoint a radiation safety officer, who agrees, in writing, to be responsible for implementing the radiation protection program. The licensee, through the radiation safety officer, shall ensure that the radiation safety activities are being performed in accordance with licensee-approved procedures and regulatory requirements.

c. For up to 60 days each year, a licensee may permit an authorized user or an individual qualified to be a radiation safety officer under 41.2(65) or 41.2(75) to function as a temporary radiation safety

officer to perform the functions of radiation safety officer, as provided in 41.2(10) “g,” if the licensee takes the actions required in 41.2(10) “b,” “e,” “g,” and “h” and notifies this agency in accordance with 41.2(5).

*d.* A licensee may simultaneously appoint more than one temporary radiation safety officer in accordance with 41.2(10) “c” if needed to ensure that the licensee has a temporary radiation safety officer who satisfies the requirements to be a radiation safety officer for each of the different types of by-product material permitted on the license.

*e.* A licensee shall establish the authority, duties, and responsibilities of the radiation safety officer in writing.

*f.* Licensees that are authorized for two or more different types of uses of radioactive materials or two or more types of units under this rule shall establish a radiation safety committee to oversee all uses of radioactive material permitted by the license.

*g.* A licensee shall provide the radiation safety officer sufficient authority, organizational freedom, time, resources, and management prerogative to:

- (1) Identify radiation safety problems;
- (2) Initiate, recommend, or provide corrective solutions;
- (3) Verify implementation of corrective actions; and
- (4) Stop unsafe operations.

*h.* A licensee shall retain a record of actions taken under 41.2(10) in accordance with 641—40.80(136C).

**41.2(11) Supervision.**

*a.* A licensee that permits the receipt, possession, use, or transfer of radioactive material by an individual under the supervision of an authorized user as allowed by 41.2(3) shall, in addition to the requirements in 641—40.111(136C):

(1) Instruct the supervised individual in the licensee’s written radiation protection procedures, written directive procedures, rules of this chapter, and license conditions appropriate to that individual’s use of radioactive material;

(2) Review the supervised individual’s use of radioactive material, provide reinstruction as needed and review records kept to reflect this use;

(3) Require the authorized user to be immediately available to communicate with the supervised individual;

(4) Require the authorized user to be able to be physically present and available to the supervised individual on one hour’s notice (the supervising authorized user need not be present for each use of radioactive material); and

(5) Require that only those individuals certified and issued a current permit to practice in accordance with 641—Chapter 42 as a nuclear medicine technologist or a radiation therapist, as applicable, or an Iowa-licensed physician and designated by the authorized user, shall be permitted to administer radionuclides (sealed sources only for radiation therapists) or radiation to patients or human research subjects. For a nuclear medicine technologist or a radiation therapist, the individual’s permit to practice shall be made available at the individual’s place of employment. If the permit holder works at more than one facility, a duplicate of the permit shall be kept at each facility.

*b.* A license shall require the supervised individual receiving, possessing, using or transferring radioactive material under 41.2(3) to:

(1) Follow the instructions of the supervising authorized user for the medical uses of by-product material;

(2) Follow the written radiation protection and written directive procedures established by the radiation safety officer; and

(3) Comply with these rules and the license conditions with respect to the use of radioactive material.

*c.* A licensee that permits the preparation of radioactive material for medical use by an individual under the supervision of an authorized nuclear pharmacist or physician who is an authorized user, as allowed by 41.2(3) “c,” shall, in addition to the requirements in 641—40.111(136C):

(1) Instruct the supervised individual in the preparation of radioactive material for medical use and the principles of and procedures for radiation safety and in the licensee's written procedures for maintaining written directives, as appropriate to that individual's use of radioactive material;

(2) Require the supervised individual to follow the instructions of the supervising authorized user or authorized nuclear pharmacist regarding the preparation of radioactive material for medical use, written radiation protection procedures established by the licensee, the regulations of this chapter and license conditions; and

(3) Require the supervising authorized nuclear pharmacist or physician who is an authorized user to periodically review the work of the supervised individual as it pertains to preparing radioactive material for medical use and the records kept to reflect that work.

*d.* A licensee that supervises an individual is responsible for the acts and omissions of the supervised individual.

**41.2(12) *Visiting authorized user and visiting authorized nuclear pharmacist.***

*a.* A licensee may permit any visiting authorized user or visiting authorized nuclear pharmacist to use licensed material for medical use under the terms of the licensee's license for 60 days each year if:

(1) The visiting authorized user or visiting authorized nuclear pharmacist has the prior written permission of the licensee's management and, if the use occurs on behalf of an institution, the institution's radiation safety committee;

(2) The licensee has a copy of an agency, agreement state, licensing state or U.S. Nuclear Regulatory Commission license that identifies the visiting authorized user or visiting authorized nuclear pharmacist by name as an authorized user for medical use; and

(3) Only those procedures for which the visiting authorized user or visiting authorized nuclear pharmacist is specifically authorized by an agency (agreement state, licensing state or U.S. Nuclear Regulatory Commission) license are performed by that individual.

*b.* A licensee need not apply for a license amendment in order to permit a visiting authorized user or visiting authorized nuclear pharmacist to use licensed material as described in 41.2(12) "a."

*c.* A licensee shall retain copies of the records specified in 41.2(12) "a" for five years from the date of the last visit.

**41.2(13) *Mobile nuclear medicine service administrative requirements.***

*a.* The agency will only license mobile nuclear medicine services in accordance with this rule and other applicable requirements of these rules.

*b.* Mobile nuclear medicine service licensees shall retain for the duration of service a letter signed by the management of each location where services are rendered that authorizes use of radioactive material and clearly delineates the authority of the licensee and client.

*c.* If a mobile nuclear medicine service provides services that the client is also authorized to provide, the client is responsible for ensuring that services are conducted in accordance with the rules in this chapter while the mobile nuclear medicine service is under the client's direction.

*d.* A mobile nuclear medicine service shall not have radioactive material delivered directly from the manufacturer or the distributor to the client's address of use.

*e.* Mobile nuclear medicine service licensees shall also perform the following:

(1) Check instruments used to measure the activity of unsealed radioactive material for proper function before use at each client's address or on each day of use, whichever is more frequent. At a minimum, the check for proper function required by this rule must include a constancy check;

(2) Check survey instruments for proper operation with a dedicated check source before use at each client's address;

(3) Before leaving a client's address, survey all areas of use to ensure compliance with the requirements of 641—Chapters 40 and 41.

**41.2(14) *Records and reports of misadministrations and reportable medical events.***

*a.* When a misadministration or reportable medical event, as defined in 641—38.2(136C), occurs, the licensee shall notify the agency by telephone. The licensee shall also notify the referring physician of the affected patient or human research subject and the patient or human research subject or a responsible relative or guardian, unless the referring physician agrees to inform the patient or human

research subject or believes, based on medical judgment, that telling the patient or human research subject or the patient's or human research subject's responsible relative or guardian would be harmful to one or the other, respectively. These notifications must be made within 24 hours after the licensee discovers the misadministration or reportable medical event. If the referring physician, patient or human research subject, or the patient's or human research subject's responsible relative or guardian cannot be reached within 24 hours, the licensee shall notify them as soon as practicable. The licensee is not required to notify the patient or human research subject or the patient's or human research subject's responsible relative or guardian without first consulting the referring physician; however, the licensee shall not delay medical care for the patient or human research subject because of this notification requirement including remedial care as a result of the misadministration or reportable medical event because of any delay in notification.

*b.* Written reports.

(1) The licensee shall submit a written report to the agency within 15 days after discovery of the misadministration or reportable medical event. The written report must include the licensee's name, the prescribing physician's name, a brief description of the event, why the event occurred, the effect on the patient or the human research subject, what improvements are needed to prevent recurrence, actions taken to prevent recurrence, whether the licensee notified the patient or the human research subject or the patient's or the human research subject's responsible relative or guardian (this individual will subsequently be referred to as "the patient or the human research subject"), and if not, why not, and if the patient or the human research subject was notified, what information was provided to that individual. The report must not include the patient's or the human research subject's name or other information that could lead to identification of the patient or the human research subject.

(2) If the patient or the human research subject was notified, the licensee shall also furnish, within 15 days after discovery of the misadministration or reportable medical event, a written report to the patient or the human research subject and the referring physician by sending either:

1. A copy of the report that was submitted to the agency; or

2. A brief description of both the event and the consequences as they may affect the patient or the human research subject, provided a statement is included that the report submitted to the agency can be obtained from the licensee.

*c.* Rescinded IAB 4/4/01, effective 5/9/01.

*d.* Each licensee shall retain a record of each misadministration for ten years and each reportable medical event for three years. The record shall contain the names of all individuals involved in the event, including the physician, allied health personnel, the patient or human research subject, and the patient's or human research subject's referring physician, the patient's or human research subject's social security number or identification number if one has been assigned, a brief description of the event, why it occurred, the effect on the patient or human research subject, what improvements are needed to prevent recurrence, and the action taken, if any, to prevent recurrence.

*e.* Aside from the notification requirement, nothing in 41.2(14) "a" to 41.2(14) "d" shall affect any rights or duties of licensees and physicians in relation to each other, patients or human research subjects, or responsible relatives or guardians.

*f.* Report and notification of a dose to an embryo/fetus or a nursing child.

(1) A licensee shall report any dose to an embryo/fetus that is greater than 5 rem (50 mSv) dose equivalent that is a result of an administration of by-product material or radiation from by-product material to a pregnant individual unless the embryo/fetus was specifically approved, in advance, by the authorized user.

(2) A licensee shall report any dose to a nursing child that is a result of an administration of by-product material to a breast-feeding individual that:

1. Is greater than 5 rem (50 mSv) total effective dose equivalent; or

2. Has resulted in unintended permanent functional damage to an organ or a physiological system of the child, as determined by a physician.

(3) The licensee shall notify this agency by telephone no later than the next calendar day after a dose to the embryo/fetus or nursing child that requires a report in 41.2(14) "f"(1) or (2).

(4) The licensee shall submit a written report to the agency within 15 days after discovery of a dose to the embryo/fetus or nursing child that requires a report in 41.2(14) "f"(1) or (2).

1. The written report must include:

- The licensee's name;
- The name of the prescribing physician;
- A brief description of the event;
- Why the event occurred;
- The effect, if any, on the embryo/fetus or the nursing child;
- What actions, if any, have been taken or are planned to prevent recurrence; and
- Certification that the licensee notified the pregnant individual or mother (or the mother's or child's responsible relative or guardian), and if not, why not.

2. The report must not contain the individual's or child's name or any other information that could lead to identification of the individual or child.

(5) The licensee shall provide notification of the event to the referring physician and also notify the pregnant individual or mother, both hereafter referred to as the mother, no later than 24 hours after discovery of an event that would require reporting under 41.2(14) "f"(1) or (2), unless the referring physician personally informs the licensee either that the physician will inform the mother or that, based on medical judgment, telling the mother would be harmful. The licensee is not required to notify the mother without first consulting with the referring physician. If the referring physician or mother cannot be reached within 24 hours, the licensee shall make the appropriate notifications as soon as possible thereafter. The licensee may not delay any appropriate medical care for the embryo/fetus or for the nursing child, including any necessary remedial care as a result of the event, because of any delay in notification. To meet the requirements of this paragraph, the notification may be made to the mother's or child's responsible relative or guardian instead of the mother. If a verbal notification is made, the licensee shall inform the mother, or the mother's or child's responsible relative or guardian, that a written description of the event can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.

(6) A licensee shall:

1. Annotate a copy of the report provided to the agency with the:

- Name of the pregnant individual or the nursing child who is the subject of the event; and
- Social security number or other identification number, if one has been assigned, of the pregnant individual or the nursing child who is the subject of the event; and

2. Provide a copy of the annotated report to the referring physician, if other than the licensee, no later than 15 days after the discovery of the event.

**41.2(15) Suppliers.** A licensee shall use for medical use only:

a. Radioactive material manufactured, labeled, packaged, and distributed in accordance with a license issued pursuant to these rules or the equivalent regulations of another agreement state, a licensing state or the U.S. Nuclear Regulatory Commission; and

b. Reagent kits that have been manufactured, labeled, packaged, and distributed in accordance with an approval issued by the U.S. Food and Drug Administration;

c. Teletherapy sources manufactured and distributed in accordance with a license issued pursuant to these rules, or the equivalent regulations of another agreement state, a licensing state, or the U.S. Nuclear Regulatory Commission.

**41.2(16) Quality control of imaging equipment.** Each licensee shall establish written quality control procedures for all equipment used to obtain images from radionuclide studies. As a minimum, the procedures shall include quality control procedures recommended by equipment manufacturers or procedures which have been approved by the agency. The licensee shall conduct quality control procedures in accordance with written procedures.

**41.2(17) Possession, use, calibration, and check of dose calibrators.**

a. A medical use licensee authorized to administer radiopharmaceuticals shall possess a dose calibrator and use it to measure the amount of activity administered to each patient or human research subject.

b. A licensee shall:

(1) Check each dose calibrator for constancy with a dedicated check source at the beginning of each day of use. To satisfy the requirement of this section, the check shall be done on frequently used settings with a sealed source of not less than 10 microcuries (370 kBq) of radium-226 or 50 microcuries (1.85 MBq) of any other photon-emitting radionuclide with a half-life greater than 90 days;

(2) Test each dose calibrator for accuracy upon installation and at 12-month intervals thereafter by assaying at least two sealed sources containing different radionuclides, the activity of which the manufacturer has determined within 5 percent of the stated activity, with minimum activity of 10 microcuries (370 kBq) for radium-226 and 50 microcuries (1.85 MBq) for any other photon-emitting radionuclide, and at least one of which has a principal photon energy between 100 keV and 500 keV;

(3) Test each dose calibrator for linearity upon installation and at 3-month intervals thereafter over the range of use between 30 microcuries (1.1 megabecquerels) and the highest dosage that will be administered; and

(4) Test each dose calibrator for geometry dependence upon installation over the range of volumes and volume configurations for which it will be used. The licensee shall keep a record of this test for the duration of the use of the dose calibrator.

c. A licensee shall mathematically correct dosage readings for any geometry or linearity error that exceeds 10 percent if the dosage is greater than 10 microcuries (370 kBq) and shall repair or replace the dose calibrator if the accuracy or constancy error exceeds 10 percent.

d. A licensee shall also perform checks and tests required by 41.2(17)“b” following adjustment or repair of the dose calibrator.

e. A licensee shall retain a record of each check and test required by 41.2(17) for three years. The records required by 41.2(17)“b” shall include:

(1) For 41.2(17)“b”(1), the model and serial number of the dose calibrator, the identity and calibrated activity of the radionuclide contained in the check source, the date of the check, the activity measured, the instrument settings, and the initials of the individual who performed the check;

(2) For 41.2(17)“b”(2), the model and serial number of the dose calibrator, the model and serial number of each source used and the identity of the radionuclide contained in the source and its activity, the date of the test, the results of the test, the instrument settings, the identity of the individual performing the test, and the signature of the radiation safety officer;

(3) For 41.2(17)“b”(3), the model and serial number of the dose calibrator, the calculated activities, the measured activities, the date of the test, the identity of the individual performing the test, and the signature of the radiation safety officer; and

(4) For 41.2(17)“b”(4), the model and serial number of the dose calibrator, the configuration calibrated activity of the source measured, the activity of the source, the activity measured and the instrument setting for each volume measured, the date of the test, the identity of the individual performing the test, and the signature of the radiation safety officer.

**41.2(18) Calibration and check of survey instruments.**

a. A licensee shall ensure that the survey instruments used to show compliance with this rule have been calibrated before first use, annually, and following repair.

b. To satisfy the requirements of 41.2(18)“a,” the licensee shall:

(1) Calibrate all required scale readings up to 1000 millirems (10 mSv) per hour with a radiation source;

(2) For each scale that shall be calibrated, calibrate two readings separated by at least 50 percent of scale rating; and

(3) Conspicuously note on the instrument the apparent dose rate from a dedicated check source as determined at the time of calibration, and the date of calibration.

c. To satisfy the requirements of 41.2(18)“b,” the licensee shall consider a point as calibrated if the indicated exposure rate differs from the calculated exposure rate by not more than 20 percent and shall conspicuously attach a correction chart or graph to the instrument. A licensee may not use survey instruments if the difference between the indicated exposure rate and the calculated exposure rate is more than 20 percent.

*d.* A licensee shall check each survey instrument for proper operation with the dedicated check source before each use. The licensee is not required to keep records of these checks.

*e.* The licensee shall retain a record of each calibration required in 41.2(18)“*a*” for three years. The record shall include:

- (1) A description of the calibration procedure; and
- (2) A description of the source used and the certified dose rates from the source, the rates indicated by the instrument being calibrated, the correction factors deduced from the calibration data, the signature of the individual who performed the calibration, and the date of calibration.

*f.* To meet the requirements of 41.2(18)“*a*,” “*b*,” and “*c*,” the licensee may obtain the services of individuals licensed by the agency, the U.S. Nuclear Regulatory Commission, an agreement state, or a licensing state to perform calibrations of survey instruments. Records of calibrations which contain information required by 41.2(18)“*e*” shall be maintained by the licensee.

*g.* Rescinded IAB 8/1/07, effective 9/5/07.

**41.2(19) Assay of radiopharmaceutical dosages.** A licensee shall:

*a.* Assay, prior to medical use, the activity of each radiopharmaceutical dosage that contains a photon-emitting radionuclide;

*b.* Measure, by direct measurement or by combination of measurements and calculations, the activity of each dosage of an alpha- or beta-emitting radionuclide prior to medical use, except for unit dosages obtained from a manufacturer or preparer licensed pursuant to 641—paragraph 39.4(29)“*j*” or equivalent NRC or agreement state requirements;

*c.* Not use a dosage if the dosage does not fall within the prescribed dosage range or if the dosage differs from the prescribed dosage by more than 20 percent unless otherwise directed by the authorized user; and

*d.* Retain a record of the assays required by 41.2(19)“*a*” for three years. To satisfy this requirement, the record shall contain the:

- (1) Generic name, trade name, or abbreviation of the radiopharmaceutical, its lot number, and expiration dates and the radionuclide;
- (2) Patient’s or human research subject’s name and identification number if one has been assigned;
- (3) Prescribed dosage and activity of the dosage at the time of assay, or a notation that the total activity is less than 30 microcuries (1.1 megabecquerels);
- (4) Date and time of the assay and administration; and
- (5) Initials of the individual who performed the assay.

**41.2(20) Authorization for calibration and reference sources.** Any person authorized by 41.2(3) for medical use of radioactive material may receive, possess, and use the following radioactive material for check, calibration and reference use:

*a.* Sealed sources manufactured and distributed by persons specifically licensed pursuant to 641—Chapter 39 or equivalent provisions of the U.S. Nuclear Regulatory Commission, agreement state or licensing state and that do not exceed 30 millicuries (1.11 GBq) each;

*b.* Any radioactive material listed in 41.2(31) or 41.2(33) with a half-life of 120 days or less in individual amounts not to exceed 15 millicuries (555 MBq);

*c.* Any radioactive material listed in 41.2(31) or 41.2(33) with a half-life greater than 120 days in individual amounts not to exceed 200 microcuries (7.4 MBq) each; and

*d.* Technetium-99m amounts as needed.

**41.2(21) Requirements for possession of sealed sources and brachytherapy sources.**

*a.* A licensee in possession of any sealed source or brachytherapy source shall follow the radiation safety and handling instructions supplied by the manufacturer or equivalent instructions approved by the agency and shall maintain the instructions for the duration of source use in a legible form convenient to users.

*b.* A licensee in possession of a sealed source shall ensure that:

- (1) The source is tested for leakage before its first use unless the licensee has a certificate from the supplier indicating that the source was tested within six months before transfer to the licensee; and

(2) The source is tested for leakage at intervals not to exceed six months or at intervals approved by the agency, another agreement state, a licensing state or the U.S. Nuclear Regulatory Commission.

*c.* To satisfy the leak test requirements of 41.2(21) “*b*,” the licensee shall ensure that:

(1) Leak tests are capable of detecting the presence of 0.005 microcurie (185 Bq) of radioactive material on the test sample or, in the case of radium, the escape of radon at the rate of 0.001 microcurie (37 Bq) per 24 hours;

(2) Test samples are taken from the source or from the surfaces of the device in which the source is mounted or stored on which radioactive contamination might be expected to accumulate; and

(3) Test samples are taken when the source is in the “off” position.

*d.* A licensee shall retain leak test records for five years. The records shall contain the model number, and serial number, if assigned, of each source tested, the identity of each source radionuclide and its estimated activity, the measured activity of each test sample expressed in microcuries (becquerels), a description of the method used to measure each test sample, the date of the test, the signature of the radiation safety officer and the signature of the individual performing the leak test.

*e.* If the leak test reveals the presence of 0.005 microcurie (185 Bq) or more of removable contamination, the licensee shall:

(1) Immediately withdraw the sealed source from use and store it in accordance with the requirements of these rules; and

(2) File a report with the agency within five days of receiving the leak test results. The report shall describe the equipment involved, the model and serial number of the leaking source, the radionuclide and its estimated activity, the test results, the date of the test, and the action taken.

*f.* A licensee need not perform a leak test on the following sources:

(1) Sources containing only radioactive material with a half-life of less than 30 days;

(2) Sources containing only radioactive material as a gas;

(3) Sources containing 100 microcuries (3.7 MBq) or less of beta or photon-emitting material or 10 microcuries (370 kBq) or less of alpha-emitting material; [and]

(4) Seeds of iridium-192 encased in nylon ribbon; and

(5) Sources stored and not being used. The licensee shall, however, test each such source for leakage before any use or transfer unless it has been tested for leakage within six months before the date of use or transfer.

*g.* A licensee in possession of a sealed source or brachytherapy source shall conduct a physical inventory of all such sources at 6-month intervals. The licensee shall retain each inventory record for five years. The inventory records shall contain the model number of each source, and serial number if one has been assigned, the identity of each source radionuclide and its estimated activity, the location of each source, date of the inventory, the signature of the radiation safety officer and the signature of the individual performing the physical inventory.

*h.* A licensee in possession of a sealed source or brachytherapy source shall survey with a radiation survey instrument at intervals not to exceed three months all areas where such sources are stored. This does not apply to teletherapy sources in teletherapy units or sealed sources in diagnostic devices.

*i.* A licensee shall retain a record of each survey required in 41.2(21) “*h*” for three years. The record shall include the date of the survey, a sketch of each area that was surveyed, the measured dose rate at several points in each area expressed in millirems (microsieverts) per hour, the model number and serial number of the survey instrument used to make the survey, and the signature of the radiation safety officer.

**41.2(22) Syringe shields.**

*a.* A licensee shall keep syringes that contain radioactive material to be administered in a radiation shield.

*b.* Unless otherwise approved by this agency, a licensee shall require each individual who prepares or administers radiopharmaceuticals to use a syringe radiation shield unless the use of the shield is contraindicated for that patient or human research subject.

**41.2(23) Syringe labels.** Unless utilized immediately, a licensee shall conspicuously label each syringe, or syringe radiation shield that contains a syringe with a radiopharmaceutical, with the

radiopharmaceutical name or its abbreviation, the type of diagnostic study or therapy procedure to be performed, or the patient's or human research subject's name.

**41.2(24) Vial shields.** A licensee shall require each individual preparing or handling a vial that contains a radiopharmaceutical to keep the vial in a vial radiation shield.

**41.2(25) Vial shield labels.** A licensee shall conspicuously label each vial radiation shield that contains a vial of a radiopharmaceutical with the radiopharmaceutical name or its abbreviation.

**41.2(26) Surveys for contamination and ambient radiation dose rate.**

a. A licensee shall survey with a radiation detection survey instrument at the end of each day of use all areas where radiopharmaceuticals are routinely prepared for use or administered.

b. A licensee shall survey with a radiation detection survey instrument at least once each week all areas where radiopharmaceuticals or radioactive wastes are stored.

c. A licensee shall conduct the surveys required by 41.2(26) "a" and "b" so as to be able to measure dose rates as low as 0.1 millirem (1  $\mu$ Sv) per hour.

d. A licensee shall establish dose rate action levels for the surveys required by 41.2(26) "a" and "b" and shall require that the individual performing the survey immediately notify the radiation safety officer if a dose rate exceeds an action level.

e. A licensee shall survey for removable contamination each day of use all areas where radiopharmaceuticals are routinely prepared for use or administered and each week where radioactive materials are stored.

f. A licensee shall conduct the surveys required by 41.2(26) "e" so as to be able to detect contamination on each wipe sample of 2000 disintegrations per minute (33.3 Bq).

g. A licensee shall establish removable contamination action levels for the surveys required by 41.2(26) "e" and shall require that the individual performing the survey immediately notify the radiation safety officer if contamination exceeds action levels.

h. A licensee shall retain a record of each survey required by 41.2(26) "a," "b," and "e" for two years. The record must include the date of the survey, a sketch of each area surveyed, action levels established for each area, the measured dose rate at several points in each area expressed in millirems (microsieverts) per hour or the removable contamination in each area expressed in disintegrations per minute (becquerels) per 100 square centimeters, the serial number and the model number of the instrument used to make the survey or analyze the samples, and the initials of the individual who performed the survey.

i. A licensee does not need to perform the surveys required in this subrule in an area where the patient or human research subject is confined and cannot be released under 41.2(27).

**41.2(27) Release of patients or human research subjects containing radiopharmaceuticals or permanent implants.**

a. The licensee may authorize the release from its control of any individual who has been administered unsealed radioactive materials or permanent implants containing radioactive material if the total effective dose equivalent to any other individual from exposure to the released individual is not likely to exceed 0.5 rem (5 mSv). (NUREG-1556, Vol. 9, "Consolidated Guidance About Materials Licenses: Program-Specific Guidance About Medical Licenses," describes methods for calculating doses to other individuals and contains tables of activities not likely to cause doses exceeding 0.5 rem (5 mSv).)

b. The licensee shall provide the released individual with instructions, including written instructions, on actions recommended to maintain doses to other individuals as low as is reasonably achievable if the total effective dose equivalent to any other individual is likely to exceed 0.1 rem (1 mSv). If the dose to a breast-feeding infant or child could exceed 0.1 rem (1 mSv) assuming there were no interruption of breast feeding, the instructions shall also include:

- (1) Guidance on the interruption or discontinuation of breast feeding, and
- (2) Information on the consequences of failure to follow the guidance.

c. The licensee shall maintain a record of the basis for authorizing the release of an individual, for three years after the date of release, if the total effective dose equivalent is calculated by:

- (1) Using the retained activity rather than the activity administered,

- (2) Using an occupancy factor less than 0.25 at 1 meter,
- (3) Using the biological or effective half-life, or
- (4) Considering the shielding by tissue.

*d.* The licensee shall maintain a record for three years after the date of release that instructions were provided to a breast-feeding woman if the radiation dose to the infant or child from continued breast feeding could result in a total effective dose equivalent exceeding 0.5 rem (5 mSv). IDPH Regulatory Guide, Release of Patients Administered Radioactive Materials describes methods for calculating doses to other individuals and contains tables of activities not likely to cause doses exceeding 0.5 rem (5 mSv).

**41.2(28) *Mobile nuclear medicine service technical requirements.*** A licensee providing mobile nuclear medicine service shall:

*a.* Transport to each address of use only syringes or vials containing prepared radiopharmaceuticals or radiopharmaceuticals that are intended for reconstitution of radiopharmaceutical kits;

*b.* Bring into each location of use all radioactive material to be used and, before leaving, remove all unused radioactive material and associated radioactive waste;

*c.* Secure or keep under constant surveillance and immediate control all radioactive material when in transit or at a location of use;

*d.* Check survey instruments and dose calibrators as required in 41.2(17) “*b*”(1) “*d*” and “*e*” and 41.2(18) “*d*” and check all other transported equipment for proper function before medical use at each location of use;

*e.* Carry a calibrated survey meter in each vehicle that is being used to transport radioactive material and, before leaving a client location of use, survey all areas of radiopharmaceutical use with a radiation detection survey instrument to ensure that all radiopharmaceuticals and all associated radioactive waste have been removed; and

*f.* Retain a record of each survey required by 41.2(28) “*e*” for three years. The record must include the date of the survey, a plan of each area that was surveyed, the measured dose rate at several points in each area of use expressed in millirems (microsieverts) per hour, the model and serial number of the instrument used to make the survey, and the initials of the individual who performed the survey.

**41.2(29) *Storage of volatiles and gases.***

*a.* A licensee shall store volatile radiopharmaceuticals and radioactive gases in the shippers’ radiation shield and container.

*b.* A licensee shall store and use a multidose container in a properly functioning fume hood.

**41.2(30) *Decay-in-storage.***

*a.* A licensee may hold radioactive material with a physical half-life of less than or equal to 120 days for decay-in-storage before disposal without regard to its radioactivity if the licensee:

(1) Holds radioactive material for decay a minimum of ten half-lives;

(2) Monitors radioactive material at the container surface before disposal as ordinary trash and determines that its radioactivity cannot be distinguished from the background radiation level with a radiation detection survey instrument set on its most sensitive scale and with no interposed shielding;

(3) Removes or obliterates all radiation labels; and

(4) Separates and monitors each generator column individually with all radiation shielding removed to ensure that its contents have decayed to background radiation level before disposal.

*b.* For radioactive material disposed in accordance with 41.2(30) “*a*,” the licensee shall retain a record of each disposal for three years. The record must include the date of the disposal, the date on which the radioactive material was placed in storage, the radionuclides disposed, the model and serial number of the survey instrument used, the background dose rate, the radiation dose rate measured at the surface of each waste container, and the name of the individual who performed the disposal.

**41.2(31) *Use of unsealed radioactive material for uptake, dilution, or excretion studies for which a written directive is not required.*** Except for quantities that require a written directive under 41.2(87), a licensee may use for uptake, dilution, or excretion studies any unsealed radioactive material prepared for medical use that:

*a.* Is obtained from a manufacturer or preparer licensed pursuant to 641—paragraph 39.4(29) “*j*” or equivalent NRC or agreement state requirements or from a PET radioactive drug producer licensed pursuant to 641—paragraph 39.4(24) “*h*” or equivalent NRC or agreement state requirements; or

*b.* Excludes production of PET radionuclides, prepared by:

(1) An authorized nuclear pharmacist;

(2) A physician who is an authorized user and who meets the requirements specified in 41.2(68) or 41.2(69) and has work experience in eluting generator systems appropriate for preparation of radioactive drugs for imaging and localization studies, measuring and testing the eluate for radionuclidic purity, and processing the eluate with reagent kits to prepare labeled radioactive drugs; or

(3) An individual under the supervision, as specified in 41.2(11), of the authorized nuclear pharmacist in 41.2(31) “*b*”(1) or the physician who is an authorized user in 41.2(31) “*b*”(2); or

*c.* Is obtained from and prepared by an NRC or agreement state licensee for use in research in accordance with Radioactive Drug Research Committee-approved protocol or an Investigational New Drug (IND) protocol accepted by FDA; or

*d.* Is prepared by the licensee for use in research in accordance with a Radioactive Drug Research Committee-approved application or an Investigational New Drug (IND) protocol accepted by FDA.

**41.2(32) *Possession of survey instrument.*** A licensee authorized to use radioactive material for uptake, dilution, and excretion studies shall possess a portable radiation detection survey instrument capable of detecting dose rates over the range 0.1 millirem (1.0  $\mu$ Sv) per hour to 50 millirems (500  $\mu$ Sv) per hour. The instrument shall be operable and calibrated in accordance with 41.2(18).

**41.2(33) *Use of unsealed by-product material for imaging and localization studies for which a written directive is not required.*** Except for quantities that require a written directive under 41.2(87), a licensee may use for imaging and localization studies any unsealed by-product material prepared for medical use that:

*a.* Is obtained from a manufacturer or preparer licensed pursuant to 641—paragraph 39.4(29) “*j*” or equivalent NRC or agreement state requirements or a PET radioactive drug producer licensed pursuant to 641—paragraph 39.4(24) “*h*” or equivalent NRC or agreement state requirements; or

*b.* Excludes production of PET radionuclides, prepared by:

(1) An authorized nuclear pharmacist;

(2) A physician who is an authorized user and who meets the requirements specified in 41.2(68) or 41.2(69);

(3) An individual under the supervision, as specified in 41.2(11), of the authorized nuclear pharmacist in 41.2(33) “*b*”(1) or the physician who is an authorized user in 41.2(33) “*b*”(2); or

*c.* Is obtained from and prepared by an NRC or agreement state licensee for use in research in accordance with Radioactive Drug Research Committee-approved protocol or an Investigational New Drug (IND) protocol accepted by FDA; or

*d.* Is prepared by the licensee for use in research in accordance with a Radioactive Drug Research Committee-approved application or an Investigational New Drug (IND) protocol accepted by FDA.

**41.2(34) *Permissible molybdenum-99, strontium-82, and strontium-85 concentrations.***

*a.* A licensee shall not administer to humans a radiopharmaceutical that contains:

(1) More than 0.15 microcurie of molybdenum-99 per millicurie of technetium-99m (0.15 kilobecquerel of molybdenum-99 per megabecquerel of technetium-99m); or

(2) More than 0.02 microcurie of strontium-82 per millicurie of rubidium-82 chloride injection (0.02 kilobecquerel strontium-82 per megabecquerel rubidium-82 chloride); or more than 0.2 microcurie of strontium-85 per millicurie of rubidium-82 chloride injection (0.2 kilobecquerel strontium-85 per megabecquerel rubidium-82 chloride).

*b.* A licensee preparing:

(1) Technetium-99m radiopharmaceuticals from molybdenum-99/technetium-99m generators shall measure the molybdenum-99 concentration in each eluate or extract; or

(2) Rubidium-82 radiopharmaceuticals from strontium-82/rubidium-82 generators shall measure the strontium-82 and strontium-85 concentration before the first patient use of the day.

c. A licensee who must measure molybdenum-99, strontium-82, or strontium-85 concentration shall retain a record of each measurement for three years. The record shall include:

(1) For each elution or extraction of technetium-99m, the ratio of the measures expressed as microcuries of molybdenum per millicurie of technetium (kilobecquerels of molybdenum per megabecquerel of technetium), the date of the test, and the initials of the individual who performed the test.

(2) For each elution or extraction of rubidium-82, the ratio of the measures expressed as microcuries of strontium-82 per millicurie of rubidium-82 (kilobecquerels of strontium-82 per megabecquerel of rubidium-82), microcuries of strontium-85 per millicurie of rubidium-82 (kilobecquerels of strontium-85 per millicurie of rubidium-82), the date of the test, and the initials of the individual who performed the test.

d. A licensee shall report immediately to the agency each occurrence of molybdenum-99 concentration exceeding the limits specified in 41.2(34)“a”(1) and strontium-82 or strontium-85 concentration exceeding the limits specified in 41.2(34)“a”(2).

**41.2(35) Control of aerosols and gases.**

a. A licensee who administers radioactive aerosols or gases shall do so with a system that will keep airborne concentrations within the limits prescribed by 641—40.15(136C) and 641—40.26(136C) of these rules.

b. The system shall either be directly vented to the atmosphere through an air exhaust or provide for collection and decay or disposal of the aerosol or gas in a shielded container.

c. A licensee shall only administer radioactive gases in rooms that are at negative pressure compared to surrounding rooms.

d. Before receiving, using, or storing a radioactive gas, the licensee shall calculate the amount of time needed after a release to reduce the concentration in the area of use to the occupational limit listed in Appendix B of 641—Chapter 40. The calculation shall be based on the highest activity of gas handled in a single container and the measured available air exhaust rate.

e. A licensee shall post the time calculated in 41.2(35)“a” at the area of use and require that, in case of a gas spill, individuals evacuate the room until the posted time has elapsed.

f. A licensee shall check the operation of collection systems monthly and measure the ventilation rates in areas of use at intervals not to exceed six months. Records of these checks and measurements shall be maintained for three years.

g. A copy of the calculations required in 41.2(35)“d” shall be recorded and retained for the duration of the license.

**41.2(36) Possession of survey instruments.** A licensee authorized to use radioactive material for imaging and localization studies shall possess a portable radiation detection survey instrument capable of detecting dose rates over the range of 0.1 millirem (1  $\mu$ Sv) per hour to 50 millirems (500  $\mu$ Sv) per hour, and a portable radiation measurement survey instrument capable of measuring dose rates over the range of 1 millirem (10  $\mu$ Sv) per hour to 1000 millirems (10 mSv) per hour. The instruments shall be operable and calibrated in accordance with 41.2(18).

**41.2(37) Use of unsealed by-product material for which a written directive is required.** A licensee may use any unsealed by-product material prepared for medical use and for which a written directive is required that:

a. Is obtained from:

(1) A manufacturer or preparer licensed under 641—paragraph 39.4(29)“j” or equivalent NRC or agreement state requirements; or

(2) A PET radioactive drug producer licensed under 641—paragraph 39.4(24)“h” or equivalent NRC or agreement state requirements; or

b. Excludes production of PET radionuclides, prepared by:

(1) An authorized nuclear pharmacist;

(2) A physician who is an authorized user and who meets the requirements of 41.2(68) or 41.2(69);

or

(3) An individual under the supervision, as specified in 41.2(11), of the authorized nuclear pharmacist in 41.2(37) "b"(1) or the physician who is an authorized user in 41.2(37) "b"(2); or

c. Is obtained from and prepared by an NRC or agreement state licensee for use in research in accordance with the Investigational New Drug (IND) protocol accepted by FDA; or

d. Is prepared by the licensee for use in research in accordance with an Investigational New Drug (IND) protocol accepted by FDA.

**41.2(38) Safety instruction.**

a. A licensee shall provide oral and written radiation safety instruction for all personnel caring for patients or human research subjects undergoing radiopharmaceutical therapy and hospitalized for compliance with 41.2(27). Refresher training shall be provided initially and at 12-month intervals or as required for patient care.

b. To satisfy 41.2(38) "a," the instruction shall describe the licensee's procedures for:

(1) Patient or human research subject control;

(2) Visitor control;

(3) Contamination control;

(4) Waste control;

(5) Notification of the radiation safety officer, radiation safety officer designee, or authorized user in case of the patient's or human research subject's death or medical emergency; and

(6) Training requirements specified in 641—40.110(136C) and 40.116(136C) and adopted by reference and included herein.

c. A licensee shall keep a record of individuals receiving instruction required by 41.2(38) "a," a description of the instruction, the date of instruction, and the name of the individual who gave the instruction. Such record shall be maintained for inspection by the agency for three years.

**41.2(39) Safety precautions.**

a. For each patient or human research subject receiving radiopharmaceutical therapy and hospitalized for compliance with 41.2(27), a licensee shall:

(1) Provide a private room with a private sanitary facility or a room, with a private sanitary facility, with another individual who also has received therapy with unsealed radioactive material and who also cannot be released under 41.2(27);

(2) Post the patient's or human research subject's door with a "Caution: Radioactive Material" sign and note on the door or on the patient's or human research subject's chart where and how long visitors may stay in the patient's or human research subject's room;

(3) Authorize visits by individuals under 18 years of age only on a case-by-case basis with the approval of the authorized user after consultation with the radiation safety officer;

(4) Promptly after administration of the dosage, measure the dose rates in contiguous restricted and unrestricted areas with a radiation measurement survey instrument to demonstrate compliance with the requirements of 641—subrule 40.26(1) which is adopted by reference and included herein and retain for three years a record of each survey that includes the time and date of the survey, a plan of the area or list of points surveyed, the measured dose rate at several points expressed in millirems ( $\mu\text{Sv}$ ) per hour, the instrument used to make the survey, and the initials of the individual who made the survey;

(5) Either monitor material and items removed from the patient's or human research subject's room to determine that any contamination cannot be distinguished from the natural background radiation level with a radiation detection survey instrument set on its most sensitive scale and with no interposed shielding, or handle these materials and items as radioactive waste;

(6) Provide the patient or human research subject with radiation safety guidance that will help to keep radiation dose to household members and the public as low as reasonably achievable before authorizing release of the patient or human research subject;

(7) Survey the patient's or human research subject's room and private sanitary facility for removable contamination with a radiation detection survey instrument before assigning another patient or human research subject to the room. The room must not be reassigned until removable contamination is less than 200 disintegrations per minute (3.33 Bq) per 100 square centimeters; and

b. A licensee shall notify the radiation safety officer or the authorized user immediately if the patient or human research subject dies or has a medical emergency.

**41.2(40) Possession of survey instruments.** A licensee authorized to use radioactive material for radiopharmaceutical therapy shall possess a portable radiation detection survey instrument capable of detecting dose rates over the range of 0.1 millirem (1  $\mu$ Sv) per hour to 50 millirems (500  $\mu$ Sv) per hour, and a portable radiation measurement survey instrument capable of measuring dose rates over the range of 1 millirem (10  $\mu$ Sv) per hour to 1000 millirems (10 mSv) per hour. The instruments shall be operable and calibrated in accordance with 41.2(18).

**41.2(41) Use of sealed sources for diagnosis.** A licensee shall use only sealed sources for diagnostic medical uses as approved in the Sealed Source and Device Registry.

**41.2(42) Availability of survey instrument.** A licensee authorized to use radioactive material as a sealed source for diagnostic purposes shall have available for use a portable radiation detection survey instrument capable of detecting dose rates over the range of 0.1 millirem (1  $\mu$ Sv) per hour to 50 millirems (500  $\mu$ Sv) per hour or a portable radiation measurement survey instrument capable of measuring dose rates over the range of 1 millirem (10  $\mu$ Sv) per hour to 1000 millirems (10 mSv) per hour. The instrument shall be operable and calibrated in accordance with 41.2(18).

**41.2(43) Use of sources for brachytherapy.** A licensee shall use only brachytherapy sources for therapeutic medical uses:

- a. As approved in the Sealed Source and Device Registry; or
- b. In research in accordance with an active Investigational Device Exemption (IDE) application accepted by the FDA provided the requirements of 41.2(15) are met.

**41.2(44) Safety instruction.**

a. The licensee shall provide oral and written radiation safety instruction to all personnel caring for a patient or human research subject receiving implant therapy. Refresher training shall be provided initially and at 12-month intervals or as required for patient care.

b. To satisfy 41.2(44) "a," the instruction shall describe:

- (1) Size and appearance of the brachytherapy sources;
- (2) Safe handling and shielding instructions in case of a dislodged source;
- (3) Procedures for patient or human research subject control;
- (4) Procedures for visitor control, to include routine visitation of hospitalized individuals in accordance with 641—40.26(136C) and visitation authorized in accordance with 641—40.26(136C);
- (5) Procedures for notification of the radiation safety officer, radiation safety officer designee, or authorized user if the patient or human research subject dies or has a medical emergency; and
- (6) Training requirements specified in 641—40.110(136C) and 40.116(136C) as adopted by reference and included herein.

c. A licensee shall maintain a record of individuals receiving instruction required by 41.2(44) "a," a description of the instruction, the date of instruction, and the name of the individual who gave the instruction for three years.

**41.2(45) Safety precautions.**

a. For each patient or human research subject receiving implant therapy a licensee shall:

- (1) Not place the patient or human research subject in the same room with a patient who is not receiving radiation therapy unless the licensee can demonstrate compliance with the requirement of 641—40.26(136C) as adopted by reference and included herein at a distance of 1 meter from the implant;
- (2) Post the patient's or human research subject's door with a "Caution: Radioactive Materials" sign and note on the door or the patient's or human research subject's chart where and how long visitors may stay in the patient's or human research subject's room;
- (3) Authorize visits by individuals under 18 years of age only on a case-by-case basis with the approval of the authorized user after consultation with the radiation safety officer;
- (4) Promptly after implanting the sources, survey the dose rates in contiguous restricted and unrestricted areas with a radiation measurement survey instrument to demonstrate compliance with 641—40.26(136C) as adopted by reference and included herein; and retain for three years a record of each survey that includes the time and date of the survey, a sketch of the area or list of points surveyed,

the measured dose rate at several points expressed in millirems (mSv) per hour, the instrument used to make the survey, and the initials of the individual who made the survey;

(5) Provide the patient or human research subject with radiation safety guidance that will help keep the radiation dose to household members and the public as low as reasonably achievable before releasing the patient or human research subject if the patient or human research subject was administered a permanent implant; and

(6) Have applicable emergency response equipment available near each treatment room to respond to a source dislodged from the patient or lodged within the patient following removal of the source applicators.

*b.* A licensee shall notify the radiation safety officer, radiation safety officer designee, or authorized user immediately if the patient or human research subject dies or has a medical emergency.

**41.2(46) Brachytherapy sources inventory.**

*a.* Each time brachytherapy sources are returned to an area of storage from an area of use, the licensee shall immediately count or otherwise verify the number returned to ensure that all sources taken from the storage area have been returned.

*b.* A licensee shall make a record of brachytherapy source utilization which includes:

(1) The names of the individuals permitted to handle the sources;

(2) The number and activity of sources removed from storage, the room number of use and patient's or human research subject's name, the time and date they were removed from storage, the number and activity of sources in storage after the removal, and the initials of the individual who removed the sources from storage; and

(3) The number and activity of sources returned to storage, the room number of use and patient's or human research subject's name, the time and date they were returned to storage, the number and activity of sources in storage after the return, and the initials of the individual who returned the sources to storage.

*c.* Immediately after implanting sources in a patient or human research subject and immediately after removal of sources from a patient or human research subject, the licensee shall make a radiation survey of the patient or human research subject and the area of use to confirm that no sources have been misplaced. The licensee shall make a record of each survey.

*d.* A licensee shall maintain the records required in 41.2(46) "b" and "c" for three years.

*e.* A licensee shall maintain accountability at all times for all brachytherapy sources in storage or use. As soon as possible after removing sources from a patient or a human research subject, a licensee shall return brachytherapy sources to a secure storage area.

**41.2(47) Release of patients or human research subjects treated with temporary implants.**

*a.* Immediately after removing the last temporary implant source from a patient or human research subject, the licensee shall perform a radiation survey of the patient or human research subject with a radiation detection survey instrument to confirm that all sources have been removed and, for remote afterloaders, returned to the safe shielded position. The licensee shall not release from confinement for medical care a patient or human research subject treated by temporary implant until all sources have been removed.

*b.* A licensee shall maintain a record of patient or human research subject surveys which demonstrate compliance with 41.2(47) "a" for three years. Each record shall include the date of the survey, the name of the patient or human research subject, the dose rate from the patient or human research subject expressed as millirems (microsieverts) per hour and measured within 1 meter from the patient or human research subject, and the initials of the individual who made the survey.

**41.2(48) Possession of survey instruments.** A licensee authorized to use radioactive material for implant therapy shall possess a portable radiation detection survey instrument capable of detecting dose rates over the range of 0.1 millirem (1  $\mu$ Sv) per hour to 50 millirems (500  $\mu$ Sv) per hour, and a portable radiation measurement survey instrument capable of measuring dose rates over the range of 1 millirem (10  $\mu$ Sv) per hour to 1000 millirems (10 mSv) per hour. The instruments shall be operable and calibrated in accordance with 41.2(18).

**41.2(49) Use of a sealed source in a remote afterloader unit, teletherapy unit, or gamma stereotactic radiosurgery unit.** A licensee shall use sealed sources in photon emitting remote afterloader units,

teletherapy units, or gamma stereotactic radiosurgery units for therapeutic medical uses as approved in the Sealed Source and Device Registry or in research in accordance with an active Investigational Device Exemption (IDE) application accepted by the FDA provided the requirements of 41.2(15) are met.

**41.2(50) *Installation, maintenance, adjustment, and repair.***

*a.* Only a person specifically licensed by the NRC or an agreement state shall install, maintain, adjust, or repair a remote afterloader unit, teletherapy unit, or gamma stereotactic radiosurgery unit that involves work on the source shielding, the source(s) driving unit, or other electronic or mechanical component that could expose the source(s), or reduce the shielding around the source(s), or compromise the radiation safety of the unit or the source(s).

*b.* Except for low-dose-rate remote afterloader units, only a person specifically licensed by the NRC or an agreement state shall install, replace, relocate, or remove a sealed source or source contained in other remote afterloader units, teletherapy units, or gamma stereotactic radiosurgery units.

*c.* For low-dose-rate remote afterloader units, only a person specifically licensed by the NRC or an agreement state or an authorized medical physicist shall install, replace, relocate, or remove a sealed source(s) contained in the unit.

*d.* A licensee shall retain a record of the installation, maintenance, adjustment, and repair of remote afterloader units, teletherapy units and gamma stereotactic radiosurgery units for three years. The record must include the date, description of the service, and the name of the individual who performed the work.

**41.2(51) *Amendments.*** In addition to the requirements specified in 41.2(4), a licensee shall apply for and receive a license amendment before:

- a.* Making any change in the treatment room shielding;
- b.* Making any change in the location of the teletherapy unit within the treatment room;
- c.* Using the teletherapy unit in a manner that could result in increased radiation levels in areas outside the teletherapy treatment room;
- d.* Relocating the teletherapy unit; or
- e.* Allowing an individual not listed on the licensee's license to perform the duties of the teletherapy physicist.

**41.2(52) *Safety procedures and instructions for remote afterloader units, teletherapy units, and gamma stereotactic radiosurgery units.***

- a.* A licensee shall:
  - (1) Secure the unit, the console, the console keys, and the treatment room when not in use or unattended;
  - (2) Permit only individuals approved by the authorized user, radiation safety officer, or authorized medical physicist to be present in the treatment room during treatment with the source;
  - (3) Prevent dual operation of more than one radiation producing device in a treatment room, if applicable; and
  - (4) Develop, implement, and maintain written procedures for responding to an abnormal situation when the operator is unable to place the source in the shielded position, or to remove the patient or human research subject from the radiation field with controls from outside the treatment room. These procedures must include:
    1. Instructions for responding to equipment failures and the names of the individuals responsible for implementing corrective actions;
    2. The process for restricting access to and posting of the treatment area to minimize the risk of inadvertent exposure; and
    3. The names and telephone numbers of the authorized users, the authorized medical physicist, and the radiation safety officer to be contacted if the unit or console operates abnormally.
- b.* A copy of the procedures required by 41.2(52) "a"(4) must be physically located at the unit console.
- c.* A licensee shall post instructions at the unit console to inform the operator of:
  - (1) The location of the procedures required by 41.2(52) "a"(4); and

(2) The names and telephone numbers of the authorized users, the authorized medical physicist, and the radiation safety officer to be contacted if the unit or console operates abnormally.

*d.* A licensee shall provide instruction, initially and at least annually, to all individuals who operate the unit, appropriate to the individual's assigned duties, in:

- (1) The procedures identified in 41.2(52) "a"(4); and
- (2) The operating procedures for the unit.

*e.* The licensee shall ensure that operators, authorized medical physicists, and authorized users participate in drills of emergency procedures, initially and at least annually.

*f.* A licensee shall retain a record for three years of individuals receiving instruction required by 41.2(52) "d," a description of the instruction, the date of instruction, and the name of the individual who gave the instruction. A copy of the procedures required in 41.2(52) "a"(4) and 41.2(52) "d"(2) shall be retained for three years.

**41.2(53) Safety precautions for remote afterloader units, teletherapy units, and gamma stereotactic radiosurgery units.**

*a.* A licensee shall control access to the teletherapy room by a door at each entrance.

*b.* A licensee shall equip each entrance to the teletherapy room with an electrical interlock system that shall:

(1) Prevent the operator from turning the primary beam of radiation "on" unless each treatment room entrance door is closed;

(2) Turn the beam of radiation "off" immediately when an entrance door is opened; and

(3) Prevent the primary beam of radiation from being turned "on" following an interlock interruption until all treatment room entrance doors are closed and the beam "on-off" control is reset at the console.

*c.* A licensee shall require any individual entering the treatment room to ensure, through the use of appropriate monitors, that radiation levels have returned to ambient levels.

*d.* Except for low-dose-rate remote afterloader units, a licensee shall construct or equip each treatment room with viewing and intercom systems to permit continuous observation of the patient or human research subject from the treatment console during irradiation.

*e.* For licensed activities where sources are placed within the patient's or human research subject's body, the licensee shall only conduct treatments which allow for expeditious removal of a decoupled or jammed source.

*f.* In addition to the requirements specified in 41.2(53) "a" through "e," a licensee shall:

(1) For medium-dose-rate and pulsed-dose-rate remote afterloader units, require:

1. An authorized medical physicist and either an authorized user or a physician, under the supervision of an authorized user, who have been trained in the operation of and emergency response for the unit to be physically present during the initiation of all patient treatments involving the unit; and

2. An authorized medical physicist and either an authorized user or an individual, under the supervision of an authorized user, who have been trained to remove the source applicator in the event of an emergency involving the unit to be immediately available during continuation of all patient treatments involving the unit.

(2) For high-dose-rate remote afterloader units, require:

1. An authorized user and an authorized medical physicist to be physically present during the initiation of all patient treatments involving the unit; and

2. An authorized medical physicist and either an authorized user or a physician, under the supervision of an authorized user, who have been trained in the operation and emergency response for the unit, to be physically present during the continuation of all patient treatments involving the unit.

(3) For gamma stereotactic radiosurgery units, require an authorized user and an authorized medical physicist to be physically present throughout all patient treatments involving the unit. As used in this subparagraph, "physically present" means to be within hearing distance of normal voice.

(4) Notify the radiation safety officer, or the radiation safety officer designee, and an authorized user as soon as possible if the patient or human research subject has a medical emergency or dies.

g. A licensee shall have applicable emergency response equipment available near each treatment room to respond to a source remaining in the unshielded position or lodged within the patient following completion of the treatment.

**41.2(54) Possession of survey instrument.** A licensee authorized to use radioactive material in a teletherapy unit shall possess either a portable radiation detection survey instrument capable of detecting dose rates over the range of 0.1 millirem ( $1 \mu\text{Sv}$ ) per hour to 50 millirems ( $500 \mu\text{Sv}$ ) per hour or a portable radiation measurement survey instrument capable of measuring dose rates over the range of 1 millirem ( $10 \mu\text{Sv}$ ) per hour to 1000 millirems (10 mSv) per hour. The instruments shall be operable and calibrated in accordance with 41.2(18).

**41.2(55) Radiation monitoring device.**

a. A licensee shall have in each teletherapy room a permanent radiation monitor capable of continuously monitoring beam status.

b. Each radiation monitor shall be capable of providing visible notice of a teletherapy unit malfunction that results in an exposed or partially exposed source. The visible indicator of high radiation levels shall be observable by an individual entering the teletherapy room.

c. Each radiation monitor shall be equipped with a backup power supply separate from the power supply to the teletherapy unit. This backup power supply may be a battery system.

d. A radiation monitor shall be checked with a dedicated check source for proper operation each day before the teletherapy unit is used for treatment of patients or human research subjects.

e. A licensee shall maintain a record of the check required by 41.2(55)“d” for three years. The record shall include the date of the check, notation that the monitor indicates when the source is exposed, and the initials of the individual who performed the check.

f. If a radiation monitor is inoperable, the licensee shall require any individual entering the teletherapy room to use a survey instrument or audible alarm personal dosimeter to monitor for any malfunction of the source exposure mechanism. The instrument or dosimeter shall be checked with a dedicated check source for proper operation at the beginning of each day of use. The licensee shall keep a record as described in 41.2(55)“e.”

g. A licensee shall promptly repair or replace the radiation monitor if it is inoperable.

**41.2(56) Viewing system.** A licensee shall construct or equip each teletherapy room to permit continuous observation of the patient or human research subject from the teletherapy unit console during irradiation.

**41.2(57) Dosimetry equipment.**

a. Except for low-dose-rate remote afterloader sources where the source output or activity is determined by the manufacturer, a licensee shall have a calibrated dosimetry system available for use. To satisfy this requirement, one of the following two conditions shall be met:

(1) The system must have been calibrated using a system or source traceable to the National Institute of Standards and Technology and published protocols accepted by nationally recognized bodies, or by a calibration laboratory accredited by the American Association of Physicists in Medicine. The calibration must have been performed within the previous two years and after any servicing that may have affected system calibration; or

(2) The system must have been calibrated within the previous four years; 18 to 30 months after that calibration, the system must have been intercompared with another dosimetry system that was calibrated within the past 24 months by the National Institute of Standards and Technology or by a calibration laboratory accredited by the American Association of Physicists in Medicine. The results of the intercomparison must indicate that the calibration factor of the licensee’s system has not changed by more than 2 percent. The licensee may not use the intercomparison result to change the calibration factor. When intercomparing dosimetry systems to be used for calibrating sealed sources for therapeutic units, the licensee shall use a comparable unit with beam attenuators or collimators, if applicable, and sources of the same radionuclide as the source used at the licensee’s facility.

b. The licensee shall have available for use a dosimetry system for spot-check measurements. To meet this requirement, the system may be compared with a system that has been calibrated in accordance with 41.2(57)“a.” This comparison must have been performed within the previous year and after each

servicing that may have affected system calibration. The spot-check system may be the same system used to meet the requirement in 41.2(57)“a.”

c. The licensee shall maintain a record of each calibration, intercomparison, and comparison for the duration of the license. For each calibration, intercomparison, or comparison, the record shall include the date, the model numbers and serial numbers of the instruments that were calibrated, intercompared, or compared as required by 41.2(57)“a” and “b,” the correction factors that were determined, the names of the individuals who performed the calibration, intercomparison, or comparison, and evidence that the intercomparison meeting was sanctioned by a calibration laboratory or radiologic physics center accredited by the American Association of Physicists in Medicine.

**41.2(58)** *Full calibration measurements on teletherapy units, remote afterloader units, and gamma stereotactic radiosurgery units.*

a. *Teletherapy units.*

(1) A licensee authorized to use a teletherapy unit for medical use shall perform full calibration measurements for each teletherapy unit:

1. Before the first medical use of the unit; and

2. Before medical use under the following conditions:

- Whenever spot-check measurements indicate that the output differs by more than 5 percent from the output of the last full calibration corrected mathematically for radioactive decay;

- Following replacement of the source or following reinstallation of the teletherapy unit in a new location;

- Following any repair of the teletherapy unit that includes removal of the source or major repair of the components associated with the source exposure assembly; and

3. At intervals not exceeding one year.

(2) To satisfy the requirements of 41.2(58)“a”(1), full calibration measurements must include determination of:

1. The output within  $\pm 3$  percent for the range of field sizes and for the distance or range of distances used for medical use;

2. The coincidence of the radiation field and the field indicated by the light beam localizing device;

3. The uniformity of the radiation field and its dependence on the orientation of the useful beam;

4. Timer accuracy and linearity over the range of use;

5. On-off error; and

6. The accuracy of all distance measuring and localization devices in medical use.

(3) A licensee shall use the dosimetry system described in 41.2(57) to measure the output for one set of exposure conditions. The remaining radiation measurements required in 41.2(58)“a”(2)“1” may be made using the dosimetry system that indicates relative dose rates.

(4) A licensee shall make full calibration measurements required by 41.2(58)“a” in accordance with published protocols accepted by nationally recognized bodies.

(5) A licensee shall mathematically correct the outputs determined in 41.2(58)“a”(2)“1” for physical decay for intervals not exceeding one month for cobalt-60, six months for cesium-137, or at intervals consistent with 1 percent of all other radionuclides.

(6) Full calibration measurements required by 41.2(58)“a”(1) and physical decay corrections required in 41.2(58)“a”(5) must be performed by the authorized medical physicist.

(7) A licensee shall maintain a record of each calibration for the duration of the license. The record shall include the date of the calibration; the manufacturer’s name, model number, and serial number for both the unit and the source; tables that describe the output of the unit over the range of field sizes and for the range of distances used in radiation therapy; a determination of the coincidence of the radiation field and the field indicated by the light beam localizing device; the measured timer accuracy for a typical treatment time; the calculated “on-off” error; the estimated accuracy of each distance measuring or localization device; and the signature of the authorized medical physicist.

b. *Remote afterloader units.*

(1) A licensee authorized to use a remote afterloader unit for medical use shall perform full calibration measurements for each unit:

1. Before the first medical use of the unit; and
  2. Before medical use under the following conditions:
    - Following replacement of the source or following reinstallation of the unit in a new location outside the facility; and
    - Following any repair of the unit that includes removal of the source or major repair of the components associated with the source exposure assembly; and
  3. At intervals not exceeding one quarter of a year for high-dose-rate, medium-dose-rate, and pulsed-dose-rate remote afterloader units with sources whose half-life exceeds 75 days; and
  4. At intervals not exceeding one year for low-dose-rate remote afterloader units.
- (2) To satisfy the requirements of 41.2(58) "b"(1), full calibration measurements must include, as applicable, determination of:
1. The output within  $\pm 5$  percent;
  2. Source positioning accuracy to within  $\pm 1$  millimeter;
  3. Source retraction with backup battery upon power failure;
  4. Length of the source transfer tubes;
  5. Timer accuracy and linearity over the typical range of use;
  6. Length of the applicators; and
  7. Function of the source transfer tubes, applicators, and transfer tube-applicator interfaces.
- (3) A licensee shall use the dosimetry system described in 41.2(57) to measure the output.
- (4) A licensee shall make full calibration measurements required by 41.2(58) "b"(1) in accordance with published protocols accepted by nationally recognized bodies.
- (5) In addition to the requirements for full calibrations for low-dose-rate remote afterloader units in 41.2(58) "b"(2), a licensee shall perform an autoradiograph of the source to verify inventory and source arrangement at intervals not exceeding one quarter of a year.
- (6) For low-dose-rate remote afterloader units, a licensee may use measurements provided by the source manufacturer that are made in accordance with 41.2(58) "b."
- (7) A licensee shall mathematically correct the outputs determined in 41.2(58) "b"(2) "1" for physical decay intervals consistent with 1 percent physical decay.
- (8) Full calibration measurements required by 41.2(58) "b"(1) and physical decay corrections required by 41.2(58) "b"(7) must be performed by the authorized medical physicist.
- (9) A licensee shall retain a record of each calibration in accordance with 41.2(58) "a"(7).
- c. Gamma stereotactic radiosurgery units.*
- (1) A licensee authorized to use a gamma stereotactic radiosurgery unit for medical use shall perform full calibration measurements on each unit:
    1. Before the first medical use of the unit;
    2. Before medical use under the following conditions:
      - Whenever spot-check measurements indicate that the output differs by more than 5 percent from the output obtained at the last full calibration corrected mathematically for radioactive decay;
      - Following replacement of the sources or following reinstallation of the gamma stereotactic radiosurgery unit in a new location; and
      - Following any repair of the gamma stereotactic radiosurgery unit that includes removal of the sources or major repair of the components associated with the source assembly; and
    3. At intervals not exceeding one year, with the exception that relative helmet factors need only be determined before the first medical use of a helmet and following any damage to a helmet.
  - (2) To satisfy the requirement of 41.2(58) "c"(1), full calibration measurements must include determination of:
    1. The output within  $\pm 3$  percent;
    2. Relative helmet factors;
    3. Isocenter coincidence;
    4. Timer accuracy and linearity over the range of use;
    5. On-off error;
    6. Trunnion centricity;

7. Treatment table retraction mechanism, using backup battery power or hydraulic backups with the unit off;

8. Helmet microswitches;

9. Emergency timing circuits; and

10. Stereotactic frames and localizing devices (trunnions).

(3) A licensee shall use the dosimetry system described in 41.2(57) to measure the output for one set of exposure conditions. The remaining radiation measurements required in 41.2(58) "c"(2)"1" may be made using a dosimetry system that indicates relative dose rates.

(4) A licensee shall make full calibration measurements required by 41.2(58) "c"(1) in accordance with published protocols accepted by nationally recognized bodies.

(5) A licensee shall mathematically correct the outputs determined in 41.2(58) "c"(2)"1" at intervals not exceeding one month for cobalt-60 and at intervals consistent with 1 percent physical decay for all other radionuclides.

(6) Full calibration measurements required by 41.2(58) "c"(1) and physical decay corrections required in 41.2(58) "c"(5) must be performed by the authorized medical physicist.

(7) A licensee shall retain a record of each calibration in accordance with 41.2(58) "a"(7).

**41.2(59) Periodic spot checks for teletherapy units, remote afterloader units, and gamma stereotactic radiosurgery units.**

*a. Teletherapy units.*

(1) A licensee authorized to use teletherapy units for medical use shall perform output spot checks on each teletherapy unit once in each calendar month that include determination of:

1. Timer accuracy and timer linearity over the range of use;

2. On-off error;

3. The coincidence of the radiation field and the field indicated by the light beam localizing device;

4. The accuracy of all distance measuring and localization devices used for medical use;

5. The output for one typical set of operating conditions measured with the dosimetry system described in 41.2(57); and

6. The difference between the measurement made in 41.2(59) "a"(1)"5" and the anticipated output expressed as a percentage of the anticipated output (i.e., the value obtained at last full calibration corrected mathematically for physical decay).

(2) A licensee shall perform measurements required by 41.2(59) "a"(1) in accordance with written procedures established by the authorized medical physicist. That individual need not actually perform the spot-check measurements.

(3) A licensee shall have the authorized medical physicist review the results of each spot check within 15 days. The authorized medical physicist shall notify the licensee as soon as possible in writing of the result of each spot check.

(4) A licensee authorized to use a teletherapy unit for medical use shall perform safety spot checks of each teletherapy facility once in each calendar month and after each source installation to ensure proper operation of:

1. Electrical interlocks at each teletherapy room entrance;

2. Electrical or mechanical stops installed for the purpose of limiting use of the primary beam of radiation (restriction of source housing angulation or elevation, carriage or stand travel and operation of the beam on-off mechanism);

3. Source exposure indicator lights on the teletherapy unit, on the control console, and in the facility;

4. Viewing and intercom systems;

5. Treatment room doors from inside and outside the treatment room; and

6. Electrically assisted treatment room doors with the teletherapy unit electrical power turned off.

(5) If the results of the spot checks required in 41.2(59) "a"(4) indicate the malfunction of any system, the licensee shall lock the control console in the off position and not use the unit except as may be necessary to repair, replace, or check the malfunctioning system.

(6) A licensee shall retain for three years a record of each spot check required in 41.2(59) "a." The record must include:

1. The date of the spot check;
2. The manufacturer's name, model number, and serial number of the teletherapy unit, source and instrument used to measure the output of the teletherapy unit;
3. An assessment of timer linearity and constancy;
4. The calculated on-off error;
5. A determination of the coincidence of the radiation field and the field indicated by the light beam localizing device;
6. The determined accuracy of each distance measuring and localization device;
7. The difference between the anticipated output and the measured output;
8. Notations indicating the operability of each entrance door electrical interlock, each electrical or mechanical source exposure indicator light, and the viewing and intercom system and doors; and
9. The name of the individual who performed the periodic spot check and the signature of the authorized medical physicist who reviewed the record of the spot check.

(7) A licensee shall retain a copy of the procedures required by 41.2(59) "a"(2) until the licensee no longer possesses the teletherapy unit.

*b. Remote afterloader units.*

(1) A licensee authorized to use a remote afterloader unit for medical use shall perform spot checks of each remote afterloader facility and on each unit:

1. Before the first use of a high-dose-rate, medium-dose-rate, or pulsed-dose-rate remote afterloader unit on a given day;
2. Before each patient treatment with a low-dose-rate remote afterloader unit; and
3. After each source installation.

(2) A licensee shall perform the measurements required by 41.2(59) "b"(1) in accordance with written procedures established by the authorized medical physicist. That individual need not actually perform the spot-check measurements.

(3) A licensee shall have the authorized medical physicist review the results of each spot check within 15 days. The authorized medical physicist shall notify the licensee as soon as possible in writing of the results of each spot check.

(4) To satisfy the requirements of 41.2(59) "b"(1), spot checks must, at a minimum, ensure proper operation of:

1. Electrical interlocks at each remote afterloader unit room entrance;
2. Source exposure indicator lights on the remote afterloader unit, on the control console, and in the facility;
3. Viewing and intercom systems in each high-dose-rate, medium-dose-rate, and pulsed-dose-rate remote afterloader facility;
4. Emergency response equipment;
5. Radiation monitors used to indicate the source position;
6. Timer accuracy;
7. Clock (date and time) in the unit's computer; and
8. Decayed source(s) activity in the unit's computer.

(5) If the results of the spot checks required in 41.2(59) "b"(4) indicate the malfunction of any system, the licensee shall lock the control console in the off position and not use the unit except as may be necessary to repair, replace, or spot check the malfunctioning system.

(6) A licensee shall retain for three years a record of each spot check required in 41.2(59) "b"(4). The record must include:

1. The date of the spot check;
2. The manufacturer's name, model number, and serial number for the remote afterloader unit and source;
3. An assessment of timer accuracy;

4. Notations indicating the operability of each entrance door electrical interlock, radiation monitors, source exposure indicator lights, viewing and intercom systems, and clock and decayed source activity in the unit's computer; and

5. The name of the individual who performed the periodic spot check and the signature of the authorized medical physicist who reviewed the record of the spot check.

(7) A licensee shall retain a copy of the procedures required in 41.2(59) "b"(2) until the licensee no longer possesses the remote afterloader unit.

*c. Gamma stereotactic radiosurgery units.*

(1) A licensee authorized to use a gamma stereotactic radiosurgery unit for medical use shall perform spot checks for the gamma stereotactic radiosurgery facility and on each unit:

1. Monthly;
2. Before the first use of the unit on a given day; and
3. After each source installation.

(2) A licensee shall:

1. Perform the measurements required by 41.2(59) "c"(1) in accordance with written procedures established by the authorized medical physicist. That individual need not actually perform the spot-check measurements.

2. Have the authorized medical physicist review the results of each spot check within 15 days. The authorized medical physicist shall notify the licensee as soon as possible in writing of the results of each spot check.

(3) To satisfy the requirements of 41.2(59) "c"(1) "1," spot checks must, at a minimum:

1. Ensure proper operation of treatment table retraction mechanism, using backup battery power or hydraulic backups with the unit off; helmet microswitches; emergency timing circuits; and stereotactic frames and localizing devices (trunnions).

2. Determine:

- The output for one typical set of operating conditions measured with the dosimetry system described in 41.2(57);

- The difference between the measurement made in the above bulleted point and the anticipated output expressed as a percentage of the anticipated output (i.e., the value obtained at last full calibration corrected mathematically for physical decay);

- Source output against computer calculation;
- Timer accuracy and linearity over the range of use;
- On-off error; and
- Trunnion centricity.

(4) To satisfy the requirements of 41.2(59) "c"(1) "2" and "3," spot checks must ensure proper functioning of:

1. Electrical interlocks at each gamma stereotactic radiosurgery room entrance;
2. Source exposure indicator lights on the gamma stereotactic radiosurgery unit, on the control console, and in the facility;
3. Viewing and intercom systems;
4. Timer termination;
5. Radiation monitors used to indicate room exposures; and
6. Emergency off buttons.

(5) A licensee shall arrange as soon as possible for the repair of any system identified in 41.2(59) "c"(3) that is not operating properly.

(6) If the results of the spot checks required in 41.2(59) "c"(4) indicate the malfunction of any system, the licensee shall lock the control console in the off position and not use the unit except as may be necessary to repair, replace, or check the malfunctioning system.

(7) A licensee shall retain for three years a record of each spot check required by 41.2(59) "c"(3) and (4). The record must include:

1. The date of the spot check;

2. The manufacturer's name, model number, and serial number for the gamma stereotactic radiosurgery unit and the survey instrument used to measure the output of the unit;
3. An assessment of timer linearity and accuracy;
4. The calculated on-off error;
5. A determination of trunnion centricity;
6. The difference between the anticipated output and the measured output;
7. An assessment of source output against computer calculations;
8. Notations indicating the operability of radiation monitors, helmet microswitches, emergency timing circuits, on-off buttons, electrical interlocks, source exposure indicator lights, viewing and intercom systems, timer termination, treatment table retraction mechanism, and stereotactic frames and localizing devices (trunnions); and
9. The name of the individual who performed the periodic spot check and the signature of the authorized medical physicist who reviewed the record of the spot check.

(8) A licensee shall retain a copy of the procedures required in 41.2(59) "c"(2) until the licensee no longer possesses the gamma stereotactic radiosurgery unit.

**41.2(60) Radiation surveys for teletherapy facilities.**

a. In addition to the survey requirements in 641—40.36(136C), a person licensed under 641—41.2(136C) shall make surveys to ensure that the maximum radiation levels and average radiation levels from the surface of the main source safe with the source in the shielded position do not exceed the levels stated in the Sealed Source and Device Registry.

b. The licensee shall make the survey required in 41.2(60) "a" at installation of a new source, and following repairs to the source shielding, the source driving unit, or other electronic or mechanical component that could expose the source, reduce the shielding around the source, or compromise the radiation safety of the source.

c. A licensee shall maintain a record of the radiation measurements made following installation of a source for the duration of the license. The record shall include the date of the measurements, the reason the survey is required, the manufacturer's name, model number and serial number of the teletherapy unit, the source, and the instrument used to measure radiation levels, each dose rate measured around the teletherapy source while in the "off" position and the average of all measurements, a plan of the areas surrounding the treatment room that were surveyed, the measured dose rate at several points in each area expressed in millirems ( $\mu\text{Sv}$ ) per hour, the calculated maximum level of radiation over a period of one week for each restricted and unrestricted area, and the signature of the radiation safety officer.

**41.2(61) Safety spot checks for teletherapy facilities.**

a. A licensee shall promptly check all systems listed in 41.2(59) "g" for proper function after each installation of a teletherapy source and after making any change for which an amendment is required by 41.2(51).

b. If the results of the safety spot checks required in 41.2(61) "a" indicate the malfunction of any system specified in 41.2(59), the licensee shall lock the control console in the "off" position and not use the unit except as may be necessary to repair, replace, or check the malfunctioning system.

c. A licensee shall maintain a record of the safety spot checks following installation of a source for three years. The record shall include notations indicating the operability of each entrance door interlock, each electrical or mechanical stop, each beam condition indicator light, the viewing system, doors, and the signature of the radiation safety officer.

**41.2(62) Modification of teletherapy unit or room before beginning a treatment program.** If the survey required by 41.2(60) indicates that any individual member of the public is likely to receive a dose greater than those permitted by 641—40.26(136C) before beginning the treatment program, the licensee shall:

a. Either equip the unit with stops or add additional radiation shielding to ensure compliance with 641—40.26(136C);

b. Perform the survey required by 41.2(60) again; and

c. Include in the report required by 41.2(63) the results of the initial survey, a description of the modification made to comply with 41.2(62) "a," and the results of the second survey; or

*d.* Request and receive a license amendment under 641—40.26(136C) that authorizes radiation levels in unrestricted areas greater than those permitted by 641—40.26(136C).

**41.2(63) Reports of teletherapy surveys, checks, tests, and measurements.** A licensee shall furnish a copy of the records required in 41.2(60), 41.2(61), and 41.2(62) and the output from the teletherapy source expressed as rems (sieverts) per hour at 1 meter from the source as determined during the full calibration required in 41.2(58) to the agency within 30 days following completion of the action that initiated the record requirement.

**41.2(64) Five-year inspection.**

*a.* A licensee shall have each teletherapy unit and gamma stereotactic radiosurgery unit fully inspected and serviced during teletherapy source replacement or at intervals not to exceed five years, whichever comes first, to ensure proper functioning of the source exposure mechanism.

*b.* This inspection and servicing shall be performed only by persons specifically licensed to do so by the agency, an agreement state, or the U.S. Nuclear Regulatory Commission.

*c.* A licensee shall maintain a record of the inspection and servicing for the duration of the license. The record shall contain the inspector's name, the inspector's license number, the date of inspection, the manufacturer's name and model number and serial number for both the teletherapy unit and gamma stereotactic radiosurgery unit and source, a list of components inspected, a list of components serviced and the type of service, a list of components replaced, and the signature of the inspector.

**41.2(65) Training for radiation safety officer.** Except as provided in 41.2(75), the licensee shall require an individual fulfilling the responsibilities of the radiation safety officer as provided in 41.2(8) to be an individual who:

*a.* Is certified by a specialty board whose certification process has been recognized by this agency, NRC, or an agreement state and who meets the requirements in 41.2(65) "d" and "e." (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC's Web page.) To have its certification process recognized, a specialty board shall:

(1) Require all candidates for certification to:

1. Hold a bachelor's or graduate degree from an accredited college or university in physical science or engineering or biological science with a minimum of 20 college credits in physical science;

2. Have five or more years of professional experience in health physics (graduate training may be substituted for no more than two years of the required experience) including at least three years in applied health physics; and

3. Pass an examination administered by diplomats of the specialty board, which evaluates knowledge and competence in radiation physics and instrumentation, radiation protection, mathematics pertaining to the use and measurement of radioactivity, radiation biology, and radiation dosimetry; or

(2) Require all candidates for certification to:

1. Hold a master's or doctor's degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university;

2. Have two years of either full-time practical training or supervised experience in medical physics under the supervision of a medical physicist who is certified in medical physics by a specialty board recognized by the agency, NRC, or an agreement state, or in clinical nuclear medicine facilities providing either diagnostic or therapeutic services under the direction of physicians who meet the requirements for authorized users in 41.2(68), 41.2(69), or 41.2(75); and

3. Pass an examination administered by diplomats of the specialty board that assesses knowledge and competence in clinical diagnostic radiological or nuclear medicine physics and in radiation safety; or

*b.* Has completed a structured educational program consisting of both:

(1) 200 hours of classroom and laboratory training in the following areas:

1. Radiation physics and instrumentation;

2. Radiation protection;

3. Mathematics pertaining to the use and measurement of radioactivity;

4. Radiation biology; and

5. Radiation dosimetry; and

(2) One year of full-time radiation safety experience under the supervision of the individual identified as the radiation safety officer on an agency, NRC, or agreement state license or permit issued by the NRC master material licensee that authorizes similar types of use of radioactive material involving the following:

1. Shipping, receiving, and performing related radiation surveys;
2. Using and performing checks for proper operation of instruments used to determine the activity of dosages, survey meters, and instruments used to measure radionuclides;
3. Securing and controlling radioactive material;
4. Using administrative controls to avoid mistakes in the administration of radioactive material;
5. Using procedures to prevent or minimize radioactive contamination and using proper decontamination procedures;
6. Using emergency procedures to control radioactive material; and
7. Disposing of radioactive material; or

c. (1) Is a medical physicist who has been certified by a specialty board whose certification process has been recognized by the agency, NRC, or an agreement state under 41.2(74) and has experience in radiation safety for similar types of use of radioactive material for which the licensee is seeking the approval of the individual as a radiation safety officer and who meets the requirements in 41.2(65)“d” and “e”; or

(2) Is an authorized user, authorized medical physicist, or authorized nuclear pharmacist identified on the licensee’s license and has experience with the radiation safety aspects of similar types of use of radioactive material for which the individual has radiation safety officer responsibilities; and

d. Has obtained written attestation, signed by a preceptor radiation safety officer, that the individual has satisfactorily completed the requirements in 41.2(65)“e” and 41.2(65)“a”(1)“1” and “2” or 41.2(65)“a”(2)“1” and “2” or 41.2(65)“b”(1) or 41.2(65)“c”(1), and has achieved a level of radiation safety knowledge sufficient to function independently as a radiation safety officer for a medical use licensee; and

e. Has training in the radiation safety, regulatory issues, and emergency procedures for the types of use for which the licensee is seeking approval. This training requirement may be satisfied by completing training that is supervised by a radiation safety officer, authorized medical physicist, authorized nuclear pharmacist, or authorized user, as appropriate, who is authorized for the type of use for which the licensee is seeking approval.

**41.2(66) Training for experienced radiation safety officer.** Rescinded IAB 3/29/06, effective 5/3/06.

**41.2(67) Training for uptake, dilution, and excretion studies.** Except as provided in 41.2(75), the licensee shall require an authorized user of unsealed radioactive material for the uses authorized under 41.2(31) to be a physician who:

a. Is certified by a medical specialty board whose certification process has been recognized by the agency, NRC, or an agreement state and who meets the requirements in 41.2(67)“c.” (The names of specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC’s Web page.) To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1) Complete 60 hours of training and experience in basic radionuclide handling techniques and radiation safety applicable to the medical use of unsealed radioactive material for uptake, dilution, and excretion studies as described in 41.2(67)“c”(1)“1” and “2”; and

(2) Pass an examination administered by diplomats of the specialty board that assesses knowledge and competence in radiation safety, radionuclide handling, and quality control; or

b. Is an authorized user under 41.2(68) or 41.2(69) or meets equivalent NRC or agreement state requirements; or

c. (1) Has completed 60 hours of training and experience, including a minimum of 8 hours of classroom and laboratory training, in basic radionuclide handling techniques applicable to the medical use of unsealed radioactive material for uptake, dilution, and excretion studies. The training and experience must include:

1. Classroom and laboratory training in radiation physics and instrumentation; radiation protection; mathematics pertaining to the use and measurement of radioactivity, chemistry of radioactive material for medical use, and radiation biology; and

2. Work experience, under the supervision of an authorized user who meets the requirements in 41.2(67), 41.2(68), 41.2(69) or 41.2(75) or equivalent NRC or agreement state requirements, involving:

- Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys;
- Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters;
- Calculating, measuring, and safely preparing patient or human research subject dosages;
- Using administrative controls to prevent a medical event involving the use of unsealed radioactive material;
- Using procedures to contain spilled radioactive material safely and using proper decontamination procedures;
- Administering dosages of radioactive drugs to patients or human research subjects; and

(2) Has obtained written attestation, signed by a preceptor authorized user who meets the requirements in 41.2(67), 41.2(68), 41.2(69) or 41.2(75) or equivalent NRC or agreement state requirements, that the individual has satisfactorily completed the requirements in 41.2(67) "a"(1) or 41.2(67) "c"(1) and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized in 41.2(31).

**41.2(68) Training for imaging and localization studies.** Except as provided in 41.2(75), the licensee shall require the authorized user of unsealed radioactive material for the uses authorized under 41.2(33) to be a physician who:

a. Is certified by a medical specialty board whose certification process has been recognized by the agency, NRC, or an agreement state and who meets the requirements in 41.2(68) "c." (The names of specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC's Web page.) To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1) Complete 700 hours of training and experience in basic radionuclide handling techniques and radiation safety applicable to the medical use of unsealed radioactive material for imaging and localization studies as described in 41.2(68) "c"(1)"1" and "2"; and

(2) Pass an examination administered by diplomats of the specialty board, which assesses knowledge and competence in radiation safety, radionuclide handling, and quality control; or

b. Is an authorized user under 41.2(69) and meets the requirements in 41.2(68) "c"(1)"2," seventh bulleted paragraph, or equivalent NRC or agreement state requirements; or

c. (1) Has completed 700 hours of training and experience, including a minimum of 80 hours of classroom and laboratory training, in basic radionuclide handling techniques applicable to the medical use of unsealed radioactive material for imaging and localization studies. The training and experience must include, at a minimum:

1. Classroom and laboratory training in the following areas:

- Radiation physics and instrumentation;
- Radiation protection;
- Mathematics pertaining to the use and measurement of radioactivity;
- Chemistry of radioactive material for medical use;
- Radiation biology, and

2. Work experience, under the supervision of an authorized user who meets the requirements in 41.2(68); 41.2(68) "c"(1)"2," seventh bulleted paragraph, and 41.2(69); 41.2(75); or equivalent NRC or agreement state requirements, involving:

- Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys;
- Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters;

- Calculating, measuring, and safely preparing patient or human research subject dosages;
- Using administrative controls to prevent a medical event involving the use of unsealed radioactive material;
- Using procedures to contain spilled radioactive material safely and using proper decontamination procedures;
- Administering dosages of radioactive drugs to patients or human research subjects; and
- Eluting generator systems appropriate for preparation of radioactive drugs for imaging and localization studies, measuring and testing the eluate for radionuclidic purity, and processing the eluate with reagent kits to prepare labeled radioactive drugs; and

(2) Has obtained written attestation, signed by a preceptor authorized user who meets the requirements in 41.2(68); 41.2(69) and 41.2(68)“c”(1)“2,” seventh bulleted paragraph; 41.2(75); or equivalent NRC or agreement state requirements, that the individual has satisfactorily completed the requirements in 41.2(68)“a”(1) or 41.2(68)“c”(1) and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized under 41.2(31) and 41.2(33).

**41.2(69) Training for use of unsealed by-product material for which a written directive is required.** Except as provided in 41.2(75), the licensee shall require an authorized user of unsealed radioactive material for the uses authorized under 41.2(37) to be a physician who:

*a.* Is certified by a medical specialty board whose certification process has been recognized by the agency, NRC, or an agreement state and who meets the requirements in 41.2(69)“b”(1)“2,” seventh bulleted paragraph, and 41.2(69)“b”(2). (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC’s Web page.) To be recognized, a specialty board shall require all candidates for certification to:

(1) Successfully complete residency training in a radiation therapy or nuclear medicine training program or a program in a related medical specialty. These residency training programs must include 700 hours of training and experience as described in 41.2(69)“b”(1)“1” through 41.2(69)“b”(1)“2,” fifth bulleted paragraph. Eligible training programs must be approved by the Residency Review Committee of the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada, or the Committee on Post-Graduate Training of the American Osteopathic Association; and

(2) Pass an examination, administered by diplomats of the specialty board, which tests knowledge and competence in radiation safety, radionuclide handling, quality assurance, and clinical use of unsealed radioactive material for which a written directive is required; or

*b.* (1) Has completed 700 hours of training and experience, including a minimum of 200 hours of classroom and laboratory training, in basic radionuclide handling techniques applicable to the medical use of unsealed radioactive material requiring a written directive. The training and experience must include:

1. Classroom and laboratory training in the following areas:

- Radiation physics and instrumentation;
- Radiation protection;
- Mathematics pertaining to the use and measurement of radioactivity;
- Chemistry of radioactive material for medical use; and
- Radiation biology; and

2. Work experience, under the supervision of an authorized user who meets the requirements in 41.2(69) or 41.2(75) or equivalent NRC or agreement state requirements. A supervising authorized user who meets the requirements in 41.2(69)“b” must also have experience in administering dosages in the same dosage category or categories (i.e., 41.2(69)“b”(1)“2,” seventh bulleted paragraph) as the individual requesting authorized user status. The work experience must involve:

- Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys;
- Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters;

- Calculating, measuring, and safely preparing patient or human research subject dosages;
- Using administrative controls to prevent a medical event involving the use of unsealed radioactive material;
  - Using procedures to contain spilled radioactive material safely and using proper decontamination procedures;
  - Reserved.
  - Administering dosages of radioactive drugs to patients or human research subjects involving a minimum of three cases in each of the following categories for which the individual is requesting authorized user status:
    - Oral administration of less than or equal to 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131, for which a written directive is required;
    - Oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131 (experience with at least three cases in this category also satisfies the requirement in the above category);
    - Parenteral administration of either any beta emitter or a photon-emitting radionuclide with a photon energy less than 150 keV for which a written directive is required; or
    - Parenteral administration of any other radionuclide for which a written directive is required; and
- (2) Has obtained written attestation that the individual has satisfactorily completed the requirements in 41.2(69) “a”(1) and 41.2(69) “b”(1)“2,” seventh bulleted paragraph, or 41.2(69) “b”(1), and has achieved a level of competency sufficient to function independently as an authorized user for the medical uses authorized under 41.2(37). The written attestation must be signed by a preceptor authorized user who meets the requirements in 41.2(69) or 41.2(75) or equivalent NRC or agreement state requirements. The preceptor authorized user who meets the requirements in 41.2(69) “b” must have experience in administering dosages in the same dosage category or categories (i.e., 41.2(69) “b”(1)“2,” seventh bulleted paragraph) as the individual requesting authorized user status.

c. For training only for oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 33 millicuries (1.22 gigabecquerels) or quantities greater than 33 millicuries (1.22 gigabecquerels), see 41.2(81) or 41.2(82).

**41.2(70) Training for use of manual brachytherapy sources.** Except as provided in 41.2(75), the licensee shall require an authorized user of a manual brachytherapy source for the uses authorized under 41.2(43) to be a physician who:

a. Is certified by a medical specialty board whose certification process has been recognized by the agency, NRC, or an agreement state, and who meets the requirements in 41.2(70) “b”(3). (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC’s Web page.) To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1) Successfully complete a minimum of three years of residency training in a radiation oncology program approved by the Residency Review Committee of the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada or the Committee on Post-Graduate Training of the American Osteopathic Association; and

(2) Pass an examination, administered by diplomats of the specialty board, that tests knowledge and competence in radiation safety, radionuclide handling, treatment planning, quality assurance, and clinical use of manual brachytherapy; or

b. (1) Has completed a structured educational program in basic radionuclide handling techniques applicable to the use of manual brachytherapy sources that includes:

1. 200 hours of classroom and laboratory training in the following areas:

- Radiation physics and instrumentation;
- Radiation protection;
- Mathematics pertaining to the use and measurement of radioactivity; and
- Radiation biology; and

2. 500 hours of work experience, under the supervision of an authorized user who meets the requirements in 41.2(70) or 41.2(75) or equivalent NRC or agreement state requirements at a medical institution, involving:

- Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys;
- Checking survey meters for proper operation;
- Preparing, implanting, and removing brachytherapy sources;
- Maintaining running inventories of material on hand;
- Using administrative controls to prevent a medical event involving the use of radioactive material; and
- Using emergency procedures to control radioactive material; and

(2) Has completed three years of supervised clinical experience in radiation oncology under an authorized user who meets the requirements in 41.2(70) or 41.2(75) or equivalent NRC or agreement state requirements, as part of a formal training program approved by the Residency Review Committee for Radiation Oncology of the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada or the Committee on Postdoctoral Training of the American Osteopathic Association. This experience may be obtained concurrently with the supervised work experience required in 41.2(70) "b"(1)"2"; and

(3) Has obtained written attestation, signed by a preceptor authorized user who meets the requirements in 41.2(70) or 41.2(75) or equivalent NRC or agreement state requirements, that the individual has satisfactorily completed the requirements in 41.2(70) "a"(1) or 41.2(70) "b"(1) and (2), and has achieved a level of competency sufficient to function independently as an authorized user of manual brachytherapy sources for the medical uses authorized under 41.2(43).

**41.2(71) Training for ophthalmic use of strontium-90.** Except as provided in 41.2(75), the licensee shall require the authorized user of strontium-90 for ophthalmic radiotherapy to be a physician who:

- a. Is an authorized user under 41.2(70) or equivalent NRC or agreement state requirements; or
- b. (1) Has completed 24 hours of classroom and laboratory training applicable to the medical use of strontium-90 for ophthalmic radiotherapy. The training must include:

1. Radiation physics and instrumentation;
2. Radiation protection;
3. Mathematics pertaining to the use and measurement of radioactivity; and
4. Radiation biology; and

(2) Has completed supervised clinical training in ophthalmic radiotherapy under the supervision of an authorized user at a medical institution, clinic, or private practice that includes the use of strontium-90 for the ophthalmic treatment of five individuals. This supervised clinical training must involve:

1. Examination of each individual to be treated;
2. Calculation of the dose to be administered;
3. Administration of the dose; and
4. Follow-up and review of each individual's case history; and

(3) Has obtained written attestation, signed by a preceptor authorized user who meets the requirements in 41.2(70), 41.2(71) or 41.2(75) or equivalent NRC or agreement state requirements, that the individual has satisfactorily completed the requirements in 41.2(71) "b"(1) and (2) and has achieved a level of competency sufficient to function independently as an authorized user of strontium-90 for ophthalmic use.

**41.2(72) Training for use of sealed sources for diagnosis.** Except as provided in 41.2(75), the licensee shall require the authorized user of a diagnostic sealed source for use in a device authorized under 41.2(41) to be a physician, dentist, or podiatrist who:

- a. Is certified by a specialty board whose certification process includes all of the requirements in 41.2(72) "b" and "c" and whose certification has been recognized by the agency, NRC, or an agreement state. (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC's Web page.); or
- b. Has completed eight hours of classroom and laboratory training in basic radionuclide handling techniques specifically applicable to the use of the device. The training must include:

- (1) Radiation physics and instrumentation;
- (2) Radiation protection;

- (3) Mathematics pertaining to the use and measurement of radioactivity; and
- (4) Radiation biology; and

c. Has completed training in the use of the device for the uses requested.

**41.2(73) Training for use of remote afterloader units, teletherapy units, and gamma stereotactic radiosurgery units.** Except as provided in 41.2(75), the licensee shall require an authorized user of a sealed source for a use authorized under 41.2(49) to be a physician who:

a. Is certified by a medical specialty board whose certification process has been recognized by the agency, NRC, or an agreement state, and who meets the requirements in 41.2(73) "b"(3) and 41.2(73) "c." (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC's Web page.) To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1) Successfully complete a minimum of three years of residency training in a radiation therapy program approved by the Residency Review Committee of the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada or the Committee on Post-Graduate Training of the American Osteopathic Association; and

(2) Pass an examination, administered by diplomats of the specialty board, which tests knowledge and competence in radiation safety, radionuclide handling, treatment planning, quality assurance, and clinical use of stereotactic radiosurgery, remote afterloaders, and external beam therapy; or

b. (1) Has completed a structured educational program in basic radionuclide techniques applicable to the use of a sealed source in a therapeutic medical unit that includes:

1. 200 hours of classroom and laboratory training in the following areas:

- Radiation physics and instrumentation;
- Radiation protection;
- Mathematics pertaining to the use and measurement of radioactivity; and
- Radiation biology; and

2. 500 hours of work experience, under the supervision of an authorized user who meets the requirements in 41.2(73) or 41.2(75) or equivalent NRC or agreement state requirements at a medical institution, involving:

- Reviewing full calibration measurements and periodic spot checks;
- Preparing treatment plans and calculating treatment doses and times;
- Using administrative controls to prevent a medical event involving the use of radioactive material;
- Implementing emergency procedures to be followed in the event of the abnormal operation of the medical unit or console;
- Checking and using survey meters; and
- Selecting the proper dose and how it is to be administered; and

(2) Has completed three years of supervised clinical experience in radiation therapy under an authorized user who meets the requirements in 41.2(73) or 41.2(75) or equivalent NRC or agreement state requirements, as part of a formal training program approved by the Residency Review Committee for Radiation Oncology of the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada or the Committee on Postdoctoral Training of the American Osteopathic Association. This experience may be obtained concurrently with the supervised work experience required by 41.2(73) "b"(1) "2"; and

(3) Has obtained written attestation that the individual has satisfactorily completed the requirements in 41.2(73) "a"(1) or 41.2(73) "b"(1) and (2), and 41.2(73) "c," and has achieved a level of competency sufficient to function independently as an authorized user of each type of therapeutic medical unit for which the individual is requesting authorized user status. The written attestation must be signed by a preceptor authorized user who meets the requirements in 41.2(73) or 41.2(75) or equivalent NRC or agreement state requirements for an authorized user for each type of therapeutic medical unit for which the individual is requesting authorized user status; and

c. Has received training in device operation, safety procedures, and clinical use for the type of use for which authorization is sought. This training requirement may be satisfied by satisfactory completion

of a training program provided by the vendor for new users or by receiving training supervised by an authorized user or authorized medical physicist, as appropriate, who is authorized for the type of use for which the individual is seeking authorization.

**41.2(74) Training for an authorized medical physicist.** Except as provided in 41.2(75), the licensee shall require the authorized medical physicist to be an individual who:

*a.* Is certified by a specialty board whose certification process has been recognized by the agency, NRC, or an agreement state and who meets the requirements in 41.2(74)“*b*”(2) and 41.2(74)“*c*.” (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC’s Web page.) To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1) Hold a master’s or doctor’s degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university;

(2) Have two years of either full-time practical training or supervised experience in medical physics:

1. Under the supervision of a medical physicist who is certified in medical physics by a specialty board recognized by the agency, NRC, or an agreement state; or

2. In clinical radiation facilities providing high-energy, external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services under the direction of physicians who meet the requirements for authorized users in 41.2(70), 41.2(73), or 41.2(75); and

(3) Pass an examination, administered by diplomats of the specialty board, that assesses knowledge and competence in clinical radiation therapy, radiation safety, calibration, quality assurance, and treatment planning for external beam therapy, brachytherapy, and stereotactic radiosurgery; or

*b.* (1) Holds a master’s or doctor’s degree in physics, medical physics, other physical science, engineering, or applied mathematics from an accredited college or university; and has completed one year of full-time training in medical physics and an additional year of full-time work experience under the supervision of an individual who meets the requirements for an authorized medical physicist for the type of use for which the individual is seeking authorization. This training and work experience must be conducted in clinical radiation facilities that provide high-energy, external beam therapy (photons and electrons with energies greater than or equal to 1 million electron volts) and brachytherapy services and must include:

1. Performing sealed source leak tests and inventories;

2. Performing decay corrections;

3. Performing full calibration and periodic spot checks of external beam treatment units, stereotactic radiosurgery units, and remote afterloading units, as applicable; and

4. Conducting radiation surveys around external beam treatment units, stereotactic radiosurgery units, and remote afterloading units, as applicable; and

(2) Has obtained written attestation that the individual has satisfactorily completed the requirements in 41.2(74)“*a*”(1) and (2) and 41.2(74)“*c*” or 41.2(74)“*b*”(1) and 41.2(74)“*c*,” and has achieved a level of competency sufficient to function independently as an authorized medical physicist for each type of therapeutic medical unit for which the individual is requesting authorized medical physicist status. The written attestation must be signed by a preceptor authorized medical physicist who meets the requirements in 41.2(74) or 41.2(75) or equivalent NRC or agreement state requirements for an authorized medical physicist for each type of therapeutic medical unit for which the individual is requesting authorized medical physicist status; and

*c.* Has training for the type of use for which authorization is sought that includes hands-on device operation, safety procedures, clinical use, and the operation of a treatment planning system. This training requirement may be satisfied by satisfactorily completing either a training program provided by the vendor or by training supervised by an authorized medical physicist who is authorized for the type of use for which the individual is seeking authorization.

**41.2(75) Training for experienced radiation safety officer, authorized medical physicist, nuclear pharmacist, authorized nuclear pharmacist, authorized users and teletherapy or medical physicists.**

a. (1) An individual identified as a radiation safety officer, teletherapy or medical physicist, or nuclear pharmacist on an agency, NRC or agreement state license or a permit issued by an NRC or agreement state broad scope licensee or master material license permit or by a master material license permittee of broad scope before January 1, 2003, does not need to comply with the training requirements of 41.2(65), 41.2(74), or 41.2(78).

(2) An individual identified as a radiation safety officer, an authorized medical physicist, or an authorized nuclear pharmacist on the agency, NRC, or agreement state license or permit issued by the agency, NRC, or agreement state broad scope licensee or issued by master material license permit or issued by a master material license permittee of broad scope between January 1, 2003, and May 3, 2006, need not comply with the training requirements of 41.2(65), 41.2(74), or 41.2(78).

b. (1) Physicians, dentists, or podiatrists identified as authorized users for the medical use of radioactive material on a license issued by the agency, the NRC, or agreement state, a permit issued by an NRC master material licensee, a permit issued by an NRC broad scope licensee, or a permit issued by an NRC master material license broad scope permittee before January 1, 2003, who perform only those medical uses for which they were authorized before that date need not comply with the training requirements of 41.2(67), 41.2(68), 41.2(69), 41.2(70), 41.2(71), 41.2(72), 41.2(73), 41.2(81), 41.2(82), or 41.2(89).

(2) Physicians, dentists, or podiatrists identified as authorized users for the medical use of radioactive material issued by the agency, the NRC, or agreement state, a permit issued by an NRC master material licensee, a permit issued by an NRC broad scope licensee, or a permit issued by an NRC master material license broad scope permittee who perform only those medical uses for which they were authorized between January 1, 2003, and May 3, 2006, need not comply with the training requirements of 41.2(67), 41.2(68), 41.2(69), 41.2(70), 41.2(71), 41.2(72), 41.2(73), 41.2(81), 41.2(82), or 41.2(89).

c. Individuals who need not comply with training requirements as described in this subrule may serve as preceptors for, and supervisors of, applicants seeking authorization on an agency license for the same uses for which these individuals are authorized.

**41.2(76)** *Physician training in a three-month program.* Rescinded IAB 8/1/07, effective 9/5/07.

**41.2(77)** *Recentness of training.* The training and experience specified in 41.2(65) to 41.2(78) and 41.2(81), 41.2(82), and 41.2(89) shall have been obtained within the seven years preceding the date of application or the individual shall have had related continuing education and continuing applicable experience since the required training and experience were completed.

**41.2(78)** *Training for an authorized nuclear pharmacist.* Except as provided in 41.2(75), the licensee shall require the authorized nuclear pharmacist to be a pharmacist who:

a. Is certified as a nuclear pharmacist by a specialty board whose certification process includes all of the requirements of 41.2(78) "b." (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC's Web page.) To have its certification process recognized, a specialty board shall require all candidates for certification to:

(1) Have graduated from a pharmacy program accredited by the American Council on Pharmaceutical Education (ACPE) or have passed the Foreign Pharmacy Graduate Examination Committee (FPGEC) examination;

(2) Hold a current, active license to practice pharmacy;

(3) Provide evidence of having acquired at least 4,000 hours of combined training and experience in nuclear pharmacy practice. Academic training may be substituted for no more than 2,000 hours of the required training and experience; and

(4) Pass an examination in nuclear pharmacy administered by diplomats of the specialty board that assesses knowledge and competency in procurement, compounding, quality assurance, dispensing, distribution, health and safety, radiation safety, provision of information and consultation, monitoring patient outcomes, research and development; or

b. Has completed 700 hours in a structured education program consisting of both:

(1) 200 hours of classroom and laboratory training in the following areas:

1. Radiation physics and instrumentation;

2. Radiation protection;

3. Mathematics pertaining to the use and measurement of radioactivity;
4. Chemistry of radioactive material for medical use; and
5. Radiation biology; and
- (2) Supervised practical experience in a nuclear pharmacy involving:
  1. Shipping, receiving, and performing related radiation surveys;
  2. Using and performing checks for proper operation of instruments used to determine the activity of dosages, survey meters and, if appropriate, instruments used to measure alpha- or beta-emitting radionuclides;
  3. Calculating, assaying, and safely preparing dosages for patients or human research subjects;
  4. Using administrative controls to avoid medical events in the administration of by-product material; and
  5. Using procedures to prevent or minimize radioactive contamination and using proper decontamination procedures; and
- c. Has obtained written attestation, signed by a preceptor authorized nuclear pharmacist, that the individual satisfactorily completed the requirements in 41.2(78) "a"(1), (2), and (3), or 41.2(78) "b"(1) and has achieved a level of competency sufficient to function independently as an authorized nuclear pharmacist.

**41.2(79)** *Training for experienced nuclear pharmacists.* Rescinded IAB 8/1/07, effective 9/5/07.

**41.2(80)** *Training for nuclear medicine technologists.* Rescinded IAB 4/2/03, effective 5/7/03.

**41.2(81)** *Training for the oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 33 millicuries (1.22 gigabecquerels).* Except as provided in 41.2(75), the licensee shall require an authorized user for the oral administration of sodium iodide I-131 requiring a written directive in quantities less than or equal to 33 millicuries (1.22 gigabecquerels) to be a physician who:

a. Is certified by a medical specialty board whose certification process includes all of the requirements in 41.2(81) "c"(1) and (2) and whose certification process has been recognized by the agency, NRC, or an agreement state and who meets the requirements in 41.2(81) "c"(3). (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC's Web page.); or

b. Is an authorized user under 41.2(69) "a" or "b" for uses in the oral administration of less than or equal to 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131 for which a written directive is required, or oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131 or 41.2(82) or equivalent NRC or agreement state requirements; or

c. (1) Has successfully completed 80 hours of classroom and laboratory training, applicable to the medical use of sodium iodide I-131 for procedures requiring a written directive. The training must include:

1. Radiation physics and instrumentation;
2. Radiation protection;
3. Mathematics pertaining to the use and measurement of radioactivity;
4. Chemistry of radioactive material for medical use; and
5. Radiation biology; and

(2) Has work experience, under the supervision of an authorized user who meets the requirements in 41.2(69) "a" or "b," 41.2(75), 41.2(81) or 41.2(82) or equivalent NRC or agreement state requirements. A supervising authorized user who meets the requirements in 41.2(69) "b" must also have experience in administering dosages as follows: oral administration of less than or equal to 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131, for which a written directive is required; or oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131. The work experience must involve:

1. Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys;
2. Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters;

3. Calculating, measuring, and safely preparing patient or human research subject dosages;
4. Using administrative controls to prevent a medical event involving the use of radioactive material;
5. Using procedures to contain spilled radioactive material safely and using proper decontamination procedures; and
6. Administering dosages to patients or human research subjects that include at least three cases involving the oral administration of less than or equal to 33 millicuries (1.22 Gigabecquerels) of sodium iodide I-131; and

(3) Has obtained written attestation that the individual has satisfactorily completed the requirements in 41.2(81)“c”(1) and (2), and has achieved a level of competency sufficient to function independently as an authorized user for medical uses authorized under 41.2(37). The written attestation must be signed by a preceptor authorized user who meets the requirements in 41.2(69), 41.2(75), 41.2(81) or 41.2(82) or equivalent NRC or agreement state requirements. A preceptor authorized user who meets the requirements in 41.2(69)“b” must also have experience in administering dosages as follows: oral administration of less than or equal to 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131, for which a written directive is required; or oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131.

**41.2(82)** *Training for the oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 33 millicuries (1.22 gigabecquerels).* Except as provided in 41.2(75), the licensee shall require an authorized user for the oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 33 millicuries (1.22 gigabecquerels) to be a physician who:

a. Is certified by a medical specialty board whose certification process includes all of the requirements in 41.2(82)“c”(1) and (2), and whose certification has been recognized by the agency, NRC, or agreement state, and who meets the requirements in 41.2(82)“c”(3). (The names of the specialty boards that have been recognized by the agency, NRC, or agreement state must be posted on the NRC’s Web page.); or

b. Is an authorized user under 41.2(69)“a” or “b” for oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131 or meets equivalent NRC or agreement state requirements; or

c. (1) Has successfully completed 80 hours of classroom and laboratory training, applicable to the medical use of sodium iodide I-131 for procedures requiring a written directive. The training must include:

1. Radiation physics and instrumentation;
2. Radiation protection;
3. Mathematics pertaining to the use and measurement of radioactivity;
4. Chemistry of radioactive material for medical use; and
5. Radiation biology; and

(2) Has work experience, under the supervision of an authorized user who meets the requirements in 41.2(69)“a” or “b,” 41.2(75) or 41.2(82) or equivalent NRC or agreement state requirements. A supervising authorized user who meets the requirements in 41.2(69)“b” must also have experience in oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131. The work experience must involve:

1. Ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys;
2. Performing quality control procedures on instruments used to determine the activity of dosages and performing checks for proper operation of survey meters;
3. Calculating, measuring, and safely preparing patient or human research subject dosages;
4. Using administrative controls to prevent a medical event involving the use of radioactive material;
5. Using procedures to contain spilled radioactive material safely and using proper decontamination procedures; and

6. Administering dosages to patients or human research subjects that include at least three cases involving the oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131; and

(3) Has obtained written attestation that the individual has satisfactorily completed the requirements in 41.2(82)“c”(1) and (2), and has achieved a level of competency sufficient to function independently as an authorized user for medical uses authorized in 41.2(37). The written attestation must be signed by a preceptor authorized user who meets the requirements in 41.2(69), 41.2(75) or 41.2(82) or equivalent NRC or agreement state requirements. A preceptor authorized user who meets the requirements in 41.2(69)“b” must also have experience in oral administration of greater than 33 millicuries (1.22 gigabecquerels) of sodium iodide I-131.

**41.2(83) Provisions for the protection of human research subjects.**

a. A licensee may conduct research involving human research subjects only if the licensee uses the radioactive materials authorized on its specific license for the uses authorized on its license.

b. If the research is conducted, funded, supported, or regulated by another federal agency that has implemented Federal Policy for the Protection of Human Subjects (Federal Policy), the licensee shall, before conducting research:

(1) Obtain review and approval of the research from an “Institutional Review Board,” as defined and described in the Federal Policy; and

(2) Obtain “informed consent,” as defined and described in the Federal Policy, from the human research subjects.

c. If the research will not be conducted, funded, supported, or regulated by another federal agency that has implemented the Federal Policy, the licensee shall, before conducting research, apply for and receive a specific amendment to its medical use license. The amendment request must include a written commitment that the licensee will, before conducting research:

(1) Obtain review and approval of the research from an “Institutional Review Board,” as defined and described in the Federal Policy; and

(2) Obtain “informed consent,” as defined and described in the Federal Policy, from the human research subjects.

d. Nothing in this subrule relieves a licensee from complying with the other requirements of these rules.

**41.2(84) Calibration measurements of brachytherapy sources.**

a. Before the first medical use of a brachytherapy source on or after January 1, 2003, a licensee shall have:

(1) Determined the source output or activity using a dosimetry system that meets the requirements of 41.2(57);

(2) Determined the source positioning accuracy within applicators; and

(3) Used published protocols currently accepted by nationally recognized bodies to meet the requirements of 41.2(84)“a.”

b. A licensee may use measurements that are provided by the source manufacturer or by a calibration laboratory accredited by the American Association of Physicists in Medicine and that are made in accordance with 41.2(84)“a”(1) and (2).

c. A licensee shall mathematically correct the outputs or activities determined in 41.2(84)“a” for physical decay at intervals consistent with 1 percent physical decay.

d. A licensee shall retain a record of each calibration for three years after the last use of the source. The record must include:

(1) The date of the calibration;

(2) The manufacturer’s name, model number, and serial number for the source and the instruments used to calibrate the source;

(3) The source output or activity;

(4) The source positioning accuracy within the applicators; and

(5) The signature of the authorized medical physicist.

**41.2(85) Decay of strontium-90 sources for ophthalmic treatment.**

a. Only an authorized medical physicist shall calculate the activity of each strontium-90 source that is used to determine the treatment times for ophthalmic treatments. The decay must be based on the activity determined under 41.2(84).

b. A licensee shall retain a record of the activity of each strontium-90 source in accordance with 41.2(84).

**41.2(86) *Therapy-related computer systems.*** The licensee shall perform acceptance testing on the treatment planning system of therapy-related computer systems in accordance with published protocols accepted by nationally recognized bodies. At a minimum, the acceptance must include, as applicable, verification of:

- a. The source-specific input parameters required by the dose calculation algorithm;
- b. The accuracy of dose, dwell time, and treatment time calculations at representative points;
- c. The accuracy of isodose plots and graphic displays;
- d. The accuracy of the software used to determine sealed source positions from radiographic images; and
- e. The accuracy of electronic transfer of the treatment delivery parameters to the treatment delivery unit from the treatment planning system.

**41.2(87) *Written directives.*** Each licensee or registrant shall meet the following objectives:

a. A written directive must be dated and signed by an authorized user before the administration of I-131 sodium iodide greater than 30 microcuries, any therapeutic dosage of unsealed by-product material or any therapeutic dose of radiation from by-product material.

(1) If, because of the emergent nature of the patient's condition, a delay in order to provide a written directive would jeopardize the patient's health, an oral directive is acceptable.

(2) The information contained in the oral directive must be documented as soon as possible in writing in the patient's record. A written directive must be prepared within 48 hours of the oral directive.

b. Prior to administration, a written directive must contain the patient's or human research subject's name and the following information:

(1) For any administration of quantities greater than 30 microcuries of either sodium iodide I-125 or I-131: the dosage;

(2) For a therapeutic administration of a radiopharmaceutical other than sodium iodide I-125 or I-131: the radiopharmaceutical, dosage, and route of administration;

(3) For gamma stereotactic radiosurgery: the total dose, treatment site, and values for the target coordinate setting per treatment for each anatomically distinct treatment site;

(4) For teletherapy: the total dose, dose per fraction, number of fractions, treatment site, and overall treatment period;

(5) For high-dose-rate remote afterloading brachytherapy: the radioisotope, treatment site, dose per fraction, number of fractions and total dose; or

(6) For all other brachytherapy, including low-, medium-, and pulsed-dose-rate remote afterloaders:

1. Prior to implantation: treatment site, the radioisotope, number of sources, and source strengths and dose; and

2. After implantation but prior to completion of the procedure: the radioisotope, treatment site, number of sources, and total source strength and exposure time (or, equivalently, the total dose);

(7) For therapeutic use of radiation machines, see 41.3(14).

c. Prior to each administration, the patient's or human research subject's identity is verified by more than one method as the individual named in the written directive.

d. The final plans of treatment and related calculations for brachytherapy, teletherapy, and gamma stereotactic radiosurgery are in accordance with the respective written directives.

e. Each administration is in accordance with the written directive through checking both manual and computer-generated dose calculations and verifying that any computer-generated dose calculations are correctly transferred into the consoles of the medical units authorized by 641—Chapter 41.

f. Any unintended deviation from the written directive is identified and evaluated, and appropriate action is taken.

g. A written revision to an existing written directive may be made if the revision is dated and signed by an authorized user before the administration of the dosage of unsealed by-product material, the brachytherapy dose, the gamma stereotactic radiosurgery dose, the teletherapy dose, or the next fractional dose.

(1) If, because of the patient's condition, a delay in order to provide a written revision to an existing written directive would jeopardize the patient's health, an oral revision to an existing written directive is acceptable.

(2) The oral revision must be documented as soon as possible in the patient's record. A revised written directive must be signed by the authorized user with 48 hours of the oral revision.

h. A copy of the written directive in auditable form shall be retained for three years after the date of administration.

**41.2(88)** *Other medical uses of by-product material or radiation from by-product material.* A licensee may use by-product material or a radiation source approved for medical use which is not specifically addressed in 641—41.2(136C)(e.g., Y-90 microspheres, liquid brachytherapy, intravascular brachytherapy) if:

a. The applicant or licensee has submitted the information required by the agency; and

b. The applicant or licensee has received written approval from the agency in a license or license amendment and uses the material in accordance with the regulations and specific conditions the agency considers necessary for the medical use of the material.

**41.2(89)** *Training for the parenteral administration of unsealed by-product material requiring a written directive.* Except as provided in 41.2(75), the licensee shall require an authorized user for the parenteral administration requiring a written directive to be a physician who:

a. Is an authorized user under 41.2(69) for parenteral administration of either any beta emitter or a photon-emitting radionuclide with a photon energy less than 150 keV for which a written directive is required or equivalent NRC or agreement state requirements; or

b. Is an authorized user under 41.2(70) or 41.2(73) or equivalent NRC or agreement state requirements, and who meets the requirements in 41.2(89) "d"; or

c. Is certified by a medical specialty board whose certification process has been recognized by the NRC or an agreement state under 41.2(70) or 41.2(73) and who meets the requirements in 41.2(89) "d"; or

d. (1) Has successfully completed 80 hours of classroom and laboratory training, applicable to parenteral administrations, for which a written directive is required, of either any beta emitter or any photon-emitting radionuclide with a photon energy less than 150 keV or parenteral administration of any other radionuclide for which a written directive is required. The training must include:

1. Radiation physics and instrumentation;
2. Radiation protection;
3. Mathematics pertaining to the use and measurement of radioactivity;
4. Chemistry of radioactive material for medical use; and
5. Radiation biology; and

(2) Has work experience, under the supervision of an authorized user who meets the requirements in 41.2(69), 41.2(75) or 41.2(89) or equivalent NRC or agreement state requirements, in the parenteral administration for which a written directive is required, of either any beta emitter or any photon-emitting radionuclide with a photon energy less than 150 keV or parenteral administration of any other radionuclide for which a written directive is required. A supervising authorized user who meets the requirements in 41.2(69) must have experience in administering dosages of either any beta emitter or any photon-emitting radionuclide with a photon energy less than 150 keV or parenteral administration of any other radionuclide for which a written directive is required. The work experience must involve:

1. Ordering, receiving, and unpacking radioactive materials safely, and performing the related radiation surveys;

2. Performing quality control procedures on instruments used to determine the activity of dosages, and performing checks for proper operation of survey meters;

3. Calculating, measuring, and safely preparing patient or human research subject dosages;

4. Using administrative controls to prevent a medical event involving the use of unsealed radioactive material;

5. Using procedures to contain spilled radioactive material safely, and using proper decontamination procedures; and

6. Administering dosages to patients or human research subjects, that include at least three cases involving the parenteral administration for which a written directive is required, of either any beta emitter or any photon-emitting radionuclide with a photon energy less than 150 keV or at least three cases involving the parenteral administration of any other radionuclide for which a written directive is required; and

(3) Has obtained written attestation that the individual has satisfactorily completed the requirements in 41.2(89)“b” or “c,” and has achieved a level of competency sufficient to function independently as an authorized user for the parenteral administration of unsealed by-product material requiring a written directive. The written attestation must be signed by a preceptor authorized user who meets the requirements in 41.2(69), 41.2(75) or 41.2(89) or equivalent NRC or agreement state requirements. A preceptor authorized user who meets the requirements in 41.2(69) must have experience in administering dosages of either any beta emitter or any photon-emitting radionuclide with a photon energy less than 150 keV or at least three cases involving the parenteral administration of any other radionuclide for which a written directive is required.

[ARC 7983B, IAB 7/29/09, effective 9/2/09; ARC 8982B, IAB 8/11/10, effective 9/15/10; ARC 0577C, IAB 2/6/13, effective 3/13/13; ARC 1639C, IAB 10/1/14, effective 11/5/14]

#### **641—41.3(136C) Therapeutic use of radiation machines.**

##### **41.3(1) Scope and applicability.**

a. This subrule establishes requirements, for which the registrant is responsible, for use of therapeutic radiation machines.

b. The use of therapeutic radiation machines shall be by, or under the supervision of, a physician who meets the training/experience criteria established by 41.3(5).

c. Unless specifically required otherwise by 641—41.3(136C), all registrants are subject to the requirements of 641—Chapters 38 to 40.

**41.3(2) Definitions.** In addition to the definitions provided in 641—38.2(136C) and 641—40.2(136C), the following definitions are specific to 641—41.3(136C).

“*Accessible surface*” means surface of equipment or of an equipment part that can be easily or accidentally touched by persons without the use of a tool.

“*Added filtration*” means any filtration which is in addition to the inherent filtration.

“*Beam-limiting device*” means a field defining collimator, integral to the therapeutic radiation machine, which provides a means to restrict the dimensions of the useful beam.

“*Beam-scattering foil*” means a thin piece of material (usually metallic) placed in the beam to scatter a beam of electrons in order to provide a more uniform electron distribution in the useful beam.

“*Bent beam linear accelerator*” means a linear accelerator geometry in which the accelerated electron beam must change direction by passing through a bending magnet.

“*Contact therapy system*” means a therapeutic radiation machine with a short target-to-skin distance (TSD), usually less than 5 centimeters.

“*Dose monitor unit (DMU)*” means a unit response from the beam monitoring system from which the absorbed dose can be calculated.

“*External beam radiation therapy*” means therapeutic irradiation in which the source of radiation is at a distance from the body.

“*Field flattening filter*” means a filter used to homogenize the absorbed dose rate over the radiation field.

“*Filter*” means material placed in the useful beam to change beam quality or its intensity profile in therapeutic radiation machines.

“*Gantry*” means that part of a radiation therapy system supporting and allowing movements of the radiation head around a center of rotation.

*“Interruption of irradiation”* means the stopping of irradiation with the possibility of continuing irradiation without resetting of operating conditions at the control panel.

*“Isocenter”* means the center of the sphere through which the useful beam axis passes while the gantry moves through its full range of motions.

*“Megavolt (MV) (mega electron volt (MeV))”* means the energy equal to that acquired by a particle with one electron charge in passing through a potential difference of 1 million volts in a vacuum. (Note: Current convention is to use MV for photons and MeV for electrons.)

*“Monitor unit (MU).”* See “Dose monitor unit.”

*“Moving beam radiation therapy”* means radiation therapy with continuous displacement of one or more mechanical axes relative to the patient during irradiation. It includes arc therapy, skip therapy, conformal therapy, intensity modulation, and rotational therapy.

*“Nominal treatment distance”* means:

1. For electron irradiation, the distance from the scattering foil, virtual source, or exit window of the electron beam to the entrance surface of the irradiated object along the central axis of the useful beam.

2. For X-ray irradiation, the virtual source or target to isocenter distance along the central axis of the useful beam. For nonisocentric equipment, this distance shall be that specified by the manufacturer.

*“Periodic quality assurance check”* means a procedure which is performed to ensure that a previous calibration continues to be valid.

*“Practical range of electrons”* corresponds to classical electron range where the only remaining contribution to dose is from bremsstrahlung X-rays. A further explanation may be found in “Clinical Electron Beam Dosimetry: Report of AAPM Radiation Therapy Committee Task Group 25” (Medical Physics 18(1): 73-109, Jan/Feb 1991) and ICRU Report 35, “Radiation Dosimetry: Electron Beams with Energies Between 1 and 50 MeV,” International Agency on Radiation Units and Measurements, September 15, 1984.

*“Radiation field.”* See “Useful beam.”

*“Radiation head”* means the structure from which the useful beam emerges.

*“Radiation therapy physicist”* means an individual qualified in accordance with 41.3(6).

*“Redundant beam monitoring system”* means a combination of two dose monitoring systems in which each system is designed to terminate irradiation in accordance with a preselected number of dose monitor units.

*“Shadow tray”* means a device attached to the radiation head to support auxiliary beam blocking material.

*“Stationary beam radiation therapy”* means radiation therapy without displacement of one or more mechanical axes relative to the patient during irradiation.

*“Target”* means that part of an X-ray tube or accelerator onto which is directed a beam of accelerated particles to produce ionizing radiation or other particles.

*“Tenth-value layer (TVL)”* means the thickness of a specified material which attenuates X-radiation or gamma radiation to an extent such that the air kerma rate, exposure rate or absorbed dose rate is reduced to one-tenth of the value measured without the material at the same point.

*“Therapeutic radiation machine”* means X-ray or electron-producing equipment designed and used for external beam radiation therapy.

*“Virtual source”* means a point from which radiation appears to originate.

**41.3(3)** Registration or license requirements. No person shall receive, possess, use, transfer, own, or acquire therapeutic radiation machines except as authorized in a registration issued pursuant to 641—39.1(136C) to 39.4(136C).

**41.3(4)** General administrative requirements for facilities using therapeutic radiation machines.

a. Administrative controls. The registrant shall be responsible for directing the operation of the therapeutic radiation machines which have been registered with the agency. The registrant or the registrant’s agent shall ensure that the requirements of 41.3(136C) are met in the operation of the therapeutic radiation machine(s).

*b.* A therapeutic radiation machine which does not meet the provisions of these regulations shall not be used for irradiation of patients unless authorized by the agency.

**41.3(5)** Training for external beam radiation therapy authorized users. The registrant for any therapeutic radiation machine subject to 41.3(17) or 41.3(18) shall require the authorized user to be a physician who:

*a.* Is certified in:

- (1) Radiology or therapeutic radiology by the American Board of Radiology; or
- (2) Radiation oncology by the American Osteopathic Board of Radiology; or
- (3) Radiology, with specialization in radiotherapy, as a British “Fellow of the Faculty of Radiology” or “Fellow of the Royal College of Radiology”; or
- (4) Therapeutic radiology by the Canadian Royal College of Physicians and Surgeons; or

*b.* Is in the active practice of therapeutic radiology, and has completed 200 hours of instruction in basic radiation techniques applicable to the use of an external beam radiation therapy unit, 500 hours of supervised work experience, and a minimum of three years of supervised clinical experience.

*c.* To satisfy the requirement for instruction in 41.3(5) “*b*” above, the classroom and laboratory training shall include:

- (1) Radiation physics and instrumentation;
- (2) Radiation protection;
- (3) Mathematics pertaining to the use and measurement of ionization radiation; and
- (4) Radiation biology.

*d.* To satisfy the requirement for supervised work experience in 41.3(4) “*b*” above, training shall be under the supervision of an authorized user and shall include:

- (1) Reviewing the full calibration measurements and periodic quality assurance checks;
- (2) Evaluating prepared treatment plans and calculation of treatment times/patient treatment settings;
- (3) Using administrative controls to prevent misadministrations;
- (4) Implementing emergency procedures to be followed in the event of the abnormal operation of an external beam radiation therapy unit or console; and
- (5) Checking and using radiation survey meters.

*e.* To satisfy the requirement for a period of supervised clinical experience, training shall include one year in a formal training program approved by the Residency Review Committee for Radiology of the Accreditation Council for Graduate Medical Education or the Committee on Postdoctoral Training of the American Osteopathic Association and an additional two years of clinical experience in therapeutic radiology under the supervision of an authorized user. The supervised clinical experience shall include:

- (1) Examining individuals and reviewing their case histories to determine their suitability for external beam radiation therapy treatment, and any limitations/contraindications;
- (2) Selecting proper dose and how it is to be administered;
- (3) Calculating the external beam radiation therapy doses and collaborating with the authorized user in the review of patients’ progress; consideration of the need to modify originally prescribed doses or treatment plans as warranted by patients’ reaction to radiation; and
- (4) Postadministration follow-up and review of case histories.

*f.* Notwithstanding the requirements of 41.3(5) “*b*,” the registrant for any therapeutic radiation machine subject to 41.3(17) and 41.3(18) may also submit the training of the prospective authorized user physician for agency review.

*g.* A physician shall not act as an authorized user for any therapeutic radiation machine until such time as said physician’s training has been reviewed and approved by the registrant.

**41.3(6)** Training for radiation therapy physicist. The registrant for any therapeutic radiation machine subject to 41.3(17) or (18) shall require the radiation therapy physicist to:

*a.* Be registered with the agency, under the provisions of 641—subrule 39.3(3) of these regulations, as a provider of radiation services in the area of calibration and compliance surveys of external beam radiation therapy units; and

*b.* Be certified by the American Board of Radiology in:

- (1) Therapeutic radiological physics; or
- (2) Roentgen-ray and gamma-ray physics; or
- (3) X-ray and radium physics; or
- (4) Radiological physics; or
- (5) Therapeutic medical physics; or
- c.* Be certified by the American Board of Medical Physics in radiation oncology physics; or
- d.* Be certified by the Canadian College of Physicists in Medicine; or
- e.* Hold a master's or doctor's degree in physics, biophysics, radiological physics, or health physics, and have completed one year of full-time training in therapeutic radiological physics and also one year of full-time work experience under the supervision of a radiation therapy physicist at a medical institution. To meet this requirement, the individual shall have performed the tasks listed in 41.3(16) "*a*," 41.3(17) "*c*" and "*d*," and 41.3(18) "*e*" and "*f*" under the supervision of a radiation therapy physicist during the year of work experience.

*f.* Rescinded IAB 4/3/02, effective 5/8/02.

**41.3(7)** Qualifications of operators. Individuals who will be operating a therapeutic radiation machine for medical use shall be adequately instructed in the safe operating procedures and hold a current permit to practice in radiation therapy as a radiation therapist under the provisions of 641—Chapter 42. The permit holder shall make the permit available at the individual's place of employment. If the permit holder works at more than one facility, a duplicate of the permit shall be kept at each facility.

**41.3(8)** Written safety procedures and rules shall be developed by a radiation therapy physicist and shall be available in the control area of a therapeutic radiation machine, including any restrictions required for the safe operation of the particular therapeutic radiation machine. The operator shall be able to demonstrate familiarity with these rules. All individuals associated with the operation of a therapeutic radiation machine shall be instructed in and shall comply with procedures for maintaining written directives.

**41.3(9)** Individuals shall not be exposed to the useful beam except for medical therapy purposes and unless such exposure has been ordered in writing by a physician. This provision specifically prohibits deliberate exposure of an individual for training, demonstration or other non-healing arts purposes.

**41.3(10)** Records of visiting authorized users. Notwithstanding the provisions of 41.3(5), a registrant may permit any physician to act as a visiting authorized user for up to 60 days per calendar year under the following conditions:

- a.* The visiting authorized user has the prior written permission of the registrant's management and, if the use occurs on behalf of an institution, the institution's radiation safety committee;
- b.* The visiting authorized user meets the requirements of 41.3(5); and
- c.* The registrant maintains copies of all records specified in 41.3(5) for five years from the date of the last visit.

**41.3(11)** Information and maintenance record and associated information. The registrant shall maintain the following information in a separate file or package for each therapeutic radiation machine for inspection by the agency:

- a.* Report of acceptance testing;
- b.* Records of all surveys, calibrations, and periodic quality assurance checks of the therapeutic radiation machine required by 41.3(136C), as well as the name(s) of person(s) who performed such activities;
- c.* Records of maintenance or modifications, or both, performed on the therapeutic radiation machine after July 9, 1997, as well as the name(s) of person(s) who performed such services;
- d.* Signature of person authorizing the return of therapeutic radiation machine to clinical use after service, repair, or upgrade.
- e.* Records of training specified in 41.3(5) and 41.3(6).

**41.3(12)** Records retention. All records required by 641—41.3(136C) shall be retained until disposal is authorized by the agency unless another retention period is specifically authorized in 41.3(136C). All required records shall be retained in an active file from at least the time of generation until the next

agency inspection. Any required record generated before the last agency inspection may be microfilmed or otherwise archived as long as a complete copy can be retrieved until such time the agency authorizes final disposal.

**41.3(13)** Form of records. Rescinded IAB 4/5/00, effective 5/10/00.

**41.3(14)** Written directives. Each registrant shall meet the following:

*a.* A written directive must be dated and signed by an authorized user prior to the administration of radiation.

(1) If, because of the patient's condition, a delay in the order to provide a written revision to an existing directive would jeopardize the patient's health, an oral revision to an existing written directive will be acceptable, provided that the oral revision is documented as soon as possible in writing in the patient's record and a revised written directive is signed by an authorized user within 48 hours of the oral revision.

(2) The written directive must contain the patient or human research subject's name, the type and energy of the beam, the total dose, dose per fraction, treatment site, and number of fractions.

(3) A written revision to an existing written directive may be made provided that the revision is dated and signed by an authorized user prior to the administration of the external beam dose, or the next fractional dose.

(4) The registrant shall retain a copy of the written directive for three years.

*b.* Procedures for administration. The registrant shall have written procedures that provide the following information:

(1) Prior to the administration of each course of radiation treatment, the patient's or human research subject's identity is verified by more than one method as the individual named in the written directive;

(2) Each administration is in accordance with the written directive;

(3) External beam radiation therapy final plans of treatment and related calculations are in accordance with the respective written directives by:

1. Checking both manual and computer-generated dose calculations to verify that they are correct and in accordance with the written directive; and

2. Verifying that any computer-generated calculations are correctly transferred into the consoles of authorized therapeutic medical units;

(4) Any unintended deviation from the written directive is identified, evaluated and appropriate action is taken; and

(5) The registrant retains a copy of the procedures for administrations for the duration of the registration.

**41.3(15)** Reports and notifications of misadministrations.

*a.* A registrant shall report any event resulting from intervention of a patient or human research subject in which the administration of external beam radiation results, or will result, in unintended permanent functional damage to an organ or a physiological system as determined by a physician.

*b.* Other than events that result from intervention by a patient or human research subject, a registrant shall report any event in which the administration of an external beam radiation therapy dose results in:

(1) A dose that differs from the prescribed dose by more than 5 rem (0.05 sievert) effective dose equivalent, 50 rem (0.5 sievert) to an organ or tissue, or 50 rem (0.5 sievert) shallow dose equivalent to the skin, and either:

1. The total dose delivered differs from the prescribed dose by 20 percent or more; or

2. The fractionated dose delivered differs from the prescribed dose for a single fraction by 50 percent or more.

(2) A dose that exceeds 5 rem (0.05 sievert) effective dose equivalent, 50 rem (0.5 sievert) to an organ or tissue, or 50 rem (0.5 sievert) shallow dose equivalent to the skin from either of the following:

1. An administration of the wrong treatment modality;

2. An administration to the wrong individual or human research subject.

(3) A dose to the skin or an organ or tissue other than the treatment site that exceeds by 50 rem (0.5 sievert) to an organ or tissue and 50 percent or more of the dose expected from the administration defined in the written directive.

*c.* The registrant shall notify the agency by telephone no later than the next calendar day after the discovery of a misadministration.

*d.* The registrant shall submit a written report to the agency within 15 days after the discovery of a misadministration. The written report shall include:

- (1) The registrant's name;
- (2) The name of the prescribing physician;
- (3) A brief description of the event;
- (4) Why the event occurred;
- (5) The effect, if any, on the individual or individuals who received the misadministration;
- (6) Actions, if any, that have been taken, or are planned, to prevent recurrence;
- (7) Certification that the registrant notified the individual or the individual's responsible relative or guardian, and if not, why not.

*e.* The report to the agency shall not contain the individual's name or any other information that could lead to the identification of the individual.

*f.* The registrant shall provide notification of the event to the referring physician and also notify the individual who is the subject of the misadministration no later than 24 hours after its discovery, unless the referring physician personally informs the registrant either that the referring physician will inform the individual or that, based on medical judgment, the physician's telling the individual would be harmful. The registrant is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within 24 hours, the registrant shall notify the individual as soon as possible thereafter. The registrant may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the misadministration, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual who is the subject of the misadministration may be made instead to that individual's responsible relative or guardian. If a verbal notification is made, the registrant shall inform the individual, or appropriate responsible relative or guardian, that a written description of the event may be obtained from the registrant upon request. The registrant shall provide such a written description if requested.

*g.* Aside from the notification requirement, nothing in this subrule affects any rights or duties of registrants and physicians in relation to each other, to individuals affected by the misadministration, or to individuals' responsible relatives or guardians.

*h.* A copy of the record required in this subrule shall be provided to the referring physician, if other than the registrant, within 15 days after discovery of the misadministration.

*i.* Records of misadministrations. A registrant shall retain a record of misadministrations reported in this subrule for three years. The record must contain the following:

- (1) The registrant's name and the names of the individuals involved;
- (2) The social security number or other identification number, if one has been assigned, of the individual who is the subject of the misadministration;
- (3) A brief description of the event; why it occurred; and the effect, if any, on the individual;
- (4) The actions, if any, taken or planned to prevent recurrence; and
- (5) Whether the registrant notified the individual or the individual's responsible relative or guardian, and, if not, whether such failure to notify was based on guidance from the referring physician.

**41.3(16)** General technical requirements for facilities using therapeutic radiation machines.

*a.* Protection surveys.

(1) The registrant shall ensure that radiation protection surveys of all new facilities, and existing facilities not previously surveyed, are performed with an operable radiation measurement survey instrument calibrated within the past 12 months. The radiation protection survey shall be performed by, or under the direction of, a radiation therapy physicist or a certified health physicist and shall verify

that, with the therapeutic radiation machine in a “BEAM-ON” condition, with the largest clinically available treatment field and with a scattering phantom in the useful beam of radiation:

1. Radiation levels in restricted areas are not likely to cause personnel exposures in excess of the limits specified in 641—subrule 40.15(1); and

2. Radiation levels in unrestricted areas do not exceed the limits specified in 641—paragraphs 40.26(1) “a” and “b.”

(2) In addition to the requirements of 41.3(16) “a”(1), a radiation protection survey shall also be performed prior to any subsequent medical use and:

1. After making any change in the treatment room shielding;

2. After making any change in the location of the therapeutic radiation machine within the treatment room;

3. After relocating the therapeutic radiation machine; or

4. Before using the therapeutic radiation machine in a manner that could result in increased radiation levels in areas outside the external beam radiation therapy treatment room.

(3) The survey record shall indicate all instances where the facility, in the opinion of the radiation therapy physicist or a certified health physicist, is in violation of applicable regulations. The survey record shall also include the date of the measurements, the reason the survey is required, the manufacturer’s name, model number and serial number of the therapeutic radiation machine, the instrument(s) used to measure radiation levels, a plan of the areas surrounding the treatment room that were surveyed, the measured dose rate at several points in each area expressed in microsieverts or millirems per hour, the calculated maximum level of radiation over a period of one week for each restricted and unrestricted area, and the signature of the individual responsible for conducting the survey.

(4) If the results of the surveys required by 41.3(16) “a”(1) or (2) indicate any radiation levels in excess of the respective limit specified in 41.3(16) “a”(1), the registrant shall lock the control in the “OFF” position and not use the unit:

1. Except as may be necessary to repair, replace, or test the therapeutic radiation machine, the therapeutic radiation machine shielding, or the treatment room shielding; or

2. Until the registrant has received a specific exemption in writing from the agency.

b. Modification of radiation therapy unit or room before beginning a treatment program. If the survey required by 41.3(16) “a” indicates that an individual in an unrestricted area may be exposed to levels of radiation greater than those permitted by 641—paragraphs 40.26(1) “a” and “b,” before beginning the treatment program the registrant shall:

(1) Either equip the unit with beam direction interlocks or add additional radiation shielding to ensure compliance with 641—paragraphs 40.26(1) “a” and “b”;

(2) Perform the survey required by 41.3(16) “a” again; and

(3) Include in the report required by 41.3(16) “d” the results of the initial survey, a description of the modification made to comply with 41.3(5) “b”(1), and the results of the second survey; or

(4) Request and receive written authorization from the agency that authorizes radiation levels in unrestricted areas greater than those permitted by 641—paragraphs 40.26(1) “a” and “b.”

c. Dosimetry equipment.

(1) The registrant shall have a calibrated dosimetry system available for use. The system shall have been calibrated by the National Institute for Standards and Technology (NIST) or by an American Association of Physicists in Medicine (AAPM) Accredited Dosimetry Calibration Laboratory (ADCL). The calibration shall have been performed within the previous 24 months and after any servicing that may have affected system calibration.

1. For beams with energies greater than 1 MV (1 MeV), the dosimetry system shall have been calibrated for Cobalt-60.

2. For beams with energies equal to or less than 1 MV (1 MeV), the dosimetry system shall have been calibrated at an energy (energy range) appropriate for the radiation being measured.

(2) The registrant shall have available for use a dosimetry system for quality assurance check measurements. To meet this requirement, the system may be compared with a system that has been

calibrated in accordance with 41.3(16) "c"(1). This comparison shall have been performed within the previous 12 months and after each servicing that may have affected system calibration. The quality assurance check system may be the same system used to meet the requirement in 41.3(16) "c"(1).

(3) The registrant shall maintain a record of each dosimetry system calibration, intercomparison, and comparison for the duration of the license or registration. For each calibration, intercomparison, or comparison, the record shall include the date, the model numbers and serial numbers of the instruments that were calibrated, intercompared, or compared as required by 41.3(16) "c"(1) and (2), the correction factors that were determined, the names of the individuals who performed the calibration, intercomparison, or comparison, and evidence that the intercomparison was performed by, or under the direct supervision and in the physical presence of, a radiation therapy physicist.

d. Reports of external beam radiation therapy surveys and measurements. The registrant for any therapeutic radiation machine subject to 41.3(17) or 41.3(18) shall furnish a copy of the records required in 41.3(16) "a" and "b" to the agency within 30 days following completion of the action that initiated the record requirement.

**41.3(17) Therapeutic radiation machines of less than 500 kV.**

a. Equipment requirements.

(1) Leakage radiation. When the X-ray tube is operated at its maximum rated tube current for the maximum kV, the leakage air kerma rate shall not exceed the value specified at the distance specified for that classification of therapeutic radiation machine:

1. 5-50 kV systems. The leakage air kerma rate measured at any position 5 centimeters from the tube housing assembly shall not exceed 100 mrad (1 mGy) in any one hour.

2. >50 and <500 kV systems. The leakage air kerma rate measured at a distance of one meter from the target in any direction shall not exceed 1 rad (1 cGy) in any one hour. This air kerma rate measurement may be averaged over areas no larger than 100 square centimeters. In addition, the air kerma rate at a distance of 5 centimeters from the surface of the tube housing assembly shall not exceed 30 rad (30 cGy) per hour.

3. For each therapeutic machine, the registrant shall determine, or obtain from the manufacturer, the leakage radiation existing at positions specified in 41.3(17) "a"(1)"1" and 41.3(17) "a"(1)"2" for the specified operating conditions. Records on leakage radiation measurements shall be maintained at the facility for inspection by the agency.

(2) Permanent beam-limiting devices. Permanent diaphragms or cones used for limiting the useful beam shall provide at least the same degree of attenuation as required for the tube housing assembly.

(3) Adjustable or removable beam-limiting devices.

1. All adjustable or removable beam-limiting devices, diaphragms, cones or blocks shall not transmit more than 5 percent of the useful beam for the most penetrating beam used;

2. When adjustable beam-limiting devices are used, the position and shape of the radiation field shall be indicated by a light beam.

(4) Filter system. The filter system shall be so designed that:

1. Filters cannot be accidentally displaced at any possible tube orientation;

2. For equipment installed after July 9, 1997, an interlock system prevents irradiation if the proper filter is not in place;

3. The air kerma rate escaping from the filter slot shall not exceed 1 rad (1 cGy) per hour at one meter under any operating conditions; and

4. Each filter shall be marked as to its material of construction and its thickness.

(5) Tube immobilization.

1. The X-ray tube shall be so mounted that it cannot accidentally turn or slide with respect to the housing aperture; and

2. The tube housing assembly shall be capable of being immobilized for stationary portal treatments.

(6) Source marking. The tube housing assembly shall be so marked that it is possible to determine the location of the source to within 5 millimeters, and such marking shall be readily accessible for use during calibration procedures.

(7) Beam block. Contact therapy tube housing assemblies shall have a removable shield of material, equivalent in attenuation to 0.5 millimeters of lead at 100 kV, which can be positioned over the entire useful beam exit port during periods when the beam is not in use.

(8) Timer. A suitable irradiation control device shall be provided to terminate the irradiation after a preset time interval.

1. A timer which has a display shall be provided at the treatment control panel. The timer shall have a preset time selector and an elapsed time or time remaining indicator;

2. The timer shall be a cumulative timer which activates with an indication of "BEAM-ON" and retains its reading after irradiation is interrupted or terminated. After irradiation is terminated and before irradiation can be reinitiated, it shall be necessary to reset the elapsed time indicator;

3. The timer shall terminate irradiation when a preselected time has elapsed, if any dose monitoring system present has not previously terminated irradiation;

4. The timer shall permit accurate presetting and determination of exposure times as short as one second;

5. The timer shall not permit an exposure if set at zero;

6. The timer shall not activate until the shutter is opened when irradiation is controlled by a shutter mechanism unless calibration includes a timer error correction to compensate for mechanical lag; and

7. Timer shall be accurate to within 1 percent of the selected value or one second, whichever is greater.

(9) Control panel functions. The control panel, in addition to the displays required by other provisions in 41.3(6), shall have:

1. An indication of whether electrical power is available at the control panel and if activation of the X-ray tube is possible;

2. An indication of whether X-rays are being produced;

3. Means for indicating X-ray tube potential and current;

4. The means for terminating an exposure at any time;

5. A locking device which will prevent unauthorized use of the therapeutic radiation machine; and

6. For therapeutic radiation machines manufactured after July 9, 1997, a positive display of specific filter(s) in the beam.

(10) Multiple tubes. When a control panel may energize more than one X-ray tube:

1. It shall be possible to activate only one X-ray tube at any time;

2. There shall be an indication at the control panel identifying which X-ray tube is activated; and

3. There shall be an indication at the tube housing assembly when that tube is energized.

(11) Target-to-skin distance (TSD). There shall be a means of determining the central axis TSD to within one centimeter and of reproducing this measurement to within two millimeters thereafter.

(12) Shutters. Unless it is possible to bring the X-ray output to the prescribed exposure parameters within five seconds after the X-ray "ON" switch is energized, the beam shall be attenuated by a shutter(s) having a lead equivalency not less than that of the tube housing assembly. In addition, after the unit is at operating parameters, the shutter(s) shall be controlled by the operator from the control panel. An indication of shutter position shall appear at the control panel.

(13) Low filtration X-ray tubes. Each therapeutic radiation machine equipped with a beryllium or other low-filtration window shall be clearly labeled as such upon the tube housing assembly and shall be provided with a permanent warning device on the control panel that is activated when no additional filtration is present, to indicate that the dose rate is very high.

*b.* Facility design requirements for therapeutic radiation machines capable of operating in the range 50 kV to 500 kV. In addition to shielding adequate to meet requirements of 41.3(19), the treatment room shall meet the following design requirements:

(1) Aural communication. Provision shall be made for continuous two-way aural communication between the patient and the operator at the control panel.

(2) Viewing systems. Provision shall be made to permit continuous observation of the patient during irradiation and the viewing system shall be so located that the operator can observe the patient

from the control panel. The therapeutic radiation machine shall not be used for patient irradiation unless at least one viewing system is operational.

(3) Additional requirements. Treatment rooms which contain a therapeutic radiation machine capable of operating above 150 kV shall meet the following additional requirements:

1. All protective barriers shall be fixed except for entrance doors or beam interceptors;
2. The control panel shall be located outside the treatment room or in a totally enclosed booth, which has a ceiling, inside the room;
3. Interlocks shall be provided such that all entrance doors, including doors to any interior booths, shall be closed before treatment can be initiated or continued. If the radiation beam is interrupted by any door opening, it shall not be possible to restore the machine to operation without closing the door and reinitiating irradiation by manual action at the control panel; and
4. When any door referred to in 41.3(17)“b”(3)“3” is opened while the radiation machine is activated, the air kerma rate at a distance of one meter from the source shall be reduced to less than 1 mGy (100 mrad) per hour.

c. Full calibration measurements.

(1) Full calibration of a therapeutic radiation machine subject to 41.3(17) shall be performed by, or under the direct supervision of, a radiation therapy physicist:

1. Before the first medical use following installation or reinstallation of the therapeutic radiation machine;
  2. At intervals not exceeding one year; and
  3. Before medical use under the following conditions:
    - Whenever quality assurance check measurements indicate that the radiation output differs by more than 5 percent from the value obtained at the last full calibration and the difference cannot be reconciled; and
    - Following any component replacement, major repair, or modification of components that could significantly affect the characteristics of the radiation beam.
  4. Notwithstanding the requirements of 41.3(17)“c”(1):
    - Full calibration of therapeutic radiation machines with multienergy capabilities is required only for those modes or energies that are not within their acceptable range; and
    - If the repair, replacement or modification does not affect all energies, full calibration shall be performed on the affected energy that is in most frequent clinical use at the facility. The remaining energies may be validated with quality assurance check procedures against the criteria in 41.3(17)“b”(3).
- (2) To satisfy the requirement of 41.3(17)“c”(1), full calibration shall include all measurements recommended for annual calibration by NCRP Report 69, “Dosimetry of X-ray and Gamma Ray Beams for Radiation Therapy in the Energy Range 10 keV to 50 MeV” (1981).

(3) The registrant shall maintain a record of each calibration for the duration of the registration. The record shall include the date of the calibration, the manufacturer’s name, model number, and serial number for both the therapeutic radiation machine and the X-ray tube, the model numbers and serial numbers of the instruments used to calibrate the therapeutic radiation machine, and the signature of the radiation therapy physicist responsible for performing the calibration.

d. Periodic quality assurance checks.

(1) Periodic quality assurance checks shall be performed on therapeutic radiation machines, subject to 41.3(17), which are capable of operation at greater than or equal to 50 kV.

(2) To satisfy the requirement of 41.3(17)“d”(1), quality assurance checks shall meet the following requirements:

1. The registrant shall perform quality assurance checks in accordance with written procedures established by the radiation therapy physicist; and
2. The quality assurance check procedures shall specify the frequency at which tests or measurements are to be performed. The quality assurance check procedures shall specify that the quality assurance check shall be performed during the calibration specified in 41.3(17)“c”(1). The acceptable tolerance for each parameter measured in the quality assurance check, when compared to the value for that parameter determined in the calibration specified in 41.3(17)“c”(1), shall be stated.

(3) The cause for a parameter exceeding a tolerance set by the radiation therapy physicist shall be investigated and corrected before the system is used for patient or human research subject irradiation;

(4) Whenever a quality assurance check indicates a significant change in the operating characteristics of a system, as specified in the radiation therapy physicist's quality assurance check procedures, the system shall be recalibrated as required in 41.3(17) "c"(1);

(5) The registrant shall use the dosimetry system described in 41.3(16) "c"(2) to make the quality assurance check required in 41.3(17) "d";

(6) The registrant shall have the radiation therapy physicist review and sign the results of each radiation output quality assurance check within one month of test completion;

(7) The registrant shall ensure that safety quality assurance checks of therapeutic radiation machines subject to 41.3(17) are performed at intervals not to exceed one month;

(8) Notwithstanding the requirements of 41.3(17) "d"(6) and (7), the registrant shall ensure that no therapeutic radiation machine is used to administer radiation to humans unless the quality assurance checks required by 41.3(17) "d"(6) and (7) have been performed within the 30 days prior to administration;

(9) To satisfy the requirement of 41.3(17) "d"(7), safety quality assurance checks shall ensure proper operation of:

1. Electrical interlocks at each external beam radiation therapy room entrance;
2. The "BEAM-ON" and termination switches;
3. Beam condition indicator lights on the access door(s), control console, and in the radiation therapy room;
4. Viewing systems;
5. If applicable, electrically operated treatment room doors from inside and outside the treatment room.

(10) The registrant shall maintain a record of each quality assurance check required by 41.3(17) "d"(1) and (7) for three years. The record shall include the date of the quality assurance check, the manufacturer's name, model number, and serial number for the therapeutic radiation machine, the manufacturer's name, model number and serial number of the instrument(s) used to measure the radiation output of the therapeutic radiation machine, and the signature of the individual who performed the periodic quality assurance check.

*e.* Operating procedures.

(1) Therapeutic radiation machines shall not be left unattended unless secured by means identified in 41.3(17) "a"(9) "5";

(2) When a patient must be held in position for radiation therapy, mechanical supporting or restraining devices shall be used;

(3) The tube housing assembly shall not be held by an individual during operation unless the assembly is designed to require such holding and the peak tube potential of the system does not exceed 50 kV. In such cases, the holder shall wear protective gloves and apron of not less than 0.5 millimeters lead equivalency at 100 kV;

(4) A copy of the current operating and emergency procedures shall be maintained at the therapeutic radiation machine control console; and

(5) No individual other than the patient shall be in the treatment room during exposures from therapeutic radiation machines operating above 150 kV. At energies less than or equal to 150 kV, any individual, other than the patient, in the treatment room shall be protected by a barrier sufficient to meet the requirements of 641—40.26(136C).

(6) The therapeutic radiation machine shall not be used for irradiation of patients unless the requirements of 41.3(17) "c" and "d" have been met.

*f.* Possession of survey instrument(s). Each facility location authorized to use a therapeutic radiation machine in accordance with 41.3(17) shall have at its disposal appropriately calibrated portable monitoring equipment. As a minimum, such equipment shall include a portable radiation measurement survey instrument capable of measuring dose rates over the range 1 mrem (10  $\mu$ Sv) per

hour to 1000 mrem (10 mSv) per hour. The survey instrument(s) shall be operable and calibrated at intervals not to exceed 12 months for the radiation measured.

**41.3(18)** Therapeutic radiation machines—photon therapy systems (500 kV and above) and electron therapy systems (500 keV and above).

*a.* Equipment requirements.

(1) Leakage radiation outside the maximum useful beam in photon and electron modes.

1. The absorbed dose due to leakage radiation (excluding neutrons) at any point outside the maximum-sized useful beam, but within a circular plane of radius two meters which is perpendicular to and centered on the central axis of the useful beam at the nominal treatment distance (i.e., patient plane), shall not exceed a maximum of 0.2 percent and an average of 0.1 percent of the absorbed dose on the central axis of the beam at the nominal treatment distance. Measurements shall be averaged over an area not exceeding 100 square centimeters at a minimum of 16 points uniformly distributed in the plane;

2. Except for the area defined in 41.3(18)“a”(1)“1,” the absorbed dose due to leakage radiation (excluding neutrons) at one meter from the electron path between the electron source and the target or electron window shall not exceed 0.5 percent of the absorbed dose on the central axis of the beam at the nominal treatment distance. Measurements shall be averaged over an area not exceeding 100 square centimeters;

3. For equipment manufactured after July 9, 1997, the neutron absorbed dose outside the useful beam shall be in compliance with International Electrotechnical Agency (IEC) Document 601-2-1 (most current revision); and

4. For each therapeutic radiation machine, the registrant shall determine, or obtain from the manufacturer, the leakage radiation existing at the positions specified in 41.3(18)“a”(1)“1” to “3” for the specified operating conditions. Records of leakage radiation measurements shall be maintained for inspection by the agency.

(2) Leakage radiation through beam-limiting devices.

1. Photon radiation. All adjustable or interchangeable beam-limiting devices shall attenuate the useful beam such that at the nominal treatment distance, the maximum absorbed dose anywhere in the area shielded by the beam-limiting device(s) shall not exceed 2 percent of the maximum absorbed dose on the central axis of the useful beam measured in a 10-centimeter by 10-centimeter radiation field;

2. Electron radiation. All adjustable or interchangeable electron applicators shall attenuate the radiation including, but not limited to, photon radiation generated by electrons incident on the beam-limiting device and electron applicator and other parts of the radiation head, such that the absorbed dose in a plane perpendicular to the central axis of the useful beam at the nominal treatment distance shall not exceed:

- A maximum of 2 percent and average of 0.5 percent of the absorbed dose on the central axis of the useful beam at the nominal treatment distance. This limit shall apply beyond a line seven centimeters outside the periphery of the useful beam; and

- A maximum of 10 percent of the absorbed dose on the central axis of the useful beam at the nominal treatment distance. This limit shall apply beyond a line two centimeters outside the periphery of the useful beam.

(3) Measurement of leakage radiation.

1. Photon radiation. Measurements of leakage radiation through the beam-limiting devices shall be made with the beam-limiting devices closed and any residual aperture blocked by at least two-tenth value layers of suitable absorbing material. In the case of overlapping beam-limiting devices, the leakage radiation through each set shall be measured independently at the depth of maximum dose. Measurements shall be made using a radiation detector with an area not exceeding ten square centimeters;

2. Electron radiation. Measurements of leakage radiation through the electron applicators shall be made with the electron beam directed into the air and using a radiation detector with an area up to but not exceeding one square centimeter suitably protected against radiation which has been scattered from material beyond the radiation detector. Measurements shall be made using one centimeter of water equivalent buildup material.

(4) Filters/wedges.

1. Each wedge filter which is removable from the system shall be clearly marked with an identification number. For removable wedge filters, the nominal wedge angle shall appear on the wedge or wedge tray (if permanently mounted to the tray). If the wedge or wedge tray is significantly damaged, the wedge transmission factor shall be redetermined;

2. If the absorbed dose rate information required by 41.3(18)“a”(9) relates exclusively to operation with a field-flattening filter or beam-scattering foil in place, such filter or foil shall be removable only by the use of tools;

3. For equipment manufactured after July 9, 1997, which utilizes a system of wedge filters, interchangeable field-flattening filters, or interchangeable beam-scattering foils:

- Irradiation shall not be possible until a selection of a filter or a positive selection to use “no filter” has been made at the treatment control panel, either manually or automatically;

- An interlock system shall be provided to prevent irradiation if the filter selected is not in the correct position;

- A display shall be provided at the treatment control panel showing the wedge filter(s), interchangeable field-flattening filter(s), and interchangeable beam-scattering foil(s) in use; and

- An interlock shall be provided to prevent irradiation if any filter or beam-scattering foil selection operation carried out in the treatment room does not agree with the filter or beam-scattering foil selection operation carried out at the treatment control panel.

(5) Stray radiation in the useful beam. For equipment manufactured after July 9, 1997, the registrant shall determine during acceptance testing, or obtain from the manufacturer, data sufficient to ensure that X-ray stray radiation in the useful electron beam, absorbed dose at the surface during X-ray irradiation and stray neutron radiation in the useful X-ray beam are in compliance with International Electrotechnical Agency (IEC) Document 601-2-1 (most current revision).

(6) Beam monitors. All therapeutic radiation machines subject to 41.3(18) shall be provided with redundant beam monitoring systems. The sensors for these systems shall be fixed in the useful beam during treatment to indicate the dose monitor unit rate.

1. Equipment manufactured after July 9, 1997, shall be provided with at least two independently powered integrating dose meters. Alternatively, common elements may be used if the production of radiation is terminated upon failure of any common element.

2. Equipment manufactured on or before July 9, 1997, shall be provided with at least one radiation detector. This detector shall be incorporated into a useful beam monitoring system. The detector and the system into which that detector is incorporated shall meet the following requirements:

- Each detector shall be removable only with tools and, if movable, shall be interlocked to prevent incorrect positioning;

- Each detector shall form part of a beam monitoring system from whose readings in dose monitor units the absorbed dose at a reference point can be calculated;

- Each beam monitoring system shall be capable of independently monitoring, interrupting, and terminating irradiation; and

3. For equipment manufactured after July 9, 1997, the design of the beam monitoring systems shall ensure that the:

- Malfunctioning of one system shall not affect the correct functioning of the other system(s); and

- Failure of any element common to both systems which could affect the correct function of both systems shall terminate irradiation or prevent the initiation of radiation.

4. Each beam monitoring system shall have a legible display at the treatment control panel. For equipment manufactured after July 9, 1997, each display shall:

- Maintain a reading until intentionally reset;

- Have only one scale and no electrical or mechanical scale multiplying factors;

- Utilize a design such that increasing dose is displayed by increasing numbers; and

- In the event of power failure, the beam monitoring information required in 41.3(18)“a”(6)“4” displayed at the control panel at the time of failure shall be retrievable in at least one system for a 20-minute period of time.

(7) Beam symmetry.

1. Bent-beam linear accelerators with beam-flattening filter(s) subject to 41.3(18) shall be provided with auxiliary device(s) to monitor beam symmetry;

2. The device(s) referenced in 41.3(18)“a”(7)“1” shall be able to detect field asymmetry greater than 10 percent, and shall be configured to terminate irradiation if field asymmetry cannot be maintained at 10 percent or less.

(8) Selection and display of dose monitor units.

1. The preselected number of dose monitor units shall be displayed at the treatment control panel until reset manually;

2. After termination of irradiation, it shall be necessary to reset the dosimeter display before subsequent treatment can be initiated; and

3. For equipment manufactured after July 9, 1997, after termination of irradiation, it shall be necessary for the operator to reset the preselected dose monitor units before irradiation can be initiated.

4. Irradiation shall not be possible until a new selection of a number of dose monitor units has been made at the treatment control panel.

(9) Air kerma rate/absorbed dose rate. For equipment manufactured after July 9, 1997, a system shall be provided from whose readings the air kerma rate or absorbed dose rate at a reference point can be calculated. (The radiation detectors specified in 41.3(18)“a”(6) may form part of this system.) In addition:

1. The dose monitor unit rate shall be displayed at the treatment control panel;

2. If the equipment can deliver under any conditions an air kerma rate or absorbed dose rate at the nominal treatment distance more than twice the maximum value specified by the manufacturer, a device shall be provided which terminates irradiation when the air kerma rate or absorbed dose rate exceeds a value twice the specified maximum. The dose rate at which the irradiation will be terminated shall be a record maintained by the registrant;

3. If the equipment can deliver under any fault condition(s) an air kerma rate or absorbed dose rate at the nominal treatment distance more than ten times the maximum value specified by the manufacturer, a device shall be provided to prevent the air kerma rate or absorbed dose rate anywhere in the radiation field from exceeding twice the specified maximum value and to terminate irradiation if the excess absorbed dose at the nominal treatment distance exceeds 400 rad (4 Gy); and

4. For each therapeutic radiation machine, the registrant shall determine, or obtain from the manufacturer, the maximum value(s) specified in 41.3(18)“a”(7)“2” and “3” for the specified operating conditions. Records of these maximum value(s) shall be maintained at the installation for inspection by the agency.

(10) Termination of irradiation by the beam monitoring system or systems during stationary beam radiation therapy.

1. Each primary system shall terminate irradiation when the preselected number of dose monitor units has been detected by the system;

2. If the original design of the equipment included a secondary dose monitoring system, that system shall be capable of terminating irradiation when not more than 15 percent or 40 dose monitor units above the preselected number of dose monitor units set at the control panel has been detected by the secondary dose monitoring system; and

3. For equipment manufactured after July 9, 1997, an indicator on the control panel shall show which monitoring system has terminated irradiation.

(11) Termination switches. It shall be possible to terminate irradiation and equipment movement or go from an interruption condition to termination condition at any time from the operator’s position at the treatment control panel.

(12) Interruption switches. If a therapeutic radiation machine has an interrupt mode, it shall be possible to interrupt irradiation and equipment movements at any time from the treatment control

panel. Following an interruption it shall be possible to restart irradiation by operator action without any reselection of operating conditions. If any change of a preselected value is made during an interruption, irradiation and equipment movements shall be automatically terminated.

(13) Timer. A suitable irradiation control device shall be provided to terminate the irradiation after a preset time interval.

1. A timer shall be provided which has a display at the treatment control panel. The timer shall have a preset time selector and an elapsed time indicator;

2. The timer shall be a cumulative timer which activates with an indication of "BEAM-ON" and retains its reading after irradiation is interrupted or terminated. After irradiation is terminated and before irradiation can be reinitiated, it shall be necessary to reset the elapsed time indicator;

3. The timer shall terminate irradiation when a preselected time has elapsed, if the dose monitoring systems have not previously terminated irradiation.

(14) Selection of radiation type. Equipment capable of both X-ray therapy and electron therapy shall meet the following additional requirements:

1. Irradiation shall not be possible until a selection of radiation type (X-rays or electrons) has been made at the treatment control panel;

2. The radiation type selected shall be displayed at the treatment control panel before and during irradiation;

3. An interlock system shall be provided to ensure that the equipment can principally emit only the radiation type which has been selected;

4. An interlock system shall be provided to prevent irradiation with X-rays, except to obtain a verification image, when electron applicators are fitted;

5. An interlock system shall be provided to prevent irradiation with electrons when accessories specific for X-ray therapy are fitted; and

6. An interlock system shall be provided to prevent irradiation if any selected operations carried out in the treatment room do not agree with the selected operations carried out at the treatment control panel.

(15) Selection of energy. Equipment capable of generating radiation beams of different energies shall meet the following requirements:

1. Irradiation shall not be possible until a selection of energy has been made at the treatment control panel;

2. The nominal energy value selected shall be displayed at the treatment control panel until reset manually for the next irradiation. After termination of irradiation, it shall be necessary to reset the nominal energy value selected before subsequent treatment can be initiated; and

3. Irradiation shall not be possible until the appropriate flattening filter or scattering foil for the selected energy is in its proper location.

4. For equipment manufactured after July 9, 1997, the selection of energy shall be in compliance with International Electrotechnical Commission (IEC) Document 60601-2-1.

(16) Selection of stationary beam radiation therapy or moving beam radiation therapy. Therapeutic radiation machines capable of both stationary beam radiation therapy and moving beam radiation therapy shall meet the following requirements:

1. Irradiation shall not be possible until a selection of stationary beam radiation therapy or moving beam radiation therapy has been made at the treatment control panel;

2. The mode of operation shall be displayed at the treatment control panel;

3. An interlock system shall be provided to ensure that the equipment can operate only in the mode which has been selected;

4. An interlock system shall be provided to prevent irradiation if any selected parameter in the treatment room does not agree with the selected parameter at the treatment control panel;

5. Moving beam radiation therapy shall be controlled to obtain the selected relationships between incremental dose monitor units and incremental movement. For equipment manufactured after July 9, 1997:

- An interlock system shall be provided to terminate irradiation if the number of dose monitor units delivered in any ten degrees of rotation or one centimeter of linear motion differs by more than 20 percent from the selected value;

- Where angle terminates the irradiation in moving beam radiation therapy, the dose monitor units delivered shall differ by less than 5 percent from the dose monitor unit value selected;

- An interlock shall be provided to prevent motion of more than five degrees or one centimeter beyond the selected limits during moving beam radiation therapy;

- An interlock shall be provided to require that a selection of direction be made at the treatment control panel in all units which are capable of both clockwise and counterclockwise moving beam radiation therapy.

- Moving beam radiation therapy shall be controlled with both primary position sensors and secondary position sensors to obtain the selected relationships between incremental dose monitor units and incremental movement.

6. Where the beam monitoring system terminates the irradiation in moving beam radiation therapy, the termination of irradiation shall be as required by 41.3(18)“a”(10); and

7. For equipment manufactured after July 9, 1997, an interlock system shall be provided to terminate irradiation if movement:

- Occurs during stationary beam radiation therapy; or
- Does not start or stops during moving beam radiation therapy unless such stoppage is a preplanned function.

*b.* Facility design requirements for therapeutic radiation machines operating above 500 kV. In addition to shielding adequate to meet requirements of 41.3(19), the following design requirements are made:

(1) Protective barriers. All protective barriers shall be fixed, except for access doors to the treatment room or movable beam interceptors.

(2) Control panel. In addition to other requirements specified in 41.3(136C), the control panel shall also:

1. Be located outside the treatment room;
2. Provide an indication of whether electrical power is available at the control panel and if activation of the radiation is possible;
3. Provide an indication of whether radiation is being produced; and
4. Include an access control (locking) device which will prevent unauthorized use of the therapeutic radiation machine.

(3) Viewing systems. Windows, mirrors, closed-circuit television or an equivalent viewing system shall be provided to permit continuous observation of the patient following positioning and during irradiation and shall be so located that the operator may observe the patient from the treatment control panel. The therapeutic radiation machine shall not be used for patient irradiation unless at least one viewing system is operational.

(4) Aural communications. Provision shall be made for continuous two-way aural communication between the patient and the operator at the control panel. The therapeutic radiation machine shall not be used for irradiation of patients unless continuous two-way aural communication is possible.

(5) Room entrances. Treatment room entrances shall be provided with warning lights in a readily observable position near the outside of all access doors, which will indicate when the useful beam is “ON” and when it is “OFF”.

(6) Entrance interlocks. Interlocks shall be provided such that all access controls are activated before treatment can be initiated or continued. If the radiation beam is interrupted by any access control, it shall not be possible to restore the machine to operation without resetting the access control and reinitiating irradiation by manual action at the control panel.

(7) Beam interceptor interlocks. If the shielding material in any protective barrier requires the presence of a beam interceptor to ensure compliance with 641—paragraphs 40.26(1)“a” and “b,” interlocks shall be provided to prevent the production of radiation, unless the beam interceptor is in place, whenever the useful beam is directed at the designated barrier(s).

(8) Emergency cutoff switches. At least one emergency power cutoff switch shall be located in the radiation therapy room and shall terminate all equipment electrical power including radiation and mechanical motion. This switch is in addition to the termination switch required by 41.3(18)“a”(11). All emergency power cutoff switches shall include a manual reset so that the therapeutic radiation machine cannot be restarted from the unit’s control console without resetting the emergency cutoff switch.

(9) Safety interlocks. All safety interlocks shall be designed so that any defect or component failure in the safety interlock system prevents or terminates operation of the therapeutic radiation machine.

(10) Surveys for residual radiation. Surveys for residual activity shall be conducted on all therapeutic radiation machines capable of generating photon and electron energies above 10 MV prior to machining, removing, or working on therapeutic radiation machine components which may have become activated due to photoneutron production.

(11) Possession of survey instrument(s). Each facility location authorized to use a therapeutic radiation machine in accordance with 41.3(18) shall have at its disposal appropriately calibrated portable monitoring equipment. As a minimum, such equipment shall include a portable radiation measurement survey instrument capable of measuring dose rates over the range 1 mrem (10  $\mu$ Sv) per hour to 1000 mrem (10 mSv) per hour. The survey instrument(s) shall be operable and calibrated at intervals not to exceed 12 months for the radiation measured.

*c. Radiation therapy physicist support.*

(1) The services of a radiation therapy physicist shall be required in facilities having therapeutic radiation machines with energies of 500 kV and above. The radiation therapy physicist shall be responsible for:

1. Full calibration(s) required by 41.3(18)“e” and protection surveys required by 41.3(16)“a”;
2. Supervision and review of dosimetry;
3. Beam data acquisition and transfer for computerized dosimetry, and supervision of its use;
4. Quality assurance, including quality assurance check review required by 41.3(18)“f”(5) of these regulations;
5. Consultation with the authorized user in treatment planning, as needed; and
6. Performing calculations/assessments regarding misadministrations.

(2) If the radiation therapy physicist is not a full-time employee of the registrant, the operating procedures required by 41.3(18)“d” shall also specifically address how the radiation therapy physicist is to be contacted for problems or emergencies, as well as the specific actions, if any, to be taken until the radiation therapy physicist can be contacted.

*d. Operating procedures.*

(1) No individual, other than the patient, shall be in the treatment room during treatment or during any irradiation for testing or calibration purposes;

(2) Therapeutic radiation machines shall not be made available for medical use unless the requirements of 41.3(16)“a,” 41.3(18)“e,” and 41.3(18)“f” have been met;

(3) Therapeutic radiation machines, when not in operation, shall be secured to prevent unauthorized use;

(4) When adjustable beam-limiting devices are used, the position and shape of the radiation field shall be indicated by a light field;

(5) If a patient must be held in position during treatment, mechanical supporting or restraining devices shall be used; and

(6) A copy of the current operating and emergency procedures shall be maintained at the therapeutic radiation machine control console.

*e. Acceptance testing, commissioning, and full calibration measurements.*

(1) Acceptance testing, commissioning, and full calibration of a therapeutic radiation machine subject to 41.3(18) shall be performed by, or under the direct supervision of, a radiation therapy physicist:

1. Acceptance testing and commissioning shall be performed in accordance with “AAPM Code of Practice for Radiotherapy Accelerators: AAPM Report No. 47,” prepared by Radiation Therapy Task Group 45, and the manufacturer’s contractual specifications and shall be conducted before the first medical use following installation or reinstallation of the therapeutic radiation machine;

2. Full calibration shall include measurement of all parameters listed in Appendix D of 641—Chapter 41 and shall be performed in accordance with “AAPM Code of Practice for Radiotherapy Accelerators: AAPM Report No. 47,” prepared by Radiation Therapy Task Group 45. Although it shall not be necessary to complete all elements of a full calibration at the same time, all parameters (for all energies) shall be completed at intervals not to exceed 12 calendar months, unless a more frequent interval is required by this agency.

3. The radiation therapy physicist shall perform all elements of a full calibration necessary to determine that all parameters are within acceptable limits:

- Whenever quality assurance check measurements indicate that the radiation output differs by more than 5 percent from the value obtained at the last full calibration and the difference cannot be reconciled. Therapeutic radiation machines with multienergy or multimode capabilities or both shall only require measurements for those modes or energies that are not within their acceptable range; and

- Following any component replacement, major repair, or modification of components that could significantly affect the characteristics of the radiation beam. If the repair, replacement or modification does not affect all modes or energies, measurements shall be performed on the affected mode/energy that is in most frequent clinical use at the facility. The remaining energies/modes may be validated with quality assurance check procedures against the criteria in 41.3(18)“e”(1)“3.”

(2) The registrant shall use the dosimetry system described in 41.3(16)“c” to measure the radiation output for one set of exposure conditions.

(3) The registrant shall maintain a record of each calibration in an auditable form for the duration of the registration. The record shall include the date of the calibration, the manufacturer’s name, model number, and serial number for the therapeutic radiation machine, the model numbers and serial numbers of the instruments used to calibrate the therapeutic radiation machine, and the signature of the radiation therapy physicist responsible for performing the calibration.

*f.* Periodic quality assurance checks.

(1) Periodic quality assurance checks shall be performed on all therapeutic radiation machines subject to 41.3(18) at intervals as specified in Appendix D of 641—Chapter 41;

(2) To satisfy the requirement of 41.3(18)“f”(1), quality assurance checks shall include determination of central axis radiation output and a representative sampling of periodic quality assurance checks contained in Appendix D of 641—Chapter 41. Representative sampling shall include all referenced periodic quality assurance checks at intervals not to exceed 12 consecutive calendar months;

(3) The registrant shall use a dosimetry system which has been intercompared within the previous 12 months with the dosimetry system described in 41.3(16)“c”(1) to make the periodic quality assurance checks required in 41.3(18)“f”(2);

(4) The registrant shall perform periodic quality assurance checks required by 41.3(18)“f”(1) in accordance with procedures established by the radiation therapy physicist;

(5) The registrant shall review the results of each periodic radiation output check according to the following procedures:

1. The authorized user and radiation therapy physicist shall be immediately notified if any parameter is not within its acceptable tolerance. The therapeutic radiation machine shall not be made available for subsequent medical use until the radiation therapy physicist has determined that all parameters are within their acceptable tolerances;

2. If all quality assurance check parameters appear to be within their acceptable range, the quality assurance check shall be reviewed and signed by either the authorized user or radiation therapy physicist within three treatment days; and

3. The radiation therapy physicist shall review and sign the results of each radiation output quality assurance check at intervals not to exceed one month.

- (6) Therapeutic radiation machines subject to 41.3(18) shall have safety quality assurance checks of each external beam radiation therapy machine performed at intervals not to exceed one week or at longer intervals as recommended by the manufacturer;

(7) To satisfy the requirement of 41.3(18)“f”(6), safety quality assurance checks shall ensure proper operation of:

1. Electrical interlocks at each external beam radiation therapy room entrance;
2. Proper operation of the “BEAM-ON,” interrupt and termination switches;
3. Beam condition indicator lights on the access doors, control console, and in the radiation therapy room;
4. Viewing systems;
5. Aural systems;
6. Electrically operated treatment room door(s) from inside and outside the treatment room;
7. At least one emergency power cutoff switch. If more than one emergency power cutoff switch is installed and not all switches are tested at once, each switch shall be tested on a rotating basis. Safety quality assurance checks of the emergency power cutoff switches may be conducted at the end of the treatment day in order to minimize possible stability problems with the therapeutic radiation machine;

(8) Rescinded IAB 4/11/07, effective 5/16/07.

(9) The registrant shall promptly repair any system identified in 41.3(18)“f”(7) that is not operating properly; and

(10) The registrant shall maintain a record of each quality assurance check required by 41.3(18)“f”(1) and 41.3(18)“f”(7) for three years. The record shall include the date of the quality assurance check, the manufacturer’s name, model number, and serial number for the therapeutic radiation machine, the manufacturer’s name, model number and serial number of the instrument(s) used to measure the radiation output of the therapeutic radiation machine, and the signature of the individual who performed the periodic quality assurance check.

**41.3(19) Shielding and safety design requirements.**

a. Each therapeutic radiation machine subject to 41.3(17) or 41.3(18) shall be provided with such primary or secondary barriers as are necessary to ensure compliance with 641—40.15(136C) and 641—40.26(136C).

b. Facility design information for all new installations of a therapeutic radiation machine or installations of a therapeutic radiation machine of higher energy into a room not previously approved for that energy shall be submitted for agency approval prior to actual installation of the therapeutic radiation machine. The minimum facility design information that must be submitted is contained in Appendix E of 641—Chapter 41.

**41.3(20) Calibration of survey instruments.**

a. The registrant shall ensure that the survey instruments used to show compliance with 645—41.3(136C) have been calibrated before first use, at intervals not to exceed 12 months, and following repair.

b. To satisfy the requirements of 41.3(20), the registrant shall:

- (1) Calibrate all required scale readings up to 1000 mrem (10 mSv) per hour with an appropriate radiation source that is traceable to the National Institute of Standards and Technology (NIST);
- (2) Calibrate at least two points on each scale to be calibrated. These points should be at approximately 1/3 and 2/3 of full scale;
- (3) Consider a point as calibrated if the indicated dose rate differs from the calculated dose rate by not more than 10 percent; and
- (4) Consider a point as calibrated if the indicated dose rate differs from the calculated dose rate by not more than 20 percent if a correction factor or graph is conspicuously attached to the instrument.

c. The registrant shall retain a record of each calibration required in 41.3(20) for three years. The record shall include:

- (1) A description of the calibration procedure; and
- (2) A description of the source used and the certified dose rates from the source, and the rates indicated by the instrument being calibrated, the correction factors deduced from the calibration data, the signature of the individual who performed the calibration, and the date of calibration.

d. The registrant may obtain the services of individuals licensed by this agency, the U.S. Nuclear Regulatory Commission, an agreement state, or a licensing state to perform calibrations of survey

instruments. Records of calibrations that contain information required in 41.3(20) shall be maintained by the registrant.

[ARC 0577C, IAB 2/6/13, effective 3/13/13; ARC 1639C, IAB 10/1/14, effective 11/5/14]

**641—41.4(136C) Radiation safety requirements for analytical X-ray equipment.** Rescinded IAB 4/8/98, effective 7/1/98.

**641—41.5(136C) Radiation safety requirements for wireline service operations and subsurface tracer studies.** Rescinded IAB 4/8/98, effective 7/1/98.

**641—41.6(136C) X-ray machines used for screening and diagnostic mammography.**

**41.6(1) Definitions.** In addition to the definitions provided in 641—38.2(136C), 641—40.2(136C), and 641—41.1(136C), the following definitions shall be applicable to this rule.

“*Accreditation body*” means an entity that has been approved by FDA to accredit mammography facilities.

“*Action limits*” or “*action levels*” means the minimum and maximum values of a quality assurance measurement that can be interpreted as representing acceptable performance with respect to the parameter being tested. Values less than the minimum or greater than the maximum action limit or level indicate that corrective action must be taken by the facility. Action limits or levels are also sometimes called control limits or levels.

“*Adverse event*” means an undesirable experience associated with mammography activities. Adverse events include but are not limited to:

1. Poor image quality;
2. Failure to send mammography reports within 30 days to the referring physician or in a timely manner to the self-referred patient; and
3. Use of personnel who do not meet the applicable requirements of this chapter.

“*Air kerma*” means kerma in a given mass of air. The unit used to measure the quantity of air kerma is the Gray (Gy). For X-rays with energies less than 300 kiloelectronvolts (keV), 1 Gray of absorbed dose is delivered by 114 roentgens (R) of exposure.

“*Annually*” means within 10 to 14 months of previous occurrence.

“*Artifact*” means a substance or structure not naturally present in living tissue but of which an authentic image appears in a radiograph.

“*Automatic exposure control systems*” means automatic exposure control systems, often referred to as phototimers, which are designed to automatically determine and provide the exposure needed to produce an adequate density image by sampling the X-ray intensity after passage through the patient and image receptor.

“*Average glandular dose*” means the energy deposited per unit mass of glandular tissue averaged over all the glandular tissue in the breast, calculated from values of entrance exposure in air, the X-ray beam quality (half-value layer), and compressed breast thickness. For a 50 percent-50 percent adipose and glandular 4.2 centimeter breast, the average glandular dose shall not exceed 300 millirad (3 mGy). See also: “Dose.”

“*Breast implant*” means a prosthetic device implanted in the breast.

“*Calendar quarter*” means any one of the following time periods during a given year: January 1 through March 31, April 1 through June 30, July 1 through September 30, or October 1 through December 31.

“*Category 1*” means medical education activities that have been designated as Category 1 by the Accreditation Council for Continuing Medical Education (ACCME), the American Osteopathic Association (AOA), a state medical society, or an equivalent organization.

“*Certificate*” means the certificate described in 41.6(2)“a”(2).

“*Certification*” means the process of approval of a facility by the FDA or this agency to provide mammography services.

“*Clinical image*” means a mammogram.

“*Compression device*” means a firm plastic paddle used to help hold the breast stationary and eliminate blurring due to motion, to help separate structures within the breast, and to decrease the thickness of breast tissue, minimizing the amount of radiation used and the amount of scattered radiation reaching the film.

“*Computed radiography mammography*” means a type of digital mammography in which the digital image receptor must be removed from the X-ray unit for the image to be read and processed by a separate image receptor reader.

“*Consumer*” means an individual who chooses to comment or complain in reference to a mammography examination, including the patient or representative of the patient (e.g., family member or referring physician).

“*Contact hour*” means an hour of training received through direct instruction.

“*Continuing education unit*” or “*continuing education credit*” means one contact hour of training.

“*Craniocaudal view*” means one of two routine views for mammography. The detector system is placed caudad to (below) the breast and the vertical X-ray beam is directed from cranial to caudad (downward) through the breast.

“*Dedicated mammography equipment*” means X-ray systems designed specifically for breast imaging, providing optimum imaging geometry, a device for breast compression and low dose exposure that can generate reproducible images of high quality.

“*Direct detector technology*” means a digital mammogram captured using a material which converts the X-ray energies directly to an electric signal.

“*Direct instruction*” means:

1. Face-to-face interaction between instructor(s) and student(s), as when the instructor provides a lecture, conducts demonstrations, or reviews student performance; or
2. The administration and correction of student examinations by an instructor(s) with subsequent feedback to the student(s).

“*Direct supervision*” means that:

1. During joint interpretation of mammograms, the supervising interpreting physician reviews, discusses, and confirms the diagnosis of the physician being supervised and signs the resulting report before it is entered into the patient’s records; or
2. During the performance of a mammography examination or survey of the facility’s equipment and quality assurance program, the supervisor is present to observe and correct, as needed, the performance of the individual being supervised who is performing the examination or conducting the survey.

“*Dose*” means the amount of energy deposited per unit mass of tissue due to X-radiation. The newer unit of absorbed dose is the Gray: 1 Gray=1 Joule of energy deposited per kilogram of tissue. The older unit of absorbed dose is the rad: 1 rad=0.01 Gray, 1 centiGray, or 10 milliGray.

“*Exposure*” means the amount of X-radiation, quantitated by measuring the amount of ionization in air caused by the radiation. The units of exposure are Coulombs of charge ionized per kilogram of air. The older unit of exposure is the Roentgen: 1 Roentgen= $2.58 \times 10E-4$  Coulombs of charge per kilogram of air.

“*Facility*” means a hospital, outpatient department, clinic, radiology practice, mobile unit, office of a physician, or other facility that conducts mammography activities, including the following: operation of equipment to produce a mammogram, initial interpretation of the mammogram, and maintaining viewing conditions for that interpretation. This term does not include a facility of the Department of Veterans Affairs.

“*FDA*” means the Food and Drug Administration.

“*First allowable time*” means the earliest time a resident physician is eligible to take the diagnostic radiology boards from an FDA-designated certifying body. The “first allowable time” may vary with the certifying body.

“*Full field digital mammography*” means radiographic imaging of the breast using a digital image receptor with minimum dimensions of 18×23 cm to allow imaging the average size breast in a single exposure.

“*Grids*” means a set of thin lead strips spaced close to one another, interspaced by carbon fiber for mammographic grids. The grid is placed between the breast and the screen-film image receptor to reduce scattered radiation reaching the image receptor.

“*Image noise.*” See “Radiographic noise.”

“*Image receptor support device*” means, for mammography X-ray systems, that part of the system designed to support the image receptor during a mammographic examination and to provide a primary protective barrier.

“*Interpreting physician*” means a licensed radiologist who interprets mammograms and who meets the requirements set forth in 41.6(3)“a.”

“*Kerma*” means the sum of the initial energies of all the charged particles liberated by uncharged ionizing particles in a material of given mass.

“*Laterality*” means the designation of either the right or left breast.

“*Lead interpreting physician*” means the interpreting physician assigned the general responsibility for ensuring that a facility’s quality assurance program meets all of the requirements of this chapter. The administrative title and other supervisory responsibilities of the individual, if any, are left to the discretion of the facility.

“*Mammogram*” means a radiographic image produced through mammography.

“*Mammographic modality*” means a technology for radiography of the breast. Examples are screen-film mammography, xeromammography, and digital mammography.

“*Mammography*” means radiography of the breast but, for the purposes of 641—41.6(136C), does not include:

1. Radiography of the breast performed during invasive interventions for localization or biopsy procedures; or
2. Radiography of the breast performed with an investigational mammography device as part of a scientific study conducted in accordance with FDA investigational device exemption regulations; or
3. Radiography of the breast performed as part of either a breast localization procedure or a post-stereotactic clip placement localization procedure.

“*Mammography equipment evaluation*” means an on-site assessment of the mammography unit or image processor performance by a medical physicist for the purpose of making a preliminary determination as to whether the equipment meets all of the applicable standards.

“*Mammography medical outcomes audit*” means a systematic collection of mammography results and the comparison of those results with outcomes data.

“*Mammography unit(s)*” means an assemblage of components for the production of X-rays for use during mammography including, at a minimum: an X-ray generator, an X-ray control, a tube housing assembly, a beam limiting device, and the supporting structures for these components.

“*Mean optical density*” means the average of the optical densities measured using phantom thicknesses of 2, 4, and 6 centimeters with values of kilovolt peak (kVp) clinically appropriate for those thicknesses.

“*Medical physicist*” means a person trained in evaluating the performance of mammography equipment and facility quality assurance programs and who meets the qualifications for a medical physicist set forth in 41.6(3)“c.”

“*Mediolateral view*” means one of the routine views for mammography in addition to the craniocaudal view. The detector system is placed lateral to the breast and the horizontal X-ray beam is directed from medial to lateral aspect through the breast.

“*MQSA*” means the Mammography Quality Standards Act of 1992.

“*Multi-reading*” means two or more physicians, at least one of whom is an interpreting physician, interpreting the same mammogram. A radiologist may count the current mammographic examination and one prior mammographic examination, provided the radiologist was not the interpreter of the prior mammographic examination. A separate tally shall be kept for the prior examinations.

“*Oblique mediolateral view*” means one of the standard two views of the breast. The detector system (cassette holder assembly) is angled 30-60 degrees from horizontal so that the cassette assembly

is parallel to the pectoral muscle and the corner of the cassette holder fits comfortably into the axilla. The X-ray beam is directed from the supero-medial to the infero-lateral aspect of the breast.

*“Patient”* means any individual who undergoes a mammography evaluation in a facility, regardless of whether the person is referred by a physician or is self-referred.

*“Phantom”* means an artificial test object used to simulate radiographic characteristics of compressed breast tissue and containing components that radiographically model aspects of breast disease and cancer.

*“Phantom image”* means a radiographic image of a phantom.

*“Physical science”* means physics, chemistry, radiation science (including medical physics and health physics), and engineering.

*“Positive mammogram”* means a mammogram that has an overall assessment of findings that are either “suspicious” or “highly suggestive of malignancy.”

*“Provisional certification”* means the six-month certification time period in which a facility has to complete the accreditation/certification process.

*“Qualified instructor”* means individuals whose training and experience adequately prepare them to carry out specified training assignments. Interpreting physicians, radiologic technologists, or medical physicists who meet the requirements of 41.6(3) would be considered qualified instructors in their respective areas of mammography. Radiological technologists who meet the requirements of 41.6(3) and have passed a state-approved mammography examination such as the examination given by the American Registry of Radiography Technologists would be considered qualified instructors in their respective areas of mammography. The examination would include, but not necessarily be limited to: breast anatomy and physiology, positioning and compression, quality assurance/quality control techniques, and imaging of patients with breast implants. Other examples of individuals who may be qualified instructors for the purpose of providing training to meet the regulations of this chapter include, but are not limited to, instructors in a post-high school training institution and manufacturers’ representatives.

*“Quality control technologist”* means an individual meeting the requirements of 41.6(5) “a”(4) who is responsible for those quality assurance responsibilities not assigned to the lead interpreting physician or to the medical physicist.

*“Radiographic equipment”* means X-ray equipment used for the production of static X-ray images.

*“Radiologic technologist”* means an individual specifically trained in the use of radiographic equipment and in the positioning of patients for radiographic examinations and who meets the requirements set forth in 41.6(3) “b.”

*“Radiologist continuing experience”* means the number of mammograms interpreted by a radiologist in the past 24-month period. For the purpose of counting, a radiologist may count the current mammographic examination and one prior mammographic examination, provided the radiologist was not the interpreter of the prior mammographic examination. A separate tally shall be kept for the prior examinations.

*“Reinstatement”* means the process of recertification of a facility that has lost or voluntarily given up previous accreditation/certification.

*“Screen-film mammography”* means mammography performed with high-detailed intensifying screen(s) in close contact with the film.

*“Screening mammography”* means X-ray breast examination of asymptomatic individuals in an attempt to detect breast cancer when it is small, nonpalpable, and confined to the breast.

*“Serious adverse event”* means an adverse event that may significantly compromise clinical outcomes or an adverse event for which a facility fails to take appropriate corrective action in a timely manner.

*“Serious complaint”* means a report of a serious adverse event.

*“Standard breast”* means a 4.2 centimeter (cm) thick compressed breast consisting of 50 percent glandular and 50 percent adipose tissue.

*“Supplier”* means the individual in control of a mammography facility whose basic responsibility is the overall quality of all mammograms conducted in that particular facility.

“*Survey*” means an on-site physics consultation and evaluation of a facility quality assurance program performed by a medical physicist.

“*Time cycle*” means the film development time.

“*Traceable to a national standard*” means an instrument is calibrated at either the National Institute of Standards and Technology (NIST) or at a calibration laboratory that participates in a proficiency program with NIST at least once every two years and the results of the proficiency test conducted within 24 months of calibration show agreement within  $\pm 3$  percent of the national standard in the mammography energy range.

“*Written report*” means interpreting physician’s technical narrative of a mammography evaluation.

“*Written statement*” means interpreting physician’s description of a mammography examination written in lay terms.

**41.6(2) *Registration and application standards and requirements.***

*a. Registration and certificates.*

(1) Each radiation machine used to perform mammography shall be registered according to 641—subrule 39.3(2).

(2) A certificate issued by the FDA or this agency is required for lawful operation of all mammography facilities subject to the provisions of this subrule. To obtain a certificate from the FDA or this agency, facilities are required to meet the quality standards in 641—41.6(136C) and to be accredited and approved by an approved accreditation body.

*b. Each facility wishing to perform mammography shall apply for agency approval by providing or verifying the following information for each mammography machine:*

(1) The mammography unit meets the criteria for agency-approved mammography accreditation bodies.

(2) The mammography equipment and facility meet the general requirements of these rules for radiation machines.

(3) The radiation machine is specifically designed to perform mammography.

(4) The radiation machine is used according to these rules on patient radiation exposure and radiation dose levels.

(5) The radiation machine is operated by individuals meeting the requirements of this subrule.

(6) The entire mammography system is evaluated at least annually by a medical physicist.

(7) The equipment, personnel, procedures, and records are evaluated annually by a physician consultant.

(8) Provisional or reinstatement certification. A new facility beginning operation after September 30, 1994, is eligible to apply for provisional or reinstatement certification. This will enable the facility to perform mammography and to obtain the clinical images needed to complete the accreditation process. To apply for and receive provisional or reinstatement certification, a facility must meet the requirements of 641—41.6(136C). Provisional or reinstatement certification shall be effective for up to six months from the date of issuance and cannot be renewed. The facility may apply for one 90-day extension.

*c. Suspension, revocation, or denial of mammography certification.*

(1) Mammography certification may be suspended or revoked with cause if any facility or machine does not meet one or more of the standards of these rules, will not permit inspections or provide access to records or information in a timely fashion, or has been guilty of misrepresentation in obtaining the certification.

(2) The facility shall have opportunity for a hearing in connection with a denial, suspension or revocation of mammography certification in accordance with 641—Chapter 173.

(3) An emergency order suspending or revoking certification may be issued in accordance with 641—173.31(17A) if the agency finds the radiation unit or facility violates rules that seriously affect the health, safety, and welfare of the public. An opportunity for hearing shall be held within 20 working days after the issuance of the order. The order shall be effective during the proceedings.

(4) If certification is revoked, the radiation machine shall not be used for mammography until reinstated.

(5) If a facility's certification is revoked, no person who owned or operated that facility at the time the act occurred may own or operate a mammography facility in Iowa within two years of the date of revocation.

*d.* Reinstatement of mammography certification after revocation.

(1) An application for reinstatement shall be submitted and processed as an initial application. Appropriate corrective actions must be submitted with the application.

(2) The agency shall inspect the radiation machine within 60 days of the approved reinstatement application.

(3) A full certificate shall be issued only after the agency has inspected the radiation machine and determined that it meets the requirements of these rules.

*e.* Inspections. The agency shall conduct an inspection of each radiation machine no later than 14 months after initial mammography certification and at least annually thereafter.

*f.* The authorization of facilities is included in the accreditation process for facilities accredited by the state of Iowa. Determination of the quality of the mammograms produced by facilities accredited by the state of Iowa will be made. To make the determination, each facility will:

(1) Provide at the time of initial accreditation, new unit installation, or reaccreditation (at least every three years) thereafter, two original (not copies) mammography examinations which meet the following criteria for the clinical image review process by the agency:

1. One mammography examination, including craniocaudal and mediolateral oblique views of each breast, of a patient with predominantly fatty breast tissue,

2. One mammography examination, including craniocaudal and mediolateral oblique views of each breast, of a patient with predominantly glandular breast tissue, and

3. Each mammography examination must have been interpreted as a "negative" or "benign" examination.

(2) Provide randomly, at the request of agency mammography inspectors, two mammography examinations (mammograms) which meet the criteria in 41.6(2) "f"(1).

(3) Provide at the time of initial accreditation, new unit installation, or reaccreditation (at least every three years) thereafter, a phantom image taken with the unit being accredited within six months of the submission date for review by the agency.

(4) Be billed the fee for the quality review process as set forth in 641—subparagraph 38.8(1) "b"(2).

(5) Be provided with a written explanation of the results of the quality review process which will accompany the returned mammograms referred to in 41.6(2) "f"(3).

*g.* Facilities accredited by an approved accrediting body other than the state of Iowa must be authorized by the agency. Quality determination for these facilities will be made by the agency through a phantom image provided at the time of initial authorization, new unit authorization, or reauthorization (at least every three years) thereafter, taken with the unit being accredited within six months of the submission date.

*h.* Federal mammography regulations. All Iowa facilities performing mammography shall comply with the applicable regulations found in 21 CFR Part 900 which has an effective date of April 28, 1999. Persons certified to perform mammography in Iowa shall be responsible for ensuring compliance with the appropriate CFR regulations or Iowa administrative rules, whichever are more stringent.

*i.* Soft copy review workstation requirements.

(1) Soft copy review workstations used for final interpretation of mammogram images must be a configuration of two monitors that meet one of the following criteria:

1. Have 5 megapixel resolution; or

2. Be approved by the United States Food and Drug Administration 510K process and be intended for digital mammography use.

(2) The workstation must have a quality control program substantially the same as that outlined by the image receptor manufacturer's quality control manual or that outlined by the image receptor manufacturer's designated soft copy review workstation quality control manual.

**41.6(3) Mammography personnel.** The following requirements apply to all personnel involved in any aspect of mammography, including the production, processing, and interpretation of mammograms and related quality assurance activities:

*a. Interpreting physicians.* All radiologists interpreting mammograms shall meet the following qualifications:

(1) Initial qualifications. Unless the exemption in 41.6(3)"a"(3)"1" applies, before beginning to interpret mammograms independently, the interpreting radiologist shall:

1. Be licensed to practice medicine in Iowa;

2. Either:

- Be certified in an appropriate specialty area by a body determined by FDA to have procedures and requirements adequate to ensure that physicians certified by the body are competent to interpret radiological procedures, including mammography; or

- Have had at least three months of documented formal training in the interpretation of mammograms and in topics related to mammography. The training shall include instruction in radiation physics, including radiation physics specific to mammography, radiation effects, and radiation protection. The mammographic interpretation component shall be under the direct supervision of a radiologist who meets the requirements of 41.6(3)"a"; and

3. Have a minimum of 60 hours of documented medical education in mammography, which shall include: instruction in the interpretation of mammograms and education in basic breast anatomy, pathology, and physiology, technical aspects of mammography, and quality assurance and quality control in mammography. All 60 of these hours shall be Category 1 and at least 15 of the Category 1 hours shall have been acquired within the 36 months immediately prior to the date that the radiologist qualifies as an interpreting physician. Hours spent in residency specifically devoted to mammography will be considered as equivalent to Category 1 continuing medical education credits and will be accepted if documented in writing by the appropriate representative of the training institution;

4. Unless the exemption in 41.6(3)"a"(3)"2" applies, have interpreted or multi-read at least 240 mammographic examinations within the six-month period immediately prior to the date that the radiologist qualifies as an interpreting physician. This interpretation or multi-reading shall be under the direct supervision of an interpreting physician; and

5. Before an interpreting physician may begin independently interpreting mammograms produced by a new mammographic modality other than the modality in which the initial training was received, the interpreting physician shall have at least 8 hours of Category 1 continuing medical education credits in the new mammographic modality or at least 8 hours of training in the new mammographic modality provided by a vendor manufacturing the new mammographic modality equipment. An interpreting physician previously qualified to interpret a new mammographic modality in another state will have six months to complete this requirement. The six-month time frame begins when the interpreting physician commences Iowa new mammographic modality interpretation.

(2) Continuing experience and education. All interpreting physicians shall maintain their qualifications by meeting the following requirements:

1. Following the second anniversary date of the end of the calendar quarter in which the requirements of 41.6(3)"a"(1) were completed, the interpreting physician shall have read or multi-read at least 960 mammographic examinations during the prior 24 months, during the 24-month period ending on the last day of the previous calendar quarter, or during any 24-month period between the two. The facility will choose one of these dates to determine the 24-month period.

2. Following the third anniversary date of the end of the calendar quarter in which the requirements of 41.6(3)"a"(1) were completed, the interpreting physician shall have taught or completed at least 15 Category 1 continuing education units in mammography during the prior 36 months, during the 36-month period ending on the last day of the previous calendar quarter, or during any 36-month period between the two. The facility will choose one of these dates to determine the 36-month period.

3. Units earned through teaching a specific course can be counted only once towards the 15 required by 41.6(3) "a"(2)"2" even if the course is taught multiple times during the previous 36 months.

4. Continuing qualifications must be met and a current state of Iowa medical license must be in effect whenever mammography interpretations are performed by the physician.

(3) Exemptions.

1. Those physicians who qualified as interpreting physicians under 41.6(3) "a" or FDA interim regulations prior to April 28, 1999, are considered to have met the initial requirements of 41.6(3) "a." They may continue to interpret mammograms provided they continue to meet the licensure requirements of 41.6(3) "a"(1)"1" and the continuing experience and education requirements of this subrule.

2. Physicians who have interpreted or multi-read at least 240 mammographic examinations under the direct supervision of an interpreting physician in any six-month period during the last two years of a diagnostic radiology residency and who become appropriately board certified at the first allowable time, as defined by an eligible certifying body, are otherwise exempt from 41.6(3) "a"(1)"4."

(4) Reestablishing qualifications. Interpreting physicians who fail to maintain the required continuing experience or continuing education requirements shall reestablish their qualifications before resuming the independent interpretation of mammograms, as follows:

1. Interpreting physicians who fail to meet the continuing experience requirements of 41.6(3) "a"(2)"1" shall:

- Interpret or multi-read at least 240 mammographic examinations under the direct supervision of an interpreting physician, or

- Interpret or multi-read a sufficient number of mammographic examinations, under the direct supervision of an interpreting physician, to bring the physician's total to at least 960 examinations for the prior 24 months, whichever is less. The interpretations required under 41.6(3) "a"(4)"1" shall be done within the six months immediately prior to resuming independent interpretation. Consecutive or back-to-back requalification of mammography personnel, due to failure to meet continuing education or experience requirements, will be allowed once without proof of extenuating circumstances. This agency will determine the validity of such proof and render a decision after review of all pertinent information. Those individuals who are denied requalification will be allowed to resubmit for requalification following a 90-day waiting period.

2. Interpreting physicians who fail to meet the continuing education requirements of 41.6(3) "a"(2)"2" shall obtain a sufficient number of additional Category 1 continuing medical education credits in mammography to bring their total up to the required 15 credits in the previous 36 months before resuming independent interpretation.

*b. Radiologic technologists.* All mammographic examinations shall be performed by general radiographers who meet the following general requirements, mammography requirements, and continuing education and experience requirements:

(1) General requirements. Be permitted to operate as a general radiographer in Iowa; and

(2) Mammography requirements. Have qualified as a radiologic technologist under 41.6(3) "b" before April 28, 1999, or have completed at least 40 contact hours of documented training specific to mammography under the supervision of a qualified instructor after successful completion of at least a two-year radiography program. The hours of documented training shall include, but not necessarily be limited to:

1. Training in breast anatomy and physiology, positioning and compression, quality assurance/quality control techniques, and imaging of patients with breast implants;

2. The performance of a minimum of 25 examinations under the direct supervision of an individual qualified under 41.6(3) "b"; and

3. Before a radiologic technologist may begin independently performing mammographic examinations using a mammographic modality other than one of those for which the technologist received training under 41.6(3) "b"(2)"3," the technologist shall have at least 8 hours of continuing education units in the new modality. The 8 hours may not be derived from the supervised examination of patients; and

(3) Continuing education requirements.

1. Following the third anniversary date of the end of the calendar quarter in which the requirements of 41.6(3) "b"(1) and (2) were completed, the radiologic technologist shall have taught or completed at least 15 continuing education units in mammography during the prior 36 months, during the 36-month period ending on the last day of the previous calendar quarter, or during any 36-month period between the two. The facility will choose one of these dates to determine the 36-month period.

2. Units earned through teaching a specific course can be counted only once towards the 15 required in 41.6(3) "b"(3) "1" even if the course is taught multiple times during the previous 36 months.

3. Requalification. A radiologic technologist who fails to meet the continuing education requirements of 41.6(3) "b"(3) "1" shall obtain a sufficient number of continuing education units in mammography to bring the total up to at least 15 in the previous 36 months. The continuing education for requalification cannot be obtained by performing supervised mammography examinations. The technologist may not resume performing unsupervised mammography examinations until the continuing education requirements are completed.

4. Continuing qualifications must be met and an Iowa permit to practice radiography must be in effect whenever mammogram procedures are performed by the radiologic technologist.

5. Only 50 percent of the total required mammography continuing education hours may be obtained through presenting, or acting as a trainer for, a continuing education or training program.

(4) Continuing experience requirements.

1. Following the second anniversary date on which the requirements of 41.6(3) "b"(1) and (2) were completed, the radiologic technologist shall have performed a minimum of 200 mammography examinations during the prior 24 months, during the 24-month period ending on the last day of the previous calendar quarter, or during any 24-month period between the two. The facility will choose one of these dates to determine the 24-month period.

2. Requalification. Radiologic technologists who fail to meet the continuing experience requirements of this subrule shall perform a minimum of 25 mammography examinations under the direct supervision of a qualified radiologic technologist before resuming the performance of unsupervised mammography examinations.

3. Continuing qualifications must be met and an Iowa permit to practice radiography must be in effect whenever mammogram procedures are performed by the radiologic technologist.

(5) Consecutive or back-to-back requalification of mammography personnel, due to failure to meet continuing education or experience requirements, will be allowed once without proof of extenuating circumstances. This agency will determine the validity of such proof and render a decision after review of all pertinent information. Those individuals who are denied requalification will be allowed to resubmit for requalification following a 90-day waiting period.

*c. Medical physicists.* All medical physicists conducting surveys of mammography facilities and providing oversight of the facility quality assurance program under 41.6(3) "c"(2) shall meet the following:

(1) Initial qualifications.

1. Be Iowa approved; and

2. Have a master's degree or higher in a physical science from an accredited institution, with no less than 20 semester hours or 30 quarter hours of college undergraduate or graduate level physics;

3. Have 20 contact hours of documented specialized training in conducting surveys of mammography facilities; and

4. Have experience conducting surveys in at least one mammography facility and have a total of at least 10 mammography units. No more than one survey of a specific unit within a period of 60 days can be counted towards the total mammography unit survey requirement. After April 28, 1999, experience conducting surveys must be acquired under the direct supervision of a medical physicist who meets all the requirements of this subrule; or

(2) Alternative initial qualifications.

1. Have qualified as a medical physicist under FDA interim regulations and have retained that qualification by maintenance of the active status of any licensure, approval, or certification required under the interim regulations; and

2. Prior to April 28, 1999, have:
  - A bachelor's degree or higher in a physical science from an accredited institution with no less than 10 semester hours or equivalent of college undergraduate or graduate level physics.
  - Forty contact hours of documented specialized training in conducting surveys of mammography facilities.
  - Experience conducting surveys in at least one mammography facility and have a total of at least 20 mammography units. No more than one survey of a specific unit within a period of 60 days can be counted towards the total mammography unit survey requirement. The training and experience requirements must be met after fulfilling the degree requirement.
  - At least eight hours of training in surveying units of the new mammographic modality before independently performing mammographic surveys of a new mammographic modality other than one for which the physicist received training to qualify under this subrule.

(3) Continuing qualifications.

1. Continuing education. Following the third anniversary date on which the requirements of 41.6(3) "c"(1) or (2) were completed, the medical physicist shall have taught or completed at least 15 continuing education units in mammography during the prior 36 months, during the 36-month period ending on the last day of the previous calendar quarter, or during any 36-month period between the two. The facility shall choose one of these dates to determine the 36-month period. Units earned through teaching a specific course shall be counted only once towards the required 15 units in a 36-month period, even if the course is taught multiple times during the 36 months.

2. Continuing experience. Following the second anniversary date on which the requirements of this subrule were completed, the medical physicist shall have surveyed at least two mammography facilities and a total of at least 6 mammography units during the prior 24 months, during the 24-month period ending on the last day of the previous calendar quarter, or during any 24-month period between the two. The facility shall choose one of these dates to determine the 24-month period. No more than one survey of a specific facility within a 10-month period or a specific unit within a period of 60 days shall be counted towards this requirement.

3. Continuing qualifications must be met whenever medical physics services are provided by the medical physicist.

(4) Reestablishing qualifications. Medical physicists who fail to maintain the required continuing qualifications of this subrule may not perform the MQSA surveys without the supervision of a qualified medical physicist. Before independently surveying another facility, medical physicists must reestablish their qualifications as follows:

1. Medical physicists who fail to meet the continuing education requirements of this subrule shall obtain a sufficient number of continuing education units to bring their total units up to the required 15 in the previous three years.

2. Medical physicists who fail to meet the continuing experience requirements of this subrule shall complete a sufficient number of surveys under the direct supervision of a medical physicist who meets the qualifications of this subrule to bring their total surveys up to the required two facilities and 6 units in the previous 24 months. No more than one survey of a specific unit within a period of 60 days can be counted towards the total mammography unit survey requirement.

*d. Retention of personnel records.* Facilities shall maintain records to document the qualifications of all personnel who worked at the facility as interpreting physicians, general radiographers, or medical physicists. These records must be available for review by the MQSA inspectors. Records of personnel no longer employed by the facility should not be discarded until the next annual inspection has been completed and the agency has determined that the facility is in compliance with the MQSA personnel requirements.

**41.6(4) Obtaining and preserving records.**

*a.* The facility performing the current mammography examination must make all reasonable efforts to obtain the patient's recent mammography records, including original images or films, copies of written reports prepared by interpreting physicians, and other relevant information pertinent to

previous mammograms that might be available from other facilities, for comparison with the current mammography records.

*b.* The facility must make, for each patient, a written report of each mammography examination performed. This report shall include:

- (1) The date the mammography procedure was performed.
- (2) The date of the interpretation.
- (3) The name of the interpreting physician.
- (4) The name of the patient and an additional patient identifier.
- (5) A description of the procedures performed.
- (6) The name of the referring physician (if any) or other physician (if any) identified by the patient to receive the interpreting physician's written report.

(7) The date the interpreting physician's written report was sent to the appropriate physician or patient.

(8) A separate and distinct section entitled, "Assessment" with the appropriate assessment term. One of the following terms in quotations or an approved equivalent must be included in the assessment:

1. "Negative": Nothing to comment upon (if the interpreting physician is aware of clinical findings or symptoms, despite the negative assessment, these shall be explained).
2. "Benign": Also a negative assessment.
3. "Probably benign": Finding(s) has a high probability of being benign.
4. "Suspicious": Finding(s) without all the characteristic morphology of breast cancer but indicating a definite probability of being malignant.
5. "Highly suggestive of malignancy": Finding(s) has a high probability of being malignant.
6. "Incomplete: Need additional imaging evaluation" shall be assigned as an assessment in cases where no final assessment category can be assigned due to incomplete workup, and reasons why no assessment can be made shall be stated by the interpreting physician.

(9) Recommendations made to the health care provider about what additional actions, if any, should be taken. All clinical questions raised by the referring health care provider shall be addressed in the report to the extent possible, even if the assessment is negative or benign.

*c.* Preservation of records.

(1) The facility must provide satisfactory assurances (as documented in its medical records) that the images or films of the first and subsequent mammography procedures and the related written reports of the interpreting physician for each patient are either placed in the patient's medical record kept by the facility or sent for placement in the patient's medical record as directed by the patient's physician or the patient.

(2) Records retained by the facility must be retained for at least 60 calendar months following the date of service, as long as the patient continues consecutive mammograms. If no additional mammograms of the patient are performed, the records must be retained for at least ten years.

(3) If the facility should cease to exist before the end of the retention period, the records must be transferred to the patient or patient's physician or other mammographic facility.

(4) The facility shall upon request by, or on behalf of, the patient, permanently or temporarily, transfer the original mammograms and copies of the patient's reports to a medical institution, or to a physician or health care provider of the patient, or to the patient directly.

(5) Any fee charged to the patient for providing the services in subparagraph (4) above shall not exceed the documented costs associated with this service.

*d.* Communication of results to the patient. Each facility shall maintain a system to ensure that the results of each mammographic examination are communicated in lay terms to each patient in a time period not to exceed 30 days from the date of the mammography examination. If assessments are "Suspicious" or "Highly suggestive of malignancy" and the patient has not named a health care provider, the facility shall make reasonable attempts to ensure that the results are communicated to the patient as soon as possible.

(1) As soon as possible, but no later than 30 days from the date of the mammography examination, patients who do not name a health care provider to receive the mammography report shall be sent the report described in 41.6(4)“e”(1) in addition to a written notification of results in lay terms.

(2) Each facility that accepts patients who do not have a primary care provider shall maintain a system for referring such patients to a health care provider when clinically indicated.

*e.* Communication of results to health care providers. When the patient has a referring health care provider or the patient has named a health care provider, the facility shall:

(1) Provide a written report of the mammography examination, including all of the items listed in 41.6(4)“b,” to the health care provider as soon as possible, but no later than 30 days from the date of the examination, and

(2) If the assessment is “Suspicious” or “Highly suggestive of malignancy,” make reasonable attempts to communicate with the health care provider as soon as possible or, if the health care provider is unavailable, to a responsible designee of the health care provider.

*f.* Mammographic image identification. Each mammographic image shall have the following information indicated on it in a permanent, legible, and unambiguous manner and placed so as not to obscure anatomic structures:

(1) Name of patient and an additional patient identifier.

(2) Date of examination.

(3) View and laterality. This information shall be placed on the image in a position near the axilla. Standardized codes specified by the accreditation body and approved by the FDA shall be used to identify view and laterality.

(4) Facility name and location. At a minimum, the location shall include the city, state, and ZIP code of the facility.

(5) Technologist identification.

(6) Cassette/screen identification.

(7) Mammography unit identification, if there is more than one unit in the facility.

**41.6(5) *Quality assurance program.***

*a.* The facility shall ensure that the facility has an equipment quality assurance program specific to mammography and covering all components of the system to ensure consistently high-quality images with minimum patient exposure. Responsibility for the quality assurance program and for each of its elements shall be assigned to individuals who are qualified for their assignments and who shall be allowed adequate time to perform these duties.

(1) Lead interpreting physician. The facility shall identify a lead interpreting physician who shall have the general responsibility of ensuring that the quality assurance program meets all requirements of these rules. No other individual shall be assigned or shall retain responsibility for quality assurance tasks unless the lead interpreting physician has determined that the individual’s qualifications for, and performance of, the assignment are adequate.

(2) Interpreting physicians. All interpreting physicians interpreting mammograms for the facility shall:

1. Follow the facility procedures for corrective action when the images they are asked to interpret are of poor quality, and

2. Participate in the facility’s medical outcomes audit program.

(3) Medical physicist. Each facility shall have the services of a medical physicist available to survey mammography equipment and oversee the equipment-related quality assurance practices of the facility. At a minimum, the medical physicist(s) shall be responsible for performing the surveys and mammography equipment evaluations and providing the facility with the applicable reports.

(4) Quality control technologist. Responsibility for all individual tasks within the quality assurance program not assigned to the lead interpreting physician or the medical physicist shall be assigned to a quality control technologist(s). The tasks are to be performed by the quality control technologist or by other personnel qualified to perform the tasks. When other personnel are utilized for these tasks, the quality control technologist shall ensure that the tasks are completed in such a way as to meet the requirements of 41.6(5)“e” through “k.”

b. The facility shall ensure that a general review of the program is conducted at least annually and have available the services of a qualified medical physicist who is capable of establishing and conducting the program.

c. Under the direction of the lead interpreting physician, the medical physicist shall have responsibility for establishing and conducting the equipment quality assurance program. The program shall include:

- (1) Conducting or training others to conduct equipment performance monitoring functions.
- (2) Analyzing the monitoring results to determine if there are any problems requiring correction.
- (3) Ensuring that the facility has procedures in place for carrying out or arranging for the necessary corrective actions as well as for the calibrations and other preventive maintenance.

d. Calibration of equipment. All variable parameters of the equipment shall be calibrated:

- (1) When the equipment is first installed.
- (2) After any major changes or replacement of parts.
- (3) At least annually during use based on recommendations of the mammography imaging medical physicist.
- (4) When quality assurance tests indicate that calibration is needed.

e. Performance monitoring. The supplier shall routinely ensure that the performance of the mammography system is monitored. The parameters to be monitored for film-screen mammography shall include but not be limited to:

- (1) Processor performance (through daily sensitometric-densitometric means).
- (2) Half-value layer.
- (3) Output reproducibility and linearity.
- (4) Automatic exposure control reproducibility and linearity.
- (5) Adequacy of film storage (both before use and after exposure if processing does not occur immediately).
- (6) Availability and use of technique charts that shall include an indication of the kV-target-filter combination to be used with each image receptor.
- (7) Darkroom integrity, to be performed at least semiannually or when conditions have changed, shall include an inspection for light leaks, a fog test, and a safe light test.
- (8) Image quality. The minimum image quality achieved at a mammography facility shall be the ability to observe the image of at least four 0.75-mm fibrils, three 0.32-mm speck groups, and three 0.75-mm masses from an FDA-approved phantom (or equivalent) on the standard mammographic film used at the facility. No mammograms shall be performed if this minimum is not met.

f. Frequency of monitoring.

- (1) Processor performance shall be accomplished daily before processing patient films.
- (2) Image quality shall be monitored at least weekly with a phantom and every time the unit is altered including the replacement of parts.
- (3) All other parameters shall be proportional to the expected variability of each parameter, but at least annually.

g. Evaluation of monitoring results. Full field digital mammography units must comply with the quality control test requirements outlined by the performance criteria in the appropriate manufacturer's quality control manual.

(1) Standards of image quality giving acceptable ranges of values for each of the parameters tested shall be established to aid in the evaluation. The standards of image quality related to dose shall include a requirement that the mean glandular dose for one craniocaudal view of a 4.2 cm compressed breast (50 percent adipose/50 percent glandular) or equivalent phantom shall not exceed 100 millirad for film-screen units with no grids, 300 millirad for film-screen units with grids, or 300 millirad for full field digital units.

(2) The monitoring results shall be compared routinely by the facility staff to the standards of image quality in 41.6(5)"k." If the results fall outside the acceptable range, the test shall be repeated. For film-screen mammography, if the results continue to be unacceptable, the source of the problem shall be identified and corrected before further examinations are conducted. For full field digital mammography,

if any test results fall outside the performance criteria range listed for the unit, specific actions as directed in the appropriate quality control manual shall be followed.

*h.* Retake analysis program—film-screen and full field digital.

(1) A program shall be established as a further aid in detecting and correcting problems affecting image quality or exposure.

(2) All retakes shall be logged including date, technologist's name and reason for retake. A retake analysis shall be performed every 250 patients or quarterly, whichever comes first. If more than 250 mammograms are performed in one week, weekly analysis is acceptable.

(3) If the total repeat or reject rate changes from the previously determined rate by more than 2.0 percent of the total films included in the analysis, the reason(s) for the change shall be determined. Any corrective actions shall be recorded and the results of these corrective actions shall be assessed.

*i.* Medical outcomes audit. Each facility shall establish a system for reviewing outcome data from all mammography performed, including follow-up on the disposition of positive mammograms and correlation of surgical biopsy results with the interpreting physician's findings. This program shall be designed to ensure the reliability, clarity, and accuracy of the interpretation of mammograms.

(1) Analysis of these outcome data shall be made individually and collectively for all interpreting physicians at the facility. In addition, any cases of breast cancer among women imaged at the facility that subsequently become known to the facility shall prompt the facility to initiate follow-up on surgical and pathology results, or both, and review of the mammograms taken prior to the diagnosis of a malignancy. Responsibility for each requirement for monitoring shall be assigned to qualified personnel and documented in the facility's records.

(2) Frequency of audit analysis. The facility's first audit analysis shall be initiated no later than 12 months after the date the facility becomes certified, or 12 months after April 28, 1999, whichever date is the latest. This audit analysis shall be completed within an additional 12 months to permit completion of diagnostic procedures and data collection. Subsequent audit analyses will be conducted at least once every 12 months.

(3) Reviewing interpreting physician. Each facility shall designate at least one interpreting physician to review the medical outcomes audit data at least once every 12 months. This individual shall record the dates of the audit period(s) and shall be responsible for analyzing results based on this audit. This individual shall also be responsible for documenting the results and notifying other interpreting physicians of the results and the facility aggregate results. If follow-up actions are taken, the reviewing interpreting physician shall also be responsible for documenting the nature of the follow-up. The reviewing physician shall sign the medical audit as proof of the evaluation of the data.

*j.* Quality assurance records. The lead interpreting physician, quality control technologist, and medical physicist shall ensure that records concerning employee qualifications to meet assigned quality assurance tasks, mammography technique and procedures, quality control (including monitoring data, problems detected by analysis of that data, corrective actions, and the effectiveness of the corrective actions), safety, and protection are properly maintained and updated. These quality control records shall be kept for each test specified in these rules until the next annual inspection has been completed and the facility is in compliance with the quality assurance requirements or until the test has been performed two additional times at the required frequency, whichever is longer.

*k.* Quality assurance—equipment.

(1) Daily quality control tests. Film processors used to develop mammograms shall be adjusted and maintained to meet the technical development specifications for the mammography film in use. A processor performance test shall be performed on each day that clinical films are processed before any clinical films are processed that day. The test shall include an assessment of base plus fog density, mid-density, and density difference, using the mammography film used clinically at the facility.

1. The base plus fog density shall be below plus 0.03 of the established operating level.

2. The mid-density shall be within plus or minus 0.15 of the established operating level.

3. The density difference shall be within plus or minus 0.15 of the established operating level.

(2) Weekly quality control tests. Facilities with screen-film systems shall perform an image quality evaluation test, using an FDA-approved phantom, at least weekly.

1. The optical density of the film at the center of an image of a standard FDA-accepted phantom shall be at least 1.20 when exposed under a typical clinical condition.

2. The optical density of the film at the center of the phantom image shall not change by more than plus or minus 0.20 from the established operating level.

3. The phantom image shall achieve at least the minimum score established by the accreditation body and accepted by the FDA.

4. The density difference between the background of the phantom and an added test object used to assess image contrast shall be measured and shall not vary by more than plus or minus 0.05 from the established operating level.

(3) Quarterly quality control tests. Facilities with screen-film systems shall perform the following quality control tests at least quarterly:

- Fixer retention in film. The residual fixer shall be no more than 5 micrograms per square centimeter.

(4) Semiannual quality control tests. Facilities with screen-film systems shall perform the following quality control tests at least semiannually:

1. Darkroom fog. The optical density attributable to darkroom fog shall not exceed 0.05 when a mammography film of the type used in the facility, which has a mid-density of no less than 1.2 OD, is exposed to typical darkroom conditions for two minutes while such film is placed on the countertop emulsion side up. If the darkroom has a safelight used for mammography film, it shall be on during this test.

2. Screen-film contact. Testing for screen-film contact shall be conducted using 40 mesh copper screen. All cassettes used in the facility for mammography shall be tested.

3. Compression device performance. The maximum compression force for the initial power drive shall be between 25 pounds (111 newtons) and 45 pounds (200 newtons).

(5) Annual quality control tests. Facilities with screen-film systems shall perform the following quality control tests at least annually:

1. Automatic exposure control (AEC) performance.

- The AEC shall be capable of maintaining film optical density (OD) within plus or minus 0.15 of the mean optical density when thickness of a homogenous material is varied over a range of 2 to 6 centimeters and the kVp is varied appropriately for such thicknesses over the kVp range used clinically in the facility.

- The optical density of the film in the center of the phantom image shall not be less than 1.20.

2. kVp accuracy and reproducibility.

- The kVp shall be accurate within plus or minus 5 percent of the indicated or selected kVp at the lowest clinical kVp that can be measured by a kVp test device, the most commonly used clinical kVp, and the highest available clinical kVp.

- At the most commonly used clinical settings of kVp, the coefficient of variation of reproducibility of the kVp shall be equal to or less than 0.02.

3. Focal spot condition. Facilities shall evaluate focal spot condition only by determining the system resolution.

- Each X-ray system used for mammography, in combination with the mammography screen-film combination used in the facility, shall provide a minimum resolution of 11 cycles/millimeters (mm) (line-pairs/mm) when a high contrast resolution bar test pattern is oriented with the bars perpendicular to the anode-cathode axis, and a minimum resolution of 13 line-pairs/mm when the bars are parallel to that axis.

- The bar pattern shall be placed 4.5 centimeters above the breast support surface, centered with respect to the chest wall edge of the image receptor, and with the edge of the pattern within 1 centimeter of the chest wall edge of the image receptor.

- When more than one target material is provided, the measurement above shall be made using the appropriate focal spot for each target material.

- When more than one SID is provided, the test shall be performed at the SID most commonly used clinically.

- Test kVp shall be set at the value used clinically by the facility for a standard breast and shall be performed in the AEC mode, if available. If necessary, a suitable absorber may be placed in the beam to increase exposure times. The screen-film cassette combination used by the facility shall be used to test for this requirement and shall be placed in the normal location used for clinical procedures.
- Focal spot dimensions. Measured values of the focal spot length (dimension parallel to the anode-cathode axis) and width (dimension perpendicular to the anode-cathode axis) shall be within tolerance limits specified in Table 1.

Table 1

Focal Spot Tolerance Limit Nominal Focal Spot Size (mm)	Maximum Measured Dimensions Width (mm)	Length (mm)
0.10	0.15	0.15
0.15	0.23	0.23
0.20	0.30	0.30
0.30	0.45	0.65
0.40	0.60	0.85
0.60	0.90	1.30

4. Beam quality and half-value layer (HVL). The HVL shall meet the specification of 41.1(4) and 41.1(6) for the minimum HVL. These values, extrapolated to the mammographic range, are shown in Table 2. Values not shown in Table 2 may be determined by linear interpolation or extrapolation.

Table 2

X-ray Tube Voltage (kilovolt peak) and Minimum HVL Designed Operating Range (kV) Below 50	
Measured Operating Voltage (kV)	Minimum HVL (millimeters of aluminum)
20	0.20
25	0.25
30	0.30

5. Breast entrance air kerma and AEC reproducibility. The coefficient of variation for both air kerma and mAs shall not exceed 0.05.

6. Dosimetry. The average glandular dose delivered during a single cranio-caudal view of an FDA-accepted phantom simulating a standard breast shall not exceed 0.3 rad (3.0 milligray (mGy)) per exposure. The dose shall be determined with technique factors and conditions used clinically for a standard breast.

7. X-ray field/light field/image receptor/compression paddle alignment.

- All systems shall have beam-limiting devices that allow the entire chest wall edge of the X-ray field to extend to the chest wall edge of the image receptor and provide means to ensure that the X-ray field does not extend beyond any edge of the image receptor by more than 2 percent of the SID.

- The chest wall edge of the compression paddle shall not extend beyond the chest wall edge of the image receptor by more than 1 percent of the SID when tested with the compression paddle placed above the breast support surface at a distance equivalent to standard breast thickness. The shadow of the vertical edge of the compression paddle shall be not be visible on the image.

8. Uniformity of screen speed. Uniformity of screen speed of all the cassettes in the facility shall be tested and the difference between the maximum and minimum optical densities shall not exceed 0.30. Screen artifacts shall also be evaluated during this test.

9. System artifacts. System artifacts shall be evaluated with a high-grade, defect-free sheet of homogeneous material large enough to cover the mammography cassette and shall be performed for all cassette sizes used in the facility using a grid appropriate for the cassette size being tested. System artifacts shall also be evaluated for all available focal spot sizes and target filter combinations used clinically.

10. Radiation output.

- The system shall be capable of producing a minimum output of 800 milliRoentgen (mR) per second (7.0 mGy air kerma per second) when operating at 28 kVp in the standard (moly/moly) mammography mode at any SID where the system is designed to operate and when measured by a detector with its center located 4.5 centimeters above the breast support surface with the compression paddle in place between the source and the detector.

- The system shall be capable of maintaining the required minimum radiation output averaged over a 3.0 second period.

11. Decompression. If the system is equipped with a provision for automatic decompression after completion of an exposure or interruption of power to the system, the system shall be tested to confirm that it provides:

- An override capability to allow maintenance of compression;
- A continuous display of the override status; and
- A manual emergency compression release that can be activated in the event of power or automatic release failure.

(6) Quality control tests—other modalities. For systems with image receptor modalities other than screen-film, the quality assurance program shall be substantially the same as the quality assurance program recommended by the image receptor manufacturer, except that the maximum allowable dose shall not exceed the maximum allowable dose for screen-film systems in 41.6(5) “k”(5)“6.”

(7) Use of test results.

1. After completion of the tests specified in 41.6(5) “k,” the facility shall compare the test results to the corresponding specified action limits; or, for non-screen-film modalities, to the manufacturer’s recommended action limits; or, for post-move, preexamination testing of mobile units, to the limits established in the test method used by the facility.

2. If the test results fall outside the action limits, the source of the problem shall be identified, and corrective actions shall be taken before any further examinations are performed or any films are processed using the component of the mammography system that failed the test, if the failed test was that described in 41.6(5) “k.”

3. Full field digital unit corrective actions shall be made as prescribed in the appropriate manufacturer’s quality control manual or in accordance with the appropriate FDA-approved alternative requirements.

(8) Surveys.

1. At least once a year, each facility shall undergo a survey by a medical physicist or by an individual under the direct supervision of a medical physicist. At a minimum, this survey shall include the performance of tests to ensure that the facility meets the quality assurance requirements of the annual tests described in 41.6(5) “k”(5) and (6), the weekly phantom image quality test described in 41.6(5) “k”(2) and the quarterly retake analysis results described in 41.6(5) “h.”

2. The results of all tests conducted by the facility in accordance with 41.6(5) “k”(1) through (7) for film-screen units, as well as written documentation of any corrective actions taken and their results, shall be evaluated for adequacy by the medical physicist performing the survey. Surveys of full field digital mammography units shall be conducted as described in the appropriate manufacturer’s quality control manual. The results of the tests, any corrective actions taken and their results shall be evaluated for adequacy by the medical physicist performing the survey.

3. The medical physicist shall prepare a survey report that includes a summary of this review and recommendations for necessary improvements.

4. The survey report shall be sent to the facility within 30 days of the date of the survey.

5. The survey report shall be dated and signed by the medical physicist performing or supervising the survey. If the survey was performed entirely or in part by another individual under the direct supervision of the medical physicist, that individual and the part of the survey that individual performed shall also be identified in the survey report.

(9) Mammography equipment evaluations. Additional evaluations of mammography units or image processors or any other applicable mammography system ancillary parts shall be conducted at new installations, at disassembly, at reassembly, at the same or a new location, or when major components are changed or repaired. These evaluations shall be used to determine whether the new or changed equipment meets the requirements of applicable standards in 41.6(5) and 41.6(6). All problems shall be corrected before the new or changed equipment is put into service for examinations or film processing. The mammography equipment evaluation shall be performed by a medical physicist or by an individual under the direct supervision of an Iowa-approved medical physicist.

(10) Facility cleanliness.

1. The facility shall establish and implement adequate protocols for maintaining darkroom, screen, and viewbox cleanliness.

2. The facility shall document that all cleaning procedures are performed at the frequencies specified in the protocols.

(11) Calibration of air kerma measuring instruments. Instruments used by medical physicists in their annual survey to measure the air kerma or air kerma rate from a mammography unit shall be calibrated at least once every two years and each time the instrument is repaired. The instrument calibration must be traceable to a national standard and calibrated with an accuracy of plus or minus 6 percent (95 percent confidence level) in the mammography energy range.

(12) Infection control. Facilities shall establish and comply with a system specifying procedures to be followed by the facility for cleaning and disinfecting mammography equipment after contact with blood or other potentially infectious materials. This system shall specify the methods for documenting facility compliance with the infection control procedures established and shall:

1. Comply with all applicable federal, state, and local regulations pertaining to infection control; and

2. Comply with the manufacturer's recommended procedures for the cleaning and disinfecting of the mammography equipment used in the facility; or

3. If adequate manufacturer's recommendations are not available, comply with generally accepted guidance on infection control, until such recommendations become available.

*l.* Mammography procedures and techniques for mammography of patients with breast implants.

(1) Each facility shall have a procedure to inquire whether or not the patient has breast implants prior to the actual mammographic examination.

(2) Except where contraindicated, or unless modified by a physician's directions, patients with breast implants undergoing mammography shall have mammographic views to maximize the visualization of breast tissue.

*m.* Consumer complaint mechanism. Each facility shall:

(1) Establish a written and documented system for collecting and resolving consumer complaints;

(2) Maintain a record of each serious complaint received by the facility for at least three years from the date the complaint was received;

(3) Provide the consumer with adequate directions for filing serious complaints with the facility's accreditation body and any other appropriate regulatory entity if the facility is unable to resolve a serious complaint to the consumer's satisfaction.

(4) Report unresolved serious complaints to the accreditation body in a manner and time frame specified by the accreditation body.

*n.* Clinical image quality. Clinical images produced by any certified facility must continue to comply with the standards for clinical image quality established by that facility's accreditation body.

*o.* Additional mammography review and patient notification.

(1) If the agency believes that mammography quality at a facility has been compromised and may present a serious risk to human health, the facility shall provide clinical images and other relevant

information, as specified by the agency, for review by the accreditation body or other entity designated by the agency. This additional mammography review will help the agency to determine whether the facility is in compliance with rule 641—41.6(136C) and, if not, whether there is a need to notify affected patients, their physicians, or the public that the reliability, clarity, and accuracy of interpretation of mammograms has been compromised.

(2) If the agency determines that any activity related to the provision of mammography at a facility may present a serious risk to human health such that patient notification is necessary, the facility shall notify patients or their designees, their physicians, or the public of action that may be taken to minimize the effects of the risk. Such notification shall occur within a time frame and a manner specified by the agency.

**41.6(6) Equipment standards.** The equipment used to perform mammography shall meet the following standards:

*a.* Design: Be specifically designed for mammography. This prohibits systems that have been modified or equipped with special attachments for mammography.

*b.* Performance standards: Meet the Food and Drug Administration (FDA) performance standards for diagnostic X-ray systems and their major components found in 21 CFR 1020.30 and FDA standards for radiographic equipment in 21 CFR 1020.31.

*c.* Image receptor systems: Have image receptor systems and individual components which are appropriate for mammography and used according to the manufacturer's recommendations.

(1) Systems using screen-film image receptors shall provide, at a minimum, for operation for image receptors of 18 × 24 centimeters and 24 × 30 centimeters.

(2) Systems using screen-film image receptors shall be equipped with moving grids matched to all image receptor sizes provided.

(3) Systems used for magnification procedures shall be capable of operation with the grid removed from between the source and image receptor.

*d.* Light fields: For any system with a light beam that passes through the X-ray beam-limiting device, the light shall provide an average illumination of not less than 160 lux (15 foot candles) at 100 centimeters or the maximum source-image receptor distance (SID), whichever is less.

*e.* Magnification:

(1) Systems used to perform noninterventional problem-solving procedures shall have radiographic magnification capability available for use by the operator.

(2) Systems used for magnification procedures shall provide, at a minimum, at least one magnification value within the range of 1.4 to 2.0.

*f.* Tube-image receptor assembly:

(1) The assembly shall be capable of being fixed in any position where it is designed to operate. Once fixed in any such position, it shall not undergo unintended motion.

(2) The mechanism ensuring compliance with this subrule shall not fail in the event of power interruption.

*g.* Film/screen contact: Shall check film/screen contact when cassettes are first placed into use and semiannually thereafter.

*h.* Focal spot: The focal spot size, magnification factor and source to image receptor distance (SID) shall be appropriate for mammography and in the ranges shown below:

SID	Nominal Focal Spot Size
> 65 cm	< or = to 0.6 mm
50 to 65 cm	< or = to 0.5 mm
< 50 cm	< or = to 0.4 mm

(1) When more than one focal spot is provided, the system shall indicate, prior to exposure, which focal spot is selected.

(2) When more than one target material is provided, the system shall indicate, prior to exposure, the preselected target material.

(3) When the target material or focal spot, or both, is selected by a system algorithm that is based on the exposure or on a test exposure, the system shall display, after the exposure, the target material or focal spot, or both, actually used during the exposure.

*i.* Compression devices: Shall have compression devices parallel to the imaging plane and able to immobilize and compress the breast with a force of at least 25 pounds per square inch and shall be capable of maintaining this compression for at least three seconds. Effective October 28, 2002, each system shall provide:

(1) An initial power-driven compression activated by hands-free controls operable from both sides of the patient; and

(2) Fine adjustment compression controls operable from both sides of the patient.

(3) Systems shall be equipped with different sized compression paddles that match the sizes of all full field image receptors provided for the system. Compression paddles for special purposes, including those smaller than the full size of the image receptor (for "spot compression"), may be provided. Such compression paddles for special purposes are not subject to 41.6(6) "i"(6) and (7).

(4) Except as provided in 41.6(6) "i"(5), the compression paddle shall be flat and parallel to the breast support table and shall not deflect from parallel by more than 1.0 cm at any point on the surface of the compression paddle when compression is applied.

(5) Equipment intended by the manufacturer's design not to be flat and parallel to the breast support table during compression shall meet the manufacturer's design specifications and maintenance requirements.

(6) The chest wall edge of the compression paddle shall be straight and parallel to the edge of the image receptor.

(7) The chest wall edge may be bent upward to allow for patient comfort but shall not appear on the image.

*j.* Grids: Shall have the capability for using antiscatter grids.

*k.* AEC: Shall have automatic exposure control such that:

(1) Each screen-film system shall provide an AEC mode that is operable in all combinations of equipment configuration provided, e.g., grid, nongrid; magnification, nonmagnification; and various target-filter combinations.

(2) The positioning or selection of the detector shall permit flexibility in the placement of the detector under the target tissue.

- The size and available positions of the detector shall be clearly indicated at the X-ray input surface of the breast compression paddle.

- The selected position of the detector shall be clearly indicated.

(3) The system shall provide means for the operator to vary the selected optical density from the normal (zero) setting.

*l.* Control panel: Shall have a control panel that:

(1) Gives a positive indication when X-rays are being produced.

(2) Gives an audible signal indicating termination of exposure.

(3) Has manual selection of milliamperere seconds (mAs) or at least one of its component parts (milliamperere (mA) or time, or both).

(4) Has the technique factors (peak tube potential in kilovolts (kV) and either tube current in mA and exposure time in seconds or the product of tube current and exposure time in mAs) to be used during an exposure indicated before the exposure begins, except when AEC is used, in which case the technique factors that are set prior to the exposure shall be indicated.

(5) Has a system that, following AEC mode use, shall indicate the actual kilovoltage peak (kVp) and mAs used during the exposure.

*m.* mAs: Shall indicate, or provide a means of determining, the mAs resulting from each exposure made with automatic exposure control.

*n.* Viewboxes: Shall have a viewbox that is checked periodically to ensure optimal conditions. When the mammogram is placed on the viewbox, the area surrounding the film must be masked to exclude extraneous light which may reduce image contrast.

*o.* X-ray film: Shall use X-ray film that has been designated by the film manufacturer as appropriate for mammography and that is matched to the screen’s spectral output as specified by the manufacturer.

*p.* Intensifying screens: Shall use intensifying screens that have been designated by the screen manufacturer as appropriate for mammography.

*q.* Chemicals: Shall use chemical solutions for processing mammography films that are capable of developing the films in a manner equivalent to the minimum requirements specified by the film manufacturer.

*r.* Hot-lights: Shall make special lights for film illumination, i.e., hot-lights, capable of producing light levels greater than that provided by the viewbox, available to the interpreting physicians.

*s.* Masking devices: Shall ensure that film masking devices that can limit the illuminated area to a region equal to or smaller than the exposed portion of the film are available to all interpreting physicians interpreting for the facility.

*t.* Mobile units and vans—film-screen.

(1) A phantom image shall be produced, processed, and evaluated after each relocation and prior to examinations being conducted.

(2) If processing is not available, a check of the radiation output shall be made and compared to a preset standard for quality. Equipment shall be recalibrated as necessary to maintain quality of phantom image.

*u.* Mobile units and vans—full field digital. Appropriate manufacturer’s quality control manual procedures and criteria shall be met.

**41.6(7) Safety standards for mammography equipment.**

*a.* Proper safety precautions shall be maintained and shall include, but not be limited to, adequate shielding for patients, personnel, and facilities. The equipment shall be operated only from a shielded position.

*b.* Equipment operators shall be monitored in accordance with 641—40.37(136C).

*c.* Annual inspections shall be conducted by an inspector from the agency to ensure compliance with these rules. Identified hazards shall be promptly corrected.

*d.* Equipment shall be shockproof and grounded to protect against electrical hazards.

*e.* Records of all inspections, reports, and consultations shall be maintained for at least seven years.

**RULE 641—41.6(136C)—APPENDIX I  
Rescinded IAB 4/5/00, effective 5/10/00**

**RULE 641—41.6(136C)—APPENDIX II  
Glandular Dose (in mrad) for 1 Roentgen Entrance Exposure  
4.5-cm Breast Thickness—50% Adipose/50% Glandular Breast Tissue\***

HVL	Mo/Mo Target Filter X-Ray Voltage (kVp)											W/AI Target Filter Combination	
	23	24	25	26	27	28	29	30	31	32	33		
0.23	109												
0.24	113	116											
0.25	117	120	122										
0.26	121	124	126	128									
0.27	126	128	130	132	134								
0.28	130	132	134	136	138	139							
0.29	135	137	139	141	142	143	144						
0.30	139	141	143	145	146	147	148	149				170	
0.31	144	146	147	149	150	151	152	153	154			175	

HVL	Mo/Mo Target Filter X-Ray Voltage (kVp)											W/AI Target Filter Combination
	23	24	25	26	27	28	29	30	31	32	33	
0.32	148	150	151	153	154	155	156	158	159	160	160	180
0.33	153	154	155	157	158	159	160	162	163	164	164	185
0.34	157	159	160	161	162	163	164	166	167	168	168	190
0.35		163	164	166	167	168	169	170	171	172	172	194
0.36			168	170	171	172	173	174	175	176	176	199
0.37				174	175	176	177	178	178	179	180	204
0.38					179	180	181	182	182	183	184	208
0.39						184	185	186	186	187	188	213
0.40							189	190	191	192	192	217
0.41								194	195	196	196	221
0.42										200	200	225
0.43											204	230
0.44												234
0.45												238

To convert from entrance exposure in air in Roentgen to mean glandular breast dose in millirads, multiply the entrance exposure by the factor shown in the table for the appropriate kVp and beam quality (HVL) combination. For example, a measured entrance exposure of 0.50 Roentgen from a Mo/Mo Target Filter system at 30 kVp with a measured HVL of 0.36-mm aluminum yields an average glandular dose of  $(0.50 \text{ R}) \times (174 \text{ mrad/R}) = 87 \text{ mrad}$  or 0.87 mGy.

\*Wu X. Breast dosimetry in screen-film mammography. In: Barnes GT, Frey GD (eds), Screen film mammography: Imaging considerations and medical physics responsibilities. Madison, WI: Medical Physics Publishing; 159-175, 1991. W/AI conversion factors are derived from fits to data from Stanton L et al. Dosage evaluation in mammography. Radiology 1984; 150:577-584.  
[ARC 1401C, IAB 4/2/14, effective 5/7/14]

#### **641—41.7(136C) X-ray machines used for stereotactically guided breast biopsy.**

**41.7(1) Definitions.** In addition to the definitions provided in rules 641—38.2(136C), 641—40.2(136C), and 641—41.1(136C), the following definitions are applicable to this rule.

“*Collaborative setting*” means a setting in which a qualified radiologist and surgeon (under 41.7(3)“a” or 41.7(3)“c”) are working together in consultation and in performing stereotactically guided breast biopsies with a common goal of the patient’s benefit.

“*Procedure*” means a stereotactically guided breast biopsy performed on a patient for diagnostic purposes.

“*Qualified training physician*” means a physician who is qualified under 41.7(3) to perform stereotactically guided breast biopsies and who has performed at least 24 procedures.

“*Stereotactically guided breast biopsy*” means a breast biopsy procedure performed with the utilization of a dedicated system which emits ionizing radiation and is designed specifically for that procedure.

“*Supervising physician*” means the physician designated by the facility/owner to:

1. Evaluate the equipment, personnel, procedures, and records annually; and
2. Establish and conduct the quality assurance program.

**41.7(2) Registration and application standards and requirements.**

a. Each radiation machine used to perform stereotactically guided breast biopsies shall be registered according to 641—subrule 39.3(2).

b. Each facility wishing to perform stereotactically guided breast biopsies shall apply to the agency for authorization by providing or verifying the following information for each machine:

(1) The stereotactically guided breast biopsy equipment and facility meet the general requirements of these rules for radiation machines.

(2) The radiation machine is specifically designed to perform stereotactically guided breast biopsies.

(3) The radiation machine is used according to these rules on patient radiation exposure and radiation dose levels.

(4) The radiation machine is operated by individuals meeting the requirements of this rule.

(5) The entire stereotactically guided breast biopsy system is evaluated annually by a medical physicist who meets the requirements of this rule.

(6) The equipment, personnel, procedures and records are evaluated annually by the supervising physician.

c. Suspension, revocation, or denial of authorization.

(1) Authorization may be suspended or revoked with cause if any machine does not meet one or more of the standards of these rules.

(2) The facility shall have an opportunity for a hearing in connection with a denial, suspension, or revocation of authorization.

(3) An emergency order suspending or revoking authorization may be issued if the agency finds the radiation machine or facility violates rules that seriously affect the health, safety and welfare of the public. An opportunity for hearing shall be held within 20 working days after the issuance of the order. The order shall be effective during the proceedings.

(4) If authorization is revoked, the radiation machine shall not be used until reinstated.

d. Reinstatement of authorization.

(1) An application for reinstatement shall be submitted and processed the same as an initial application.

(2) The agency shall inspect the radiation machine within 60 days of the approved reinstatement application. If the reinstatement is after a revocation, appropriate corrective action shall be submitted with the application.

(3) A full reinstatement shall be issued only after the agency has inspected the radiation machine and facility and determined that they meet the requirements of these rules.

e. Inspections. The agency shall conduct an inspection of each radiation machine no later than 14 months after initial authorization and at least annually thereafter.

**41.7(3) Physicians.** Physicians must be qualified according to the setting and their role in performing stereotactically guided breast biopsies as outlined below.

a. Requirements for a radiologist in a collaborative setting are as follows:

(1) Initial training and qualifications.

1. Must be qualified according to 41.6(3) "a."

2. Shall have performed at least 12 stereotactically guided breast biopsies prior to July 1, 1998, or at least 3 hands-on stereotactically guided breast biopsies under a physician who is qualified under 41.7(3) and has performed at least 24 stereotactically guided breast biopsies.

3. Shall have at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy.

4. Shall be responsible for mammographic interpretation, be experienced as noted in 41.7(3) "a"(1)"2" above and be experienced in the specific recommendations for each biopsy and lesion identification at time of each biopsy performed by that physician.

5. Shall be responsible for the supervision of the radiologic technologist during the procedure.

(2) Maintenance of proficiency and CME requirements.

1. Perform at least 12 stereotactically guided breast biopsies per year. If experience is not maintained, the physician must requalify by performing 3 procedures under direct supervision of a qualified training physician or an agency-approved manufacturer applications specialist before resuming unsupervised procedures.

2. Obtain at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy every 36 months. If education is not maintained, the physician

must requalify by obtaining additional CME credits to reach 3 CME credits in the prior 36 months before resuming unsupervised procedures. These CMEs cannot be obtained by the performance of supervised procedures.

3. Continuing qualifications must be met and a current state of Iowa medical license must be in effect whenever procedures are performed independently by the physician.

b. Requirements for a physician other than a qualified radiologist in a collaborative setting are as follows:

(1) Initial training and qualifications.

1. Must be licensed to practice medicine in Iowa.

2. Must have at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy which includes instruction on triangulation for lesion location.

3. Must have performed at least 12 stereotactically guided breast biopsies prior to May 9, 2001, or at least 3 hands-on stereotactically guided breast biopsy procedures under a physician who is both qualified to perform stereotactic biopsy procedures according to 41.7(3) and has performed at least 24 stereotactically guided breast biopsies.

4. Shall be responsible for post-biopsy management of the patient.

5. Shall be responsible for supervision of the radiologic technologist during the procedure.

(2) Maintenance of proficiency and CME requirements.

1. Perform or participate in at least 12 stereotactically guided breast biopsies per year or requalify by performing 3 procedures under direct supervision of a qualified training physician or an agency-approved manufacturer applications specialist before resuming unsupervised procedures.

2. Obtain at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy every 36 months. If education is not maintained, the physician must requalify by obtaining additional CME credits to reach 3 CME credits in the prior 36 months before resuming unsupervised procedures. These CMEs cannot be obtained by the performance of supervised procedures.

3. Continuing qualifications must be met and a current state of Iowa medical license must be in effect whenever unsupervised procedures are performed by the physician.

c. Requirements for a radiologist performing stereotactically guided breast biopsy independently are as follows:

(1) Initial training and requirements.

1. Must be qualified according to 41.6(3) "a."

2. Initially, must have at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy.

3. Initially, must obtain at least 15 hours of CME in breast imaging including benign and malignant breast diseases.

4. Must have performed at least 12 stereotactically guided breast biopsies prior to July 1, 1998, or at least 3 hands-on stereotactically guided breast biopsy procedures under a physician who is both qualified according to 41.7(3) and has performed at least 24 stereotactically guided breast biopsies.

5. Must be responsible for mammographic interpretation.

6. Must be responsible for patient selection.

7. Must be responsible for the supervision of the radiologic technologist during the procedure.

8. Must be responsible for post-biopsy management of the patient which may include referral to a surgeon for a follow-up on certain lesions.

(2) Maintenance of proficiency and CME requirements.

1. Perform at least 12 stereotactically guided breast biopsies per year or requalify by performing 3 procedures under direct supervision of a qualified training physician or an agency-approved manufacturer applications specialist.

2. Obtain at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy every 36 months which includes post-biopsy management of the patient. If education is not maintained, the physician must requalify by obtaining additional CME credits

to reach 3 CME credits in the prior 36 months before resuming unsupervised procedures. These CMEs cannot be obtained by the performance of supervised procedures.

3. Continuing qualifications must be met and a current state of Iowa medical license must be in effect whenever unsupervised procedures are performed by the physician.

*d.* Requirements for a physician other than a qualified radiologist (under 41.7(3) “c”) performing stereotactically guided breast biopsy independently are as follows:

(1) Initial training and requirements.

1. Must be licensed to practice medicine in Iowa.

2. Must have evaluated at least 480 mammograms in the prior 24 months in consultation with a physician who is qualified according to 41.6(3) “a.”

3. Initially, must have at least 15 hours of Category 1 CME or 15 hours of training approved by the agency in stereotactically guided breast imaging and biopsy or three years’ experience having performed at least 36 stereotactically guided breast biopsies.

4. Must have four hours of Category 1 CME in medical radiation physics.

5. Must have performed at least 12 stereotactically guided breast biopsies prior to May 9, 2001, or at least 3 hands-on stereotactically guided breast biopsy procedures under a physician who is both qualified according to 41.7(3) and has performed at least 24 stereotactically guided breast biopsies.

6. Must be responsible for patient selection.

7. Must be responsible for the supervision of the radiologic technologist during the procedure.

8. Must be responsible for post-biopsy management of the patient.

(2) Maintenance of proficiency and CME requirements.

1. Continue to evaluate at least 480 mammograms every 24 months in consultation with a physician who is qualified according to 41.6(3) “a.”

2. Perform at least 12 stereotactically guided breast biopsies per year or requalify by performing 3 procedures under direct supervision of a qualified training physician or an agency-approved manufacturer applications specialist.

3. Obtain at least three hours of Category 1 CME or three hours of training approved by the agency in stereotactically guided breast biopsy every 36 months. If education is not maintained, the physician must requalify by obtaining additional CME credits to reach 3 CME credits in the prior 36 months before resuming unsupervised procedures. The CME credits for requalification cannot be obtained by performing procedures.

4. Continuing qualifications must be met and a current state of Iowa medical license must be in effect whenever unsupervised procedures are performed by the physician.

**41.7(4) Medical physicist.**

*a.* Must be qualified according to 41.6(3) “c.”

*b.* Must have performed three hands-on stereotactically guided breast biopsy system physics surveys prior to July 1, 1998; or one hands-on stereotactically guided breast biopsy system physics survey under the guidance of a medical physicist qualified through 41.7(4) “a” and 41.7(4) “b.”

*c.* Maintenance of proficiency and continuing education requirements.

(1) Have performed at least one stereotactically guided breast biopsy system physics survey per year after the initial qualifications are met or requalify by performing one survey supervised by a qualified medical physicist; and

(2) Following the third anniversary in which the requirements of this subrule were met, have obtained at least three hours of continuing education in stereotactically guided breast biopsy system physics during the previous 36 months or requalify by obtaining additional CME credits to reach 3 CME credits in the prior 36 months.

**41.7(5) Radiologic technologist.**

*a.* Must be qualified according to 41.6(3) “b.”

*b.* Must meet the following initial requirements:

(1) Five hands-on stereotactically guided breast biopsy procedures on patients under the supervision of a physician or technologist qualified under rule 641—41.7(136C).

(2) Three hours of continuing education in stereotactically guided breast biopsy. The required continuing education cannot be obtained through the performance of supervised stereotactically guided breast biopsy procedures.

c. Maintenance of proficiency and continuing education and experience requirements.

(1) Following the first anniversary in which the requirements of this subrule were met, have performed at least 12 stereotactically guided breast biopsies per year or requalify by performing 3 stereotactically guided breast biopsies under the supervision of a physician or radiologic technologist qualified under 41.7(3) or 41.7(5).

(2) Following the third anniversary in which the requirements of this subrule were met, have at least three hours of continuing education in stereotactically guided breast biopsy system physics during the previous 36 months or requalify by obtaining additional CME credits to reach 3 CME credits in the prior 36 months. The CMEs cannot be obtained by the performance of supervised procedures.

(3) If a stereotactic radiologic technologist performs only stereotactic procedures, the radiologic technologist must perform at least 100 stereotactic procedures during the prior 24 months.during the 24-month period ending on the last day of the previous calendar quarter, or any 24-month period between the two. In this case, all requirements for radiologic technologists must be met with the exception of 41.6(3) "b"(4)"1."

(4) Only 50 percent of the total required stereotactic continuing education hours may be obtained through presenting or acting as a trainer for a continuing education or training program.

**41.7(6) *Obtaining and preserving records.***

a. The facility must make, for each procedure, a record of the service provided including:

- (1) The date of the procedure.
- (2) The name of the patient and one additional patient identifier.
- (3) The name of the radiologic technologists and physicians performing the procedure.
- (4) A description of the service provided.
- (5) The name of the referring physician, if any.

b. Records retained by the medical facility must be retained for at least ten years.

**41.7(7) *Quality assurance program.***

a. The facility shall have an equipment quality assurance program specific to stereotactically guided breast biopsy systems and covering all components of the system to ensure high-quality images with minimum patient exposure.

b. The facility shall ensure that a general review of the program is conducted at least annually and have available the services of a qualified medical physicist who is capable of establishing and conducting the program.

c. The facility shall name a supervising stereotactic biopsy physician who shall be responsible for:

- (1) Quality assurance activities including the medical audit,
- (2) Oversight of the quality control program, and
- (3) Supervision of the radiologic technologist(s) and the medical physicist.

d. Under the direction of the supervising physician, the medical physicist shall have the responsibility for establishing and conducting the equipment quality assurance program. The program shall include:

(1) Conducting equipment performance monitoring functions, initially and then at least annually, to include:

1. Evaluation of biopsy unit assembly. Any failed items must be corrected within 30 days of the survey unless the medical physicist deems that the failure poses a serious injury risk to the patient, at which time the failure needs to be corrected before further procedures are performed.

2. Collimation.

- Digital – X-ray field must not extend beyond the image receptor by more than 5 mm on any side.
- Film-screen – On all sides other than the chest wall side, the X-ray field must be within the image receptor. The chest wall side must not extend beyond the image receptor by more than 2 percent.
- Any failures must be corrected within 30 days of the survey.

3. Evaluation of focal spot.
  - Digital – Focal spot must not degrade from initial measurement. If reduction in lp/mm is found, focal spot must be corrected within 30 days of survey.
  - Film-screen – Film-screen must show 13 lp/mm parallel to the anode-cathode axis and 11 lp/mm perpendicular to the anode-cathode axis. Failure to meet the performance criteria must be corrected within 30 days of survey.
4. kVp accuracy/reproducibility. kVp accuracy/reproducibility must be accurate to within +/- 5% of nominal kVp setting. Failures must be corrected before further procedures are performed.
5. Half-value layer measurement. HVL shall be greater than kVp/100 (in units of mm Al). Failures must be corrected before further procedures are performed.
6. Exposure reproducibility. Exposure must be reproducible to within +/- 15% of mean exposure. Failures must be corrected before further procedures are performed.
7. Breast entrance exposure, average glandular dose. Average glandular dose must be less than 300 millirad (3 milliGray) per exposure of a 50 percent glandular/50 percent adipose 4.5 centimeter breast. Failures must be corrected before further procedures are performed.
8. Image quality evaluation.
  - Digital – Phantom image must meet the criteria of 5 fibers, 4 speck groups and 3 masses for the ACR accreditation phantom or 3 fibers, 3 speck groups and 2.5 masses for the mini phantom unless otherwise stated by the phantom manufacturer.
  - Film-screen – Phantom image must meet the criteria of 4 fibers, 3 speck groups and 3 masses for the ACR phantom or 2 fibers, 2 speck groups and 2 masses for the mini phantom unless otherwise stated by the phantom manufacturer. The background density must be within +/- .20 of the established aim, and the density differences must be within +/- .05 of the established aim.
  - Failures must be corrected before further procedures are performed.
9. Artifact evaluation. Any significant black or white artifacts seen in the image detector field must be corrected within 30 days of the survey.
10. Digital field uniformity. For units with region of interest (ROI) capability, the SNR in each corner must be within +/- 15% of the SNR in the center. Failures must be corrected within 30 days of the survey.
11. Localization simulation (gelatin phantom) test. Localization accuracy must be within 1 mm of target, and the test must include a portion of the test “lesion” in the sample chamber. Failures must be corrected before further procedures are performed.
  - (2) Analyzing the monitoring results to determine if there are any problems requiring correction.
  - (3) Ensuring that the facility has procedures in place for carrying out or arranging for the necessary corrective actions as well as for the calibrations and other preventative maintenance.

e. The supervising physician shall have the responsibility for establishing and conducting the quality control program in a facility with a fixed unit. In the case of a mobile stereotactic unit, the owner or designee shall assume the responsibility for establishing and conducting the quality assurance program. The program shall include:

  - (1) Localization accuracy (daily before use and before using the localization unit after it is adjusted). Each coordinate must be within manufacturer specifications for the intended target value. Failures must be corrected before further procedures are performed.
  - (2) Visual checklist (monthly). Any failed items must be corrected within 30 days.
  - (3) Phantom image (weekly). Phantom image must meet the criteria of 5 fibers, 4 speck groups and 3 masses for the ACR accreditation phantom or 3 fibers, 3 speck groups and 2.5 masses for the mini phantom unless otherwise stated by the phantom manufacturer. Failures must be corrected before further procedures are performed.
  - (4) Compression (semiannually). The maximum auto drive compression force shall not exceed 45 pounds. Failures must be corrected within 30 days.
  - (5) Any additional quality control testing indicated by the stereotactic breast biopsy unit manufacturer must be completed as outlined in the quality control manual applicable to the unit.

*f.* Each facility shall establish a medical audit program to ensure the accuracy and appropriateness of the procedures performed. This program shall include an imaging-pathology correlation for each biopsy performed, an ongoing analysis of biopsy results and periodic review of the utilization of the procedure. The program must include the number of biopsies performed, the number of cancers found, the number of benign lesions found, and the number of biopsies repeated.

*g.* Additional medical physicist evaluations of stereotactic units shall be conducted whenever a new unit is installed, a unit is disassembled and reassembled at the same or a new location, or major components of a stereotactic unit are changed or repaired. These evaluations shall be used to determine whether the new or changed equipment meets the requirements of applicable standards in 41.7(7). All problems shall be corrected before the new or changed equipment is put into service for examinations. The stereotactic equipment evaluation shall be performed by a medical physicist qualified under 41.7(4) or by an individual under the direct supervision of a medical physicist qualified under 41.7(4).

**41.7(8)** *Equipment standards.*

*a.* Be specifically designed for stereotactically guided breast biopsy.

*b.* Meet the Food and Drug Administration (FDA) standards found in 21 CFR.

**41.7(9)** *Safety standards.*

*a.* Proper safety precautions shall be maintained and shall include, but not be limited to, adequate shielding for patients, personnel and facilities. The equipment shall be operated only from a shielded position.

*b.* Equipment operators shall wear personnel monitors to monitor their radiation exposure.

*c.* Annual inspections shall be conducted by an inspector from the agency to ensure compliance with these rules. Identified hazards shall be promptly corrected.

*d.* Equipment shall be shockproof and grounded to protect against electrical hazards.

*e.* Records of all inspections, reports and consultations shall be maintained for at least seven years.

This rule is intended to implement Iowa Code chapter 136C.

[ARC 1401C, IAB 4/2/14, effective 5/7/14]

## CHAPTER 41—APPENDIX A

INFORMATION ON RADIATION SHIELDING  
REQUIRED FOR PLAN REVIEWS (EXCLUDING THERAPY MACHINES)

In order for the agency to provide an evaluation and verification that national standards have been met on shielding requirements for a radiation installation, the following information shall be submitted.

1. The plans should show, as a minimum, the following:

(a) The normal location of the X-ray system's radiation port; the port's travel and traverse limits; general direction(s) of the useful beam; locations of any windows and doors; the location of the operator's booth; and the location of the X-ray control panel.

(b) The structural composition and thickness or lead equivalent of all walls, doors, partitions, floor, and ceiling of the room(s) concerned.

(c) The dimensions of the room(s) concerned.

(d) The type of occupancy of all adjacent areas inclusive of space above and below the room(s) concerned. If there is an exterior wall, show distance to the closest area(s) where it is likely that individuals may be present.

(e) The make and model of the X-ray equipment, the energy waveform (single phase, three phase, etc.) and the maximum technique factors.

(f) The type of examination(s) or treatment(s) which will be performed with the equipment.

2. Information on the anticipated workload of the X-ray system(s) in mA-minutes per week.

3. If the services of a qualified expert have been utilized to determine the shielding requirements, a report, including all basic assumptions used, shall be submitted with the plans.

## CHAPTER 41—APPENDIX B

DESIGN REQUIREMENTS FOR AN  
OPERATOR'S BOOTH1. Space requirements:

(a) The operator shall be allotted not less than 7.5 square feet (0.697 m) of unobstructed floor space in the booth.

(b) The operator's booth may be any geometric configuration with no dimension of less than 2 feet (0.61 m).

(c) The space shall be allotted excluding any encumbrance by the X-ray control panel, such as overhang, cables, or other similar encroachments.

(d) The booth shall be located or constructed such that unattenuated direct scatter radiation originating on the examination table or at the wall cassette will not reach the operator's station in the booth.

2. Structural requirements:

(a) The booth walls shall be permanently fixed barriers of at least 7 feet (2.13 m) high.

(b) When a door or movable panel is used as an integral part of the booth structure, it must have an interlock which will prevent an exposure when the door or panel is not closed.

(c) Shielding shall be provided to meet the requirements of 641—Chapter 40.

3. X-ray control placement:

The X-ray control for the system shall be fixed within the booth; and

(a) Shall be at least 40 inches (1.02 m) from any point subject to direct scatter, leakage or primary beam radiation.

(b) Shall allow the operator to use the majority of the available viewing windows or mirrors.

4. Viewing system requirements:

(a) Each booth shall have at least one viewing device which will:

(1) Be so placed that the operator can view the patient during any exposure, and

(2) The device shall be so placed that the operator can have full view of any occupant of the room and should be so placed that the operator can view any entry into the room. If any door which allows access to the room cannot be seen from the booth, then outside that door there shall be an "X-ray" warning sign that will be lighted anytime the rotor of the X-ray tube is activated. Alternatively, that door must have an interlock controlling the exposure which will prevent the exposure if the door is not closed.

(b) When the viewing system is a window, the following requirements also apply:

(1) The viewing area shall be at least 1 square foot (0.0929 m<sup>2</sup>).

(2) Regardless of size or shape, at least 0.09 m<sup>2</sup> (1 sq ft) of window area must be centered no less than 0.6 m (2 feet) from the open edge of the booth and no less than 1.5 m (5.0 feet) from the floor.

(3) The material constituting the window shall have the same lead equivalence as that required in the booth's wall in which it is mounted.

(c) When the viewing system is by mirrors, the mirror(s) shall be so located as to accomplish the general requirements of Appendix B, 4(a).

(d) When the viewing system is by electronic means:

(1) The camera shall be so located as to accomplish the general requirements of Appendix B, 4(a), and

(2) There shall be an alternate viewing system as a backup for the primary system.

## CHAPTER 41—APPENDIX C

INFORMATION TO BE SUBMITTED BY PERSONS  
PROPOSING TO CONDUCT HEALING  
ARTS SCREENING

Persons requesting that the agency approve a healing arts screening program shall submit the following information and evaluation:

1. Name and address of the applicant and, where applicable, the names and addresses of agents within this state.

2. Diseases or conditions for which the X-ray examinations are to be used in diagnoses.

3. A detailed description of the X-ray examinations proposed in the screening program.

4. Description of the population to be examined in the screening program, i.e., age, sex, physical condition, and other appropriate information. Any person conducting a screening program for cardiac scoring shall conduct screening only on either women over age 45 or men over age 50 who meet any two of the following criteria: family history, smoker, high blood pressure, high cholesterol, obesity (at least 20 pounds overweight), diabetes.

5. An evaluation of any known alternate methods not involving ionizing radiation which could achieve the goals of the screening program and why these methods are not used instead of the X-ray examinations.

6. An evaluation by a qualified expert of the X-ray system(s) to be used in the screening program. The evaluation by the qualified expert shall show that such system(s) does satisfy all requirements of these regulations. The evaluation shall include a measurement of patient exposures from the X-ray examinations to be performed.

7. A description of the diagnostic film quality control program.

8. A copy of the technique chart for the X-ray examination procedures to be used.

9. The qualifications of each individual who will be operating the X-ray system(s).

10. The qualifications of the individual who will be supervising the operators of the X-ray system(s). The extent of supervision and the method of work performance evaluation shall be specified.

11. The name and address of the physician who will interpret the radiograph(s) and a copy of the physician's license to practice in Iowa.

12. A description of the procedures to be used in advising the individuals screened and their private practitioners of the healing arts of the results of the screening procedure and any further medical needs indicated.

13. A description of the procedures for the retention or disposition of the radiographs and other records pertaining to the X-ray examinations.

14. An indication of the frequency of screening and the duration of the entire screening program.

15. Documentation justifying the reason for the screening. The applicant must submit data which supports the efficacy of the screening test in diagnosing the disease or condition being screened. Data which will be acceptable to the department includes, but is not limited to, the following: (1) the recommendation of a nationally recognized certifying medical or government body; (2) the recommendation of one of the following national organizations: American Cancer Association, American Lung Association, American Heart Association; or (3) medical literature from peer-reviewed journals supporting the screening.

16. The procedures for preventing pregnant individuals from participating in the screening or justification for allowing pregnant individuals to participate.

17. The dates of the screening to include beginning and ending dates.

18. A copy of IRB for a research project or information justifying the research project.

## CHAPTER 41—APPENDIX D

## QA for Therapeutic Radiation Machines

Frequency	Procedure	Tolerance <sup>a</sup>
Daily	<u>Dosimetry</u>	
	X-ray output constancy	3%
	Electron output constancy <sup>b</sup>	3%
	<u>Mechanical</u>	
	Localizing lasers	2mm
	Distance indicator (ODI)	2mm
	<u>Safety</u>	
	Door interlocks	functional
	Audiovisual monitors	functional
	Monthly	<u>Dosimetry</u>
X-ray output constancy <sup>c</sup>		2%
Electron output constancy <sup>c</sup>		2%
Backup monitor constancy		2%
X-ray central axis dosimetry parameter (PDD, TAR) constancy		2%
Electron central axis dosimetry parameter constancy (PDD)		2mm @ therapeutic depth
X-ray beam flatness constancy		2%
Electron beam flatness constancy		3%
X-ray and electron symmetry		3%
<u>Safety Interlocks</u>		
Wedge, electron cone interlocks		functional
<u>Mechanical</u>		
Light/radiation field coincidence		2mm or 1% on a side <sup>d</sup>
Gantry/collimator angle indicators		1 degree
Wedge position		2mm (or 2% change in transmission factor)
Tray position		2mm
Applicator position		2mm
Field size indicators		2mm
Cross-hair centering		2mm diameter
Treatment couch position indicators		2mm/1deg
Latching of wedges, blocking tray		functional
Jaw symmetry <sup>e</sup>	2mm	
Field Light intensity	functional	
Annual	<u>Dosimetry</u>	
	X-ray/electron output calibration constancy	2%
	Field size dependence of X-ray output constancy	2%

<sup>a</sup> The tolerances listed in the tables should be interpreted to mean that if a parameter either: (1) exceeds the tabulated value (e.g., the measured isocenter under the gantry exceeds 2 mm diameter); or (2) that the change in the parameter exceeds the nominal value (e.g., the output changes by more than 2%), then an action is required. The distinction is emphasized by the use of the term constancy for the latter case. Moreover, for constancy, percent values  $\pm$  the deviation of the parameter with respect to its nominal value; distances are referenced to the isocenter or nominal SSD.

<sup>b</sup> All electron energies need not be checked daily, but all electron energies are to be checked at least twice weekly.

<sup>c</sup> A constancy check with a field instrument using temperature pressure corrections.

<sup>d</sup> Whichever is greater. Should also be checked after change of light field source.

<sup>e</sup> Jaw symmetry is defined as the difference in distance of each jaw from the isocenter.

Frequency	Procedure	Tolerance <sup>a</sup>
	Output factor constancy for electron applicators	2%
	Central axis parameter constancy (PDD, TAR)	2%
	Off-axis factor constancy	2%
	Transmission factor constancy for all treatment accessories	2%
	Wedge transmission factor constancy <sup>f</sup>	2%
	Monitor chamber linearity	1%
	X-ray output constancy vs. gantry angle	2%
	Electron output constancy vs. gantry angle	2%
	Off-axis factor constancy vs. gantry angle	2%
	Arc mode	Mfrs. specs.
	<u>Safety Interlocks</u>	
	Follow manufacturer's test procedures	functional
	<u>Mechanical</u>	
	Collimator rotation isocenter	2mm diameter
	Gantry rotation isocenter	2mm diameter
	Couch rotation isocenter	2mm diameter
	Coincidence of collimetry, gantry, couch axes with isocenter	2mm diameter
	Coincidence of radiation and mechanical isocenter	2mm diameter

<sup>f</sup> Most wedges' transmission factors are field size and depth dependent.

<sup>a</sup> The tolerances listed in the tables should be interpreted to mean that if a parameter either: (1) exceeds the tabulated value (e.g., the measured isocenter under the gantry exceeds 2 mm diameter); or (2) that the change in the parameter exceeds the nominal value (e.g., the output changes by more than 2%), then an action is required. The distinction is emphasized by the use of the term constancy for the latter case. Moreover, for constancy, percent values  $\pm$  the deviation of the parameter with respect to its nominal value; distances are referenced to the isocenter or nominal SSD.

## CHAPTER 41—APPENDIX E

INFORMATION ON RADIATION SHIELDING REQUIRED  
FOR PLAN REVIEWS FOR THERAPY MACHINES

## I. All therapeutic radiation machines.

A. Basic facility information including: name, telephone number and agency registration number of the individual responsible for preparation of the shielding plan; name and telephone number of the facility supervisor; and the street address (including room number if applicable) of the external beam radiation therapy facility. The plan should also indicate whether this is a new structure or a modification to existing structure(s).

B. All wall, floor, and ceiling areas struck by the useful beam shall have primary barriers.

C. Secondary barriers shall be provided in all wall, floor, and ceiling areas not having primary barriers.

## II. Therapeutic machines up to 150 kV (photons only).

In addition to the requirements listed in Section I above, therapeutic radiation machine facilities which produce only photons with a maximum energy less than or equal to 150 kV shall submit shielding plans which contain, as a minimum, the following additional information:

A. Equipment specifications, including the manufacturer and model number of the therapeutic radiation machine, as well as the maximum technique factors.

B. Maximum design workload for the facility including total weekly radiation output (expressed in gray (rad) or air kerma at one meter), total beam-on time per day or week, the average treatment time per patient, along with the anticipated number of patients to be treated per day or week.

C. A facility blueprint/drawing indicating: scale (0.25 inch = 1 foot is typical); direction of north; normal location of the therapeutic radiation machine's radiation port(s); the port's travel and traverse limits; general direction(s) of the useful beam; locations of any windows and doors; and the location of the therapeutic radiation machine control panel. If the control panel is located inside the external beam radiation therapy treatment room, the location of the operator's booth shall be noted on the plan and the operator's station at the control panel shall be behind a protective barrier sufficient to ensure compliance with 641—40.15(136C).

D. The structural composition and thickness or lead/concrete equivalent of all walls, doors, partitions, floor, and ceiling of the room(s) concerned.

E. The type of occupancy of all adjacent areas inclusive of space above and below the room(s) concerned. If there is an exterior wall, show distance to the closest area(s) where it is likely that individuals may be present.

F. At least one example calculation which shows the methodology used to determine the amount of shielding required for each physical condition (i.e., primary and secondary leakage barriers, restricted and unrestricted areas, entry door(s)) and shielding material in the facility.

(1) If commercial software is used to generate shielding requirements, identify the software used and the version/revision date.

(2) If the software used to generate shielding requirements is not in the open literature, submit quality control sample calculations to verify the result obtained with the software.

## III. Therapeutic radiation machines over 150 kV.

In addition to the requirements listed in Section I above, therapeutic radiation machine facilities which produce photons or electrons with a maximum energy in excess of 150 kV or electrons shall submit shielding plans which contain, as a minimum, the following additional information:

A. Equipment specifications including the manufacturer and model number of the therapeutic radiation machine, and gray (rad) at the isocenter and the energy(s) and type(s) of radiation produced (i.e., photon, electron). The target to isocenter distance shall be specified.

B. Maximum design workload for the facility including total weekly radiation output (expressed in gray (rad) at one meter), total beam-on time per day or week, the average treatment time per patient, along with the anticipated number of patients to be treated per day or week.

C. Facility blueprint/drawing (including both floor plan and elevation views) indicating relative orientation of the therapeutic radiation machine, scale (0.25 inch = 1 foot is typical), type(s), thickness and minimum density of shielding material(s), direction of north, the locations and size of all penetrations through each shielding barrier (ceiling, walls and floor), as well as details of the door(s) and maze.

D. The structural composition and thickness or concrete equivalent of all walls, doors, partitions, floor, and ceiling of the room(s) concerned.

E. The type of occupancy of all adjacent areas inclusive of space above and below the room(s) concerned. If there is an exterior wall, show distance to the closest area(s) where it is likely that individuals may be present.

F. Description of all assumptions that were in shielding calculations including, but not limited to, design energy (i.e., room may be designed for 6 MV unit although only a 4 MV unit is currently proposed), workload, presence of integral beam-stop in unit, occupancy and use(s) of adjacent areas, fraction of time that useful beam will intercept each permanent barrier (walls, floor and ceiling) and “allowed” radiation exposure in both restricted and unrestricted areas.

G. At least one example calculation which shows the methodology used to determine the amount of shielding required for each physical condition (i.e., primary and secondary leakage barriers, restricted and unrestricted areas, small angle scatter, entry door(s) and maze) and shielding material in the facility.

(1) If commercial software is used to generate shielding requirements, also identify the software used and the version/revision date.

(2) If the software used to generate shielding requirements is not in the open literature, submit quality control sample calculations to verify the result obtained with the software.

#### IV. Neutron shielding.

In addition to the requirements listed in Section III above, therapeutic radiation machine facilities which are capable of operating above 10 MV shall submit shielding plans which contain, as a minimum, the following additional information:

A. The structural composition, thickness, minimum density and location of all neutron shielding material.

B. Description of all assumptions that were used in neutron shielding calculations including, but not limited to, neutron spectra as a function of energy, neutron fluency rate, absorbed dose and dose equivalent (due to neutrons) in both restricted and unrestricted areas.

C. At least one example calculation which shows the methodology used to determine the amount of neutron shielding required for each physical condition (i.e., restricted and unrestricted areas, entry door(s) and maze) and neutron shielding material utilized in the facility.

(1) If commercial software is used to generate shielding requirements, also identify the software used and the version/revision date.

(2) If the software used to generate shielding requirements is not in the open literature, submit quality control sample calculations to verify the result obtained with the software.

D. The method(s) and instrumentation which will be used to verify the adequacy of all neutron shielding installed in the facility.

#### V. References.

A. NCRP Report 49, “Structural Shielding Design and Evaluation for Medical Use of X-Rays and Gamma Rays of Energies Up to 10 MeV” (1976).

B. NCRP Report 51, “Radiation Protection Design Guidelines for 0.1-100 MeV Particle Accelerator Facilities” (1977).

C. NCRP Report 79, “Neutron Contamination from Medical Electron Accelerator” (1984).

D. NCRP Report 144, “Radiation Protection for Particle Accelerator Facilities” (2003).

These rules are intended to implement Iowa Code chapter 136C.

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<sup>◇</sup> Two or more ARCs

CHAPTER 70  
LEAD-BASED PAINT ACTIVITIES

**641—70.1(135) Applicability.** This chapter applies to all persons who are lead professionals in Iowa, all firms that perform lead professional activities in Iowa, and training providers that offer training for lead professionals. This chapter requires lead professionals and firms to be certified and establishes specific requirements for how lead-based paint activities must be performed if a property owner, manager, or occupant chooses to undertake them. However, nothing in this chapter requires a property owner, manager, or occupant to undertake any particular lead-based paint activity. This chapter also provides for the approval of courses that provide training for lead professionals.

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**641—70.2(135) Definitions.**

*“Adequate quality control”* means a plan or design which ensures the authenticity, integrity, and accuracy of samples, including dust, soil, and paint chip or paint film samples. Adequate quality control also includes provisions for representative sampling.

*“Approved course”* means a course that has been approved by the department for the training of lead professionals.

*“Approved lead-safe work practices training program”* means a lead-safe work practices training program that has been approved by the department.

*“Arithmetic mean”* means the algebraic sum of data values divided by the number of data values. For example, the sum of the concentration of lead in several soil samples divided by the number of samples is the arithmetic mean.

*“Certified elevated blood lead (EBL) inspection agency”* means an agency that has met the requirements of 641—70.5(135) and that has been certified by the department.

*“Certified elevated blood lead (EBL) inspector/risk assessor”* means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

*“Certified firm”* means a firm that employs certified lead professionals and has met the requirements of 641—70.7(135) for certification and has been certified by the department.

*“Certified lead abatement contractor”* means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

*“Certified lead abatement worker”* means a person who has met the requirements of 641—70.5(135) and who has been certified by the department.

*“Certified lead inspector/risk assessor”* means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

*“Certified lead professional”* means a person who has been certified by the department as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, lead abatement worker, project designer, sampling technician, or lead-safe renovator.

*“Certified lead-safe renovator”* means a person who has met the requirements of 641—70.5(135) for certification and who has been certified by the department.

*“Certified project designer”* means a person who has met the requirements of 641—70.5(135) for certification or interim certification and who has been certified by the department.

*“Certified sampling technician”* means a person who has met the requirements of 641—70.5(135) and who has been certified by the department.

*“Chewable surface”* means an interior or exterior surface painted with lead-based paint that a young child can mouth or chew.

*“Child-occupied facility”* means a building, or portion of a building, constructed prior to 1978, that is described by all of the following: (1) The building is visited on a regular basis by the same child, who is less than six years of age, on at least two different days within any week. For purposes of this chapter, a week is a Sunday through Saturday period. (2) Each day’s visit by the child lasts at least 3 hours, and the combined annual visits total at least 60 hours. A child-occupied facility may include, but

is not limited to a child care center, preschool, or kindergarten classroom. A child-occupied facility also includes common areas that are routinely used by children who are less than six years of age, such as restrooms and cafeterias, and the exterior walls and adjoining space of the building that are immediately adjacent to the child-occupied facility or the common areas routinely used by children under the age of six years. "Child-occupied facility" also includes any building where lead-based paint activities are conducted immediately prior to or during the conversion of the building to a child-occupied facility.

"*Cleaning verification card*" means a card developed and distributed, or otherwise approved, by the U.S. Environmental Protection Agency (EPA) for the purpose of determining, through comparison of wet and dry disposable cleaning cloths with the card, whether postrenovation cleaning has been properly completed.

"*Clearance level*" means the value at which the amount of lead in dust on a surface following completion of interim controls, lead abatement, paint stabilization, standard treatments, ongoing lead-based paint maintenance, rehabilitation, or renovation is a dust-lead hazard and fails clearance testing. The clearance level for a single-surface dust sample from a floor is greater than or equal to 40 micrograms per square foot. The clearance level for a single-surface dust sample from an interior windowsill is greater than or equal to 250 micrograms per square foot. The clearance level for a single-surface dust sample from a window trough is greater than or equal to 400 micrograms per square foot.

"*Clearance testing*" means an activity conducted following interim controls, lead abatement, paint stabilization, standard treatments, ongoing lead-based paint maintenance, rehabilitation, or renovation to determine that the hazard reduction activities are complete. Clearance testing includes a visual assessment, the collection and analysis of environmental samples, the interpretation of sampling results, and the preparation of a report.

"*Common area*" means a portion of the building that is generally accessible to all occupants. This includes, but is not limited to, hallways, stairways, laundry and recreational rooms, porches, exteriors, playgrounds, community centers, garages, and boundary fences.

"*Common area group*" means a group of common areas that are similar in design, construction, and function. Common area groups include, but are not limited to, hallways, stairwells, and laundry rooms.

"*Component*" or "*building component*" means specific design or structural elements or fixtures of a building, residential dwelling, or child-occupied facility that are distinguished from each other by form, function, and location. These include, but are not limited to, interior components such as ceilings, crown moldings, walls, chair rails, doors, door trim, floors, fireplaces, radiators and other heating units, shelves, shelf supports, stair treads, stair risers, stair stringers, newel posts, railing caps, balustrades, windows and trim (including sashes, window heads, jambs, sills or stools and troughs), built-in cabinets, columns, beams, bathroom vanities, countertops, and air conditioners; and exterior components such as painted roofing, chimneys, flashing, gutters and downspouts, ceilings, soffits, fascias, rake boards, cornerboards, bulkheads, doors and door trim, fences, floors, joists, latticework, railings and railing caps, siding, handrails, stair risers and treads, stair stringers, columns, balustrades, windowsills or stools and troughs, casings, sashes and wells, and air conditioners. Each side of a door is considered a component within its respective room.

"*Component type*" means a group of like components constructed of the same substrate in the same multifamily housing. For example, "wood door" is a component type.

"*Composite sample*" means the collection of more than one sample of the same medium (e.g., dust, soil, or paint) from the same type of surface (e.g., floor, interior windowsill, or window trough) such that multiple samples can be analyzed as a single sample.

"*Concentration*" means the relative content of a specific substance contained within a larger mass, such as the amount of lead (in micrograms per grams or parts per million of weight) in a sample of soil or dust.

"*Containment*" means a system of temporary barriers to protect workers, residents, and the environment by controlling exposures to the dust-lead hazards and debris created during renovation or lead abatement.

“*Course agenda*” means an outline of the key topics to be covered during a training course, including the time allotted to teach each topic.

“*Course test*” means an evaluation of the overall effectiveness of the training which shall test the trainees’ knowledge and retention of the topics covered during the course.

“*Course test blueprint*” means written documentation identifying the proportion of course test questions devoted to each major topic in the course curriculum.

“*Department*” means the Iowa department of public health.

“*Deteriorated paint*” means any interior or exterior paint or other coating that is cracking, flaking, chipping, peeling, or chalking, or any paint or coating located on an interior or exterior surface that is otherwise damaged or separated from the substrate of a building component.

“*Discipline*” means one of the specific types or categories of lead-based paint activities identified in this chapter for which individuals may receive training from approved courses and become certified by the department. For example, “lead inspector/risk assessor” is a discipline, and “lead-safe renovator” is a discipline.

“*Distinct painting history*” means the application history, as indicated by its visual appearance or a record of application, over time, of paint or other surface coatings to a component or room.

“*Documented methodologies*” means methods or protocols used to sample for the presence of lead in paint, dust, and soil.

“*Dripline*” means the area within three feet surrounding the perimeter of a building.

“*Dry disposable cleaning cloth*” means a commercially available dry, electrostatically charged, white disposable cloth designed to be used for cleaning hard surfaces such as uncarpeted floors or countertops.

“*Dry sanding*” means sanding a surface that is partially coated with paint or other surface coating without moisture and includes hand and mechanical methods of sanding.

“*Dry scraping*” means scraping a surface that is partially coated with paint or other surface coating without moisture and includes hand and mechanical methods of scraping.

“*Dust-lead hazard*” means surface dust in residential dwellings or child-occupied facilities that contains a mass-per-area concentration of lead greater than or equal to 40 micrograms per square foot on floors, 250 micrograms per square foot on interior windowsills, and 400 micrograms per square foot on window troughs based on wipe samples. A dust-lead hazard is present in a residential dwelling or child-occupied facility when the weighted arithmetic mean lead loading for all single-surface or composite samples of floors and interior windowsills is greater than or equal to 40 micrograms per square foot on floors, 250 micrograms per square foot on interior windowsills, and 400 micrograms per square foot on window troughs based on wipe samples. A dust-lead hazard is present on floors, interior windowsills, or window troughs in an unsampled residential dwelling in a multifamily dwelling if a dust-lead hazard is present on floors, interior windowsills, or window troughs, respectively, in at least one sampled residential unit on the property. A dust-lead hazard is present on floors, interior windowsills, or window troughs in an unsampled common area in a multifamily dwelling if a dust-lead hazard is present on floors, interior windowsills, or window troughs, respectively, in at least one sampled common area in the same common area group on the property.

“*Elevated blood lead (EBL) child*” means any child who has had one venous blood lead level greater than or equal to 20 micrograms per deciliter or at least two venous blood lead levels of 15 to 19 micrograms per deciliter.

“*Elevated blood lead (EBL) inspection*” means an inspection to determine the sources of lead exposure for an elevated blood lead (EBL) child and the provision within ten working days of a written report explaining the results of the investigation to the property owner and occupant of the residential dwelling or child-occupied facility being inspected and to the parents of the elevated blood lead (EBL) child. A certified elevated blood lead (EBL) inspector/risk assessor shall not determine that a residential dwelling is free of lead-based paint as a result of an elevated blood lead (EBL) inspection.

“*Elevated blood lead (EBL) inspection agency*” means an agency that employs or contracts with individuals who perform elevated blood lead (EBL) inspections. Elevated blood lead (EBL) inspection agencies may also employ or contract with individuals who perform other lead-based paint activities.

*“Emergency renovation”* means renovation, remodeling, or repainting activities necessitated by nonroutine failures of equipment or of a structure that were not planned but resulted from a sudden, unexpected event that, if not immediately attended to, presents a safety or public health hazard or threatens equipment or property with significant damage. “Emergency renovation” includes interim controls, renovation, remodeling, or repainting activities that are conducted in response to an elevated blood lead (EBL) inspection.

*“Encapsulant”* means a substance that forms a barrier between lead-based paint and the environment using a liquid-applied coating (with or without reinforcement materials) or an adhesively bonded coating material.

*“Encapsulation”* means the application of an encapsulant.

*“Enclosure”* means the use of rigid, durable construction materials that are mechanically fastened to the substrate in order to act as a barrier between lead-based paint and the environment.

*“Firm”* means a company, partnership, corporation, sole proprietorship, individual doing business, association, or other business entity; a federal, state, tribal, or local government agency; or a nonprofit organization that performs or offers to perform lead-based paint activities.

*“Friction surface”* means an interior or exterior surface that is subject to abrasion or friction including, but not limited to, certain window, floor, and stair surfaces.

*“Guest instructor”* means an individual designated by the training program manager or principal instructor to provide instruction specific to the lecture, hands-on work activities, or work practice components of a course.

*“Hands-on skills assessment”* means an evaluation which tests the trainees’ ability to satisfactorily perform the work practices and procedures identified in 641—70.6(135), as well as any other skill taught in a training course.

*“Hazardous lead-based paint”* means lead-based paint that is present on a friction surface where there is evidence of abrasion or where the dust-lead level on the nearest horizontal surface underneath the friction surface (e.g., the windowsill or floor) is greater than or equal to the dust-lead hazard level, lead-based paint that is present on an impact surface that is damaged or otherwise deteriorated from impact, lead-based paint that is present on a chewable surface, or any other deteriorated lead-based paint in any residential building or child-occupied facility or on the exterior of any residential building or child-occupied facility.

*“Hazardous waste”* means any waste as defined in 40 CFR 261.3.

*“HEPA exhaust control”* means a HEPA vacuum attached to the machine in such a manner that it captures the air, dust, and debris disturbed by the machine.

*“HEPA vacuum”* means a vacuum cleaner which has been designed, operated, and maintained with a high-efficiency particulate air (HEPA) filter as the last filtration stage. A HEPA filter is a filter that is capable of capturing particles of 0.3 microns with 99.97 percent efficiency. The vacuum cleaner must be designed, operated, and maintained so that all of the air drawn into the machine is expelled through the HEPA filter with none of the air leaking past it. HEPA vacuums must be operated and maintained in accordance with the manufacturer’s instructions.

*“Housing for the elderly”* means retirement communities or similar types of housing reserved for households composed of one or more persons 62 years of age or older or an age recognized as elderly by a specific federal housing assistance program.

*“Immediate family”* means spouse, parents and grandparents, children and grandchildren, brothers and sisters, mother-in-law and father-in-law, brothers-in-law and sisters-in-law, daughters-in-law and sons-in-law, and adopted and step family members.

*“Impact surface”* means an interior or exterior surface that is subject to damage by repeated sudden force such as certain parts of door frames.

*“Inconclusive classification”* means any XRF reading falling within the inconclusive range on the performance characteristic sheet, including the boundary values defining the range.

*“Interim controls”* means a set of measures designed to temporarily reduce human exposure or likely exposure to lead-based paint hazards, including repairing deteriorated lead-based paint, specialized cleaning, maintenance, painting, temporary containment, ongoing monitoring of lead-based

paint hazards or potential hazards, and the establishment and operation of management and resident education programs.

*“Interior windowsill”* means the portion of the horizontal window ledge that protrudes into the interior of the room.

*“Lead abatement”* means any measure or set of measures designed to permanently eliminate lead-based paint hazards in a residential dwelling or child-occupied facility. Lead abatement includes, but is not limited to, (1) the removal of lead-based paint and dust-lead hazards, the permanent enclosure or encapsulation of lead-based paint, the replacement of lead-painted surfaces or fixtures, and the removal or covering of soil-lead hazards and (2) all preparation, cleanup, disposal, repainting or refinishing, and postabatement clearance testing activities associated with such measures. “Lead abatement” specifically includes projects for which there is a written contract or other documentation, which provides that an individual will be conducting lead abatement in or around a residential dwelling or child-occupied facility.

In addition, “lead abatement” includes, but is not limited to, (1) projects for which there is a written contract or other document, which provides that an individual will be conducting activities in or to a residential dwelling or child-occupied facility that shall result in or are designed to permanently eliminate lead-based paint hazards, (2) projects resulting in the permanent elimination of lead-based paint hazards that are conducted by firms or individuals certified under 641—70.5(135), (3) projects resulting in the permanent elimination of lead-based paint hazards that are conducted by firms or individuals who, through their company name or promotional literature, represent, advertise, or hold themselves out to be in the business of performing lead abatement, and (4) projects resulting in the permanent elimination of lead-based paint that are conducted in response to a lead abatement order. However, in the case of items (1) through (4) of this definition, “lead abatement” does not include renovation, remodeling, landscaping, or other activities, when such activities are not designed to permanently eliminate lead-based paint hazards, but, instead, are designed to repair, restore, or remodel a given structure or dwelling, even though these activities may incidentally result in a reduction or elimination of lead-based paint hazards. Furthermore, “lead abatement” does not include interim controls, operations and maintenance activities, renovation, or other measures and activities designed to temporarily, but not permanently, reduce lead-based paint hazards.

*“Lead-based paint”* means paint or other surface coatings that contain lead greater than or equal to 1.0 milligram per square centimeter or greater than 0.5 percent by weight. Lead-based paint is present on any surface that is tested and found to contain lead greater than or equal to 1.0 milligram per square centimeter or greater than 0.5 percent by weight and on any surface like a surface tested in the same room equivalent that has a similar painting history and that is found to be lead-based paint.

*“Lead-based paint activities”* means, in the case of target housing and child-occupied facilities, lead-free inspection, lead inspection, elevated blood lead (EBL) inspection, lead hazard screen, risk assessment, lead abatement, visual risk assessment, clearance testing conducted after lead abatement, clearance testing conducted after renovation, clearance testing conducted after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35, and renovation.

*“Lead-based paint hazard”* means hazardous lead-based paint, a dust-lead hazard, or a soil-lead hazard.

*“Lead-based paint hazard reduction activity”* means an activity that permanently or temporarily reduces or eliminates lead-based paint hazards. “Lead-based paint hazard reduction activity” includes lead abatement, renovation, or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35.

*“Lead-free inspection”* means an inspection to determine whether a single dwelling unit or multifamily housing is free of lead-based paint and qualifies for the exemption in 24 CFR Part 35 and 40 CFR Part 745 for target housing being leased that is free of lead-based paint and the provision of a written report explaining the results of the lead-free inspection and options for reducing lead-based paint hazards to the property owner and to the person requesting the lead inspection.

*“Lead hazard screen”* means a limited risk assessment activity that involves limited paint and dust sampling and the provision of a written report explaining the results of the lead hazard screen to the property owner and to the person requesting the lead hazard screen.

*“Lead inspection”* means a surface-by-surface investigation to determine the presence of lead-based paint and a determination of the existence, nature, severity, and location of lead-based paint hazards in a residential dwelling or child-occupied facility and the provision of a written report explaining the results of the investigation and options for reducing lead-based paint hazards to the property owner and to the person requesting the lead inspection. A certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall not determine that a residential dwelling is free of lead-based paint as a result of a lead inspection.

*“Lead professional”* means a person who conducts lead abatement, renovation, lead inspections, elevated blood lead (EBL) inspections, lead hazard screens, risk assessments, visual risk assessments, clearance testing after lead abatement, clearance testing after renovation, paint testing, or clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35.

*“Lead-safe work practices”* means methods that are used to minimize hazards when conducting renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35.

*“Lead-safe work practices training program”* means an 8-hour training program that provides training on how to work safely with lead-based paint.

*“Living area”* means any area of a residential dwelling used by at least one child under the age of six years, including, but not limited to, living rooms, kitchen areas, dens, playrooms, and children’s bedrooms.

*“Loading”* means the quantity of a specific substance present per unit of surface area, such as the amount of lead in micrograms contained in the dust collected from a certain surface area divided by the surface area in square feet or square meters.

*“Mid-yard”* means an area of a residential yard approximately midway between the dripline of a residential building and the nearest property boundary or between the driplines of a residential building and another building on the same property.

*“Minor repair and maintenance activities”* means activities, including minor heating, ventilation or air-conditioning work, electrical work, and plumbing, that disrupt less than the minimum areas of a painted surface established in this definition where none of the work practices prohibited or restricted by this chapter are used and where the work does not involve window replacement or demolition of painted surface areas. When painted components or portions of painted components are removed, the entire surface area removed is the amount of painted surface disturbed. Projects, other than emergency renovation, performed in the same room within the same 30 days must be considered the same project for the purpose of determining whether the project is a minor repair and maintenance activity. Renovations performed in response to an elevated blood lead (EBL) inspection are not considered minor repair and maintenance activities. The minimum area for minor repair and maintenance activities is:

1. Less than 1.0 square foot of an interior painted or finished wood surface per renovation;
2. Less than 6.0 square feet of a painted or finished drywall or plaster surface per room; or
3. Less than 20.0 square feet of an exterior painted or finished surface per renovation.

Projects performed pursuant to 24 CFR Part 35 shall comply with the de minimis levels in 24 CFR 35.1350 if these de minimis levels are more restrictive than the minimum areas of a painted surface established in this definition.

*“Multifamily dwelling”* means a structure that contains more than one separate residential dwelling unit, which is used or occupied, or intended to be used or occupied, in whole or in part, as the home or residence of one or more persons.

*“Multifamily housing”* means one or more multifamily dwellings that are under the same ownership or management.

*“Negative classification”* means any value defined by the performance characteristics sheet as indicating that lead-based paint is not present.

“*NIST 1.02 standard film*” means the National Institute of Standards and Technology 1.02 milligrams of lead per square centimeter standard reference material. If the specific 1.02 milligrams of lead per square centimeter standard is not available from NIST, then the lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the closest available standard from NIST (1.0X).

“*Occupant protection plan*” means a plan developed by a certified lead abatement contractor prior to the commencement of lead abatement in a residential dwelling or child-occupied facility that describes the measures and management procedures that will be taken during lead abatement to protect the building occupants from exposure to any lead-based paint hazards.

“*Ongoing lead-based paint maintenance*” means the maintenance of housing pursuant to 24 CFR Part 35.

“*Painted component*” means a component or building component that is at least partially covered with paint or other surface coating.

“*Paint-lead hazard*” means the presence of hazardous lead-based paint in a residential dwelling or a child-occupied facility.

“*Paint sample*” means a sample collected in a representative location using ASTM E1729, “Standard Practice for Field Collection of Dried Paint Samples for Lead Determination by Atomic Spectrometry Techniques,” or equivalent method.

“*Paint stabilization*” means repairing any physical defect in the substrate of a painted surface that is causing paint deterioration, removing loose paint and other material from the surface to be treated, and applying a new protective coating or paint pursuant to 24 CFR Part 35.

“*Paint testing*” means the process of determining the presence or the absence of lead-based paint on a specific component or surface. Paint testing shall only be conducted by certified lead inspector/risk assessors or certified elevated blood lead (EBL) inspector/risk assessors using approved methods for testing. Approved methods for paint testing are XRF analysis and laboratory analysis.

“*Performance characteristics sheet (PCS)*” means an information sheet developed by the U.S. Environmental Protection Agency and U.S. Department of Housing and Urban Development that defines acceptable operating specifications and procedures for a specific model of X-ray fluorescence analyzer (XRF). The PCS contains information about XRF readings taken on specific substrates, calibration check tolerances, interpretation of XRF readings, and other aspects of the model’s performance.

“*Permanently covered soil*” means soil which has been separated from human contact by the placement of a barrier consisting of solid, relatively impermeable materials, such as pavement or concrete. Grass, mulch, and other landscaping materials are not considered permanent covering.

“*Play area*” means an area of frequent soil contact by children of less than six years of age as indicated by, but not limited to, factors including the following: the presence of play equipment (sandboxes, swing sets, and sliding boards), toys, or other children’s possessions, observations of play patterns, or information provided by parents, residents, caregivers, or property owners.

“*Positive classification*” means any value defined by the performance characteristics sheet as indicating the presence of lead-based paint.

“*Postrenovation cleaning verification*” means the use of a wet or dry disposable cleaning cloth to wipe the interior windowsill, window trough, uncarpeted floor, and countertops of the renovation work area and the comparison of the cloth to a cleaning verification card to determine if the work area has been adequately cleaned.

“*Principal instructor*” means the individual who has the primary responsibility for organizing and teaching a particular course.

“*Random selection*” means a method of choosing residential dwellings from multifamily housing consisting of similarly constructed and maintained residential dwellings such that each residential dwelling has an equal chance of being selected.

“*Recognized laboratory*” means an environmental laboratory recognized by the U.S. Environmental Protection Agency pursuant to Section 405(b) of the federal Toxic Substance Control Act as capable of performing an analysis for lead compounds in paint, soil, and dust.

“*Recognized test kit*” means a commercially available kit recognized by the EPA under 40 CFR 745.88 as being capable of allowing a user to determine the presence of lead at levels equal to or in

excess of 1.0 milligrams per square centimeter, or more than 0.5 percent by weight, in a paint chip, paint, powder, or painted surface.

*“Reduction”* means measures designed to reduce or eliminate human exposure to lead-based paint hazards through methods including interim controls and lead abatement.

*“Reevaluation”* means a visual assessment of painted surfaces and limited dust and soil sampling conducted periodically following a lead-based paint hazard reduction activity where lead-based paint is still present and the provision of a written report explaining the results of the reevaluation.

*“Refresher training course”* means a course taken by a certified lead professional to maintain certification in a particular discipline.

*“Regulated entity”* means any lead professional or firm that is regulated by the department by virtue of these rules, the Iowa Code, certification documents, approval documents, lead abatement notices, or other official regulatory promulgation.

*“Rehabilitation”* means the improvement of an existing structure through alterations, incidental additions, or enhancements. Rehabilitation includes repairs necessary to correct the results of deferred maintenance, the replacement of principal fixtures and components, improvements to increase the efficient use of energy, and installation of security devices.

*“Renovation”* means the modification of any existing structure, or portion thereof, that results in the disturbance of painted surfaces, unless that activity is performed as part of lead abatement as defined by this chapter. The term “renovation” includes, but is not limited to, the removal, modification, or repair of painted surfaces or painted components such as modification of painted doors, surface restoration, and window repair; surface preparation activity such as sanding, scraping, or other such activities that may generate paint dust; the partial or complete removal of building components such as walls, ceilings, and windows; weatherization projects such as cutting holes in painted surfaces to install blown-in insulation or to gain access to attics and planing thresholds to install weatherstripping; and interim controls that disturb painted surfaces. “Renovation” does not include minor repair and maintenance activities.

*“Residential building”* means a building containing one or more residential dwellings.

*“Residential dwelling”* means (1) a detached single-family dwelling unit, including the surrounding yard, attached structures such as porches and stoops, and detached buildings and structures including, but not limited to, garages, farm buildings, and fences, or (2) a single-family dwelling unit in a structure that contains more than one separate residential dwelling unit, which is used or occupied, or intended to be used or occupied, in whole or part, as the home or residence of one or more persons.

*“Risk assessment”* means an investigation to determine the existence, nature, severity, and location of lead-based paint hazards in a residential dwelling or child-occupied facility and the provision of a written report explaining the results of the investigation and options for reducing lead-based paint hazards to the property owner and to the person requesting the risk assessment.

*“Room”* means a separate part of the inside of a building, such as a bedroom, living room, dining room, kitchen, bathroom, laundry room, or utility room. To be considered a separate room, the room must be separated from adjoining rooms by built-in walls or archways that extend at least six inches from an intersecting wall. Half walls or bookcases count as room separators if built-in. Movable or collapsible partitions or partitions consisting solely of shelves or cabinets are not considered built-in walls. A screened-in porch that is used as a living area is a room. Each exterior side of the house is considered a separate room.

*“Soil-lead hazard”* means bare soil on residential real property or on the property of a child-occupied facility that contains total lead greater than or equal to 400 parts per million for the dripline, mid-yard, and play areas. A soil-lead hazard is present in a dripline, mid-yard, or play area when the soil-lead concentration from a composite sample of bare soil is greater than or equal to 400 parts per million.

*“Soil sample”* means a sample collected in a representative location using ASTM E1727, “Standard Practice for Field Collection of Soil Samples by Atomic Spectrometry Techniques,” or equivalent method.

*“Standard treatments”* means a series of hazard reduction measures designed to reduce all lead-based paint hazards in a residential dwelling without the benefit of a risk assessment or other evaluation pursuant to 24 CFR Part 35. Standard treatments consist of the stabilization of all deteriorated

interior and exterior paint, the provision of smooth and cleanable horizontal hard surfaces, the correction of dust-generating conditions (i.e., conditions causing rubbing, binding, or crushing of surfaces known to or presumed to be coated with lead-based paint), and the treatment of bare soil to control known or presumed soil-lead hazards.

*“State certification examination”* means a discipline-specific examination approved by the department to test the knowledge of a person who has completed an approved training course and is applying for certification in a particular discipline. The state certification examination may not be administered by the provider of an approved course.

*“Substrate”* means the material underneath the paint or finish on a surface. Substrates are classified as brick, concrete, drywall, metal, plaster, or wood.

*“Substrate correction”* means adjustments that must be made to readings obtained from some X-ray fluorescence analyzers to correct for systematic biases due to interference from the substrate beneath the paint.

*“Substrate correction value”* means the value that is used to adjust readings obtained from some X-ray fluorescence analyzers to correct for systematic biases due to interference from the substrate beneath the paint.

*“Targeted selection”* means selecting residential dwellings from multifamily housing for risk assessments or lead hazard screens using information supplied by the property owner.

*“Target housing”* means housing constructed prior to 1978 with the exception of housing for the elderly or for persons with disabilities and housing which does not contain a bedroom, unless at least one child under the age of six years resides or is expected to reside in the housing for the elderly or persons with disabilities or housing which does not contain a bedroom. Target housing also includes any nonresidential building where lead-based paint activities are conducted prior to or during the conversion of the nonresidential building to target housing.

*“Testing combination”* means the unique combination of the room, component, substrate, and distinct painting history.

*“Training hour”* means at least 50 minutes of actual learning, including, but not limited to, time devoted to lecture, learning activities, small group activities, demonstrations, evaluations, or hands-on experience.

*“Training manager”* means the individual responsible for administering an approved course and monitoring the performance of principal instructors and guest instructors.

*“Training program”* means a person or organization sponsoring a lead professional training course(s).

*“Visual inspection for clearance testing”* means the visual examination of a residential dwelling or a child-occupied facility following lead abatement or following interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR 35.1340 to determine whether or not the lead abatement, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation has been successfully completed.

*“Visual risk assessment”* means a visual assessment to determine the presence of deteriorated paint or other potential sources of lead-based paint hazards in a residential dwelling or child-occupied facility and the provision of a written report explaining the results of the assessment to the property owner and to the person requesting the visual risk assessment. For the purpose of compliance with this chapter, housing quality standards inspections conducted in housing owned by a public housing authority and housing that is receiving tenant-based rental assistance from a public housing authority are not considered visual risk assessments.

*“Weighted arithmetic mean”* means the arithmetic mean of sample results weighted by the number of subsamples in each sample. Its purpose is to give influence to a sample relative to the surface area it represents. A single surface dust sample is comprised of a single dust subsample. A composite dust sample may contain from two to four dust subsamples of the same area as each other and of each single surface dust sample in the composite. The weighted arithmetic mean is obtained by summing, for all dust samples, the product of the dust sample’s result multiplied by the number of dust subsamples in the dust sample, and dividing the sum by the total number of dust subsamples contained in all dust samples.

For example, the weighted arithmetic mean of a single surface dust sample containing 60 micrograms per square foot ( $\mu\text{g}/\text{ft}^2$ ), a composite dust sample (three dust subsamples) containing 100  $\mu\text{g}/\text{ft}^2$ , and a composite dust sample (four dust subsamples) containing 110  $\mu\text{g}/\text{ft}^2$  is 100  $\mu\text{g}/\text{ft}^2$ . This result is based on the equation  $[60+(3\times 100)+(4\times 110)] / (1+3+4)$ .

*“Wet disposable cleaning cloth”* means a commercially available, premoistened white disposable cloth designed to be used for cleaning hard surfaces such as uncarpeted floors or countertops.

*“Wet mopping system”* means a device with the following characteristics: a long handle, a mop head designed to be used with disposable absorbent cleaning pads, a reservoir for cleaning solution, and a built-in mechanism for distributing or spraying the cleaning solution onto a floor, or a method of equivalent efficiency.

*“Wet sanding”* means a process of removing loose paint in which a surface that is partially coated with paint or other surface coating is kept wet or moist during sanding to minimize the dispersal of paint chips and airborne dust.

*“Wet scraping”* means a process of removing loose paint in which a surface that is partially coated with paint or other surface coating is kept wet or moist during scraping to minimize the dispersal of paint chips and airborne dust.

*“Windowsill”* means the portion of the horizontal window ledge that protrudes into the interior of the room when the window is closed.

*“Window trough”* means, for a typical double-hung window, the portion of the exterior windowsill between the interior windowsill (or stool) and the frame of the storm window. If there is no storm window, the window trough is the area that receives both the upper and lower window sashes when they are both lowered. The window trough is sometimes referred to as the window well.

*“Wipe sample”* means a sample collected by wiping a representative surface of known area, as determined by ASTM E1728, “Standard Practice for Field Collection of Settled Dust Samples Using Wipe Sampling Methods for Lead Determination by Atomic Spectrometry Techniques,” or equivalent method, with an acceptable wipe material as defined in ASTM E1792, “Standard Specification for Wipe Sampling Materials for Lead in Surface Dust.” The minimum area for a floor wipe sample shall be 0.50 square feet or 72 square inches. The minimum area for a windowsill wipe sample and for a window trough wipe sample shall be 0.25 square feet or 36 square inches.

*“Worksite”* or *“work area”* means an interior or exterior area where lead-based paint hazard reduction activity or renovation takes place. There may be more than one worksite in a dwelling unit or at a residential property.

*“Worst case selection”* means conducting a walk-through survey of all residential dwellings in the multifamily housing to select the highest-risk residential dwellings for risk assessments or lead hazard screens.

*“X-ray fluorescence analyzer (XRF)”* means an instrument that determines lead concentrations in milligrams per square centimeter ( $\text{mg}/\text{cm}^2$ ) using the principle of X-ray fluorescence.

*“XRF reading”* means the number obtained when a surface is tested with an X-ray fluorescence analyzer.

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 0482C, IAB 12/12/12, effective 1/16/13; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.3(135) Lead professional certification.** A person or a firm shall not conduct lead abatement, renovation, clearance testing after lead abatement, lead-free inspections, lead inspections, elevated blood lead (EBL) inspections, lead hazard screens, risk assessments, visual risk assessments, clearance testing after renovation, or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35 unless the person or firm has been certified by the department in the appropriate discipline. However, persons who perform these activities within residential dwellings that they own are not required to be certified, unless the residential dwelling is occupied by a person other than the owner or a member of the owner’s immediate family while these activities are being performed. In addition, elevated blood lead (EBL) inspections shall be conducted only by certified elevated blood lead (EBL) inspector/risk assessors employed by or under contract with

a certified elevated blood lead (EBL) inspection agency. In addition, persons who perform renovation under the supervision of a certified lead-safe renovator, certified lead abatement contractor, or certified lead abatement worker and who have completed on-the-job training are not required to be certified. However, on-the-job training does not meet the training requirement for work conducted pursuant to 24 CFR Part 35. Lead professionals and firms shall not state that they have been certified by the state of Iowa unless they have met the requirements of 641—70.5(135) and been issued a current certificate by the department. Elevated blood lead (EBL) inspection agencies must be certified by the department. Elevated blood lead (EBL) inspection agencies shall not state that they have been certified by the state of Iowa unless they have met the requirements of 641—70.5(135) and been issued a current certificate by the department.

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.4(135) Course approval and standards.** All lead professional training courses for initial certification and refresher training must be approved by the department. Training programs shall not state that they have been approved by the state of Iowa unless they have met the requirements of 641—70.4(135) and been approved by the department.

**70.4(1)** Training courses shall meet the following requirements:

*a.* The training program offering the course shall employ a training manager who has the following qualifications:

(1) A bachelor's or graduate degree in building construction technology, engineering, industrial hygiene, safety, public health, or a related field; or two years of experience in managing a training program specializing in environmental hazards.

(2) Demonstrated experience, education, or training in lead professional activities, including lead inspection, lead abatement, lead-safe work practices, painting, carpentry, renovation, remodeling, occupational safety and health, or industrial hygiene.

*b.* The training manager shall designate a qualified principal instructor for each course who has the following qualifications:

(1) Demonstrated experience, education, or training in teaching workers or adults.

(2) Certification as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, or lead abatement contractor. In the case of a course for training lead-safe renovators, the principal instructor may be certified as a sampling technician.

(3) Demonstrated experience, education, or training in lead professional activities, including lead inspection, lead abatement, lead-safe work practices, painting, carpentry, renovation, remodeling, occupational safety and health, or industrial hygiene.

*c.* The principal instructor shall be responsible for the organization of the course and oversight of the teaching of all course material. The training manager may designate guest instructors as needed to provide instruction specific to the lecture, hands-on activities, or work practice components of a course.

*d.* The training program shall ensure the availability of, and provide adequate facilities for, the delivery of the lecture, course test, hands-on training, and assessment activities. This includes providing training equipment that reflects current work practices and maintaining or updating the equipment as needed.

*e.* The training manager shall maintain the validity and integrity of the hands-on skills assessment to ensure that it accurately evaluates the trainees' performance of the work practices and procedures associated with the course topics contained in subrules 70.4(3) to 70.4(17).

*f.* The training manager shall maintain the validity and integrity of the course test to ensure that it accurately evaluates the trainees' knowledge and retention of the course topics.

*g.* The course test shall be developed in accordance with the test blueprint submitted with the course approval application.

*h.* The training program shall issue unique course completion certificates to each student who passes the course. The course completion certificate shall be issued in color. The course completion certificate shall include:

(1) The first name, last name and middle initial of the student.

- (2) The address of the student.
- (3) A photograph of the student, and a unique identification number.
- (4) The name of the particular course that the student completed and the course length in hours.
- (5) Dates of course completion and test passage.
- (6) The name, address, and telephone number of the training program.
- (7) The signature of the training manager.

*i.* The training manager shall develop and implement a quality control plan. The plan shall be used to maintain and improve the quality of the training program over time. This plan shall contain at least the following elements:

(1) Procedures for periodic revision of training materials and the course test to reflect changes in regulations and recommended practices.

(2) Procedures for the training manager to conduct an annual review of the competency of the principal instructor and all other instructors.

*j.* The training program shall offer courses that teach the work practice standards for conducting lead-based paint activities contained in 641—70.6(135) and other standards developed by the department. These standards shall be taught in the appropriate courses to provide trainees with the knowledge needed to perform the lead-based paint activities they are responsible for conducting.

*k.* The training manager shall ensure that each course meets the requirements in this rule for the number of training hours and hours of hands-on training. The training manager shall ensure that any student who misses more than 20 minutes of class time makes up the time before taking the course test.

*l.* The training manager shall ensure that the training program complies at all times with all requirements in this rule.

*m.* The training manager shall allow the department to audit the training program to verify the contents of the application for approval and for reapproval.

*n.* The training program shall maintain, and make available to the department, upon request, the following records:

(1) All documents specified in paragraph 70.4(2) “*f.*”

(2) Current curriculum/course materials and documents reflecting any changes made to these materials.

(3) The course test blueprint and the course test.

(4) Information regarding how the hands-on assessment is conducted including, but not limited to, who conducts the assessment, how the skills are graded, what facilities are used, and the pass/fail rate.

(5) The quality control plan as described in paragraph 70.4(1) “*i.*”

(6) A file for each student who has completed a course. Each student file shall contain the following:

1. The student’s name, address, and telephone number.

2. The student’s test and answer sheet.

3. A copy of the student’s course completion certificate.

4. A copy of the student’s hands-on skill assessment, if applicable.

5. A photograph of the student as taken by the training program.

(7) A file for each individual course that has been offered. Each file shall include the following:

1. The dates of the course.

2. The location of the course.

3. The instructors who taught the course.

4. A paper or electronic copy of the curriculum used for the course.

5. A copy of the test used for the course.

6. Documentation of the times that each student was present at the course, including documentation of how a student made up missed time.

7. The course evaluations.

(8) Any other materials that have been submitted to the department as part of the program’s application for approval.

*o.* The training program shall retain all required records at the address specified on the training program approval application for a minimum of six years.

*p.* The training program shall notify the department in writing within 30 days of changing the address specified on its training program approval application or transferring the records from that address.

*q.* A training program shall notify the department in writing at least 7 days in advance of offering an approved course. The notification shall include the date(s), time(s), and location(s) where the approved course will be held. A training program shall notify the department at least 24 hours in advance of canceling an approved course.

*r.* The training program shall take a digital photograph of each student. The digital photograph shall be the same photograph that appears on the training certificate and is submitted to the department. The photograph shall meet the following specifications:

- (1) The individual shall be facing the camera.
- (2) The individual's head shall not be tilted.
- (3) The individual's head shall cover approximately half of the photo area.
- (4) The individual shall be in front of a neutral or light-colored background.
- (5) The individual shall not wear any items that detract from the face, such as hats or sunglasses.

Only head coverings worn for religious reasons may be worn. Religious head coverings may not cover the face of the individual.

- (6) Photographs shall be 24-bit color depth.

*s.* A training program shall roster each student who has taken the approved course into a database specified by the department. All students shall be rostered into the department database within 20 days of conclusion of an approved course. Rostering shall include:

- (1) Name and address.
- (2) Course completion certificate number.
- (3) Test score.
- (4) The photograph of each student as taken by the training program in a format specified by the department.

**70.4(2)** If a training program desires approval of a course by the department, the training program shall apply to the department for approval at least 90 days before the initial offering of the course. The department may allow courses to be offered sooner if the department completes the approval in less than 90 days. The application shall include:

- a.* Training program name, contact person, address, e-mail address, and telephone number.
- b.* Course for which approval is sought.
- c.* Course locations, including a description of the facilities and equipment to be used for lecture and hands-on training.
- d.* Course agenda, including approximate times allotted to each training segment.
- e.* A copy of each reference material, text, student manual, instructor manual, and audiovisual material used in the course.

*f.* The name(s) and qualifications of the training manager, principal instructor(s), and guest instructor(s). The following documents shall be submitted as evidence that training managers and principal instructors have the education, work experience, training requirements, or demonstrated experience required by subrule 70.4(1):

- (1) Official transcripts or diplomas as evidence of meeting the education requirements.
- (2) Résumés, letters of reference, or documentation of work experience, as evidence of meeting the work experience requirements.
- (3) Certificates from lead-specific training courses, as evidence of meeting the training requirements.

*g.* A copy of the course test blueprint.

*h.* A description of the activities and procedures that will be used for conducting the assessment of hands-on skills for each course.

*i.* Maximum class size.

*j.* A copy of the quality control plan for the course.

*k.* A nonrefundable fee of \$200.

**70.4(3)** To be approved for the training of lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors, a course must be at least 40 training hours with a minimum of 12 hours devoted to hands-on training activities. Lead inspector/risk assessor and elevated blood lead (EBL) inspector/risk assessor training courses shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a. Role and responsibilities of an inspector/risk assessor.
- b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.
- c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.
- d. Lead-based paint inspection methods, including selection of rooms and components for sampling or testing to determine if a property is free of lead-based paint as specified in the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing ((2012), U.S. Department of Housing and Urban Development), and methods to determine if lead-based paint hazards are present in a property.\*
- e. Paint, dust, and soil sampling methodologies.\*
- f. Clearance standards and testing, including random sampling.\*
- g. Collection of background information to perform a risk assessment.
- h. Sources of environmental lead contamination such as paint, surface dust and soil, and water.
- i. Visual inspection to identify lead-based paint hazards.\*
- j. Lead hazard screen protocol.
- k. Visual risk assessment protocol.
- l. Reevaluation protocol.
- m. In the case of renovation, procedures for using recognized test kits to determine whether paint is lead-based paint.\*
- n. In the case of renovation, methods to ensure that the renovation has been properly completed, including postrenovation cleaning verification and clearance testing.\*
- o. Sampling for other sources of lead exposure.\*
- p. Interpretation of lead-based paint and other lead sampling results, including all applicable federal, state, and local guidance or regulations pertaining to lead-based paint hazards.\*
- q. Development of lead hazard control options.
- r. The role of interim controls, operation and maintenance activities, and renovation in reducing lead-based paint hazards.
- s. Approved methods for conducting lead-based paint abatement, interim controls, operation and maintenance activities, and renovation.
- t. Prohibited methods for conducting lead-based paint abatement, interim controls, operation and maintenance activities, and renovation.
- u. Interior dust abatement and cleanup.
- v. Soil and exterior dust abatement and cleanup.
- w. Preparation of the final reports for lead inspections, lead-free inspections, risk assessments, visual assessments, lead hazard screens, clearance testing after lead abatement, clearance testing after renovation, reevaluation, and clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR Part 35.
- x. Record keeping.
- y. The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.
- z. The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the

department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*aa.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(4)** To be approved for the training of lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors who have already completed an approved sampling technician course, a course must be at least 20 training hours with a minimum of 8 hours devoted to hands-on training activities. The training course shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

*a.* Role and responsibilities of a lead inspector/risk assessor and elevated blood lead (EBL) inspector/risk assessor.

*b.* Lead-based paint inspection methods, including selection of rooms and components for sampling or testing to determine if a property is free of lead-based paint as specified in the work practice standards in 641—70.6(135), and methods to determine if lead-based paint hazards are present in a property.\*

*c.* Collection of background information to perform a risk assessment.

*d.* Lead hazard screen protocol.

*e.* Reevaluation protocol.

*f.* Sampling for other sources of lead exposure.\*

*g.* Interpretation of lead-based paint and other lead sampling results, including all applicable federal, state, and local guidance or regulations pertaining to lead-based paint hazards.\*

*h.* Development of lead hazard control options, including lead abatement.\*

*i.* The role of interim controls, operation and maintenance activities, and renovation in reducing lead-based paint hazards.

*j.* Approved methods for conducting lead abatement, interim controls, operation and maintenance activities, and renovation.

*k.* Prohibited methods for conducting lead abatement, interim controls, operation and maintenance activities, and renovation.

*l.* Preparation of the final reports for lead inspections, lead-free inspections, risk assessments, lead hazard screens, reevaluation, and clearance testing after lead abatement.

*m.* Record keeping.

*n.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*o.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*p.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(5)** Rescinded IAB 3/31/04, effective 5/5/04.

**70.4(6)** Rescinded IAB 3/31/04, effective 5/5/04.

**70.4(7)** Rescinded IAB 3/31/04, effective 5/5/04.

**70.4(8)** To be approved for the training of lead abatement contractors, a course must be at least 40 training hours with a minimum of 12 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a. Role and responsibilities of a lead abatement contractor.
- b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.
- c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.
- d. Liability and insurance issues relating to lead abatement, interim controls, and renovation.
- e. Identification of lead-based paint and lead-based paint hazards.\*
- f. Interpretation of lead inspection reports.\*
- g. Development and implementation of an occupant protection plan, lead abatement report, and renovation report.
- h. Respiratory protection and protective clothing.\*
- i. Employee information and training.
- j. Approved methods for conducting lead abatement, interim controls, and renovation.\*
- k. Prohibited methods for conducting lead abatement, interim controls, and renovation.
- l. Interior dust abatement and cleanup.\*
- m. Soil and exterior dust abatement and cleanup.\*
- n. Clearance standards and testing, including random sampling.
- o. Cleanup, waste handling, and waste disposal.
- p. In the case of renovation, interior and exterior containment and cleanup methods.\*
- q. In the case of renovation, providing on-the-job training to other workers.\*
- r. In the case of renovation, procedures for using recognized test kits to determine whether paint is lead-based paint, including preparation of the required report.\*
- s. In the case of renovation, methods to ensure that the renovation has been properly completed, including postrenovation cleaning verification and clearance testing.\*
- t. In the case of renovation, record preparation and record keeping.
- u. Record keeping for lead abatement.
- v. The course shall conclude with a course test and, if applicable, a hands-on skills assessment.

The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

w. The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

x. All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(9)** To be approved for the training of lead abatement contractors who have already completed an approved lead abatement worker course, a course must be at least 16 training hours with a minimum of 4 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a. Role and responsibilities of a lead abatement contractor.
- b. Liability and insurance issues relating to lead abatement.
- c. Interpretation of lead inspection reports.\*
- d. Development and implementation of an occupant protection plan and abatement report.
- e. Employee information and training.
- f. Clearance standards and testing, including random sampling.
- g. Record keeping for lead abatement.

*h.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*i.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*j.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(10)** To be approved for the training of lead abatement workers, a course must be at least 24 training hours with a minimum of 8 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a.* Role and responsibilities of a lead abatement worker.
- b.* Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.
- c.* Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.
- d.* Identification of lead-based paint and lead-based paint hazards.\*
- e.* Approved methods for conducting lead abatement, interim controls, and renovation.\*
- f.* Prohibited methods for conducting lead abatement, interim controls, and renovation.
- g.* Interior dust abatement and cleanup.\*
- h.* Soil and exterior dust abatement and cleanup.\*
- i.* Cleanup, waste handling, and waste disposal.
- j.* Respiratory protection and protective clothing.\*
- k.* Personal hygiene.
- l.* In the case of renovation, interior and exterior containment and cleanup methods.\*
- m.* In the case of renovation, providing on-the-job training to other workers.\*
- n.* In the case of renovation, procedures for using recognized test kits to determine whether paint is lead-based paint, including preparation of the required report.\*
- o.* In the case of renovation, methods to ensure that the renovation has been properly completed, including postrenovation cleaning verification and clearance testing.\*
- p.* In the case of renovation, record preparation and record keeping.
- q.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment.

The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*r.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*s.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(11)** To be approved for the training of sampling technicians, a course must be at least 20 training hours with a minimum of 4 hours devoted to hands-on training activities. The training course shall cover

at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a. Role and responsibilities of a sampling technician.
- b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.
- c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.
- d. Methods of conducting visual risk assessments.\*
- e. Paint, dust, and soil sampling methodologies.\*
- f. In the case of renovation, procedures for using recognized test kits to determine whether paint is lead-based paint.\*
- g. Clearance standards and testing.\*
- h. Identification of lead-based paint hazards.\*
- i. Sources of environmental lead contamination such as paint, surface dust and soil, and water.
- j. Visual inspection to identify lead-based paint hazards.\*
- k. Approved methods for conducting lead abatement, interim controls, operation and maintenance activities, and renovation.
- l. Prohibited methods for conducting lead abatement, interim controls, operation and maintenance activities, and renovation.
- m. Methods of interim controls and lead abatement for interior dust and cleanup.
- n. Methods of interim controls and lead abatement for exterior dust and soil and cleanup.
- o. Preparation of the final visual assessment report.
- p. Preparation of clearance testing reports for clearance testing after renovation and clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR Part 35.
- q. Record keeping.
- r. The course shall conclude with a course test and, if applicable, a hands-on skills assessment.

The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

s. The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

t. All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(12)** To be approved for the training of project designers, a course must be at least 48 instructional training hours with a minimum of 12 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a. Role and responsibilities of a lead abatement contractor.
- b. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.
- c. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint and lead-based paint activities.
- d. Liability and insurance issues relating to project design.
- e. Identification of lead-based paint and lead hazards.\*
- f. Interpretation of lead inspection reports.\*

- g.* Development and implementation of an occupant protection plan, lead abatement report, and renovation report.
- h.* Respiratory protection and protective clothing.\*
- i.* Employee information and training.
- j.* Approved methods for conducting lead abatement, interim controls, and renovation.\*
- k.* Prohibited methods for conducting lead abatement, interim controls, and renovation.
- l.* Interior dust abatement and cleanup.\*
- m.* Soil and exterior dust abatement and cleanup.\*
- n.* Clearance standards and testing, including random sampling.
- o.* Cleanup, waste handling, and waste disposal.
- p.* In the case of renovation, providing on-the-job training to other workers.\*
- q.* In the case of renovation, procedures for using recognized test kits to determine whether paint is lead-based paint, including preparation of the required report.\*
- r.* In the case of renovation, methods to ensure that the renovation has been properly completed, including postrenovation cleaning verification and clearance testing.\*
- s.* In the case of renovation, record preparation and record keeping.
- t.* Record keeping for lead abatement.
- u.* Role and responsibilities of a project designer.
- v.* Development and implementation of an occupant protection plan for large-scale lead abatement projects.
- w.* Lead abatement and lead hazard reduction methods, including restricted practices for large-scale lead abatement projects.
- x.* Interior dust abatement/cleanup or lead hazard control and reduction methods for large-scale lead abatement projects.
- y.* Clearance standards and testing for large-scale lead abatement projects.
- z.* Integration of lead abatement methods with modernization and rehabilitation projects for large-scale lead abatement projects.
- aa.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.
- ab.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.
- ac.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(13)** To be approved for the training of project designers who have already completed an approved lead abatement contractor course, a course must be at least 8 instructional training hours and shall cover at least the following subjects:

- a.* Role and responsibilities of a project designer.
- b.* Development and implementation of an occupant protection plan for large-scale abatement projects.
- c.* Lead abatement and lead hazard reduction methods, including restricted practices for large-scale lead abatement projects.
- d.* Interior dust abatement/cleanup or lead hazard control and reduction methods for large-scale lead abatement projects.
- e.* Clearance standards and testing for large-scale lead abatement projects.

*f.* Integration of lead abatement methods with modernization and rehabilitation projects for large-scale lead abatement projects.

*g.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*h.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*i.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(14)** To be approved for the training of project designers who have already completed an approved lead abatement worker course, a course must be at least 24 instructional training hours with a minimum of 4 hours devoted to hands-on activities and shall cover at least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a.* Role and responsibilities of a lead abatement contractor.
- b.* Liability and insurance issues relating to lead abatement.
- c.* Interpretation of lead inspection reports.\*
- d.* Development and implementation of an occupant protection plan and lead abatement report.
- e.* Employee information and training.
- f.* Clearance standards and testing, including random sampling.
- g.* Record keeping.
- h.* Role and responsibilities of a project designer.
- i.* Development and implementation of an occupant protection plan for large-scale lead abatement projects.

*j.* Lead abatement and lead hazard reduction methods, including restricted practices for large-scale lead abatement projects.

*k.* Interior dust abatement/cleanup or lead hazard control and reduction methods for large-scale lead abatement projects.

*l.* Clearance standards and testing for large-scale lead abatement projects.

*m.* Integration of lead abatement methods with modernization and rehabilitation projects for large-scale lead abatement projects.

*n.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*o.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*p.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(15)** To be approved for the training of lead-safe renovators, a course must be at least 8 instructional training hours with a minimum of 2 hours devoted to hands-on activities and shall cover at

least the following subjects (requirements ending in an asterisk (\*) indicate areas that require hands-on activities as an integral component of the course):

- a. Background information on lead and its adverse health effects, how children and adults are exposed to lead, and how to prevent lead exposure in children and adults.
- b. Background information on federal, state, and local regulations and guidance that pertain to lead-based paint, lead-based paint activities, and renovation activities.
- c. Procedures for using recognized test kits to determine whether paint is lead-based paint, including preparation of the required report.\*
- d. Renovation methods to minimize the creation of dust and lead-based paint hazards.\*
- e. Prohibited methods of renovation.
- f. Interior and exterior containment and cleanup methods.\*
- g. Methods to ensure that the renovation has been properly completed, including postrenovation cleaning verification and clearance testing.\*
- h. Waste handling and disposal.
- i. Providing on-the-job training to other workers.\*
- j. Record preparation and record keeping.
- k. The course shall conclude with a course test and, if applicable, a hands-on skills assessment.

The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*l.* The instructor shall provide an introduction of the online certification system used by the department. The instructor shall advise each student on the procedures needed to apply to the department for certification and provide information to each student on the procedures needed for taking the state certification examination. The instructor shall also provide each student with a current copy of this chapter and 641—Chapter 69.

*m.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(16)** To be approved for refresher training of sampling technicians, lead abatement contractors, lead abatement workers, and project designers, a course must be at least 8 training hours. To be approved for refresher training of lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors who completed an approved 24-hour training course, a course must be at least 8 training hours to meet the recertification requirements of subrule 70.5(3). To be approved for refresher training of lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors to meet the recertification requirements of subrule 70.5(6), a course must be at least 16 training hours. To be approved for refresher training of lead-safe renovators, a course must be at least 4 hours and must include a hands-on component. All refresher training courses shall cover at least the following topics:

- a. A review of the curriculum topics of the initial certification course for the appropriate discipline as listed in subrules 70.4(3) to 70.4(15).
- b. An overview of current safety practices relating to lead-based paint activities in general, as well as specific information pertaining to the appropriate discipline.
- c. Current laws and regulations relating to lead-based paint activities in general, as well as specific information pertaining to the appropriate discipline.
- d. Current technologies relating to lead-based paint activities in general, as well as specific information pertaining to the appropriate discipline.

*e.* The course shall conclude with a course test and, if applicable, a hands-on skills assessment. The student must achieve a score of at least 80 percent on the examination and successfully complete the hands-on skills assessment to successfully complete the course. The student may take the course test no more than three times within six months of completing the course. If an individual does not pass the course test within six months of completing the course, the individual must retake the appropriate approved course.

*f.* All of the course materials must be provided to each student. The materials may be provided electronically unless an individual student requests that the materials be provided on paper.

**70.4(17)** Approvals of training courses shall expire three years after the date of issuance. The training manager shall submit the following at least 30 days prior to the expiration date for a course to be reapproved:

- a.* Sponsoring organization name, contact person, address, and telephone number.
- b.* A list of the courses for which reapproval is sought.
- c.* A description of any changes to the training staff, facility, equipment, or course materials since the approval of the training program.
- d.* A statement signed by the training manager stating that the training program complies at all times with 641—70.4(135).
- e.* A nonrefundable fee of \$200.

**70.4(18)** The department shall consider a request for approval of a training course that has been approved by a state or tribe authorized by the U.S. Environmental Protection Agency.

- a.* The course shall be approved if it meets the requirements of 641—70.4(135).
- b.* If the course does not meet all of the requirements of 641—70.4(135), the department shall inform the training provider of additional topics and training hours that are needed to meet the requirements of 641—70.4(135).

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.5(135) Certification, interim certification, and recertification.** The department shall issue certifications and recertifications for a three-year time period. All applications for certification or recertification may be made to the department electronically in a format specified by the department or may be made to the department using a paper application supplied by the department.

**70.5(1)** A person wishing to become a certified lead professional shall provide the following information:

- a.* A completed application form.
- b.* A certificate of completion of an approved course for the discipline in which the applicant wishes to become certified.
- c.* If wishing to become a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor, documentation of successful completion of the manufacturer's training course or equivalent for the X-ray fluorescence (XRF) analyzer that the inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor will use to conduct lead inspections.
- d.* If wishing to become a certified elevated blood lead (EBL) inspector/risk assessor, documentation of successful completion of 8 hours of training from the department's childhood lead poisoning prevention program. This training shall cover the roles and responsibilities of an elevated blood lead (EBL) inspector/risk assessor and the environmental and medical case management of elevated blood lead (EBL) children.
- e.* Documentation that the applicant meets the additional experience and education requirements in subrule 70.5(2) for the discipline in which the applicant wishes to become certified. The following documents shall be submitted as evidence that the applicant has the education and work experience required by subrule 70.5(2):
  - (1) Official transcripts or diplomas as evidence of meeting the education requirements.
  - (2) Résumés, letters of reference, or documentation of work experience, as evidence of meeting the work experience requirements.
- f.* To become certified as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, or project designer, a certificate showing that the applicant has passed the state certification examination in the discipline in which the applicant wishes to become certified.
- g.* A \$180 nonrefundable fee.
- h.* A person may receive interim certification from the department as a lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, or project designer by submitting the items required by paragraphs 70.5(1) "a" to "e" and "g" to the department.

Interim certification shall expire six months from the date of completion of an approved course. An applicant shall upgrade an interim certification to a certification by submitting a certificate to the department showing that the applicant has passed the state certification examination as required by paragraph 70.5(1)“f.” Interim certification is equivalent to certification.

**70.5(2)** To become certified by the department as a lead professional, an applicant must meet the education and experience requirements for the appropriate discipline:

*a.* Lead inspector/risk assessors and elevated blood lead (EBL) inspector/risk assessors must meet one of the following requirements:

(1) Bachelor’s degree and one year of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(2) Associate’s degree and two years of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(3) High school diploma and three years of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(4) Certification as an industrial hygienist, professional engineer, registered architect, registered sanitarian, registered environmental health specialist, or registered nurse.

*b.* Lead abatement contractors must meet one of the following requirements:

(1) One year of experience as a certified lead abatement worker.

(2) Two years of related experience or education (e.g., lead, housing inspection, building trades, property management and maintenance).

*c.* No additional education or experience is required for lead abatement workers.

*d.* Sampling technicians must meet one of the following requirements:

(1) Associate’s degree.

(2) High school diploma and one year of related experience (e.g., lead, environmental health, public health, housing inspection, building trades).

(3) Certification as an industrial hygienist, professional engineer, registered architect, registered sanitarian, registered environmental health specialist, or registered nurse.

*e.* Project designers must meet one of the following requirements:

(1) Bachelor’s degree in engineering, architecture, or a related profession, and one year of experience in building construction and design or a related field.

(2) Four years of experience in building construction and design or a related field.

*f.* No additional education or experience is required for lead-safe renovators.

**70.5(3)** and **70.5(4)** Reserved.

**70.5(5)** All agencies that perform or offer to perform elevated blood lead (EBL) inspections must be approved by the department. An agency wishing to become an approved elevated blood lead (EBL) inspection agency shall apply in a format specified by the department. The agency must submit:

*a.* A completed application form.

*b.* Documentation that the agency has the authority to require the repair of lead hazards identified through an elevated blood lead (EBL) inspection.

*c.* Documentation that the agency employs or has contracted with a certified elevated blood lead (EBL) inspector/risk assessor to provide environmental case management of all elevated blood lead (EBL) children in the agency’s service area, including follow-up to ensure that lead-based paint hazards identified as a result of elevated blood lead (EBL) inspections are corrected, and that lead-based paint activities will be conducted only by appropriately certified lead professionals. In addition, the agency must document that the agency and its employees or contractors will follow the work practice standards in 641—70.6(135) for conducting lead-based paint activities.

*d.* A statement that the approved elevated blood lead (EBL) inspection agency will maintain all records required by subrule 70.6(12).

**70.5(6)** Individuals applying for recertification as lead professionals must submit the following:

*a.* A completed application form.

*b.* A \$180 nonrefundable fee.

c. A certificate showing that the applicant has successfully completed an approved refresher training course for the appropriate discipline. The refresher training course must be completed no more than three years prior to the date of the application for recertification.

**70.5(7)** The department shall approve the state certification examinations for the disciplines of lead inspector/risk assessor, elevated blood lead (EBL) inspector/risk assessor, lead abatement contractor, and project designer. The state certification examination shall be administered by selected community college testing centers in Iowa. A community college testing center shall set the fee for administering the state certification examination to each applicant and shall collect the fee from each applicant.

a. An individual must achieve a score of at least 80 percent on the examination. An individual may take the state certification examination no more than three times within six months of receiving a certificate of completion from an approved course.

b. If an individual does not pass the state certification examination within six months of receiving a certificate of completion from an approved course, the individual must retake the appropriate approved course before reapplying for certification.

**70.5(8)** Reciprocity. Each applicant for certification who is certified in any of the disciplines specified in this rule in another state may request reciprocal certification. The department shall evaluate the requirements for certification to determine that the requirements for certification in such other state are as protective of health and the environment as the requirements for certification in Iowa. For all disciplines except lead-safe renovator and lead abatement worker, if the department determines that the requirements for certification in such other state are as protective of health and the environment as the requirements for certification in Iowa, the applicant may be certified after passing a proctored test covering Iowa-specific lead information with a score of at least 80 percent. For a lead-safe renovator and lead abatement worker, if the department determines that the requirements for certification in such other state are as protective of health and the environment as the requirements for certification in Iowa, the applicant may be certified after signing a statement indicating that the applicant has read and understands Iowa-specific lead information provided by the department. Each applicant for certification pursuant to this subrule shall submit the appropriate application accompanied by the fee for each discipline as specified in 641—70.5(135).

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.6(135) Work practice standards for lead professionals conducting lead-based paint activities in target housing and child-occupied facilities.** All lead-based paint activities shall be performed according to the work practice standards in 641—70.6(135), and a certified individual must perform that activity in compliance with the appropriate requirements below.

**70.6(1)** A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct a lead-free inspection according to the following standards. A lead-free inspection shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

a. When conducting a lead-free inspection in a residential dwelling, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following procedures:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test paint in each room, including each exterior side.

(2) Except for components known to have been replaced after December 31, 1977, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test each testing combination in each room. On windows, the window frame, interior windowsill, window sash, and window trough shall each be considered a separate testing combination. Except for walls, one sample shall be taken for each testing combination in a room. Each wall in a room shall be tested. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall require one of the following two types of evidence to determine that components were replaced after 1977:

1. Detailed specifications showing which components were to be replaced, restored, enclosed, or encapsulated and evidence that the work was actually completed such as receipts for building materials,

city building records showing a date of remodeling, or a final inspection by the city or another inspector showing that the work was actually completed.

2. A certification under penalty of perjury per Iowa Code section 622.1 from the contractor who did the work or from the person(s) who owned the property at the time outlining all of the components that were removed and replaced.

If one of these two types of evidence is not available, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test the component.

(3) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall note any components where lead-based paint has been enclosed or encapsulated. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not make a determination that the residential dwelling is lead-free where components that are painted with lead-based paint have been enclosed or encapsulated.

(4) Paint shall be tested using adequate quality control by X-ray fluorescence (XRF) or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

1. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

2. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use standards provided by the manufacturer and the NIST 1.02 standard film for calibration of the X-ray fluorescence analyzer.

3. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection, every four hours, and at the end of the inspection.

4. Prior to taking the final set of calibration readings and if recommended by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface and take three XRF readings with the XRF used to conduct the inspection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16.

5. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated

blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint.

6. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If instructed by the property owner or the person requesting the report, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume that inconclusive readings are positive, but shall not assume that inconclusive readings are negative.

7. As described by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct retesting of 10 surfaces, calculate the retest tolerance limit, and determine whether the inspection meets the retest tolerance limit. If the retest tolerance limit is not met, then this procedure shall be repeated with 10 additional surfaces. If the retest tolerance limit is not met with the 20 retested surfaces, then all results of the inspection shall be considered invalid.

(5) If each testing combination in the residential dwelling is found to be free of lead-based paint, then the residential dwelling is free of lead-based paint. If any surface in the residential dwelling is found to be painted with lead-based paint, then the residential dwelling is not free of lead-based paint.

(6) If lead-based paint is identified through a lead-free inspection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards including bare soil in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated.

(7) A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a lead-free inspection is completed. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the lead-free inspection, if different. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no less than three years. The report shall include, at least:

1. A statement that the inspection was conducted to determine whether the residential dwelling is free of lead-based paint;
2. Date of inspection;
3. Address of building;
4. Date of construction;
5. Apartment numbers (if applicable);
6. The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;
7. Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the inspection;
8. Name and certification number of the certified firm(s) conducting the inspection;
9. Name, address, and telephone number of each laboratory conducting an analysis of collected samples;
10. Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) device;

11. XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated at each required calibration;

12. Specific locations by room of each painted component tested for the presence of lead-based paint and the results for each component expressed in terms appropriate to the sampling method used;

13. The results of retesting of 10 surfaces, calculations to determine the retest tolerance limit, and the determination of whether the inspection meets the retest tolerance limit;

14. If the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that the residential dwelling is free of lead-based paint, the report shall contain the following statement:

“The results of this inspection indicate that no lead in amounts greater than or equal to 1.0 mg/cm<sup>2</sup> in paint was found on any building components, using the inspection protocol in Chapter 7 of the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing ((2012), U.S. Department of Housing and Urban Development). Therefore, this residential dwelling qualifies for the exemption in 24 CFR Part 35 and 40 CFR Part 745 for target housing being leased that is free of lead-based paint, as defined in the rule. However, some painted surfaces may contain levels of lead below 1.0 mg/cm<sup>2</sup>, which could create lead dust or lead-contaminated soil hazards if the paint is turned into dust by abrasion, scraping, or sanding. This report should be kept by the owner and all future owners for the life of the residential dwelling. Per the disclosure requirements of 24 CFR Part 35 and 40 CFR Part 745, prospective buyers are entitled to all available inspection reports should the property be resold.”;

15. If any lead-based paint is identified, a description of the location, type, and severity of identified lead-based paint hazards, including the classification of each tested surface as to whether it is a lead-based paint hazard, and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated;

16. A description of interim controls and lead abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure;

17. Information regarding the owner’s obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;

18. Information regarding Iowa’s prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa’s regulations for renovation, remodeling and repainting found in 641—Chapter 70; and

19. The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

*b.* When conducting a lead-free inspection in multifamily housing, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following procedures:

(1) A certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may randomly select residential dwellings for testing when conducting a lead-free inspection in multifamily housing. If built before 1960 or if the date of construction is unknown, the multifamily housing shall contain at least 20 similarly constructed and maintained residential dwellings in order to use random selection. If built from 1960 to 1977, the multifamily housing shall contain at least 10 similarly constructed and maintained residential dwellings in order to use random selection. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not randomly select the residential dwellings for testing or if there are not enough residential dwellings to randomly select them for sampling, all residential dwellings shall be tested. If random selection is used, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor

conducting the lead-free inspection shall randomly select the residential dwellings to be tested. The property owner, manager, or another interested party shall not specify which residential dwellings are to be tested. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the number of residential dwellings to randomly select for testing.

Table 1

Minimum Number of Residential Dwellings to be Randomly Selected in Multifamily Housing for Lead-Free Inspection, Risk Assessment, Lead Hazard Screen, or Clearance Testing

Number of Similar Residential Dwellings, Similar Common Areas, or Similar Exteriors in Multifamily Housing	Lead-Free Inspection, Risk Assessment, or Lead Hazard Screen		Clearance Testing
	Number of Pre-1960 Residential Dwellings or Residential Dwellings of Unknown Date of Construction to Randomly Select for Testing	Number of 1960-1977 Residential Dwellings to Randomly Select for Testing	Number of Residential Dwellings to Randomly Select for Clearance Testing
1-9	All	All	All
10-13	All	10	All
14	All	11	All
15	All	12	All
16-17	All	13	All
18	All	14	All
19	All	15	All
20	All	16	All
21-26	20	16	20
27	21	17	21
28	22	18	22
29	23	18	23
30	23	19	23
31	24	19	24
32	25	19	25
33-34	26	19	26
35	27	19	27
36	28	19	28
37	29	19	29
38-39	30	20	30
40-48	31	21	31
49-50	31	22	31
51	32	22	32
52-53	33	22	33
54	34	22	34
55-56	35	22	35
57-58	36	22	36
59	37	23	37
60-69	38	23	38
70-73	38	24	38
74-75	39	24	39
76-77	40	24	40

Number of Similar Residential Dwellings, Similar Common Areas, or Similar Exteriors in Multifamily Housing	Lead-Free Inspection, Risk Assessment, or Lead Hazard Screen		Clearance Testing
	Number of Pre-1960 Residential Dwellings or Residential Dwellings of Unknown Date of Construction to Randomly Select for Testing	Number of 1960-1977 Residential Dwellings to Randomly Select for Testing	Number of Residential Dwellings to Randomly Select for Clearance Testing
78-79	41	24	41
80-88	42	24	42
89-95	42	25	42
96-97	43	25	43
98-99	44	25	44
100-109	45	25	45
110-117	45	26	45
118-119	46	26	46
120-138	47	26	47
139-157	48	26	48
158-159	49	26	49
160-177	49	27	49
178-197	50	27	50
198-218	51	27	51
219-258	52	27	52
259-279	53	27	53
280-299	53	28	53
300-379	54	28	54
380-499	55	28	55
500-776	56	28	56
777-939	57	28	57
940-1004	57	29	57
1005-1022	58	29	58
1023-1032	59	29	59
1033-1039	59	30	59
1040+	5.8%, rounded to the next highest whole number	2.9%, rounded to the next highest whole number	5.8%, rounded to the next highest whole number

(2) A certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may randomly select each type of common area in the multifamily housing, including but not limited to hallways, exterior sides of a building, and laundry rooms, for testing. Each type of common area shall be counted separately. If built before 1960, the multifamily housing shall contain at least 20 of a type of common area in order to use random selection. If built from 1960 to 1977, the multifamily housing shall contain at least 10 of a type of common area in order to use random selection. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not randomly select the common areas for testing or if there are not enough common areas to randomly select them for testing, all common areas shall be tested. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the number of each type of common area to randomly select for testing.

(3) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test paint in each room of each residential dwelling selected for testing and in each common area selected for testing.

(4) Except for components known to have been replaced after December 31, 1977, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test each testing combination in each room of a residential dwelling chosen for testing and in each common area chosen for testing. On windows, the window frame, interior windowsill, window sash, and window trough shall each be considered a separate testing combination. Each wall in a room or a common area shall be tested. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall require one of the following two types of evidence to determine that components were replaced after 1977:

1. Detailed specifications showing which components were to be replaced, restored, enclosed, or encapsulated and evidence that the work was actually completed such as receipts for building materials, city building records showing a date of remodeling, or evidence of a final inspection by the city or another inspector showing that the work was actually completed.

2. A certification under penalty of perjury per Iowa Code section 622.1 from the contractor who did the work or from the person(s) who owned the property at the time outlining all of the components that were removed and replaced.

If one of these two types of evidence is not available, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test the component.

(5) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall note any components where lead-based paint has been enclosed or encapsulated. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not make a determination that a component or the multifamily housing is lead-free where components that are painted with lead-based paint have been enclosed or encapsulated.

(6) Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

1. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor must use an X-ray fluorescence analyzer which has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

2. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not use an X-ray fluorescence analyzer using a software version or a mode of operation that could result in inconclusive readings or that recommends substrate correction.

3. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use standards provided by the manufacturer and the NIST 1.02 standard film for calibration of the X-ray fluorescence analyzer.

4. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection, every four hours, and at the end of the inspection.

5. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading as positive or negative according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood

lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint.

6. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall count the number of XRF readings taken for each component type. If fewer than 40 of any component type were tested, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall randomly choose additional testing combinations for the component type to reach a total of 40 XRF readings. If fewer than 40 testing combinations are available for testing, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test each testing combination.

(7) For each component type where at least 40 testing combinations have been tested, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall determine the number and percentage of each component type that is classified as positive or negative. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each component type as follows:

1. Lead-based paint is not present on a component type if all readings are classified as negative.

2. Lead-based paint is present on a component type if at least 15 percent of the readings are classified as positive.

3. Lead-based paint is present on a component type if greater than or equal to 5 percent but less than 15 percent of the XRF readings are classified as positive, unless the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor collects paint samples and obtains laboratory analyses for all positive XRF readings. If the laboratory analyses show that lead-based paint is not present on any components, then the component type is negative. If the laboratory analyses show that lead-based paint is present on any component, then the component type is positive.

4. Lead-based paint is present on a component type if greater than 0 but less than 5 percent of the XRF readings are classified as positive, unless the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor collects paint samples and obtains laboratory analyses for all positive XRF readings or randomly selects a second set of residential dwellings for testing. If the laboratory analyses show that lead-based paint is not present on any components, then the component type is negative. If the laboratory analyses show that lead-based paint is present on any component, then the component type is positive. If a second set of randomly selected residential dwellings is sampled and greater than 0 but less than 2.5 percent of the combined set of results is positive, the component type may be considered as not having lead-based paint developmentwide but rather, having lead-based paint in isolated locations, with a reasonable degree of confidence. Individual components that are classified as positive should be considered lead-based painted and managed or abated appropriately.

5. If a particular component type in the sampled residential dwellings is classified as positive, that same component type in the unsampled residential dwellings is also classified as positive.

(8) If fewer than 40 of a component type are available for testing, each testing combination must be classified individually as positive or negative.

(9) If any component type or individual component is classified as positive, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not state that the multifamily housing is free of lead-based paint.

(10) As specified by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct retesting of 10 surfaces selected from two residential dwellings, calculate the retest tolerance limit, and determine whether the inspection meets the retest tolerance limit. If the retest tolerance limit is not met, then this procedure shall be repeated with 10 additional surfaces selected from the two residential dwellings. If the retest tolerance limit is not met with the 20 retested surfaces, then all results of the inspection shall be considered invalid.

(11) If lead-based paint is identified on any component or component type, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified on exterior components

or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated.

(12) A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility inspected. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the inspection, if different. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no less than three years. The inspection report shall include, at least:

1. Date of each inspection;
2. Address of each building in the multifamily housing;
3. Date of construction for each building in the multifamily housing;
4. A list of the apartments and common areas in each building in the multifamily housing;
5. The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;
6. A statement that the inspection was conducted to determine that lead-based paint is not present;
7. The name of the Iowa-certified inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor who randomly selected the residential dwellings and common areas for testing;
8. The number of residential dwellings and common areas that were selected for testing, how these numbers were determined, and a list of the residential dwellings and common areas that were selected for testing;
9. Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the inspection;
10. Name and certification number of the certified firm(s) conducting the inspection;
11. Name, address, and telephone number of each laboratory conducting an analysis of collected samples;
12. Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) analyzer;
13. XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated at each required calibration;
14. Specific locations by room of each painted component tested for the presence of lead-based paint and by residential dwelling or common area and the results for each component expressed in terms appropriate to the sampling method used;
15. Component aggregations and the determination of whether lead-based paint is present by component type;
16. The results of retesting of 10 surfaces, calculations to determine the retest tolerance limit, and the determination of whether the inspection meets the retest tolerance limit;
17. If the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that the multifamily housing is free of lead-based paint, the report shall contain the following statement:

“The results of this inspection indicate that no lead in amounts greater than or equal to 1.0 mg/cm<sup>2</sup> in paint was found on any building components, using the inspection protocol in Chapter 7 of the Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing ((2012), U.S. Department of Housing and Urban Development). Therefore, this multifamily housing qualifies for the exemption in 24 CFR Part 35 and 40 CFR Part 745 for target housing being leased that is free of lead-based paint, as defined in the rule. However, some painted surfaces may contain levels of lead below 1.0 mg/cm<sup>2</sup>, which could create lead dust or lead-contaminated soil hazards if the paint is turned into dust by abrasion, scraping, or sanding. This report should be kept by the owner and all future owners for the life of the multifamily housing. Per the disclosure requirements of 24 CFR Part 35 and 40 CFR Part 745, prospective buyers are entitled to all available inspection reports should the property be resold.”;

18. If any lead-based paint is identified, a description of the location, type, and severity of identified lead-based paint hazards, including the classification of each tested surface as to whether it is a lead-based paint hazard, and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated;

19. A description of interim controls and lead abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure;

20. Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;

21. Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69 and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and

22. The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

**70.6(2)** A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct lead inspections according to the following standards. Lead inspections shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

*a.* When conducting a lead inspection in a residential dwelling or child-occupied facility, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following procedures:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test paint in each room, including each exterior side.

(2) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test each testing combination in each room. On windows, the window frame, interior windowsill, window sash, and window trough shall each be considered a separate testing combination. One sample shall be taken for each testing combination in a room, including the walls. If a testing combination is painted and not tested, it shall be assumed to be painted with lead-based paint.

*b.* Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

(2) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the NIST 1.02 standard film or standards provided by the manufacturer for calibration of the X-ray fluorescence analyzer. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not state that any surface is free of lead-based paint unless the NIST 1.02 standard film is used for calibration.

(3) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection.

(4) If recommended by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface, and take three XRF readings with the XRF used to conduct the inspection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not conduct substrate correction where recommended by the performance characteristics sheet, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that all of the readings are positive and shall not state that a surface is free of lead-based paint.

(5) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume that all inconclusive readings are positive and classify them as such.

(6) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not resolve inconclusive readings by laboratory analysis, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the inconclusive readings are positive.

*c.* If lead-based paint is identified through an inspection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated.

*d.* A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility inspected. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the inspection, if different. A certified lead inspector/risk assessor or

a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no less than three years. The inspection report shall include, at least:

- (1) A statement that the inspection was conducted to identify lead-based paint and lead-based paint hazards in the residential dwelling;
- (2) Date of each inspection;
- (3) Address of building;
- (4) Date of construction;
- (5) Apartment numbers (if applicable);
- (6) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;
- (7) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the inspection;
- (8) The name and certification number of the certified firm(s) conducting the inspection;
- (9) Name, address, and telephone number of each laboratory conducting an analysis of collected samples;
- (10) Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) analyzer;
- (11) XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated;
- (12) Specific locations by room of each painted component tested for the presence of lead-based paint and the results for each component expressed in terms appropriate to the sampling method used;
- (13) A statement that all painted or finished components that were not tested must be assumed to contain lead-based paint;
- (14) A description of the location, type, and severity of identified lead-based paint hazards, including the classification of each tested surface as to whether it is a lead-based paint hazard, and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated;
- (15) A description of interim controls and lead abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure;
- (16) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;
- (17) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and
- (18) The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

**70.6(3)** A certified elevated blood lead (EBL) inspector/risk assessor must conduct elevated blood lead (EBL) inspections according to the following standards. Elevated blood lead (EBL) inspections shall be conducted only by a certified elevated blood lead (EBL) inspector/risk assessor.

*a.* When conducting an elevated blood lead (EBL) inspection, the certified elevated blood lead (EBL) inspector/risk assessor shall use the following procedures:

- (1) The certified elevated blood lead (EBL) inspector/risk assessor shall test paint in each room, including each exterior side.

(2) The certified elevated blood lead (EBL) inspector/risk assessor shall test each testing combination in each room. One sample shall be taken for each testing combination in a room, including walls. On windows, the window frame, interior windowsill, window sash, and window trough shall each be considered a separate testing combination. If a testing combination is painted and not tested, it shall be assumed to be painted with lead-based paint.

*b.* Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

(1) The certified elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

(2) The certified elevated blood lead (EBL) inspector/risk assessor shall use the NIST 1.02 standard film or standards provided by the manufacturer for calibration of the X-ray fluorescence analyzer. The certified elevated blood lead (EBL) inspector/risk assessor shall not state that any surface is free of lead-based paint unless the NIST 1.02 standard film is used for calibration.

(3) The certified elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection.

(4) If recommended by the performance characteristics sheet, the certified elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface, and take three XRF readings with the XRF used to conduct the inspection. The certified elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16. If the certified elevated blood lead (EBL) inspector/risk assessor does not conduct substrate correction where recommended by the performance characteristics sheet, then the certified elevated blood lead (EBL) inspector/risk assessor shall assume that all of the readings are positive and shall not state that a surface is free of lead-based paint.

(5) The certified elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified elevated blood lead (EBL) inspector/risk assessor may assume that all inconclusive readings are positive and classify them as such.

(6) The certified elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If the certified elevated blood lead (EBL) inspector/risk assessor does not resolve inconclusive readings, then the certified elevated blood lead (EBL) inspector/risk assessor shall assume that the inconclusive readings are positive.

c. If lead-based paint is identified through an elevated blood lead (EBL) inspection, the certified elevated blood lead (EBL) inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards, including bare soil in the play area or in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated.

d. No later than two weeks after the receipt of laboratory results, a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where an elevated blood lead (EBL) inspection has been conducted and shall provide a copy of this report to the property owner and the occupant of the dwelling. The report shall include, at least:

(1) A statement that the elevated blood lead (EBL) inspection was conducted to identify lead-based paint and lead-based paint hazards in the residential dwelling;

(2) Date of each elevated blood lead (EBL) inspection;

(3) Address of building;

(4) Date of construction;

(5) Apartment numbers (if applicable);

(6) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(7) Name, signature, and certification number of each certified elevated blood lead (EBL) inspector/risk assessor conducting the inspection;

(8) Name and certification number of the certified firm(s) conducting the inspection;

(9) Name, address, and telephone number of each laboratory conducting an analysis of collected samples;

(10) Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) analyzer;

(11) XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated;

(12) Specific locations by room of each painted component tested for the presence of lead-based paint and the results for each component expressed in terms appropriate to the sampling method used;

(13) A statement that all painted or finished components that were not tested must be assumed to contain lead-based paint;

(14) A description of the location, type, and severity of identified lead-based paint hazards, including the classification of each tested surface as to whether it is a lead-based paint hazard, and any other potential lead hazards, including bare soil in the play area or in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated;

(15) A description of interim controls and lead abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure;

(16) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;

(17) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and

(18) The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by an elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

*e.* A certified elevated blood lead (EBL) inspector/risk assessor shall maintain for no fewer than ten years a written record for each residential dwelling or child-occupied facility where an elevated blood lead (EBL) inspection has been conducted. The record shall include, at least:

(1) A copy of the written report required by paragraph 70.6(3)“*d.*”

(2) Blood lead test results for the elevated blood lead (EBL) child.

(3) A record of conversations held with the owners and occupants of each residential dwelling or child-occupied facility prior to, during, and after the EBL inspection.

(4) Records of follow-up visits made to each residential dwelling or child-occupied facility where lead-based paint hazards are identified and, when issued, a copy of the clearance report.

**70.6(4)** A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct lead hazard screens according to the following standards. Lead hazard screens shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

*a.* Background information regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years shall be collected.

*b.* A visual inspection of the residential dwelling or child-occupied facility shall be conducted to determine if any deteriorated paint is present and to locate at least two dust sampling locations.

*c.* If deteriorated paint is present, each surface with deteriorated paint which is determined to have a distinct painting history must be tested for the presence of lead. In addition, friction surfaces where there is evidence of abrasion and impact surfaces that are damaged or otherwise deteriorated from impact and that have a distinct painting history shall be tested for the presence of lead.

*d.* In residential dwellings, a minimum of two composite or single-surface dust samples shall be collected. One sample shall be collected from the floors and the other from the interior windowsills in rooms, hallways, or stairwells where at least one child under the age of six years is most likely to come in contact with dust.

*e.* In multifamily dwellings and child-occupied facilities, single-surface or composite dust samples shall also be collected from common areas where at least one child under the age of six years is likely to come in contact with dust.

*f.* Dust samples shall be collected by wipe samples using the documented methodologies specified in guidance documents issued by the department. The minimum area for a floor wipe sample shall be 0.50 square feet or 72 square inches. The minimum area for a windowsill wipe sample and for a window trough wipe sample shall be 0.25 square feet or 36 square inches. Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

*g.* Soil samples shall be collected and analyzed for lead content in exterior play areas and dripline areas where bare soil is present. In addition, soil samples shall be collected and analyzed for lead content from any other areas of the yard where bare soil is present. Soil and paint samples shall be collected using the documented methodologies specified in guidance documents issued by the department and shall be analyzed by a recognized laboratory to determine the level of lead.

*h.* Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

(2) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the National Institute of Standards and Technology 1.02 milligrams of lead per square

centimeter standard reference material or standards provided by the manufacturer for calibration of the X-ray fluorescence analyzer.

(3) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection.

(4) If recommended by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface, and take three XRF readings with the XRF used to conduct the inspection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not conduct substrate correction where recommended by the performance characteristics sheet, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that all the readings are positive and shall not state that a surface is free of lead-based paint.

(5) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume that all inconclusive readings are positive and classify them as such.

(6) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not resolve inconclusive readings by laboratory analysis, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the inconclusive readings are positive.

*i.* The following standards shall be used to determine whether a residential dwelling or child-occupied facility fails a lead hazard screen:

(1) A residential dwelling or child-occupied facility shall fail a lead hazard screen if any deteriorated paint or paint on friction or impact surfaces is found to be lead-based paint.

(2) A residential dwelling shall fail a lead hazard screen if any floor dust lead level in a single-surface or composite-surface dust sample is greater than or equal to 25 micrograms per square foot.

(3) A residential dwelling shall fail a lead hazard screen if any interior windowsill dust level in a single-surface or composite-surface dust sample is greater than or equal to 125 micrograms per square foot.

(4) A residential dwelling or child-occupied facility shall fail a lead hazard screen if any bare soil is found to be a soil-lead hazard.

*j.* When conducting a lead hazard screen in multifamily housing, a certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor may sample each residential dwelling or choose residential dwellings for sampling by random selection, targeted selection, or worst case selection.

(1) If built before 1960 or if the date of construction is unknown, the multifamily housing shall contain at least 20 similarly constructed and maintained residential dwellings in order to use random selection. If built from 1960 to 1977, the multifamily housing shall contain at least 10 similarly constructed and maintained residential dwellings in order to use random selection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the number of residential dwellings to randomly select for testing.

(2) If the multifamily housing contains five or more similar residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may use targeted selection. If using targeted selection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 2 to determine the number of residential dwellings to test. If the multifamily housing has fewer than five similar dwellings, all residential dwellings shall be tested. Residential dwellings chosen by targeted selection shall meet as many of the following criteria as possible:

1. The residential dwelling has been cited with a housing or building code violation within the past year.

2. The property owner believes that the residential dwelling is in poor condition.

3. The residential dwelling contains two or more children between the ages of six months and six years. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall give preference to residential dwellings that house the largest number of children.

4. The residential dwelling serves as a day care facility.

5. The residential dwelling has been prepared for reoccupancy within the past three months.

If additional residential dwellings are needed to meet the minimum number specified in Table 2, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall select them randomly. If too many residential dwellings meet the criteria, residential dwellings shall be eliminated randomly.

Table 2  
Minimum Number of Residential Dwellings in Multifamily Housing for Risk Assessment  
or Lead Hazard Screen Through Targeted Selection

Number of Similar Residential Dwellings	Number of Residential Dwellings to Sample*
1-4	All
5-20	4 residential dwellings or 50% (whichever is greater)**
21-75	10 residential dwellings or 20% (whichever is greater)**
76-125	17
126-175	19
176-225	20
226-300	21
301-400	22
401-500	23
501+	24 + 1 residential dwelling for each additional increment of 100 residential dwellings or less

\*Does not include residential dwellings housing children with elevated blood lead levels.

\*\*For percentages, round up to determine number of residential dwellings to be sampled.

*k.* If the multifamily housing contains five or more similar residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may use worst case selection. If using worst case selection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 2 to determine the number of residential dwellings to test. If the multifamily housing has fewer than five similar dwellings, all residential dwellings shall be tested.

*l.* The following standards shall be used to determine whether multifamily housing fails a lead hazard screen:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean of the dust lead levels for carpeted floors, uncarpeted floors, and interior windowsills. If the arithmetic mean for carpeted floors or uncarpeted floors is greater than or equal to 25 micrograms per square foot, the multifamily housing shall fail the lead hazard screen. If the arithmetic mean for interior windowsills is greater than or equal to 125 micrograms per square foot, the multifamily housing shall fail the lead hazard screen. If the arithmetic mean for carpeted floors or uncarpeted floors is less than 25 micrograms per square foot, but some of the samples have dust lead levels that are greater than or equal to 25 micrograms per square foot, then the residential dwellings where these samples were taken and all other similar residential dwellings in the multifamily housing shall fail the lead hazard screen. If the arithmetic mean for interior windowsills is less than 125 micrograms per square foot, but some of the samples have dust lead levels that are greater than or equal to 125 micrograms per square foot, then the residential dwellings where these samples were taken and all other similar residential dwellings in the multifamily housing shall fail the lead hazard screen.

(2) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall evaluate the results of paint sampling by component and location. If all components at a given location are determined to be painted with lead-based paint or are determined to not be painted with lead-based paint, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume this condition is true for all similar residential dwellings. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not assume that the multifamily housing is free of lead-based paint. If a component at a given location is found to be painted with lead-based paint in some residential dwellings and not painted with lead-based paint in other residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the component is a lead-based paint hazard in all similar residential dwellings. If a component in a residential dwelling is determined or assumed to be

lead-based paint, then the entire group of similar residential dwellings in the multifamily housing shall fail the lead hazard screen.

(3) Multifamily housing shall fail a lead hazard screen if any bare soil is found to be a soil-lead hazard.

*m.* A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a lead hazard screen is conducted. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the lead hazard screen, if different. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no less than three years. The report shall include, at least:

- (1) Date of each lead hazard screen.
- (2) Address of building.
- (3) Date of construction.
- (4) Apartment numbers (if applicable).
- (5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility.
- (6) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the lead hazard screen.
- (7) Name and certification number of the certified firm(s) conducting the lead hazard screen.
- (8) Name, address, and telephone number of each recognized laboratory conducting an analysis of collected samples, including the identification number for each such laboratory recognized by EPA under Section 405(b) of the Toxic Substances Control Act (15 U.S.C. 2685(b)).
- (9) Results of the visual inspection.
- (10) Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) analyzer.
- (11) If used, XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated.
- (12) Specific locations by room of each painted component tested for the presence of lead-based paint and the results for each component tested expressed in terms appropriate to the sampling method used.
- (13) All results of laboratory analysis of collected paint, dust, and soil samples. The results of dust sampling shall be reported in micrograms of lead per square foot, and the results of soil sampling shall be reported in parts per million of lead. Results shall not be reported as “not detectable.”
- (14) Any other sampling results.
- (15) A statement that all painted or finished components that were not tested must be assumed to contain lead-based paint.
- (16) Background information collected regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years.
- (17) Whether the residential dwelling or child-occupied facility passed or failed the lead hazard screen and recommendations, if warranted, for a follow-up lead inspection or risk assessment, and, as appropriate, any further actions.
- (18) Information regarding the owner’s obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745.
- (19) Information regarding Iowa’s prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa’s regulations for renovation found in 641—Chapter 70.
- (20) The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

**70.6(5)** A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct risk assessments according to the following standards. Risk assessments shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

*a.* Background information regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years shall be collected.

*b.* A visual inspection for risk assessment shall be undertaken to locate the existence of deteriorated paint and other potential lead hazards and to assess the extent and causes of the paint deterioration.

*c.* If deteriorated paint is present, each surface with deteriorated paint which is determined to have a distinct painting history must be tested for the presence of lead.

*d.* Friction surfaces where there is evidence of abrasion and impact surfaces that are damaged or otherwise deteriorated from impact and that have a distinct painting history shall be tested for the presence of lead.

*e.* In residential dwellings, dust samples shall be collected from the interior windowsill, window trough, and floor in all living areas where at least one child is most likely to come in contact with dust. Dust samples shall be analyzed for lead concentration and may be either composite or single-surface samples.

*f.* In multifamily dwellings, dust samples shall also be collected from interior windowsills, window troughs, and floors in common areas adjacent to the sampled residential dwellings or child-occupied facility and in other common areas where the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that at least one child under the age of six years is likely to come in contact with dust. Dust samples shall be analyzed for lead concentration and may be either composite or single-surface samples.

*g.* In child-occupied facilities, dust samples shall be collected from the interior windowsill, window trough, and floor in each room, hallway, or stairwell utilized by one or more children under the age of six years and in other common areas where the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that at least one child under the age of six years is likely to come in contact with dust. Dust samples shall be analyzed for lead concentration and may be either composite or single-surface samples.

*h.* Soil samples shall be collected and analyzed for lead content in exterior play areas and dripline areas where bare soil is present. In addition, soil samples shall be collected and analyzed for lead content from any other areas of the yard where bare soil is present.

*i.* Dust samples shall be collected by wipe samples using the documented methodologies specified in guidance documents issued by the department. The minimum area for a floor wipe sample shall be 0.50 square feet. The minimum area for a windowsill wipe sample and for a window trough wipe sample shall be 0.25 square feet. Soil and paint samples shall be collected using the documented methodologies specified in guidance documents issued by the department. Dust and soil samples shall be analyzed by a recognized laboratory to determine the level of lead. The results of dust sampling shall be reported in micrograms of lead per square foot, and the results of soil sampling shall be reported in parts per million of lead. The results shall not be reported as “not detectable.”

*j.* Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead

inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

(2) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the NIST 1.02 standard film material or standards provided by the manufacturer for calibration of the X-ray fluorescence analyzer. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not state that any surface is free of lead-based paint unless the NIST 1.02 standard film is used for calibration.

(3) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection.

(4) If recommended by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface, and take three XRF readings with the XRF used to conduct the inspection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not conduct substrate correction where recommended by the performance characteristics sheet, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that all of the readings are positive and shall not state that a surface is free of lead-based paint.

(5) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume that all inconclusive readings are positive and classify them as such.

(6) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If the certified lead inspector/risk assessor or elevated

blood lead (EBL) inspector/risk assessor does not resolve inconclusive readings by laboratory analysis, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the inconclusive readings are positive.

k. When conducting a risk assessment in multifamily housing, a certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor may sample each residential dwelling or choose residential dwellings for sampling by random selection, targeted selection, or worst case selection.

(1) If built before 1960 or if the date of construction is unknown, the multifamily housing shall contain at least 20 similarly constructed and maintained residential dwellings in order to use random selection. If built from 1960 to 1977, the multifamily housing shall contain at least 10 similarly constructed and maintained residential dwellings in order to use random selection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the number of residential dwellings to randomly select for testing.

(2) If the multifamily housing contains five or more similar residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may use targeted selection. If using targeted selection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 2 to determine the number of residential dwellings to test. If the multifamily housing has fewer than five similar dwellings, all residential dwellings shall be tested. Residential dwellings chosen by targeted selection shall meet as many of the following criteria as possible. If additional residential dwellings are needed to meet the minimum number specified in Table 2, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall select them randomly. If too many residential dwellings meet the criteria, residential dwellings shall be eliminated randomly. Targeted selection criteria are as follows:

1. The residential dwelling has been cited with a housing or building code violation within the past year.
2. The property owner believes that the residential dwelling is in poor condition.
3. The residential dwelling contains two or more children between the ages of six months and six years. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall give preference to residential dwellings that house the largest number of children.
4. The residential dwelling serves as a day care facility.
5. The residential dwelling has been prepared for reoccupancy within the past three months.

(3) If the multifamily housing contains five or more similar residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may use worst case selection. If using worst case selection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 2 to determine the number of residential dwellings to test. If the multifamily housing has fewer than five similar dwellings, all residential dwellings shall be tested.

(4) The following standards shall be used to determine the extent of lead-based paint hazards throughout multifamily housing that is sampled by random selection, targeted selection, or worst case selection:

1. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean of the dust lead levels for carpeted floors, uncarpeted floors, interior windowsills, and window troughs. If the arithmetic mean is greater than or equal to the level defined as a dust lead hazard for the component, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall determine that a dust lead hazard has been identified on the component throughout the multifamily housing. If the arithmetic mean is less than the level defined as a dust lead hazard for the component, but some of the individual components have dust lead levels that are greater than or equal to the level defined as a dust lead hazard, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall determine that a dust lead hazard has been identified on the individual components and on all other similar components throughout the multifamily housing.

2. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall evaluate the results of paint sampling by component and location. If all components at a given

location are determined to be painted with lead-based paint or are determined to not be painted with lead-based paint, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume this condition is true for all similar residential dwellings. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not assume that the multifamily housing is free of lead-based paint. If a component at a given location is found to be painted with lead-based paint in some residential dwellings and not painted with lead-based paint in other residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the component is a lead-based paint hazard in all similar residential dwellings.

*l.* A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a risk assessment is conducted. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the risk assessment, if different. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of the report for no less than three years. The report shall include, at least:

- (1) Date of each risk assessment;
- (2) Address of building;
- (3) Date of construction;
- (4) Apartment numbers (if applicable);
- (5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;
- (6) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the risk assessment;
- (7) Name and certification number of the certified firm(s) conducting the risk assessment;
- (8) Name, address, and telephone number of each recognized laboratory conducting an analysis of collected samples, including the identification number for each such laboratory recognized by EPA under Section 405(b) of the Toxic Substances Control Act (15 U.S.C. 2685(b));
- (9) Results of the visual inspection;
- (10) Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) analyzer;
- (11) If used, XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated;
- (12) Specific locations by room of each painted component tested for the presence of lead-based paint and the results for each component tested expressed in terms appropriate to the sampling method used;
- (13) All results of laboratory analysis of collected paint, dust, and soil samples;
- (14) Any other sampling results;
- (15) A statement that all painted or finished components that were not tested must be assumed to contain lead-based paint;
- (16) Background information collected regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years;
- (17) To the extent that they are used as part of the lead-based paint hazard determination, the results of any previous inspections or analyses for the presence of lead-based paint, or other assessments of lead-based paint hazards;
- (18) A description of the location, type, and severity of identified lead-based paint hazards, and any other potential lead hazards, including bare soil in the play area or in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated;

(19) A description of interim controls and lead abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure;

(20) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;

(21) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and

(22) The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

**70.6(6)** A certified lead abatement contractor or certified lead abatement worker must conduct lead abatement according to the following standards. Lead abatement shall be conducted only by a certified lead abatement contractor or a certified lead abatement worker.

*a.* A certified lead abatement contractor must be on site during all work site preparation and during the postabatement cleanup of work areas. At all other times when lead abatement is being conducted, the certified lead abatement contractor shall be on site or available by telephone, pager, or answering service, and be able to be present at the work site in no more than two hours.

*b.* A certified lead abatement contractor shall ensure that lead abatement is conducted according to all federal, state, and local requirements.

*c.* A certified lead abatement contractor shall notify the department in writing at least seven days prior to the commencement of lead abatement in a residential dwelling or child-occupied facility. The notification shall include the following information:

(1) The address, including apartment numbers, where lead abatement will be conducted.

(2) The dates when lead abatement will be conducted.

(3) The name, address, telephone number, Iowa certification number, and signature of the contact for the certified firm that will conduct the work.

(4) The name, address, telephone number, Iowa certification number, and signature of the certified lead abatement contractor who will serve as the contact person for the project.

(5) The name, address, and telephone number of the property owner.

(6) Whether the dwelling is owner-occupied or a rental dwelling.

(7) If the dwelling is an occupied rental, the names of the occupants.

(8) The approximate year that the dwelling was built.

(9) A brief description of the lead abatement work to be done.

*d.* A certified lead abatement contractor shall submit a revised notification to the department if any information in the original notification changes.

*e.* A certified lead abatement contractor shall ensure that the worksite(s) is accessed only by certified lead professionals according to Iowa Administrative Code 641—70.3(135) and 70.5(135). Noncertified individuals shall not be allowed access to a worksite. A worksite shall remain inaccessible to noncertified individuals until it passes clearance testing.

*f.* A certified lead abatement contractor or a certified project designer shall develop a written occupant protection plan for all lead abatement projects prior to starting lead abatement and shall implement the occupant protection plan during the lead abatement project. The occupant protection plan shall be unique to each residential dwelling or child-occupied facility. If the occupants will be living at the property where lead abatement is taking place, then the written occupant plan shall be given to the occupants prior to the start date of the lead abatement project and must contain at least the following information:

(1) A description of the type and location of the physical barriers that will keep occupants out of the designated worksite(s).

(2) An explanation of how the contractor will ensure that the worksite(s) is not entered by the occupants.

(3) An explanation of how the contractor will ensure that the occupants have access to a kitchen, bathroom, and living area that are not in the worksite(s).

g. Approved methods must be used to conduct lead abatement, and prohibited work practices must not be used to conduct lead abatement.

(1) Signs must be posted and readable. All signs must be posted before lead abatement begins and must remain in place until dust-lead clearance has been passed.

1. To the extent practicable, all signage must be posted in the occupants' primary language.

2. The signs must clearly define the work area.

3. The signs must warn occupants and other persons not involved with the lead abatement to remain outside the work area.

4. The signs must be posted at the entrance(s) to all work areas.

(2) The work area must be effectively contained before the lead abatement begins. To be effective, containment must:

1. Isolate the work area so that no dust or debris leaves the work area while the lead abatement is being performed.

2. Be monitored and maintained so that any plastic or other impermeable materials are not torn or displaced.

3. Be installed in such a manner that it does not interfere with occupant and worker egress in an emergency.

(3) For interior lead abatement, containment shall include:

1. The removal or covering of all objects from the work area, including but not limited to furniture, rugs, and window coverings. Objects that are not removed from the work area must be covered with plastic sheeting or other impermeable material with all seams and edges taped or otherwise sealed.

2. Closing and covering all duct openings in the work area. Ducts must be covered with plastic sheeting or other impermeable material that is taped down.

3. Closing windows and doors in the work area. Doors must be covered with plastic sheeting or other impermeable material. Doors used as an entrance to the work area must be covered with plastic sheeting or other impermeable material in a manner that allows workers to pass through while confining dust and debris to the work area.

4. Covering the floor surface, including installed carpet, with taped-down plastic sheeting or other impermeable material in the work area six feet beyond the perimeter of the surfaces undergoing lead abatement or a sufficient distance to contain the dust, whichever is greater.

5. Ensuring that all personnel, tools, and other items, including the exteriors of containers of waste, are free of dust and debris before leaving or being removed from the work area.

(4) For exterior lead abatement, containment shall include:

1. Closing all doors and windows within 20 feet of the lead abatement. On multistory buildings, all doors and windows within 20 feet of the lead abatement on the same story as the lead abatement shall be closed, and all doors and windows on all stories below the lead abatement that are the same horizontal distance from the lead abatement shall be closed.

2. Ensuring that doors within the work areas that will be used while the lead abatement is being performed are covered with plastic sheeting or other impermeable material in a manner that allows workers to pass through while confining dust and debris to the work area.

3. Covering the ground with plastic sheeting or other disposable impermeable material extending 10 feet beyond the perimeter of surfaces undergoing lead abatement or a sufficient distance to collect falling paint debris, whichever is greater, unless the property line prevents 10 feet of such ground cover. Exterior ground cover shall include anchors or weights to ensure that the covering remains effective even during weather conditions such as high wind.

4. Vertical containment. In certain situations, such as where other buildings are in close proximity to the work area, when conditions are windy, or where the work area abuts a property line, the certified lead abatement contractor or certified lead abatement worker shall erect a system of vertical containment designed to prevent dust and debris from migrating to adjacent property or contaminating the ground, other buildings, or any object beyond the work area.

(5) The following are prohibited work practices:

1. Open-flame burning or torching of lead-based paint.

2. Machine sanding or grinding or abrasive blasting or sandblasting of lead-based paint unless used with high-efficiency particulate air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at 99.97 percent or greater efficiency.

3. Uncontained water blasting of lead-based paint.

4. Dry scraping or dry sanding of lead-based paint except in conjunction with the use of a heat gun or around electrical outlets.

5. Operating a heat gun at a temperature at or above 1100 degrees Fahrenheit.

(6) All waste generated during lead abatement shall be contained to prevent the release of dust and debris before the waste is removed from the work area for storage or disposal. Any chutes used to remove waste from the work area shall be covered.

1. At the conclusion of each workday and at the conclusion of the lead abatement, waste that has been collected from lead abatement activities must be stored under containment, in an enclosure, or behind a barrier that prevents release of dust and debris out of the work area and prevents access to dust and debris.

2. All waste from lead abatement must be contained during transportation so that no dust or debris is released.

(7) The work area shall be cleaned so that no dust, debris, or residue remains after lead abatement. Cleaning shall include:

1. The collection of all paint chips and debris and, without dispersing the paint chips and debris, the sealing of the materials in heavy-duty bags.

2. The removal of the protective sheeting used as required in this subrule. The sheeting shall be misted, then the sheeting shall be folded dirty side inward. All sheeting shall be taped shut or otherwise sealed inside heavy-duty bags. Sheeting used to separate work areas from non-work areas must remain in place until after the cleaning and removal of other sheeting. All sheeting shall be disposed of as waste.

3. For interior lead abatement, all objects and surfaces in the work area and within two feet of the work area must be cleaned from high to low in the following manner:

- Walls must either be vacuumed with a HEPA vacuum or wiped with a wet cloth, beginning at the ceiling and working toward the floor.

- All remaining surfaces including objects and fixtures must be thoroughly vacuumed with a HEPA vacuum. For carpeted floors and rugs, the HEPA vacuum must be equipped with a beater bar.

- All remaining surfaces, except for carpeted or upholstered surfaces, must also be wiped with a damp cloth. Uncarpeted floors must be thoroughly mopped using a method that keeps the wash water separate from the rinse water, such as the two-bucket mopping method, or using a wet mopping system.

*h.* Soil abatement shall be conducted using one of the following methods:

(1) If soil is removed, soil that is a soil-lead hazard shall be replaced by soil with a lead concentration as close to the local background as practicable, but less than 400 parts per million. The soil that is removed shall not be used as topsoil at another residential property or child-occupied facility.

(2) If soil is not removed, the soil that is a soil-lead hazard shall be remediated to meet the definition of “permanently covered soil.”

*i.* If lead-based paint is removed from a surface, the surface shall be repainted or refinished prior to postabatement clearance dust sampling. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall visually verify that lead-based paint was removed from a surface prior to repainting or refinishing.

*j.* If components painted with lead-based paint are removed, the replacement components shall be installed prior to postabatement clearance testing.

k. Postabatement clearance procedures shall be conducted by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor. If the abatement is conducted in response to an elevated blood lead (EBL) inspection, clearance must be conducted by a certified elevated blood lead (EBL) inspector/risk assessor. Postabatement clearance testing shall be performed by persons or entities independent of those performing lead abatement, unless the designated party uses qualified in-house employees to conduct postabatement clearance testing. An in-house employee shall not conduct both lead abatement and the postabatement clearance testing for this work. Postabatement clearance testing shall be conducted using the following procedures:

(1) Following a lead abatement, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall review the report of the lead inspection, risk assessment, or visual assessment done prior to the lead abatement project and the lead abatement specifications to determine the lead-based paint hazards that were to be abated by the lead abatement project. The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall perform a visual inspection to determine if all lead-based paint hazards that were to be abated have been abated and to determine if deteriorated paint surfaces or visible amounts of dust, debris, or residue are still present in the rooms where lead abatement was conducted. If lead-based paint hazards that were to be abated by the project or deteriorated paint surfaces or visible amounts of dust, debris, or residue are present in the rooms where lead abatement was conducted, these conditions must be eliminated prior to the continuation of the clearance procedures. However, elimination of deteriorated paint is not required if it has been determined through paint testing or a lead-based paint inspection that the deteriorated paint is not lead-based paint. Following an exterior lead abatement, a visual inspection shall be conducted to determine if all lead-based paint hazards that were to be abated have been abated and to determine if any visible dust or debris remains on any horizontal surfaces in the outdoor living areas close to the abated surface. In addition, a visual inspection shall be conducted to determine the presence of paint chips on the dripline or next to the foundation below any exterior surface that was abated. If lead-based paint hazards that were to be abated by the project are still present, these conditions must be eliminated prior to the continuation of the clearance procedures. If visible dust, debris, or paint chips are present, they must be removed from the site and properly disposed of according to all applicable federal, state, and local standards.

(2) Following the visual inspection and any required postabatement cleanup, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall conduct clearance sampling for lead in dust. Clearance sampling may be conducted by employing single-surface sampling or composite dust sampling. Interior dust-lead testing shall be performed for all projects that include window replacement.

(3) Dust samples shall be collected a minimum of one hour after the completion of final postabatement cleanup activities.

(4) Dust samples shall be collected by wipe samples using the documented methodologies specified in guidance documents issued by the department. The minimum area for a floor wipe sample shall be 0.50 square feet or 72 square inches. The minimum area for a windowsill wipe sample and for a window trough wipe sample shall be 0.25 square feet or 36 square inches. Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

(5) The following postabatement clearance activities shall be conducted as appropriate based upon the extent or manner of lead abatement activities conducted in the residential dwelling or child-occupied facility:

1. After conducting a lead abatement with containment between abated and unabated areas, three dust samples shall be taken from each of no fewer than four rooms, hallways, or stairwells within the containment area. Dust samples shall be taken from one interior windowsill and from one window trough (if available), and one dust sample shall be taken from the floor of each of no fewer than four rooms, hallways, or stairwells within the containment area. In addition, one dust sample shall be taken from the floor outside of each individual containment area. If there are fewer than four rooms, hallways, or stairwells within the containment area, then all rooms, hallways, and stairwells shall be sampled.

2. After conducting a lead abatement with no containment between abated and unabated areas, three dust samples shall be taken from each of no fewer than four rooms, hallways, or stairwells in the residential dwelling or child-occupied facility. Dust samples shall be taken from one interior windowsill and from one window trough (if available), and one dust sample shall be taken from the floor of each room, hallway, or stairwell selected. If there are fewer than four rooms, hallways, or stairwells in the residential dwelling or child-occupied facility, then all rooms, hallways, and stairwells shall be sampled.

3. The certified lead abatement contractors and certified lead abatement workers who abate or clean the dwellings shall not have any knowledge of which rooms or surfaces will be selected for the dust samples.

(6) Reserved.

(7) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall compare the residual lead level as determined by the laboratory analysis from each single-surface dust sample with applicable single-surface clearance levels for lead in dust on floors, interior windowsills, and window troughs. If the residual lead level in a single-surface dust sample is greater than or equal to the applicable clearance level for a floor, interior windowsill, or window trough, then the failed component in each room with a failed single-surface dust sample and that type of component in each room that was not tested shall be recleaned. Additional clearance samples shall be taken from the failed component in each room where it failed and from enough additional rooms that were not previously tested so that four rooms are sampled. If four rooms are not available, then each available room shall be retested. The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall evaluate the results of this testing to determine if the recleaned components meet the clearance level. The components must be recleaned and retested until the clearance level is met.

(8) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall compare the residual lead level as determined by the laboratory analysis from each composite dust sample with applicable single-surface clearance levels for lead in dust on floors, interior windowsills, and window troughs divided by half the number of subsamples in the composite sample. If the residual lead level in a composite dust sample is greater than or equal to the applicable clearance level divided by half the number of subsamples in the composite sample, then all the components represented by the failed composite dust sample shall be recleaned and retested until clearance levels are met.

*l.* In multifamily housing consisting of at least 20 similarly constructed and maintained residential dwellings, random selection for the purpose of clearance testing may be conducted if the following conditions are met:

(1) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall randomly select the residential dwellings that will be sampled. The certified lead abatement contractors and certified lead abatement workers who abate or clean the dwellings do not know which residential dwellings will be selected for the random selection or which rooms or surfaces will be selected for the dust samples.

(2) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the minimum number of residential dwellings selected for dust sampling. This shall provide a 95 percent level of confidence that no more than 5 percent or 50 of the residential dwellings (whichever is smaller) in the randomly sampled population are greater than or equal to the appropriate clearance levels.

(3) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall sample the randomly selected residential dwellings and evaluate them for clearance according to the procedures found in paragraphs 70.6(6) "*i*" through "*k*."

*m.* No later than three weeks after the property passes clearance, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a report to the lead abatement contractor that contains the items required by subparagraphs 70.6(6) "*n*"(7) through (9).

*n.* The certified lead abatement contractor or a certified project designer shall prepare a lead abatement report containing the following information:

- (1) A copy of the original and any revised lead abatement notifications.
  - (2) Starting and completion dates of the lead abatement project.
  - (3) The name, address, and telephone number of the property owner(s).
  - (4) The name, address, and signature of the certified lead abatement contractor and of the certified firm contact for the firm conducting the lead abatement.
  - (5) Whether or not containment was used and, if containment was used, the locations of the containment.
  - (6) The occupant protection plan required by paragraph 70.6(6) “f.”
  - (7) The name, address, and signature of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting clearance sampling, the date on which the clearance testing was conducted, the results of the visual inspection for the presence of lead hazards that were not abated as specified, deteriorated paint and visible dust, debris, residue, or paint chips in the interior rooms and exterior areas where lead abatement was conducted, and the results of all postabatement clearance testing and all soil analyses, if applicable. The results of dust sampling shall be reported in micrograms of lead per square foot by location of sample, and the results of soil sampling shall be reported in parts per million of lead. The results shall not be reported as “not detectable.” If random selection was used to select the residential dwellings that were sampled, the report shall state that random selection was used, the number of residential dwellings that were sampled, and how this number was determined.
  - (8) A statement that the lead abatement was or was not done as specified and that the rooms and exterior areas where lead abatement was conducted did or did not pass the visual clearance and the clearance dust testing. If the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the clearance testing cannot verify that all lead-based paint hazards have been abated, the report shall contain the following statement:

“The purpose of this clearance report is to verify that the lead abatement project was done according to the project specifications. This residential dwelling may still contain hazardous lead-based paint, soil-lead hazards, or dust-lead hazards in the rooms or exterior areas that were not included in the lead abatement project.”
  - (9) The name, address, and telephone number of each recognized laboratory conducting an analysis of clearance samples and soil samples, including the identification number for each such laboratory recognized by EPA under Section 405(b) of the Toxic Substances Control Act (15 U.S.C. 2685(b)).
  - (10) A detailed written description of the lead abatement project, including lead abatement methods used, locations of rooms and components where lead abatement occurred, reasons for selecting particular lead abatement methods, and any suggested monitoring of encapsulants or enclosures.
  - (11) Information regarding the owner’s obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745.
  - (12) Information regarding Iowa’s prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa’s regulations for renovation found in 641—Chapter 70.
  - (13) If applicable, a copy of the written consent or waiver required by subrule 70.6(13).
    - o.* The lead abatement report shall be completed no later than 30 days after the lead abatement project passes clearance testing.
    - p.* The certified lead abatement contractor shall maintain all reports and plans required in this subrule for a minimum of three years.
    - q.* The certified lead abatement contractor shall provide a copy of all reports required by this subrule to the building owner and to the person who contracted for the lead abatement, if different.
- 70.6(7)** A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician must conduct visual risk assessments according to the following standards. Visual risk assessments shall be conducted only by a certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician.

a. Background information regarding the physical characteristics of the residential dwelling or child-occupied facility and occupant use patterns that may cause lead-based paint exposure to at least one child under the age of six years shall be collected.

b. A visual inspection for risk assessment shall be undertaken to locate the existence of deteriorated paint and other potential lead-based paint hazards and to assess the extent and causes of the paint deterioration. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall assess each component in each room, including each exterior side. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall identify the following conditions as potential lead-based paint hazards:

- (1) All interior and exterior surfaces with deteriorated paint.
- (2) Horizontal hard surfaces, including but not limited to floors and windowsills, that are not smooth or cleanable.
- (3) Dust-generating conditions, including but not limited to conditions causing rubbing, binding, or crushing of surfaces known or presumed to be coated with lead-based paint.
- (4) Bare soil in the play area and dripline of the home.

c. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall prepare a written report for each residential dwelling or child-occupied facility where a visual risk assessment is conducted. No later than three weeks after completing the visual risk assessment, the certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician shall send a copy of the report to the property owner and to the person requesting the visual risk assessment, if different. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall maintain a copy of the report for no less than three years. The report shall include, at least:

- (1) Date of each visual risk assessment;
- (2) Address of building;
- (3) Date of construction;
- (4) Apartment numbers (if applicable);
- (5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;
- (6) Name, signature, and certification number of each certified sampling technician, certified lead inspector/risk assessor, or certified elevated blood lead (EBL) inspector/risk assessor conducting the visual risk assessment;
- (7) Name and certification number of the certified firm(s) conducting the visual risk assessment;
- (8) A statement that all painted or finished components must be assumed to contain lead-based paint;
- (9) Specific locations of painted or finished components identified as likely to contain lead-based paint and likely to be lead-based paint hazards;
- (10) Specific locations of bare soil in the play area and the dripline of a home;
- (11) Information for the owner and occupants on how to reduce lead hazards in the residential dwelling or child-occupied facility;
- (12) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;
- (13) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and
- (14) The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by

a sampling technician, lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

**70.6(8)** A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician must conduct clearance testing according to the following standards. Clearance testing following lead abatement shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor. Clearance testing after renovation and clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR Part 35 shall be conducted only by certified sampling technicians, certified lead inspector/risk assessors, or certified elevated blood lead (EBL) inspector/risk assessors. If the abatement, renovation, or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35 is conducted in response to an elevated blood lead (EBL) inspection, clearance must be conducted by a certified elevated blood lead (EBL) inspector/risk assessor.

*a.* Clearance testing following lead abatement shall be conducted according to paragraphs 70.6(6) “*i*” through “*m*.”

*b.* Clearance testing after renovation and clearance testing after interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35 shall be conducted according to the following standards:

(1) A certified sampling technician shall perform clearance testing only for a single-family property or for individual residential dwellings and associated common areas in multifamily housing. A certified sampling technician shall not perform clearance testing using random selection of residential dwellings or common areas in multifamily housing.

(2) A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall review the report of the lead inspection, risk assessment, or visual assessment done prior to interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation conducted pursuant to 24 CFR Part 35 and the project specifications to determine the lead-based paint hazards that were to be controlled by the project. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall perform a visual inspection to determine if all lead-based paint hazards that were to be controlled by the project have been controlled and to determine if deteriorated paint surfaces or visible amounts of dust, debris, or residue are still present in the rooms where interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation were conducted pursuant to 24 CFR Part 35. If lead-based paint hazards that were to be controlled by the project, deteriorated paint surfaces or visible amounts of dust, debris, or residue are present in these rooms, these conditions must be eliminated prior to the continuation of the clearance testing. However, elimination of deteriorated paint is not required if it has been determined through a lead-based paint inspection that the deteriorated paint is not lead-based paint. If exterior painted surfaces have been disturbed by the interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation conducted pursuant to 24 CFR Part 35, the visual inspection shall include an assessment to determine if all exterior lead-based paint hazards that were to be controlled by the project have been controlled and to determine if any visible dust or debris remains on any horizontal surfaces in the outdoor living areas close to the affected exterior painted surfaces. In addition, a visual inspection shall be conducted to determine if paint chips are present on the dripline or next to the foundation below any exterior painted surface that was treated. If lead-based paint hazards that were to be controlled by the project are still present, these conditions must be eliminated prior to the continuation of the clearance procedures. If visible dust, debris, or paint chips are present, they must be removed from the site and properly disposed of according to all applicable federal, state, and local standards.

(3) Following the visual inspection and any required cleanup, clearance sampling for lead in dust shall be conducted. Clearance sampling may be conducted by employing single-surface sampling or composite dust sampling.

(4) Dust samples shall be collected a minimum of one hour after the completion of final cleanup activities.

(5) Dust samples shall be collected by wipe samples using the documented methodologies specified in guidance documents issued by the department. The minimum area for a floor wipe sample shall be 0.50 square feet or 72 square inches. The minimum area for a windowsill wipe sample and for a window trough wipe sample shall be 0.25 square feet or 36 square inches. Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

(6) The following clearance activities shall be conducted as appropriate based upon the extent or manner of renovation or of interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation conducted pursuant to 24 CFR Part 35 in the residential dwelling or child-occupied facility:

1. After conducting renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35, with containment between treated and untreated areas, three dust samples shall be taken from each of no fewer than four rooms, hallways, or stairwells within the containment area. Dust samples shall be taken from one interior windowsill and from one window trough (if available), and one dust sample shall be taken from the floor of each of no fewer than four rooms, hallways, or stairwells within the containment area. In addition, one dust sample shall be taken from the floor outside of each individual containment area. If there are fewer than four rooms, hallways, or stairwells within the containment area, then all rooms, hallways, and stairwells shall be sampled. Interior dust-lead testing shall be performed for all projects that include window replacement.

2. After conducting renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35, with no containment between treated and untreated areas, three dust samples shall be taken from each of no fewer than four rooms, hallways, or stairwells in the residential dwelling or child-occupied facility. Dust samples shall be taken from one interior windowsill and window trough (if available), and one dust sample shall be taken from the floor of each room, hallway, or stairwell selected. If there are fewer than four rooms, hallways, or stairwells in the residential dwelling or child-occupied facility, then all rooms, hallways, and stairwells shall be sampled. Interior dust-lead testing shall be performed for all projects that include window replacement.

(7) The contractors conducting the work or cleaning the dwellings shall not know which rooms or surfaces will be selected for the dust samples.

(8) The certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician shall compare the residual lead level as determined by the laboratory analysis from each single-surface dust sample with applicable single-surface clearance levels for lead in dust on floors, interior windowsills, and window troughs. If the residual lead level in a single-surface dust sample is greater than or equal to the applicable clearance level for a floor, interior windowsill, or window trough, then the failed component in each room with a failed single-surface dust sample and that type of component in each room that was not tested shall be recleaned. Additional clearance samples shall be taken from the failed component in each room where it failed and from enough additional rooms that were not previously tested so that four rooms are sampled. If four rooms are not available, then each available room shall be retested. The certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician shall evaluate the results of this testing to determine if the recleaned components meet the clearance level. The components must be recleaned and retested until the clearance level is met.

(9) The certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician shall compare the residual lead level as determined by the laboratory analysis from each composite dust sample with applicable single-surface clearance levels for lead in dust on floors, interior windowsills, and window troughs divided by half the number of subsamples in the composite sample. If the residual lead level in a composite dust sample is greater than or equal to the applicable clearance level divided by half the number of subsamples in the composite sample, then all the components represented by the failed composite dust sample shall be recleaned and retested until clearance levels are met.

c. In multifamily housing consisting of at least 20 similarly constructed and maintained residential dwellings, random selection for the purpose of clearance testing may be conducted if the following conditions are met:

(1) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall randomly select the dwellings that will be sampled. The contractors and the workers who conducted the lead abatement, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation do not know which residential dwellings will be selected for the random selection.

(2) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the minimum number of dwellings selected for dust sampling. This shall provide a 95 percent level of confidence that no more than 5 percent or 50 of the residential dwellings (whichever is smaller) in the randomly sampled population are greater than or equal to the appropriate clearance levels.

(3) The certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall sample the randomly selected residential dwellings and evaluate them for clearance according to the procedures found in paragraphs 70.6(6)“h” through “j.”

(4) The clearance testing is conducted by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

d. A clearance report must be prepared that provides documentation of the lead abatement, renovation, or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation conducted pursuant to 24 CFR Part 35 as well as the clearance testing. When lead abatement is performed, the report shall be a lead abatement report in accordance with paragraph 70.6(6)“n.” When renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35 is performed, the certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician shall prepare a written report for each residential dwelling or child-occupied facility where clearance testing is conducted. No later than 30 days after the property passes clearance, the certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician shall send a copy of the report to the property owner and to the person requesting the clearance testing, if different. The clearance report shall include the following information:

(1) The address of the residential property and, if only part of a multifamily property is affected, the specific dwelling units and common areas affected.

(2) The following information regarding the clearance testing:

1. The date(s) of the clearance testing.

2. The name, address, and signature of each certified lead professional performing the clearance examination, including the certification number.

3. The name and certification number of the certified firm(s) conducting the clearance testing.

4. Whether or not containment was used and, if containment was used, the locations of the containment.

5. If random selection was used to select the residential dwellings that were sampled, the report shall state that random selection was used, the number of residential dwellings that were sampled, and how this number was determined.

6. The results of the visual inspection for the presence of deteriorated paint and visible dust, debris, residue, or paint chips in the rooms where renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation was conducted pursuant to 24 CFR Part 35.

7. All of the results of the analysis of dust samples, in micrograms per square foot, by location of sample. The results shall not be reported as “not detectable.”

8. A statement that the renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation conducted pursuant to 24 CFR Part 35 was or was not done as specified and that the rooms and exterior areas where these activities were conducted

did or did not pass the visual clearance and the clearance dust testing. If the certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician conducting the clearance testing cannot verify that all lead-based paint hazards have been controlled, the report shall contain the following statement:

“The purpose of this clearance report is to verify that this lead hazard control project was done according to the project specifications. This residential dwelling may still contain hazardous lead-based paint, soil-lead hazards, or dust-lead hazards in the rooms or exterior areas that were not included in the lead hazard control project.”

9. The name, address, and telephone number of each recognized laboratory conducting an analysis of the dust samples, including the identification number for each such laboratory recognized by EPA under Section 405(b) of the Toxic Substances Control Act (15 U.S.C. 2685(b)).

(3) The following information on the renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation pursuant to 24 CFR Part 35 for which clearance testing was performed:

1. The start and completion dates of the renovation, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation.

2. The name and address of each firm or organization conducting the renovation, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation and the name of each supervisor assigned.

3. A detailed written description of the renovation, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, including the methods used, locations of exterior surfaces, interior rooms, common areas, and components where the hazard reduction activity occurred.

4. If interim control of soil hazards was conducted, a detailed description of the location(s) of the interim controls and the method(s) used.

5. Information regarding the owner’s obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745.

6. Information regarding Iowa’s prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa’s regulations for renovation found in 641—Chapter 70.

7. The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a sampling technician, lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

*e.* A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor or a certified sampling technician shall maintain a copy of the clearance testing information included in the lead abatement report specified in paragraph 70.6(6) “*m*” for no fewer than three years. A certified lead inspector/risk assessor, a certified elevated blood lead (EBL) inspector/risk assessor, or a certified sampling technician shall maintain a copy of the clearance testing report specified in paragraph 70.6(8) “*d*” for no fewer than three years.

*f.* Clearance testing shall be performed by persons or entities independent of those performing lead abatement, renovation, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation, unless the designated party uses qualified in-house employees to conduct clearance testing. An in-house employee shall not conduct both lead abatement, renovation, interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, or rehabilitation and the clearance examination for this work.

**70.6(9)** A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall conduct paint testing pursuant to 24 CFR Part 35 according to the following standards. Paint testing pursuant to 24 CFR Part 35 shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

a. When conducting paint testing in a residential dwelling or child-occupied facility, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following procedures:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall test paint on each deteriorated paint surface and on each painted surface that will be disturbed or replaced. On windows, the window frame, interior windowsill, window sash, and window trough shall each be tested.

(2) Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If testing by laboratory analysis, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect paint samples using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

1. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

2. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the NIST 1.02 standard film or standards provided by the manufacturer for calibration of the X-ray fluorescence analyzer. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not state that any surface is free of lead-based paint unless the NIST 1.02 standard film is used for calibration.

3. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings at the beginning of the inspection.

4. If recommended by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface, and take three XRF readings with the XRF used to conduct the inspection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not conduct substrate correction where recommended by the performance characteristics sheet, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that all of the readings are positive and shall not state that a surface is free of lead-based paint.

5. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated

blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume that all inconclusive readings are positive and classify them as such.

6. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not resolve inconclusive readings by laboratory analysis, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the inconclusive readings are positive.

b. If lead-based paint is identified through paint testing, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor must conduct a visual inspection to determine the presence of lead-based paint hazards and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated.

c. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where paint testing is conducted. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the inspection, if different. A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of each written report for no less than three years. The report shall include, at least:

(1) A statement that the inspection was conducted to determine whether lead-based paint is present on deteriorated paint surfaces and on painted surfaces that will be disturbed or replaced;

(2) Date of the testing;

(3) Address of building;

(4) Date of construction;

(5) Apartment numbers (if applicable);

(6) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;

(7) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the paint testing;

(8) Name and certification number of the certified firm(s) conducting the paint testing;

(9) Name, address, and telephone number of each laboratory conducting an analysis of collected samples;

(10) Each testing method and sampling procedure employed for paint analysis, including quality control data and, if used, the manufacturer, serial number, software, and operating mode of any X-ray fluorescence (XRF) analyzer;

(11) XRF readings taken for calibration and calculations to demonstrate that the XRF is properly calibrated;

(12) Specific locations by room of each painted component tested for the presence of lead-based paint and the results for each component expressed in terms appropriate to the sampling method used;

(13) A statement that all painted or finished components that were not tested must be assumed to contain lead-based paint;

(14) A description of the location, type, and severity of identified lead-based paint hazards, including the classification of each tested surface as to whether it is a lead-based paint hazard, and any other potential lead hazards, including bare soil in the dripline of a home where lead-based paint is identified

on exterior components or lead-based paint previously existed on exterior components, but has been removed, enclosed, or encapsulated;

(15) A description of interim controls and lead abatement options for each identified lead-based paint hazard and a suggested prioritization for addressing each hazard. If the use of an encapsulant or enclosure is recommended, the report shall recommend a maintenance and monitoring schedule for the encapsulant or enclosure;

(16) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;

(17) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and

(18) The report shall contain the following statement:

“The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135).”

**70.6(10)** A certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor must conduct reevaluations according to the following standards. Reevaluations shall be conducted only by a certified lead inspector/risk assessor or a certified elevated blood lead (EBL) inspector/risk assessor.

*a.* All available information regarding lead-based paint for the property being reevaluated shall be reviewed, including but not limited to reports of any lead-based paint activities conducted in a residential dwelling, multifamily dwelling, or child-occupied facility.

*b.* A visual inspection of the property shall be undertaken to locate the existence of deteriorated paint; bare soil; recommended lead abatement, interim controls, or standard treatments that were not implemented; and failed interim controls, standard treatments, encapsulation, or enclosure.

*c.* Deteriorated paint for which the lead content is unknown shall be tested for the presence of lead.

*d.* Soil samples shall be collected and analyzed from bare soil for which the lead content is unknown. Soil samples shall be collected using the documented methodologies specified in guidance documents issued by the department and shall be analyzed by a recognized laboratory to determine the level of lead.

*e.* If any lead-based paint hazards, recommended lead abatement, interim controls, or standard treatments that were not implemented, or failed interim controls, standard treatments, encapsulation, or enclosure is identified, then the reevaluation is failed. These conditions shall be controlled through lead abatement or interim controls before the reevaluation can continue. Clearance testing shall be conducted following control of the conditions through lead abatement or interim controls.

*f.* If there are no lead-based paint hazards present and all of the recommended lead abatement or interim controls were implemented and have not failed, then single-surface or composite dust samples shall be collected. The reevaluation is passed if all of the dust samples taken are below the clearance level.

*g.* In residential dwellings, single-surface or composite dust samples shall be collected from floors and interior windowsills in at least four rooms, hallways, or stairwells where at least one child under the age of six years is most likely to come in contact with dust.

*h.* In multifamily dwellings, single-surface or composite dust samples shall also be collected from common areas where at least one child under the age of six years is likely to come in contact with dust.

*i.* In child-occupied facilities, single-surface or composite dust samples shall be collected from the floor and interior windowsill in at least four rooms, hallways, or stairwells utilized by one or more children under the age of six years and in other common areas where the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor determines that at least one child under the age of six years is likely to come in contact with dust.

*j.* Dust samples shall be collected by wipe samples using the documented methodologies specified in guidance documents issued by the department. The minimum area for a floor wipe sample shall be 0.50 square feet or 72 square inches. The minimum area for a windowsill wipe sample and for a window trough wipe sample shall be 0.25 square feet or 36 square inches. Dust samples shall be analyzed by a recognized laboratory to determine the level of lead.

*k.* Paint shall be tested using adequate quality control by X-ray fluorescence or by laboratory analysis using a recognized laboratory to determine the presence of lead-based paint on a surface. If tested by laboratory analysis, the paint shall be sampled using the documented methodologies specified in guidance documents issued by the department. If testing by X-ray fluorescence, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the following methodologies:

(1) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use an X-ray fluorescence analyzer that has a performance characteristics sheet and shall use the X-ray fluorescence analyzer according to the performance characteristics sheet.

(2) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use the NIST 1.02 standard film or standards provided by the manufacturer for calibration of the X-ray fluorescence analyzer. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not state that any surface is free of lead-based paint unless the NIST 1.02 standard film is used for calibration.

(3) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall take calibration readings consisting of an average of three readings.

(4) If recommended by the performance characteristics sheet, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall conduct substrate correction for all XRF readings less than 4.0 milligrams of lead per square centimeter. For each substrate that requires substrate correction, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall completely remove all paint from an area of two different testing combinations for that substrate. If possible, the areas chosen for substrate correction should have initial XRF readings of less than 2.5 milligrams of lead per square centimeter. For each testing combination, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall remove paint from an area that is at least as large as the XRF probe faceplate. On each of the two areas, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall place the NIST 1.02 standard film over the surface, and take three XRF readings with the XRF used to conduct the inspection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean for these six readings and shall subtract 1.02 from this arithmetic mean to obtain the substrate correction value. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall then subtract the substrate correction value from each XRF reading for the substrate requiring substrate correction to obtain the corrected XRF reading. For example, if the six readings taken on the NIST 1.02 standard film were 1.1, 1.3, 1.4, 1.0, 1.2, and 1.1, the arithmetic mean is calculated by the equation  $(1.1 + 1.3 + 1.4 + 1.0 + 1.2 + 1.1)/6$  and is equal to 1.18. The substrate correction value is equal to 1.18 minus 1.02, or 0.16. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not conduct substrate correction where recommended by the performance characteristics sheet, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that all of the readings are positive and shall not state that a surface is free of lead-based paint.

(5) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall classify each XRF reading that did not require substrate correction and each corrected XRF reading for XRF readings that required substrate correction as positive, negative, or inconclusive, according to the performance characteristics sheet for the XRF. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not discard XRF readings unless instructed to do so by the performance characteristics sheet or the operating instructions from the manufacturer. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor believes that a reading classified as positive is in error, the certified lead inspector/risk assessor or elevated blood lead

(EBL) inspector/risk assessor shall collect a paint sample for laboratory analysis. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall change the positive classification to negative only if the results of the laboratory analysis indicate that the surface is not painted with lead-based paint. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume that all inconclusive readings are positive and classify them as such.

(6) The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall resolve inconclusive readings as defined by the performance characteristics sheet for the XRF by collecting paint samples for laboratory analysis. If the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor does not resolve inconclusive readings by laboratory analysis, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the inconclusive readings are positive.

*l.* When conducting reevaluation in multifamily housing, a certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor may sample each residential dwelling or choose residential dwellings for sampling by random selection, targeted selection, or worst case selection.

(1) If built before 1960 or if the date of construction is unknown, the multifamily housing shall contain at least 20 similarly constructed and maintained residential dwellings in order to use random selection. If built from 1960 to 1977, the multifamily housing shall contain at least 10 similarly constructed and maintained residential dwellings in order to use random selection. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 1 to determine the number of residential dwellings to randomly select for testing.

(2) If the multifamily housing contains 5 or more similar residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may use targeted selection. If using targeted selection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 2 to determine the number of residential dwellings to test. If the multifamily housing has fewer than 5 similar dwellings, all residential dwellings shall be tested. Residential dwellings chosen by targeted selection shall meet as many of the following criteria as possible. If additional residential dwellings are needed to meet the minimum number specified in Table 2, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall select them randomly. If too many residential dwellings meet the criteria, residential dwellings shall be eliminated randomly. Targeted selection criteria are as follows:

1. The residential dwelling has been cited with a housing or building code violation within the past year.

2. The property owner believes that the residential dwelling is in poor condition.

3. The residential dwelling contains two or more children between the ages of six months and six years. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall give preference to residential dwellings that house the largest number of children.

4. The residential dwelling serves as a child-occupied facility.

5. The residential dwelling has been prepared for reoccupancy within the past three months.

(3) If the multifamily housing contains 5 or more similar residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may use worst case selection. If using worst case selection, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall use Table 2 to determine the number of residential dwellings to test. If the multifamily housing has fewer than 5 similar dwellings, all residential dwellings shall be tested.

(4) The following standards shall be used to determine the extent of lead-based paint hazards throughout multifamily housing that is sampled by random selection, targeted selection, or worst case selection:

1. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall calculate the arithmetic mean of the dust-lead levels for carpeted floors, uncarpeted floors, interior windowsills, and window troughs. If the arithmetic mean is greater than or equal to the level defined as a dust-lead hazard for the component, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall determine that a dust-lead hazard has been identified on the

component throughout the multifamily housing. If the arithmetic mean is less than the level defined as a dust-lead hazard for the component, but some of the individual components have dust-lead levels that are greater than or equal to the level defined as a dust-lead hazard, then the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall determine that a dust-lead hazard has been identified on the individual components and on all other similar components throughout the multifamily housing.

2. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall evaluate the results of paint sampling by component and location. If all components at a given location are determined to be painted with lead-based paint or are determined not to be painted with lead-based paint, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor may assume this condition is true for all similar residential dwellings. The certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall not assume that the multifamily housing is free of lead-based paint. If a component at a given location is found to be painted with lead-based paint in some residential dwellings and not painted with lead-based paint in other residential dwellings, the certified lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor shall assume that the component is a lead-based paint hazard in all similar residential dwellings.

*m.* If reevaluation is conducted, the first reevaluation shall be conducted no later than two years from completion of lead abatement, interim controls, or standard treatments. Subsequent reevaluation shall be conducted at intervals of two years, plus or minus 60 days. To be exempt from additional reevaluation, a residential dwelling or child-occupied facility shall have at least two consecutive passing reevaluations conducted at such two-year intervals. If, however, a reevaluation fails, at least two more consecutive reevaluations conducted at such two-year intervals must be conducted.

*n.* A certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall prepare a written report for each residential dwelling or child-occupied facility where a reevaluation is conducted. No later than three weeks after the receipt of laboratory results, the certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall send a copy of the report to the property owner and to the person requesting the reevaluation, if different. A certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall maintain a copy of the report for no less than three years. The report shall include, at least:

- (1) Date of each reevaluation;
- (2) Address of building;
- (3) Date of construction;
- (4) Apartment numbers (if applicable);
- (5) The name, address, and telephone number of the owner or owners of each residential dwelling or child-occupied facility;
- (6) Name, signature, and certification number of each certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor conducting the reevaluation;
- (7) Name and certification number of the certified firm(s) conducting the reevaluation;
- (8) All of the information gathered for the review as outlined in 70.6(10)“a”;
- (9) Results of the visual inspection including details of any newly identified lead-based paint hazards, the status of past lead hazard control measures, and repair options for any lead-based paint hazards identified during the reevaluation;
- (10) An indication of whether or not the property passed or failed the reevaluation;
- (11) An indication of when the next reevaluation, if any, should occur;
- (12) The results of any environmental samples taken, including all XRF readings, all laboratory analyses and clearance testing results, if necessary;
- (13) Name, address, and telephone number of each recognized laboratory conducting an analysis of collected samples, including the identification number for each such laboratory recognized by EPA under Section 405(b) of the Toxic Substances Control Act (15 U.S.C. 2685(b));

(14) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745;

(15) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation found in 641—Chapter 70; and

(16) The report shall contain the following statement:

"The Iowa Department of Public Health may review this report for compliance purposes. It is a violation of law for anyone other than the certified lead professional signing it to alter this report. This report may be supplemented with additional information, so long as any addendum is signed by a sampling technician, lead inspector/risk assessor or elevated blood lead (EBL) inspector/risk assessor certified according to Iowa Administrative Code 641—70.3(135) and 70.5(135)."

**70.6(11)** All renovations performed in target housing and child-occupied facilities, except for emergency renovations and minor repair and maintenance activities, shall be performed according to the work practice standards in 70.6(11). Renovation activities conducted in housing or on surfaces determined to be free of lead-based paint by a certified lead inspector/risk assessor or certified elevated blood lead (EBL) inspector/risk assessor shall be exempt from all work practice standards except record keeping. All renovations shall be performed by a certified firm under the supervision of a certified lead abatement contractor or a certified lead abatement worker who completes initial certification on or after January 13, 2010, or if certified prior to January 13, 2010, completes a lead abatement worker, lead abatement contractor, or lead-safe renovator refresher course on or after January 13, 2010, or shall be performed by a certified lead-safe renovator in accordance with the requirements below.

*a.* A firm shall assign at least one certified lead abatement contractor, a certified lead abatement worker, or a certified lead-safe renovator to each individual renovation project. The certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator assigned to each individual renovation project shall ensure the following:

(1) A certified lead abatement contractor, a certified lead abatement worker, or a certified lead-safe renovator must be on site during all worksite preparation and during the cleanup of work areas. At all other times when renovation is being conducted, a certified lead abatement contractor, a certified lead abatement worker, or a certified lead-safe renovator shall be on site or available by telephone, pager, or answering service and be able to be present at the worksite in no more than two hours.

(2) Signs are posted and readable. All signs must be posted before the renovation begins and must remain in place until the postrenovation cleaning verification has been completed.

1. To the extent practicable, all signage must be posted in the occupants' primary language.

2. The signs must clearly define the work area.

3. The signs must warn occupants and other persons not involved with the renovation activity to remain outside the work area.

4. The signs must be posted at the entrance(s) to all work areas.

(3) The work area must be effectively contained before the renovation is begun. To be effective, containment must:

1. Isolate the work area so that no dust or debris leaves the work area while the renovation is being performed.

2. Be monitored and maintained so that any plastic or other impermeable materials are not torn or displaced.

3. Be installed in such a manner that it does not interfere with occupant and worker egress in an emergency.

(4) For interior renovations, containment shall include:

1. The removal or covering of all objects from the work area, including but not limited to furniture, rugs, and window coverings. Objects that are not removed from the work area must be covered with plastic sheeting or other impermeable material with all seams and edges taped or otherwise sealed.

2. Closing and covering all duct openings in the work area. Ducts must be covered with plastic sheeting or other impermeable material that is taped down.

3. Closing windows and doors in the work area. Doors must be covered with plastic sheeting or other impermeable material. Doors used as an entrance to the work area must be covered with plastic sheeting or other impermeable material in a manner that allows workers to pass through while confining dust and debris to the work area.

4. Covering the floor surface, including installed carpet, with taped-down plastic sheeting or other impermeable material in the work area six feet beyond the perimeter of the surfaces undergoing renovation or a sufficient distance to contain the dust, whichever is greater.

5. Ensuring that all personnel, tools, and other items, including the exteriors of containers of waste, are free of dust and debris before leaving or being removed from the work area.

(5) For exterior renovations, containment shall include:

1. Closing all doors and windows within 20 feet of the renovation. On multistory buildings, all doors and windows within 20 feet of the renovation on the same story as the renovation shall be closed, and all doors and windows on all stories below the renovation that are the same horizontal distance from the renovation shall be closed.

2. Ensuring that doors within the work areas that will be used while the renovation is being performed are covered with plastic sheeting or other impermeable material in a manner that allows workers to pass through while confining dust and debris to the work area.

3. Covering the ground with plastic sheeting or other disposable impermeable material extending 10 feet beyond the perimeter of surfaces undergoing renovation or a sufficient distance to collect falling paint debris, whichever is greater, unless the property line prevents 10 feet of such ground cover. Exterior ground cover shall include anchors or weights to ensure the covering remains effective even during weather conditions such as high wind.

4. Vertical containment. In certain situations, such as where other buildings are in close proximity to the work area, when conditions are windy, or where the work area abuts a property line, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall erect a system of vertical containment designed to prevent dust and debris from migrating to adjacent property or contaminating the ground, other buildings, or any object beyond the work area.

(6) Prohibited practices are not used during the renovation. Prohibited practices include:

1. Open-flame burning or torching of paint.

2. Machine sanding or grinding or abrasive blasting or sandblasting of paint unless used with high-efficiency particulate air (HEPA) exhaust control that removes particles of 0.3 microns or larger from the air at 99.97 percent or greater efficiency.

3. Uncontained water blasting of paint.

4. Dry scraping or dry sanding of paint except in conjunction with the use of a heat gun or around electrical outlets.

5. Operating a heat gun at a temperature at or above 1100 degrees Fahrenheit.

(7) All workers that are not certified lead abatement contractors, certified lead abatement workers, or certified lead-safe renovators must have on-the-job training as required by 70.6(11)“d.” However, on-the-job training does not meet the training requirement for work conducted pursuant to 24 CFR 35.1340.

(8) If desired, perform all testing with recognized test kits in accordance with 70.6(11)“e.”

(9) Perform the postrenovation cleaning verification as outlined in 70.6(11)“b.”

(10) All waste generated during renovation activities is contained to prevent the release of dust and debris before the waste is removed from the work area for storage or disposal. Any chutes used to remove waste from the work area shall be covered.

1. At the conclusion of each workday and at the conclusion of the renovation, waste that has been collected from renovation activities must be stored under containment, in an enclosure, or behind a barrier that prevents release of dust and debris out of the work area and prevents access to dust and debris.

2. All waste from renovation activities must be contained during transportation so that no dust or debris is released.

(11) The work area shall be cleaned so that no dust, debris, or residue remains after the renovation. Cleaning shall include:

1. The collection of all paint chips and debris and, without dispersing the paint chips and debris, the sealing of the materials in heavy-duty bags.

2. The removal of the protective sheeting used as required in this subrule. The sheeting shall be misted, then the sheeting shall be folded dirty side inward. All sheeting shall be taped shut or otherwise sealed inside heavy-duty bags. Sheeting used to separate work areas from non-work areas must remain in place until after the cleaning and removal of other sheeting. All sheeting shall be disposed of as waste.

3. For interior renovations, all objects and surfaces in the work area and within two feet of the work area must be cleaned from high to low in the following manner:

- Walls must either be vacuumed with a HEPA vacuum or wiped with a wet cloth, beginning at the ceiling and working toward the floor.

- All remaining surfaces including objects and fixtures must be thoroughly vacuumed with a HEPA vacuum. For carpeted floors and rugs, the HEPA vacuum must be equipped with a beater bar.

- All remaining surfaces, except for carpeted or upholstered surfaces, must also be wiped with a damp cloth. Uncarpeted floors must be thoroughly mopped using a method that keeps the wash water separate from the rinse water, such as the two-bucket mopping method, or using a wet mopping system.

b. Postrenovation cleaning verification. A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall use the following procedure for conducting postrenovation cleaning verification. In lieu of postrenovation cleaning verification, clearance testing as outlined in 70.6(8) can be performed. If the work is done in response to an elevated blood lead (EBL) inspection, clearance testing shall be performed by a certified elevated blood lead (EBL) inspector/risk assessor in lieu of postrenovation cleaning verification. Warning signs may be removed after all of the work areas in a renovation project have been adequately cleaned and verified or passed clearance testing.

(1) For interior renovations, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall perform a visual inspection to determine whether dust, debris, or residue is still present. If dust, debris, or residue is still present, these conditions must be removed by recleaning, and another visual inspection must be performed. Following a successful visual inspection, a certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator must:

1. Verify that each windowsill and window trough in the work area has been adequately cleaned, using the following procedure:

- Wipe the windowsill and window trough with a wet disposable cleaning cloth that is damp to the touch. If the cloth matches or is lighter than the cleaning verification card, the windowsill has been adequately cleaned.

- If the cloth does not match and is darker than the cleaning verification card, reclean the windowsill or window trough as directed in 70.6(11)“a”(11). Then wipe the windowsill or window trough again, using a new cloth or the same cloth folded in such a way that an unused surface is exposed. If the cloth matches or is lighter than the cleaning verification card, that windowsill has been adequately cleaned.

- If the cloth does not match and is darker than the cleaning verification card, wait for one hour or until the surface has dried completely, whichever is longer.

- After waiting for the windowsill or window trough to dry, wipe the windowsill or window trough with a dry disposable cleaning cloth. After this wipe, that windowsill or window trough has been adequately cleaned.

2. Verify that uncarpeted floors and countertops in the work area have been adequately cleaned, using the following procedure. If the surface within the work area is greater than 40 square feet, the surface within the work area must be divided into roughly equal sections that are each less than 40 square feet.

- Wipe uncarpeted floors and countertops within the work area with a wet disposable cleaning cloth. Floors must be wiped using an application device with a long handle and a head to which the cloth is attached. The cloth must remain damp at all times while it is being used to wipe the surface

for postrenovation cleaning verification. Wipe each such section separately with a new wet disposable cleaning cloth. If the cloth used to wipe each section of the surface within the work area matches or is lighter than the cleaning verification card, the surface has been adequately cleaned.

- If the cloth does not match and is darker than the cleaning verification card, reclean the surface as in 70.6(11)“a”(11). Then wipe the floor or countertop again, using a new cloth. If the cloth matches or is lighter than the cleaning verification card, that surface has been adequately cleaned.

- If the cloth does not match and is darker than the cleaning verification card, wait for one hour or until the surface has dried completely, whichever is longer.

- After waiting for the surface to dry, wipe each section of the surface that has not yet achieved the postrenovation cleaning verification with a dry disposable cleaning cloth. After this wipe, that surface has been adequately cleaned.

(2) For exterior renovations, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall perform a visual inspection to determine whether dust, debris, or residue is still present on surfaces in and below the work area, including windowsills and the ground. If dust, debris, or residue is present, these conditions must be eliminated and another visual inspection must be performed. When the area passes the visual inspection, the exterior has been adequately cleaned.

(3) A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall only use cleaning verification cards that are approved by the U.S. Environmental Protection Agency (EPA).

(4) A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall not use cleaning verification cards that have expired.

*c.* Clearance testing. Postrenovation cleaning verification is not required if the contract between the renovation firm and the person contracting for the renovation or another federal, state, territorial, tribal, or local law or regulation requires the renovation firm to perform clearance testing at the conclusion of a renovation covered by this chapter.

(1) The dust samples must be collected by a certified lead inspector/risk assessor, certified elevated blood lead (EBL) inspector/risk assessor, or certified sampling technician. If the work is done in response to an elevated blood lead (EBL) inspection, the dust samples must be collected by a certified elevated blood lead (EBL) inspector/risk assessor.

(2) The firm conducting the renovation is required to reclean the work area until the dust clearance sample results are below the clearance standards in subrule 70.6(8).

*d.* On-the-job training. The certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator assigned to the renovation project shall ensure that each noncertified individual conducting renovation activities has been or is currently being trained on how to safely conduct renovation activities. However, on-the-job training does not meet the training requirement for work conducted pursuant to 24 CFR Part 35.

(1) All on-the-job training shall be conducted by a certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator.

(2) Each noncertified individual shall be trained by a certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator who is employed by the same certified firm. A certified firm shall not accept on-the-job training that was performed by another firm. On-the-job training does not meet the requirement for work conducted pursuant to 24 CFR Part 35.

(3) On-the-job training shall be specific for the type of work the noncertified individual is performing and must include at least the following topics:

1. An overview of the requirements described in this chapter.
2. An overview of the health effects of lead poisoning.
3. Methods to prevent taking lead dust home from the worksite.
4. How and why to properly set up a work area for lead-safe renovations.
5. How and where to properly post signage.
6. Personal protection.
7. How and why to properly set up containment.

8. How and why to minimize dust and debris.
9. Proper cleaning techniques and time lines for cleaning in renovation activities.
10. How to properly handle and control waste generated from renovation activities.
11. An overview of the postrenovation cleaning verification and clearance testing.
12. An overview of the prerenovation notification requirements found in 641—Chapter 69.
13. Prohibited work practices.

*e.* Recognized test kits. A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator may use recognized test kits to determine whether surfaces to be affected by renovation activities are painted with lead-based paint. The result from each individual test performed applies only to the individual surface tested. Surfaces which are determined by proper use of a recognized test kit to be free of lead-based paint are exempt from the requirements of 70.6(11)“*a*” through “*d*.” Results obtained from recognized test kits are only valid if the testing was performed according to the manufacturer’s directions. Any results from test kits which are not recognized shall be invalid. A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall not discard a valid result from a recognized test kit.

*f.* A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator must complete a written report when conducting a renovation. The report shall include the results of any testing performed with a recognized test kit, information regarding the work practices used in the renovation and, if applicable, a copy of the clearance testing report. When the final invoice for the renovation is delivered or within 30 days after the renovation activity is complete, whichever is earlier, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall send a copy of the report to the owner of the building. If the renovation took place within a residential dwelling, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall send a copy of the report to an adult occupant of the residential dwelling and to the person requesting the renovation, if different from the owner. If the renovation took place within a child-occupied facility, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall send a copy of the report to an adult representative of the child-occupied facility and to the person requesting the renovation, if different from the owner. If the renovation took place within common areas of multifamily target housing, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall post in areas where it is likely to be seen by the occupants of all of the affected units the report required by this paragraph or instructions on how interested occupants can obtain a copy of this report at no charge. If the renovation took place within a child-occupied facility, the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall post in areas where it is likely to be seen by the parents or guardians of children frequenting the child-occupied facility the report required by this paragraph or instructions on how interested parents or guardians of children frequenting the child-occupied facility can obtain a copy of this report at no charge. A certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator shall maintain a copy of the report for no less than three years. The report shall include, at least:

- (1) The date(s) of the renovation.
- (2) Address of the building, including apartment numbers, if applicable.
- (3) The name, address, and telephone number of the owner(s) of the address(es) where the renovation took place.
- (4) The name, address, signature, certification number, and telephone number of the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator who performed the renovation.
- (5) The name and certification number of the certified firm performing the renovation.
- (6) If testing was performed with a recognized test kit, the location of each test. The location shall be specific to the room and component.
- (7) The results of testing. The results shall be classified as either positive for lead-based paint or negative for lead-based paint.

(8) The name and manufacturer of the recognized test kit(s) used, the expiration date, and the EPA approval number.

(9) The work practices used in the renovation, including the location(s) where each work practice was used. The location shall be specific to the room and component.

(10) If applicable, a copy of the clearance report.

(11) Information regarding the owner's obligations to disclose known lead-based paint and lead-based paint hazards upon sale or lease of residential property as required by Subpart H of 24 CFR Part 35 and Subpart I of 40 CFR Part 745.

(12) Information regarding Iowa's prerenovation notification requirements found in 641—Chapter 69; and information regarding Iowa's regulations for renovation, remodeling and repainting found in 641—Chapter 70.

g. Record keeping. Records shall be kept for each renovation project that involves target housing or child-occupied facilities. The records for each renovation shall include:

(1) The name and certification number of the certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator responsible for the renovation.

(2) The name and certification number of the certified firm that performed the renovation.

(3) The address(es) of the property where the renovation activity was performed.

(4) The name, address, and telephone number of the property owner where the renovation activity was performed.

(5) Renovations considered emergency pursuant to 641—70.2(135) shall contain a description of the circumstances explaining why the renovations were immediately required and which work practice standards were not followed as a result.

(6) Any reports or documentation completed by a certified lead professional concerning the renovation project, including documentation from certified lead inspector/risk assessors or certified elevated blood lead (EBL) lead inspector/risk assessors regarding housing, components, or surfaces that have been determined to be free of lead-based paint and clearance reports from clearance testing performed in lieu of postrenovation cleaning verification.

(7) Documentation that each noncertified individual working on the renovation project had, or was receiving, the appropriate on-the-job training outlined in 70.6(11)“d.” The documentation must include the names of all of the noncertified individuals who worked on the renovation. However, on-the-job training does not meet the training requirement for work conducted pursuant to 24 CFR 35.1340.

(8) Documentation that the certified lead-safe renovator followed the work practices for renovation activities outlined in 70.6(11). This shall include documentation that the following work practices were followed:

1. Signs were posted at the entrance to the work area.

2. The work area was contained.

3. All objects in the work area were covered or removed.

4. All HVAC ducts in the work area were closed and covered.

5. All windows in the work area were closed, and all windows within 20 feet of exterior work areas were closed.

6. All doors not used to enter the work area were closed and sealed, and all doors within 20 feet of exterior work areas were closed and sealed.

7. All doors used as an entrance to the work area had containment in place to prevent the spread of dust and debris.

8. All floors in the work area were covered for a sufficient distance to contain the dust and debris from the renovation.

9. Adequate ground cover was in place to contain the dust and debris for exterior renovations.

10. Adequate vertical containment was in place to contain the dust and debris for exterior renovations.

11. All waste generated during the renovations was contained throughout the renovation and the transportation to disposal.

(9) Documentation that the renovation work area was cleaned and passed the postrenovation cleaning verification procedures outlined in 70.6(11)“b,” including the expiration date of the cleaning verification cards used.

(10) Documentation regarding the use of any recognized test kits outlined in 70.6(11)“e.” The documentation shall include a copy of the written report required by 70.6(11)“f.”

*h.* Emergency renovations.

(1) Renovation activities that are deemed to be an emergency are exempt from the certification requirements and all of the work practice standards, except for the cleaning requirements, postrenovation cleaning verification, and the written report required by 70.6(11)“f.” All postrenovation cleaning must take place under the direction of a certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator. The postrenovation cleaning verification after an emergency renovation must be performed by a certified lead abatement contractor, certified lead abatement worker, or certified lead-safe renovator.

(2) Emergency renovations that are required as a result of an elevated blood lead (EBL) inspection are initially exempt from the certification requirements. The work practice standards found in 70.6(11)“a” shall apply. All individuals who perform emergency renovations in response to an elevated blood lead (EBL) inspection are required to obtain certification as a lead-safe renovator, lead abatement contractor, or lead abatement worker within six months from the date the elevated blood lead (EBL) inspection report was issued. Renovations and interim controls performed in response to an elevated blood lead (EBL) inspection are required to pass clearance testing that is performed by a certified elevated blood lead (EBL) inspector/risk assessor.

**70.6(12)** A certified elevated blood lead (EBL) inspection agency shall maintain for a period of at least 10 years the written records for all elevated blood lead (EBL) inspections conducted by persons that the agency employs or contracts with to provide elevated blood lead (EBL) inspections in the agency’s service area.

**70.6(13)** A person may be certified as a lead inspector/risk assessor, sampling technician, or elevated blood lead (EBL) inspector/risk assessor and as a lead abatement contractor or lead abatement worker. Except as specified by paragraph 70.6(6)“k” and paragraph 70.6(8)“f,” a person who is certified both as a lead inspector/risk assessor, sampling technician, or elevated blood lead (EBL) inspector/risk assessor and as a lead abatement contractor or lead abatement worker shall not provide both lead inspection or visual risk assessment and lead abatement services at the same site unless a written consent or waiver, following full disclosure by the person, is obtained from the owner or manager of the site.

**70.6(14)** Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in subrules 70.6(1) to 70.6(6) and 70.6(9) shall be collected by persons certified as a lead inspector/risk assessor or an elevated blood lead (EBL) inspector/risk assessor. Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in subrule 70.6(8) for clearance testing following lead abatement shall be collected by persons certified as a lead inspector/risk assessor or an elevated blood lead (EBL) inspector/risk assessor. Any dust or soil samples collected pursuant to the work practice standards contained in subrule 70.6(8) for clearance testing after renovation or interim controls, paint stabilization, standard treatments, ongoing lead-based paint maintenance, and rehabilitation pursuant to 24 CFR Part 35 shall be collected only by certified sampling technicians, certified lead inspector/risk assessors, or certified elevated blood lead (EBL) inspector/risk assessors. Any paint chip, dust, or soil samples collected pursuant to the work practice standards contained in 641—70.6(135) shall be analyzed by a recognized laboratory.

**70.6(15)** Composite dust sampling shall be conducted only in the situations specified in subrules 70.6(4) to 70.6(6) and 70.6(8). If composite sampling is conducted, it shall meet the following requirements:

- a.* Composite dust samples shall consist of at least two subsamples.
- b.* Every component that is being tested shall be included in the sampling.
- c.* Composite dust samples shall not consist of subsamples from more than one type of component.
- d.* The results of composite dust samples shall be evaluated by comparing the residual lead level as determined by the laboratory analysis from each composite dust sample with applicable single-surface

dust-lead hazard or clearance levels for lead in dust on floors, interior windowsills, and window troughs divided by half the number of subsamples in the composite sample. For example, the applicable clearance level for a composite window trough sample consisting of three subsamples would be 267 micrograms per square foot (400/1.5).

**70.6(16)** Rescinded IAB 6/7/17, effective 7/12/17.

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.7(135) Firms.** All firms that perform or offer to perform lead-based paint activities must be certified by the department. Firms shall employ only appropriately certified employees to conduct lead-based paint activities, and the firm and its employees shall follow the work practice standards in 641—70.6(135) for conducting lead-based paint activities. A firm must employ at least one certified individual in order to receive or maintain firm certification.

**70.7(1)** A firm wishing to be certified shall apply to the department electronically in a format specified by the department or may apply using a paper application supplied by the department. The firm must submit:

a. A completed application.

b. Documentation that the firm will employ only appropriately certified lead professionals to perform lead-based paint activities. In addition, the firm must document that the agency and its employees or contractors will follow the work practice standards in 641—70.6(135) for conducting lead-based paint activities.

c. The certified firm must maintain all records required by 641—70.6(135), with the exception of elevated blood lead (EBL) inspection reports, for three years. Certified firms that are also certified as elevated blood lead (EBL) inspection agencies must maintain elevated blood lead (EBL) inspection reports for at least 10 years.

**70.7(2)** Firms must be recertified every three years. To be recertified, the firm must submit the following:

a. A completed application.

b. Documentation that the firm will employ only appropriately certified lead professionals to perform lead-based paint activities. In addition, the firm must document that the firm and its employees or contractors will follow the work practice standards in 641—70.6(135) for conducting lead-based paint activities.

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.8(135) Lead-safe work practices training program approval and lead-safe work practices contractor registration.** Rescinded IAB 2/10/10, effective 1/13/10.

**641—70.9(135) Compliance inspections.**

**70.9(1)** The department may enter premises or facilities where violations of the provisions regarding lead-based paint activities may occur for the purpose of conducting compliance inspections.

**70.9(2)** The department may enter premises or facilities where training programs conduct business.

**70.9(3)** The department may take samples and review records as part of the lead-based paint activities compliance inspection process.

**70.9(4)** The department may review all reports involving lead-based paint activities.

**70.9(5)** The department may issue subpoenas pursuant to 641—Chapter 173, Iowa Administrative Code, for the purposes of determining compliance.

[ARC 8502B, IAB 2/10/10, effective 1/13/10]

**641—70.10(135) Denial, suspension, or revocation of certification; denial, suspension, revocation, or modification of course approval; and imposition of penalties.**

**70.10(1)** When the department finds that the applicant, certified lead professional, certified elevated blood lead (EBL) inspection agency, or certified firm has committed any of the following acts, the department may deny an application for certification, may suspend or revoke a certification, may prohibit specific work practices, may require a project conducted by persons or firms that are not

certified or a project where prohibited work practices are being used to be halted, may require the cleanup of lead hazards created by the use of prohibited work practices, may impose a civil penalty, may place on probation, may require additional education, may require reexamination of the state certification examination, may issue a warning, may refer the case to the office of the county attorney for possible criminal penalties pursuant to Iowa Code section 135.38, or may impose other sanctions allowed by law as may be appropriate.

- a.* Failure or refusal to comply with any requirements of this chapter.
- b.* Failure or refusal to establish, maintain, provide, copy, or permit access to records or reports as required by rules 641—70.3(135) to 70.7(135).
- c.* Failure or refusal to permit entry or inspection as described in subrules 70.9(1) to 70.9(3).
- d.* Obtaining or attempting to obtain certification through fraudulent representation.
- e.* Failure to obtain certification from the department and performing work requiring certification.
- f.* Fraudulently obtaining certification and engaging in any lead-based paint activities requiring certification.
- g.* Conducting any part of a lead-based paint activity that requires certification without being certified or with a certification that has lapsed.
- h.* Obtained documentation of training through fraudulent means.
- i.* Gained admission to an accredited training program through misrepresentation of admission requirements.
- j.* Obtained certification through misrepresentation of certification requirements or related documents pertaining to education, training, professional registration, or experience.
- k.* Performed work requiring certification at a job site without having proof of current certification.
- l.* Permitted the duplication or use of the individual's or firm's own certificate by another.
- m.* Failed to follow the standards of conduct required by 641—70.6(135).
- n.* Failed to comply with federal, state, or local lead-based paint statutes and regulations, including the requirements of this chapter.
- o.* Performed work for which certification is required with employees or persons under the control of the certified elevated blood lead (EBL) inspection agency or certified firm who were not appropriately certified.
- p.* Knowingly made misleading, deceptive, untrue, or fraudulent representations in the practice of lead professional activities or engaged in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.
- q.* Used untruthful or improbable statements in advertisements. This includes, but is not limited to, an action by a lead professional making information or intention known to the public that is false, deceptive, misleading, or promoted through fraud or misrepresentation.
- r.* Falsified reports and records required by this chapter.
- s.* Accepted any fee by fraud or misrepresentation.
- t.* Negligence by the firm or individual in the practice of lead professional activities. This includes a failure to exercise due care, including negligent delegation of duties or supervision of employees or other individuals, whether or not injury results; or any conduct, practice, or conditions that impair the ability of the firm or individual to safely and skillfully practice the profession.
- u.* Revocation, suspension, or other disciplinary action taken by a certification or licensing authority of this state, another state, territory, or country; or failure by the firm or individual to report such action in writing within 30 days of the final action by such certification or licensing authority. A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board.
- v.* Failed to comply with the terms of a department order or the terms of a settlement agreement or consent order.
- w.* Representation by a firm or individual that the firm or individual is certified when the certification has been suspended or revoked or has not been renewed.

- x. Failed to respond within 20 days of receipt of communication from the department that was sent by registered or certified mail.
- y. Engaged in any conduct that subverts or attempts to subvert a department investigation.
- z. Failed to comply with a subpoena issued by the department or failure to cooperate with a department investigation.
  - aa. Failed to pay costs assessed in any disciplinary action.
  - ab. Been convicted of a felony or misdemeanor related to lead professional activities or the conviction of any felony or misdemeanor that would affect the ability of the firm or individual to perform lead professional activities. A copy of the record of conviction or plea of guilty shall be conclusive evidence.
    - ac. Unethical conduct. This includes, but is not limited to, the following:
      - (1) Verbally or physically abusing a client or coworker.
      - (2) Improper sexual conduct with or making suggestive, lewd, lascivious, or improper remarks or advances to a client or coworker.
      - (3) Engaging in a professional conflict of interest.
      - (4) Mental or physical inability reasonably related to and adversely affecting the ability of the firm or individual to practice in a safe and competent manner.
      - (5) Being adjudged mentally incompetent by a court of competent jurisdiction.
      - (6) Habitual intoxication or addiction to drugs.
        - 1. The inability of a lead professional to practice with reasonable skill and safety by reason of the excessive use of alcohol on a continuing basis.
        - 2. The excessive use of drugs which may impair a lead professional's ability to practice with reasonable skill or safety.
        - 3. Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.

**70.10(2)** Reserved.

**70.10(3)** The department may deny, suspend, revoke, or modify the approval for a course, or may place on probation, or impose other sanctions allowed by law as may be appropriate, or may impose a civil penalty or may refer the case to the office of the county attorney for possible criminal penalties pursuant to Iowa Code section 135.38 when it finds that the training program, training manager, or other person with supervisory authority over the course has committed any of the following acts:

- a. Misrepresented the contents of a training course to the department or to the student population.
- b. Failed to submit required information or notifications in a timely manner.
- c. Failed to maintain required records.
- d. Falsified approval records, instructor qualifications, or other information or documentation related to course approval.
- e. Failed to comply with the training standards and requirements in 641—70.4(135).
- f. Made false or misleading statements to the department in its application for approval or reapproval which the department relied upon in approving the application.
- g. Failed to comply with federal, state, or local lead-based paint statutes and regulations, including the requirements of this chapter.
- h. Knowingly made misleading, deceptive, untrue, or fraudulent representations in the practice of conducting a training program or engaged in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.
- i. Used untruthful or improbable statements in advertisements. This includes, but is not limited to, an action by a training program making information or intention known to the public that is false, deceptive, misleading, or promoted through fraud or misrepresentation.
- j. Falsified reports and records required by this chapter.
- k. Accepted any fee by fraud or misrepresentation.
- l. Revocation, suspension, or other disciplinary action taken by a certification or licensing authority of this state, another state, territory, or country; or failure by the firm or individual to report such action in writing within 30 days of the final action by such certification or licensing authority.

A stay by an appellate court shall not negate this requirement; however, if such disciplinary action is overturned or reversed by a court of last resort, the report shall be expunged from the records of the board.

*m.* Failed to comply with the terms of a department order or the terms of a settlement agreement or consent order.

*n.* Failed to respond within 20 days of receipt of communication from the department that was sent by registered or certified mail.

*o.* Engaged in any conduct that subverts or attempts to subvert a department investigation.

*p.* Failed to comply with a subpoena issued by the department or failure to cooperate with a department investigation.

*q.* Failed to pay costs assessed in any disciplinary action.

**70.10(4)** Complaints and other requests for action under this rule. Complaints regarding a certified lead professional, a certified elevated blood lead (EBL) inspection agency, a certified firm, or an approved course shall be submitted in writing to the Iowa Department of Public Health, Lead Poisoning Prevention Program, 321 East 12th Street, Des Moines, Iowa 50319-0075. The complainant shall provide:

*a.* The name of the certified lead professional, certified elevated blood lead (EBL) inspection agency, or certified firm and the specific details of the action(s) by the certified lead professional, certified elevated blood lead (EBL) inspection agency, or certified firm that did not comply with the rules; or

*b.* The name of the lead professional or firm that conducted lead professional activities without the appropriate certification or approval as required by the rules; or

*c.* The name of the sponsoring person or organization of an approved course and the specific way(s) that an approved course did not comply with the rules; or

*d.* The name of the sponsoring person or organization that provided a course without the approval required by these rules.

**70.10(5)** Civil penalties.

*a.* Before instituting any proceeding to impose a civil penalty under Iowa Code section 135.105A, the department shall serve a written notice of violation upon the person charged. The notice of violation shall specify the date or dates, facts, and the nature of the alleged act or omission with which the person is charged and shall identify specifically the particular provision or provisions of the law, rule, regulation, certification, approval, or cease and desist order involved in the alleged violation and must state the amount of each proposed penalty. The notice of violation shall also advise the person charged that the civil penalty may be paid in the amount specified therein, or the proposed imposition of the civil penalty may be protested in its entirety or in part, by a written answer, either denying the violation or showing extenuating circumstances. The notice of violation shall advise the person charged that upon failure to pay a civil penalty subsequently determined by the department, if any, unless compromised, remitted, or mitigated, the fee shall be collected by civil action, pursuant to Iowa Code section 135.105A.

*b.* Within 20 days of the date of a notice of violation or other time specified in the notice, the person charged may either pay the penalty in the amount proposed or answer the notice of violation. The answer to the notice of violation shall state any facts, explanations, and arguments denying the charges of violation, or demonstrating any extenuating circumstances, error in the notice of violation, or other reason why the penalty should not be imposed and may request remission or mitigation of the penalty.

*c.* If the person charged with violation fails to answer within the time specified in paragraph 70.10(5)“*b.*,” an order may be issued imposing the civil penalty in the amount set forth in the notice of violation described in paragraph 70.10(5)“*a.*”

*d.* If the person charged with violation files an answer to the notice of violation, the department, upon consideration of the answer, will issue an order dismissing the proceeding or imposing, mitigating, or remitting the civil penalty. The person charged may, within 20 days of the date of the order or other time specified in the order, request a hearing.

*e.* If the person charged with violation requests a hearing, the department will issue an order designating the time and place of hearing. The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

*f.* If a hearing is held, an order will be issued after the hearing by the presiding officer or the department dismissing the proceeding or imposing, mitigating, or remitting the civil penalty.

*g.* The department may compromise any civil penalty. If the civil penalty is not compromised, or is not remitted by the presiding officer or the department, and if payment is not made within ten days following either the service of the order described in paragraph 70.10(5)“*c*” or “*f*,” or the expiration of the time for requesting a hearing described in paragraph 70.10(5)“*d*,” the department may refer the matter to the attorney general for collection.

*h.* Except when payment is made after compromise or mitigation by the department of justice or as ordered by a court of the state, following reference of the matter to the attorney general for collection, payment of civil penalties imposed under Iowa Code section 135.105A shall be made by check, draft, or money order payable to the Iowa Department of Public Health.

**70.10(6) Appeals.**

*a.* Notice of denial, suspension or revocation of certification, or denial, suspension, revocation, or modification of course approval shall be sent to the affected individual or organization by restricted certified mail, return receipt requested, or by personal service. The affected individual or organization shall have a right to appeal the denial, suspension or revocation.

*b.* An appeal of a denial, suspension or revocation or other disciplinary action shall be submitted by certified mail, return receipt requested, within 20 days of the receipt of the department’s notice to the Iowa Department of Public Health, Lead Poisoning Prevention Program, 321 East 12th Street, Des Moines, Iowa 50319-0075. If such a request is made within the 20-day time period, the notice of denial, suspension or revocation or other disciplinary action shall be deemed to be suspended. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, suspension or revocation or other disciplinary action 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 denial, suspension or revocation or other disciplinary action. If no appeal is submitted within 20 days, the denial, suspension or revocation or other disciplinary action shall become the department’s final agency action.

*c.* Upon receipt of an appeal that meets contested case status, the appeal shall be transmitted to the department of inspections and appeals within five working days of receipt pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the denial, suspension or revocation is based shall be provided to the department of inspections and appeals.

*d.* The hearing shall be conducted according to the procedural rules of the department of inspections and appeals found in 481—Chapter 10, Iowa Administrative Code.

*e.* 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 ten days after it is received by the aggrieved party unless an appeal to the director is taken as provided in paragraph 70.10(6)“*f*.”

*f.* Any appeal to the director for review of the proposed decision and order of the administrative law judge shall be filed in writing and mailed to the director by certified mail, return receipt requested, or delivered by personal service within ten days after the receipt of the administrative law judge’s proposed decision and order by the aggrieved party. A copy of the appeal shall also be mailed to the administrative law judge. Any request for appeal shall state the reason for appeal.

*g.* Upon receipt of an appeal request, the administrative law judge shall prepare the record of the hearing or submission to the director. The record shall include the following:

- (1) All pleadings, motions, and rulings.
- (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, objection, and rulings thereon.
- (5) All proposed findings and exceptions.
- (6) The proposed findings and order of the administrative law judge.

*h.* The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and shall be delivered by restricted certified mail, return receipt requested, or by personal service.

*i.* It is not necessary to file an application for a rehearing to exhaust administrative remedies when appealing to the director or the district court as provided in Iowa Code section 17A.19. The aggrieved party to the final agency action of the department who has exhausted all administrative remedies may petition for judicial review of that action pursuant to Iowa Code chapter 17A.

*j.* Any petition for judicial review of a decision and order shall be filed in the district court within 20 days after the decision and order becomes final. A copy of the notice of appeal shall be sent to the department by certified mail, return receipt requested, or by personal service to the Iowa Department of Public Health, Lead Poisoning Prevention Program, 321 East 12th Street, Des Moines, Iowa 50319-0075.

*k.* 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.

**70.10(7) Public notification.**

*a.* The public shall be notified of the suspension, revocation, modification, or reinstatement of course approval through appropriate mechanisms.

*b.* The department shall maintain a list of courses for which the approval has been suspended, revoked, modified, or reinstated.

*c.* The public shall be notified of the suspension or revocation of the certification of a lead professional or firm.

*d.* The department shall maintain a list of lead professionals and firms for which certification has been suspended or revoked.

[ARC 8502B, IAB 2/10/10, effective 1/13/10; ARC 3104C, IAB 6/7/17, effective 7/12/17]

**641—70.11(135) Waivers.** Rules in this chapter are not subject to waiver or variance pursuant to 641—Chapter 178 or any other provision of law.

These rules are intended to implement Iowa Code section 135.105A.

[Filed emergency 9/16/96—published 10/9/96, effective 9/16/96]

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[Filed emergency 9/17/99—published 10/6/99, effective 9/17/99]

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[Filed Emergency After Notice ARC 8502B (Notice ARC 8357B, IAB 12/2/09), IAB 2/10/10, effective 1/13/10]

[Filed ARC 0482C (Notice ARC 0369C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]

[Filed ARC 3104C (Notice ARC 2969C, IAB 3/15/17), IAB 6/7/17, effective 7/12/17]

<sup>◇</sup> Two or more ARCs

## CHAPTER 107

## BOARD-CERTIFIED BEHAVIOR ANALYST AND BOARD-CERTIFIED ASSISTANT BEHAVIOR ANALYST (BCBA/BCaBA) GRANTS PROGRAM

**641—107.1(135) Scope and purpose.** The board-certified behavior analyst and board-certified assistant behavior analyst (BCBA/BCaBA) grants program is established to increase access for Iowans to applied behavior analysis services by providing grants to Iowa resident and nonresident applicants who have been accepted for admission or are attending a university, a community college, or an accredited private institution, within or outside the state of Iowa; are enrolled in a program, offered at a physical location or online, that is accredited and meets coursework requirements to prepare the applicant to be eligible for board certification as a behavior analyst or assistant behavior analyst; and demonstrate financial need. [ARC 2765C, IAB 10/12/16, effective 11/16/16]

**641—107.2(135) Definitions.** For the purposes of these rules, the following definitions shall apply:

*“Board-certified assistant behavior analyst”* or *“BCaBA”* means a person who has a bachelor’s degree from an accredited university, has completed approved coursework as defined by the international Behavior Analyst Certification Board, has completed a defined period of supervised practical experience, and has passed the BCaBA examination.

*“Board-certified behavior analyst”* or *“BCBA”* means a person who has an acceptable graduate degree from an accredited university as defined by the international Behavior Analyst Certification Board, has completed acceptable graduate coursework in behavior analysis, has completed a defined period of supervised practical experience, and has passed the BCBA examination.

*“Department”* means the Iowa department of public health.

*“Director”* means the director of the Iowa department of public health.

*“Full-time enrollment”* means the applicant is enrolled in a program to be eligible for board certification as a behavior analyst or assistant behavior analyst with the appropriate number of semester credit hours as defined by the educational institution.

*“Nonresident”* means a person who is not a resident.

*“Part-time enrollment”* means the applicant is enrolled in a program to be eligible for board certification as a behavior analyst or assistant behavior analyst with the appropriate number of semester credit hours as defined by the educational institution.

*“Resident”* means a natural person who physically resides in Iowa as the person’s principal and primary residence and who establishes evidence of such residency by providing the department with one of the following:

1. A valid Iowa driver’s license,
2. A valid Iowa nonoperator’s identification card,
3. A valid Iowa voter registration card,
4. A current Iowa vehicle registration certificate,
5. A utility bill,
6. A statement from a financial institution,
7. A residential lease agreement,
8. A check or pay stub from an employer,
9. A child’s school or child care enrollment documents,
10. Valid documentation establishing a filing for homestead or military tax exemption on property located in Iowa, or
11. Other valid documentation as deemed acceptable by the department to establish residency.

[ARC 2765C, IAB 10/12/16, effective 11/16/16]

**641—107.3(135) Eligibility criteria.** To be eligible for a grant, the applicant shall:

**107.3(1)** Be an Iowa resident or nonresident.

**107.3(2)** Be accepted for admission to or be attending a university, a community college, or an accredited private institution, within or outside the state of Iowa, be enrolled in a program, offered at a physical location or online, that is accredited and meets coursework requirements to prepare the applicant

to be eligible for board certification as a behavior analyst or assistant behavior analyst, and demonstrate financial need.

**107.3(3)** Have on file with the college student aid commission a current Free Application for Federal Student Aid (FAFSA) and Iowa Financial Aid Application or similar financial aid documentation from another state and submit documentation of financial need as described in the department's request for proposal process.

**107.3(4)** Agree to practice in the state of Iowa for a period of time, not to exceed four years, as specified in the contract entered into between the applicant and the department at the time the grant is awarded.

**107.3(5)** Agree, as specified in the contract between the applicant and the department at the time the grant is awarded, that during the contract period, the applicant will assist in supervising an individual working toward board certification as a behavior analyst or assistant behavior analyst or to consult with schools and service providers that provide services and supports to individuals with autism.

[ARC 2765C, IAB 10/12/16, effective 11/16/16]

**641—107.4(135) Priority in grant awards.** Priority in the awarding of a grant shall be given to resident applicants.

[ARC 2765C, IAB 10/12/16, effective 11/16/16]

**641—107.5(135) Amount of a grant.** The department shall award funds based upon the amount set aside in the special fund, as identified in Iowa Code section 135.181 as amended by 2016 Iowa Acts, House File 2460, sections 57 and 58. Moneys appropriated to, and all other moneys specified for deposit in, the fund shall be dedicated to the board-certified behavior analyst and board-certified assistant behavior analyst (BCBA/BCaBA) grants program as established in Iowa Code section 135.181 as amended by 2016 Iowa Acts, House File 2460, sections 57 and 58. These rules shall be implemented only to the extent that funding is available. The amount of funding awarded to each applicant shall be based on the applicant's enrollment status (full-time enrollment or part-time enrollment), the number of applicants, and the total amount of available funds. The total amount of funds awarded to an individual applicant shall not exceed 50 percent of the total costs attributable to program tuition and fees, annually. Awarded grant funds will be payable to the student and prorated on the number of semesters or other terms of study to complete the program.

[ARC 2765C, IAB 10/12/16, effective 11/16/16]

**641—107.6(135) Use of funds.** Funds awarded may be used to offset the costs attributable to tuition and fees for the accredited behavior analyst or assistant behavior analyst program.

[ARC 2765C, IAB 10/12/16, effective 11/16/16]

**641—107.7(135) Review process.**

**107.7(1)** An applicant shall complete and submit an application to the program in the manner specified by the department. An applicant, if awarded a grant, shall enter into a contract with the department. The department shall follow requirements for competitive selection contained in 641—Chapter 176 in awarding these funds.

**107.7(2)** The department shall establish an application process for applicants eligible to receive funding. The application review process and review criteria for preference in awarding the grants shall be described in a request for proposals.

**107.7(3)** An applicant may appeal the denial of a properly submitted grant application. Appeals shall be governed by rule 641—176.8(135).

[ARC 2765C, IAB 10/12/16, effective 11/16/16; ARC 3105C, IAB 6/7/17, effective 7/12/17]

**641—107.8(135) Reporting.** The department shall submit a report to the governor and the general assembly by January 1, annually. The report shall include the number of applications received for the immediately preceding fiscal year; the number of applications approved; the total amount of funding

awarded in grants in the immediately preceding fiscal year; the cost of administering the program in the immediately preceding fiscal year; and recommendations for any changes to the program.

[ARC 2765C, IAB 10/12/16, effective 11/16/16]

These rules are intended to implement Iowa Code section 135.181 as amended by 2016 Iowa Acts, House File 2460, sections 57 and 58.

[Filed ARC 2765C (Notice ARC 2460C, IAB 3/16/16; Amended Notice ARC 2621C, IAB 7/20/16),  
IAB 10/12/16, effective 11/16/16]

[Filed ARC 3105C (Notice ARC 2970C, IAB 3/15/17), IAB 6/7/17, effective 7/12/17]



CHAPTER 136  
TRAUMA REGISTRY

**641—136.1(147A) Definitions.** For the purposes of these rules, the following definitions shall apply:

“*Cases*” means trauma patients that meet the trauma registry inclusion criteria.

“*Department*” means the Iowa department of public health.

“*Director*” means the director of the Iowa department of public health.

“*ICD10*” means International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).

“*Inclusion criteria*” means criteria determined by the department and adopted by reference to determine which trauma patients are to be included in the trauma registry.

“*Reportable patient data*” means data elements and definitions determined by the department and adopted by reference to be reported to the trauma registry on trauma patients meeting the inclusion criteria.

“*Trauma care facility*” means a hospital or emergency care facility which provides trauma care and has been verified by the department as having Level I, Level II, Level III or Level IV care capabilities and has been issued a certificate of verification pursuant to Iowa Code section 147A.23(2)“c.”

“*Trauma patient*” means a victim of an external cause of injury that results in major or minor tissue damage or destruction caused by intentional or unintentional exposure to thermal, mechanical, electrical or chemical energy, or by the absence of heat or oxygen.

“*Trauma registry*” means the data repository operated by the department to collect and analyze reportable patient data on the incidence, severity, and causes of trauma, including the central registry for brain and spinal cord injuries (IAC 641—21.1(135)) and farm-related injuries.

[ARC 3106C, IAB 6/7/17, effective 7/12/17]

**641—136.2(147A) Trauma registry.**

**136.2(1)** Adoption by reference.

a. “Iowa Trauma Patient Data Dictionary” (January 2017) is incorporated by reference for inclusion criteria and reportable patient data to be reported to the trauma registry. For any differences which may occur between the adopted reference and this chapter, the administrative rules shall prevail.

b. “Iowa Trauma Patient Data Dictionary” is available through the Iowa Department of Public Health, Bureau of Emergency and Trauma Services (BETS), Lucas State Office Building, Des Moines, Iowa 50319-0075, or the BETS Web site (<http://idph.iowa.gov/BETS>).

**136.2(2)** A trauma care facility shall report data as follows:

a. Trauma care facilities shall submit reportable patient data identified in 136.2(1) electronically to the department. Data shall be submitted in a format approved by the department.

b. Trauma care facilities that enter required trauma data elements identified in 136.2(1) directly into the state registry shall, at a minimum, enter 80 percent of cases within 60 days of a patient’s discharge. Within 120 days of a patient’s discharge, 100 percent of cases shall be entered into the registry.

c. Trauma care facilities that submit required trauma data elements identified in 136.2(1) via upload shall, at a minimum, submit 80 percent of cases discharged within the previous 60 days of the first business day of every even-numbered calendar month. Within 120 days of a patient’s discharge or next scheduled data upload, 100 percent of cases shall be entered into the registry.

**136.2(3)** Reportable patient data compilations. The department shall prepare compilations for release or dissemination on reportable patient data entered into the trauma registry during the reporting period. The compilations shall include, but not be limited to, trends and patient care outcomes for local, regional and statewide evaluations. The compilations shall be made available to all providers submitting reportable patient data to the registry.

**136.2(4)** Access and release of reportable patient data and information.

a. The data collected by the trauma registry and furnished to the department pursuant to this rule are confidential records of the condition, diagnosis, care, or treatment of patients or former patients,

including outpatients, pursuant to Iowa Code section 22.7. The compilations prepared for release or dissemination from the data collected are not confidential under Iowa Code section 22.7(2). However, information which individually identifies patients shall not be disclosed and state and federal law regarding patient confidentiality shall apply.

*b.* The department may approve requests for reportable patient data for special studies and analysis provided:

(1) The request has been reviewed and approved by the department with respect to the scientific merit and confidentiality safeguards; and

(2) The department has given administrative approval for the proposal.

(3) The confidentiality of patients and trauma care facilities is protected pursuant to Iowa Code sections 22.7 and 147A.24.

*c.* The department may require those requesting the data to pay any or all of the reasonable costs associated with furnishing the reportable patient data.

**136.2(5)** Data collection methods. To the extent possible, activities under this rule shall be coordinated with other health data collection methods.

**136.2(6)** Quality assurance.

*a.* For the purpose of ensuring the completeness and quality of reportable patient data, the department or authorized representative may examine all or part of the patient's medical records as necessary to verify or clarify all reportable patient data submitted by a trauma care facility.

*b.* Review of a patient's medical record by the department shall be scheduled in advance with the trauma care facility and completed in a timely manner.

*c.* The director, pursuant to 641—Chapter 178, may grant a variance from the requirements of rules adopted under this chapter for a trauma care facility that meets the requirements of this chapter.

[ARC 9444B, IAB 4/6/11, effective 5/11/11; ARC 3106C, IAB 6/7/17, effective 7/12/17]

**641—136.3(147A) Offenses and penalties.** All complaints, offenses and penalties will be addressed pursuant to rule 641—134.3(147A).

[ARC 3106C, IAB 6/7/17, effective 7/12/17]

These rules are intended to implement Iowa Code section 147A.26.

[Filed 11/14/96, Notice 10/9/96—published 12/4/96, effective 1/8/97]

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[Filed ARC 9444B (Notice ARC 9343B, IAB 1/26/11), IAB 4/6/11, effective 5/11/11]

[Filed ARC 3106C (Notice ARC 2902C, IAB 1/18/17), IAB 6/7/17, effective 7/12/17]

## PHARMACY BOARD[657]

[Prior to 2/10/88, see Pharmacy Examiners, Board of [620], renamed Pharmacy Examiners Board[657]  
under the “umbrella” of Public Health Department by 1986 Iowa Acts, ch 1245; renamed by 2007 Iowa Acts, Senate File 74]

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CHAPTER 2  
PHARMACIST LICENSES

[Prior to 2/10/88, see Pharmacy Examiners[620] Chs 1, 5]

**657—2.1(147,155A) Licensure by examination.** The board of pharmacy, in conjunction with the National Association of Boards of Pharmacy (NABP), shall provide for the administration of pharmacist licensure examinations.

**2.1(1) Components.** Applicants shall take and pass the following components: the North American Pharmacist Licensure Examination (NAPLEX); the Multistate Pharmacy Jurisprudence Examination (MPJE), Iowa Edition. A total scaled score of no less than 75 is required to pass each examination.

**2.1(2) Timeliness.** To be eligible for a license by examination, the candidate shall pass all components in Iowa within a period of one year beginning with the date the candidate passed an initial component. A candidate may request waiver or variance from this deadline pursuant to the procedures and requirements of 657—Chapter 34.

**657—2.2(155A) Application for examination—requirements.** Application for examination shall be on forms provided by the board, and all requested information shall be provided on or with such application. An applicant shall complete the NABP Computerized Examination Registration Form to apply for registration to take the NAPLEX. An applicant shall complete an additional registration form to apply for registration to take the MPJE, Iowa Edition.

**2.2(1) Required information.** The application for examination shall require that the applicant provide, at a minimum, the following: name; address; telephone number; date of birth; social security number; name and location of college of pharmacy and date of graduation; one current photograph of a quality at least similar to a passport photograph; and internship experience. Each applicant shall also declare the following: history of prior pharmacist licensure examinations and record of offenses including but not limited to charges, convictions, and fines which relate to the profession or that may affect the licensee's ability to practice pharmacy.

**2.2(2) Sworn statement.** The application for examination shall be made as a sworn statement before a notary public, and the notary public shall witness the signature of the applicant.

**657—2.3(147,155A) Examination fee.** The fee for examination shall consist of the biennial license fee, a processing fee, administration fees, and examination registration fees.

**2.3(1) Fees to the board.** The biennial license fee shall be the fee established by rule 657—2.11(147,155A), including surcharge. The processing fee shall be \$72. No refunds of the processing fee shall be made for cancellation or withdrawal of applications. The license fee and processing fee shall be payable to the Iowa Board of Pharmacy and may be remitted in the form of personal check, money order, cashier's check, or certified check. No refund of fees shall be made for failure to complete all licensure requirements within the period specified in subrule 2.1(2).

**2.3(2) Fees to NABP.** The examination registration and administration fees shall be amounts determined by NABP, shall be payable to the National Association of Boards of Pharmacy, and shall be in the form of a certified check or money order. Refunds of fees paid to NABP shall be at the discretion of NABP.

**2.3(3) Submission of forms and fees.** The biennial license fee including surcharge, the processing fee, the administration fees, and the examination registration fees shall accompany the applications and registration forms and shall be submitted to the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688, or as otherwise directed by the board.

[ARC 0504C, IAB 12/12/12, effective 1/16/13]

**657—2.4(155A) Internship requirements.** Each applicant shall furnish to the board evidence certifying completion of satisfactory internship experience. The board will not certify an applicant eligible to take any of the examination components prior to receipt of evidence of satisfactory completion of internship experience. Internship experience shall comply with the requirements in 657—Chapter 4. Internship experience completed in compliance with the requirements in 657—Chapter 4 shall be

valid for application for licensure in Iowa by examination or score transfer for a period of three years following graduation from an approved college of pharmacy or as otherwise approved by the board on a case-by-case basis.

**657—2.5(155A) College graduate certification.** Each applicant shall furnish a certificate from a recognized college of pharmacy stating that the applicant has successfully graduated from a school or college of pharmacy with either a bachelor of science degree in pharmacy or a doctor of pharmacy (Pharm.D.) degree. Certification shall be completed by an individual authorized by the college on a form provided by the board. A recognized college of pharmacy is a United States institution that meets the minimum standards of the Accreditation Council on Pharmaceutical Education and appears on its list of accredited colleges of pharmacy published by the council as of July 1 of each year.

[Editorial change: IAC Supplement 2/6/13]

**657—2.6(147) Reexamination applications and fees.** A candidate who fails to pass either the NAPLEX or the MPJE, Iowa Edition, once shall be allowed to schedule a time to retake the examination as provided in this rule. To ensure the integrity of the examinations, no waiver or variance of the specified waiting period between reexaminations will be granted.

**2.6(1) NAPLEX.** A candidate who fails to pass the NAPLEX once shall be allowed to schedule a time to retake the examination no less than 45 days following administration of the failed examination. The candidate may be approved to retake the NAPLEX no more than three times in a 12-month period.

**2.6(2) MPJE, Iowa Edition.** A candidate who fails to pass the MPJE, Iowa Edition, once shall be allowed to schedule a time to retake the examination no less than 30 days following administration of the failed examination.

**2.6(3) Reexamination after two or more attempts.** A candidate who fails to pass either examination following a second or subsequent examination may petition the board for permission to take the examination again. Determination of a candidate's eligibility to take an examination more than two times shall be at the discretion of the board.

**2.6(4) Applications and fees.** Each applicant for reexamination shall file an application on forms provided by the board. A processing fee of \$36 will be charged for each NAPLEX or MPJE, Iowa Edition, reexamination and shall be paid to the board as provided in subrule 2.3(1). In addition, candidates will be required to complete the appropriate examination registration application as provided in rule 657—2.2(155A) and to pay to NABP the registration and administration fees for each examination as provided in subrule 2.3(2). All applications, registration forms, and fees shall be submitted as provided in subrules 2.3(2) and 2.3(3).

[ARC 0504C, IAB 12/12/12, effective 1/16/13; ARC 3099C, IAB 6/7/17, effective 7/12/17]

**657—2.7(147) Examination results.** Examination scores and original license certificates shall be provided to each new licensee as soon after the examinations as possible.

**657—2.8(155A) Transfer of examination scores.** The board of pharmacy participates in the NAPLEX score transfer program offered by NABP. This program allows candidates for pharmacist licensure to take the standardized NAPLEX in one state and have the score from that examination transferred to other participant states in which the candidate is seeking licensure. MPJE scores cannot be transferred.

**2.8(1) Score transfer application.** The NAPLEX Score Transfer Form must be completed and submitted with the proper fee to NABP prior to, or postmarked no later than, the date on which the candidate takes the NAPLEX. The fee to NABP for score transfer is determined by NABP. Payment shall be made in the form of a money order or certified check payable to the National Association of Boards of Pharmacy. NABP makes no refunds of score transfer fees.

**2.8(2) Requirements and deadline.** Score transfer candidates shall meet the requirements established in rules 657—2.1(147,155A) through 657—2.5(155A) within 12 months of the date of transfer. No refund of fees paid to the board will be made for failure to complete all licensure requirements within this one-year period.

**2.8(3) Fees.** In addition to the score transfer fee identified in subrule 2.8(1), fees for licensure pursuant to the NABP score transfer program shall consist of the fees identified in rule 657—2.3(147,155A) excluding the NAPLEX examination registration and administration fees.

**657—2.9(147,155A) Licensure by license transfer/reciprocity.** An applicant for license transfer/reciprocity must be a pharmacist licensed by examination in a state or territory of the United States with which Iowa has a reciprocal agreement, and the license by examination upon which the transfer is based must be in good standing at the time of the application and license transfer. All candidates shall take and pass the MPJE, Iowa Edition, as provided in subrule 2.1(1). Any candidate who fails to pass the examination shall be eligible for reexamination as provided in rule 657—2.6(147).

**2.9(1) Eligibility.** Each applicant for license transfer to this state who obtains the applicant's original license after January 1, 1980, must have passed the NABP Licensure Examination (NABPLEX), the NAPLEX, or an equivalent examination as determined by NABP.

*a. Preliminary application.* Each applicant for license transfer/reciprocity to Iowa shall complete and submit to NABP, with the appropriate fee as indicated on the application, the NABP Preliminary Application for Transfer of Pharmaceutic Licensure. Refunds of fees paid to NABP shall be at the discretion of NABP.

*b. Foreign pharmacy graduates.* If the applicant is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board, proof of qualifications shall include certification from the FPGEC pursuant to subrule 2.10(1).

**2.9(2) Application requirements.** Application to the board shall consist of the final application for license transfer prepared by NABP pursuant to the NABP license transfer program. A foreign pharmacy graduate shall submit certification from the FPGEC as provided in subrule 2.10(1). Applications, together with other required information and fees, shall be submitted as provided in subrule 2.3(3).

**2.9(3) MPJE required.** An applicant shall also be required to submit the registration application for MPJE, Iowa Edition, as provided in rule 657—2.2(155A). The form and fees shall be submitted as provided in subrules 2.3(2) and 2.3(3).

**2.9(4) Fees.** The fee for license transfer shall consist of the biennial license fee established by rule 657—2.11(147,155A) including surcharge and a processing fee of \$90. No refunds of the processing fee shall be made for cancellation or withdrawal of an application. The license fee and processing fee shall be payable to the Iowa Board of Pharmacy and may be remitted in the form of personal check, money order, cashier's check, or certified check.

**2.9(5) Timeliness.** A final application for license transfer is valid for 12 months following the date of issuance by NABP. A candidate for license transfer shall complete, within that one-year period, all licensure requirements established by this rule. No refund of fees will be made for failure to complete all licensure requirements within this one-year period.

[ARC 0504C, IAB 12/12/12, effective 1/16/13; ARC 1031C, IAB 9/18/13, effective 10/23/13]

**657—2.10(155A) Foreign pharmacy graduates.**

**2.10(1) Education equivalency.** Any applicant who is a graduate of a school or college of pharmacy located outside the United States that has not been recognized and approved by the board shall be deemed to have satisfied the requirements of Iowa Code section 155A.8, subsection 1, by certification by the Foreign Pharmacy Graduate Examination Committee (FPGEC). Each applicant shall have successfully passed the Foreign Pharmacy Graduate Equivalency Examination (FPGEE) given by the FPGEC established by the NABP. The FPGEE is hereby recognized and approved by the board. Each applicant shall also demonstrate proficiency in written English by passing the Test of English as a Foreign Language (TOEFL) and proficiency in spoken English by passing the Test of Spoken English (TSE) or proficiency in basic English language skills by passing the Internet Based TOEFL (TOEFL iBT). The TOEFL, TOEFL iBT, and TSE are hereby recognized and approved by the board. Certification by the FPGEC shall be evidence of the applicant's successfully passing the FPGEE, TSE, and TOEFL, or the FPGEE and TOEFL iBT, and certification is a prerequisite to taking the licensure examinations required in subrule 2.1(1).

**2.10(2) Internship.** A foreign pharmacy graduate applicant shall also be required to obtain internship experience in one or more board-licensed community or hospital pharmacies as provided in rule 657—4.7(155A). Internship requirements shall, in all other aspects, meet the requirements established in 657—Chapter 4.

**657—2.11(147,155A) License expiration and renewal.** A license to practice pharmacy shall expire on the second thirtieth day of June following the date of issuance of the license, with the exception that a new pharmacist license issued between April 1 and June 29 shall expire on the third thirtieth day of June following the date of issuance. The license renewal certificate shall be issued upon completion of the renewal application and timely payment of a \$180 fee plus applicable surcharge pursuant to 657—30.8(155A).

**2.11(1) Late payment penalty.** Failure to renew the license before July 1 following expiration shall require payment of the renewal fee, a penalty fee of \$180, and applicable surcharge pursuant to 657—30.8(155A). Failure to renew the license before August 1 following expiration shall require payment of the renewal fee, a penalty fee of \$270, and applicable surcharge pursuant to 657—30.8(155A). Failure to renew the license before September 1 following expiration shall require payment of the renewal fee, a penalty fee of \$360, and applicable surcharge pursuant to 657—30.8(155A). Failure to renew the license before October 1 following expiration may require an appearance before the board and shall require payment of the renewal fee, a penalty fee of \$450, and applicable surcharge pursuant to 657—30.8(155A). In no event shall the combined fee and penalty fee for late renewal of the license exceed \$630 plus applicable surcharge pursuant to 657—30.8(155A). The provisions of Iowa Code section 147.11 shall apply to a license that is not renewed within five months of the expiration date.

**2.11(2) Delinquent license.** If a license is not renewed before its expiration date, the license is delinquent and the licensee may not practice pharmacy in the state of Iowa until the licensee reactivates the delinquent license. Reactivation of a delinquent license shall include submission of a completed application and appropriate fees and may include requirements relating to the reactivation of an inactive license pursuant to subrule 2.13(2). A pharmacist who continues to practice pharmacy in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.1(4).

[ARC 0504C, IAB 12/12/12, effective 1/16/13]

**657—2.12(272C) Continuing education requirements.** Pharmacists shall complete continuing education for license renewal pursuant to the requirements of this rule. For purposes of this rule, “continuing education” means a structured educational activity that is applicable to the practice of pharmacy, that promotes problem solving and critical thinking, and that is designed or intended to support the continuing development of pharmacists to maintain and enhance their competence in the practice of pharmacy. Nothing in these rules precludes the board from requiring an applicant for renewal to submit to a relicensure examination.

**2.12(1) Continuing education unit required.** The nationally accepted measurement of continuing education is referred to as CEU (continuing education unit), and the board employs that measurement. Ten contact hours of approved continuing education are equivalent to one CEU.

*a.* The board will require 3.0 CEUs each renewal period except as provided in subrule 2.12(5) or rule 657—2.17(272C). For purposes of this rule, “renewal period” means the 27-month period commencing April 1 prior to the previous license expiration and ending June 30, the date of current license expiration.

*b.* A pharmacist who fails to complete the required CEUs within the renewal period shall be required to complete one and one-half times the number of delinquent CEUs prior to reactivation of the license.

*c.* CEUs that are used to satisfy the continuing education requirement for one renewal period shall not be used to satisfy the requirement for a subsequent renewal period.

d. Failure to receive a license renewal application or notice of license renewal shall not relieve the pharmacist of the responsibility of meeting continuing education requirements.

**2.12(2) Continuing education activity completion.** Continuing education activities that carry the seal of an Accreditation Council for Pharmacy Education (ACPE)-accredited provider will automatically qualify for continuing education credit. Successful completion and record of continuing education activities in CPE Monitor is mandated in order for a pharmacist to receive credit for ACPE-accredited provider continuing education activities.

a. *Non-ACPE provider activity.* A maximum of 1.3 CEUs (13 contact hours) of the total 3.0 CEUs of continuing education credits required pursuant to subrule 2.12(4) may be obtained through completion of non-ACPE provider activities if such activities are provided by an accredited health-professional continuing education provider, such as a continuing medical education (CME) provider, and if the activity content directly relates to the pharmacist's professional practice. Non-ACPE provider activity completion shall be recorded, evaluated, and reported pursuant to the provisions of rule 657—2.17(272C) regarding continuing professional development.

(1) The pharmacist is responsible for ensuring that the activity content directly relates to the pharmacist's professional practice.

(2) If one or more non-ACPE provider activities are intended to fulfill the requirement in paragraph 2.12(4) "c," the pharmacist is responsible for ensuring the activity content relates to patient or medication safety.

(3) If the non-ACPE provider is not able to transmit the activity record to CPE Monitor, the provider shall provide to the pharmacist a statement of credit that indicates the pharmacist's participation in and successful completion of the continuing education activity. The statement of credit shall include all information identified in subrule 2.12(3), except for the pharmacist's CPE Monitor e-profile identification number.

b. *Exemption for health-related graduate studies.* A pharmacist who is continuing formal education in a health-related graduate program, including participation in a pharmacy residency program, may be exempted from meeting the continuing education requirements during the period of such enrollment or participation. As an alternative to requesting exemption from meeting the continuing education requirements, the pharmacist may complete a CPD portfolio pursuant to rule 657—2.17(272C).

(1) An applicant for this exemption shall petition the board, as soon as possible following enrollment in the qualifying graduate program or commencement of the pharmacy residency program and prior to completion of the qualifying program, on forms provided by the board office.

(2) At the discretion of the board, exemption during part-time or short-term enrollment in a health-related graduate program may be prorated for the actual period of such enrollment.

**2.12(3) Continuing education activity record of credit.** An ACPE-accredited provider will be required to transmit to CPE Monitor information regarding an individual pharmacist's participation in and successful completion of a continuing education activity. The record shall be accessible to the board and shall include the following information:

- a. Pharmacist's full name and CPE Monitor e-profile identification number.
- b. Number of contact hours or CEUs awarded for activity completion.
- c. Date of live activity or date of completion of home study activity.
- d. Name of accredited provider.
- e. Activity title and universal activity number.

**2.12(4) Continuing education activity topics.** Each pharmacist is required to obtain continuing education by completing activities in the topics specified in this subrule.

a. *Drug therapy.* A minimum of 1.5 CEUs (15 contact hours) of the pharmacist's required 3.0 CEUs shall be in ACPE-accredited provider activities dealing with drug therapy. Activities qualifying for the drug therapy requirement will include the ACPE topic designator "01" or "02" followed by the letter "P" at the end of the universal activity number.

b. *Pharmacy law.* A minimum of 0.2 CEUs (2 contact hours) of the pharmacist's required 3.0 CEUs shall be in ACPE-accredited provider activities dealing with pharmacy law. Activities qualifying

for the pharmacy law requirement will include the ACPE topic designator “03” followed by the letter “P” at the end of the universal activity number.

*c. Patient or medication safety.* A minimum of 0.2 CEUs (2 contact hours) of the pharmacist’s required 3.0 CEUs shall be in activities dealing with patient or medication safety. Activities completed to fulfill this requirement may be ACPE-accredited provider activities, in which case the universal activity number will end with the ACPE topic designator “05” followed by the letter “P.” A pharmacist may complete non-ACPE provider activities as provided in paragraph 2.12(2)“a” to fulfill this topic requirement.

**2.12(5) *New license holders licensed by examination.*** After the initial license is issued by examination, the new license holder is exempt from meeting continuing education requirements for the first license renewal. However, if the licensee qualifies as a mandatory abuse reporter, the licensee shall not be exempt from mandatory training for identifying and reporting abuse pursuant to rule 657—2.16(235B,272C). Regardless of when the license is first issued, the new license holder will be required to obtain, prior to the second renewal, 30 contact hours (3.0 CEUs) of continuing education pursuant to subrules 2.12(1) through 2.12(4) or to complete a CPD portfolio pursuant to rule 657—2.17(272C).

**2.12(6) *New license holders licensed by license transfer/reciprocity.*** After the initial license is issued by license transfer, the new license holder will be required to obtain, prior to the first license renewal, 30 contact hours (3.0 CEUs) of continuing education credits pursuant to subrules 2.12(1) through 2.12(4) or to complete a CPD portfolio pursuant to rule 657—2.17(272C).

**2.12(7) *Reporting continuing education credits.***

*a.* A pharmacist shall provide or report to the board, in the format specified on or with the pharmacist license renewal application, evidence that the continuing education requirements have been met.

*b.* The board may require a pharmacist to submit activity statements of credit or other documented evidence of successful completion of the activities reported as fulfilling the continuing education requirements.

**2.12(8) *Physical disability or illness.*** The board may, in individual cases involving physical disability or illness, grant waivers of the minimum continuing education requirements or extensions of time within which to fulfill the same or make the required reports. No waiver or extension of time shall be granted unless written application is made and signed by the licensee and the licensee’s physician. The board may grant waivers of the minimum continuing education requirements for physical disability or illness for any period of time not to exceed one renewal period. In the event that the physical disability or illness upon which a waiver has been granted continues beyond the period of the waiver, the licensee must reapply for an extension of the waiver. The board may, as a condition of any waiver granted, require the licensee to make up all or any portion of the waived continuing education requirements by any method prescribed by the board.

[ARC 8672B, IAB 4/7/10, effective 5/12/10; ARC 9406B, IAB 3/9/11, effective 4/13/11; ARC 9782B, IAB 10/5/11, effective 11/9/11; ARC 0595C, IAB 2/6/13, effective 3/13/13]

### **657—2.13(272C) Active and inactive license status.**

**2.13(1) *Active license.*** Active license status applies to a pharmacist who has submitted the renewal application and fee and has met Iowa requirements for continuing education or has completed a CPD portfolio pursuant to rule 657—2.17(272C). Active license status also applies to a pharmacist who has submitted the renewal application and fee and who is a resident of another state, is licensed to practice pharmacy in that state, and has met the continuing education requirements of that state. A pharmacist who meets the continuing education requirements of another state shall provide documentation on the renewal application of the pharmacist’s license status in that state. An Iowa licensee actively practicing in a state that does not require continuing education for license renewal shall be required to meet Iowa continuing education or CPD requirements.

**2.13(2) *Inactive license.*** Failure of a pharmacist to comply with the continuing education or CPD requirements during the renewal period shall result in the issuance of a renewal card marked “inactive”

upon submission of the renewal application and fee. Reactivation of an inactive pharmacist license shall be accomplished by the appropriate method described below. Internship, in each instance where internship is mentioned below, shall be in a pharmacy approved by the board. The pharmacist may be required to obtain a pharmacist-intern registration, including payment of the appropriate registration fee, and be issued an intern registration certificate.

*a.* An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in any state or states which required continuing education during that five-year period shall submit proof of continued licensure in good standing in the state or states of such practice.

*b.* An inactive pharmacist who wishes to become active and who has been actively practicing pharmacy during the last five years in a state which does not require continuing education shall submit proof of continued licensure in good standing in the state or states of such practice. The pharmacist shall also complete one of the following options:

- (1) Take and successfully pass the MPJE, Iowa Edition, as provided in subrule 2.1(1);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours);
- (3) Obtain one and one-half times the number of continuing education credits required under subrule 2.12(1) for each renewal period the pharmacist was inactive; or
- (4) Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

*c.* An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy during the past five years, and whose license has been inactive for not more than five years, shall complete one of the following options:

- (1) Successfully pass all components of the licensure examination as required in rule 657—2.1(147,155A);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status;
- (3) Obtain one and one-half times the number of continuing education credits required under subrule 2.12(1) for each renewal period the pharmacist was inactive; or
- (4) Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

*d.* An inactive pharmacist who wishes to become active and who has not been actively practicing pharmacy for more than five years shall petition the board for reactivation of the license to practice pharmacy under one or more of the following options:

- (1) Successfully pass all components of the licensure examination as required in rule 657—2.1(147,155A);
- (2) Complete 160 hours of internship for each year the pharmacist was on inactive status (not to exceed 1,000 hours);
- (3) Obtain one and one-half times the number of continuing education credits required under subrule 2.12(1) for each renewal period the pharmacist was inactive; or
- (4) Complete a CPD portfolio pursuant to rule 657—2.17(272C) identifying a minimum of 45 learning outcomes for each renewal period the pharmacist was inactive.

[ARC 0595C, IAB 2/6/13, effective 3/13/13]

**657—2.14(155A) Fees for additional license certificates.** Only original license certificates issued by the board of pharmacy for licensed pharmacists are valid. Additional original license certificates for licensed pharmacists may be obtained from the board of pharmacy for a prepaid fee of \$20 each. The fee shall be considered a repayment receipt as defined in Iowa Code section 8.2.

**657—2.15(155A) Notifications to the board.** A pharmacist shall report to the board within ten days a change of the pharmacist's name, address, or pharmacy employment.

**657—2.16(235B,272C) Mandatory training for identifying and reporting abuse.** “Mandatory training for identifying and reporting abuse” means training on identifying and reporting child abuse or dependent adult abuse required of a pharmacist who qualifies as a mandatory abuse reporter under Iowa Code section 232.69 or 235B.16. A licensed pharmacist shall be responsible for determining whether or not, by virtue of the pharmacist’s practice or employment, the pharmacist qualifies as a mandatory abuse reporter under either or both of these sections.

**2.16(1) Training required.** A licensed pharmacist who qualifies as a mandatory abuse reporter shall have completed approved abuse education training as follows.

*a. Mandatory reporter of child abuse.* A pharmacist who qualifies as a mandatory reporter of child abuse shall have completed two hours of training in child abuse identification and reporting within the previous five years.

*b. Mandatory reporter of dependent adult abuse.* A pharmacist who qualifies as a mandatory reporter of dependent adult abuse shall have completed two hours of training in dependent adult abuse identification and reporting within the previous five years.

*c. Mandatory reporter of child abuse and dependent adult abuse.* A pharmacist who qualifies as a mandatory reporter of child abuse and dependent adult abuse may complete separate courses pursuant to paragraphs “a” and “b” or may complete, within the previous five years, one combined two-hour course that includes curricula for identifying and reporting child abuse and dependent adult abuse.

**2.16(2) Persons exempt from training requirements.** The requirements of this rule shall not apply to a pharmacist during periods that the pharmacist serves honorably on active duty in the military or during periods that the pharmacist resides outside Iowa and does not practice pharmacy in Iowa.

**2.16(3) Mandatory training records.** A pharmacist subject to the requirements of this rule shall maintain documentation of completion of the mandatory training for identifying and reporting abuse, including dates, subjects, duration of programs, and proof of participation, for five years following the date of the training. The board may audit this information at any time within the five-year period.

**2.16(4) Approved programs.** “Approved abuse education training” means a training program using a curriculum approved by the abuse education review panel of the Iowa department of public health.

**657—2.17(272C) Continuing professional development portfolio.** A pharmacist may complete and submit with the pharmacist’s license renewal a continuing professional development (CPD) portfolio to fulfill the continuing education requirements in rule 657—2.12(272C). For purposes of these rules, “CPD” means a self-directed, ongoing, systematic, and outcomes-focused approach to learning and professional development including active participation in learning activities that assist a pharmacist in developing and maintaining continuing competence in the practice of pharmacy, enhancing the pharmacist’s professional practice, and supporting achievement of the pharmacist’s career goals. Definitions and descriptions of the terms “continuing education,” “CEU,” and “renewal period” included in rule 657—2.12(272C) shall apply to those terms as used in this rule.

**2.17(1) Declaration of intent.** A pharmacist shall declare on or with the previous license renewal, or shall notify the board no later than January 1 of the year the pharmacist’s license is scheduled for renewal, of the pharmacist’s intent to complete a CPD portfolio for the next license renewal.

*a.* The pharmacist’s declaration of intent shall be in writing. Oral declaration of intent to complete a CPD portfolio will not be accepted.

*b.* A declaration of intent may be delivered to the board office via e-mail, facsimile transmission, or alternate hard-copy delivery.

**2.17(2) Prerequisite.** A pharmacist, prior to submitting the pharmacist’s initial CPD portfolio, shall complete an ACPE-accredited provider activity regarding the objectives and processes relating to CPD. Record of the pharmacist’s participation in this prerequisite activity shall be included in the pharmacist’s initial CPD portfolio.

**2.17(3) CPD portfolio requirements.** A pharmacist shall combine traditional continuing education activities with professional development activities. The pharmacist shall incorporate the record of completion and evaluation of any traditional continuing education activities into the CPD portfolio.

a. The pharmacist is responsible for ensuring that the activity content identified in the CPD portfolio directly relates to the pharmacist's professional practice and career goals.

b. The pharmacist is responsible for ensuring that the activities identified in the CPD portfolio comply with the continuing education topic requirements identified in subrules 2.12(4) and 2.17(4).

**2.17(4) CPD portfolio content.** In addition to the record of completion of the one-time prerequisite activity identified in subrule 2.17(2), a completed CPD portfolio shall include or identify the following:

a. A minimum of 30 documented learning outcomes in the form of completed learning statements. The learning statement form or format shall be provided by the board.

b. Documented learning outcomes shall include a minimum of two outcomes relating to patient or medication safety, two outcomes relating to pharmacy law, and 15 outcomes relating to drug therapy.

c. Documented learning outcomes shall include any number of continuing education activities that carry the seal of an ACPE-accredited provider. Successful completion and record of these continuing education activities in CPE Monitor as provided in subrule 2.12(2), in addition to the documented CPD learning outcomes, is required for the pharmacist to receive credit for these activities.

d. Documented learning outcomes shall include any continuing education activities provided by non-ACPE, accredited, health-professional continuing education providers pursuant to subrule 2.12(2).

**2.17(5) CPD portfolio review.** The board shall review or may contract for peer review of CPD portfolios submitted for pharmacist license renewal. The board shall respond to a submitting pharmacist with comments, suggestions, and recommendations regarding the pharmacist's CPD portfolio and processes.

[ARC 0595C, IAB 2/6/13, effective 3/13/13]

These rules are intended to implement Iowa Code sections 147.10, 147.36, 147.94, 147.96, 155A.8, 155A.9, 155A.11, 155A.39, and 272C.2.

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CHAPTER 10  
CONTROLLED SUBSTANCES  
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 8]

**657—10.1(124) Purpose and definitions.** Any person or business located in Iowa that manufactures, distributes, dispenses, prescribes, imports or exports, conducts research or instructional activities, or conducts chemical analysis with controlled substances in the state of Iowa, or that proposes to engage in such activities with controlled substances in the state, shall obtain and maintain a registration issued by the board unless exempt from registration pursuant to rule 657—10.6(124). A person or business required to be registered shall not engage in any activity for which registration is required until the application for registration is granted and the board has issued a certificate of registration to such person or business.

**10.1(1) Who shall register:** Manufacturers, distributors, reverse distributors, importers and exporters, individual practitioners (M.D., D.O., D.D.S., D.V.M., D.P.M., O.D., P.A., resident physician, advanced registered nurse practitioner), pharmacies, hospitals and animal shelters, care facilities, researchers and dog trainers, analytical laboratories, and teaching institutions shall register on forms provided by the board office. To be eligible to register, individual practitioners must hold a current, active license in good standing, issued by the appropriate Iowa professional licensing board, to practice their profession in Iowa.

**10.1(2) Definitions.** For the purpose of this chapter, the following definitions shall apply:

*“Authorized collection program”* means a program administered by a registrant that has modified its registration with DEA to collect controlled substances for the purpose of disposal. Federal regulations for such programs can be found at [http://deadiversion.usdoj.gov/drug\\_disposal/](http://deadiversion.usdoj.gov/drug_disposal/). Modification to the registrant’s Iowa Controlled Substances Act registration shall not be required.

*“DEA”* means the United States Department of Justice, Drug Enforcement Administration.  
[ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.2(124) Application forms.** Application forms may be obtained from the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Forms are also available on the board’s Web site, [www.state.ia.us/ibpe](http://www.state.ia.us/ibpe). Registration renewal forms will be mailed to each registrant approximately 60 days before the expiration date of the registration. A registrant who has not received a renewal form 45 days before the expiration date of the registration is responsible for contacting the board to request an application.

**10.2(1) Signature requirements.** Each application, attachment, or other document filed as part of an application shall be signed by the applicant as follows:

*a.* If the applicant is an individual practitioner, the practitioner shall sign the application and supporting documents.

*b.* If the applicant is a business, the application and supporting documents shall be signed by the person ultimately responsible for the security and maintenance of controlled substances at the registered location.

**10.2(2) Submission of multiple applications.** Any person or business required to obtain more than one registration may submit all applications in one package. Each application shall be complete and shall not refer to any accompanying application or any attachment to an accompanying application for required information.

**657—10.3(124) Registration and renewal.** For each registration or timely renewal of a registration to manufacture, distribute, dispense, prescribe, import or export, conduct research or instructional activities, or conduct chemical analysis with controlled substances listed in Schedules I through V of Iowa Code chapter 124, registrants shall pay a biennial fee of \$90.

**10.3(1) Time and method of payment.** Registration and renewal fees shall be paid at the time the application for registration or renewal is submitted. Payment should be made in the form of a personal, certified, or cashier’s check or a money order made payable to the Iowa Board of Pharmacy. Payments made in the form of foreign currency or third-party endorsed checks will not be accepted.

**10.3(2) *Late renewal.*** Any registered person or business may apply, on forms provided by the board office, for registration renewal not more than 60 days prior to the expiration of the registration. Failure to renew a registration prior to the first day of the month following expiration shall require payment of the renewal fee and a penalty fee of \$90. Payment shall be made as specified in subrule 10.3(1).

[ARC 0504C, IAB 12/12/12, effective 1/16/13]

**657—10.4(124) Exemptions—registration fee.** The registration fee is waived for federal, state, and local law enforcement agencies and for the following federal and state institutions: hospitals, health care or teaching institutions, and analytical laboratories authorized to possess, manufacture, distribute, and dispense controlled substances in the course of official duties.

**10.4(1) *Law enforcement officials.*** In order to enable law enforcement agency laboratories to obtain and transfer controlled substances for use as standards in chemical analysis, such laboratories shall maintain a registration to conduct chemical analysis. Such laboratories shall be exempt from payment of a fee for registration.

**10.4(2) *Registration and duties not exempt.*** Exemption from payment of a registration or registration renewal fee as provided in this rule does not relieve the agency or institution of registration or of any other requirements or duties prescribed by law.

**657—10.5(124) Separate registration for independent activities; coincident activities.** The following activities are deemed to be independent of each other and shall require separate registration. Any person or business engaged in more than one of these activities shall be required to separately register for each independent activity, provided, however, that registration in an independent activity shall authorize the registrant to engage in activities identified coincident with that independent activity.

**10.5(1) *Manufacturing controlled substances.*** A person or business registered to manufacture controlled substances in Schedules I through V may distribute any substances for which registration to manufacture was issued. A person or business registered to manufacture controlled substances in Schedules II through V may conduct chemical analysis and preclinical research, including quality control analysis, with any substances listed in those schedules for which the person or business is registered to manufacture.

**10.5(2) *Distributing controlled substances.*** This independent activity includes the delivery, other than by administering or dispensing, of controlled substances listed in Schedules I through V. No coincident activities are authorized.

**10.5(3) *Dispensing or instructing with controlled substances.*** This independent activity includes, but is not limited to, prescribing by individual practitioners, dispensing by pharmacies and hospitals, and conducting instructional activities with controlled substances listed in Schedules II through V. A person or business registered for this independent activity may conduct research and instructional activities with those substances for which the person or business is registered to the extent authorized under state law.

**10.5(4) *Conducting research with controlled substances listed in Schedule I.*** A researcher may manufacture or import the substances for which registration was issued provided that such manufacture or import is permitted under the federal Drug Enforcement Administration (DEA) registration. A researcher may distribute the substances for which registration was issued to persons or businesses registered or authorized to conduct research with that class of substances or registered or authorized to conduct chemical analysis with controlled substances.

**10.5(5) *Conducting research with controlled substances listed in Schedules II through V.*** A researcher may conduct chemical analysis with controlled substances in those schedules for which registration was issued, may manufacture such substances if and to the extent such manufacture is permitted under the federal DEA registration, and may import such substances for research purposes. A researcher may distribute controlled substances in those schedules for which registration was issued to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances, and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3), and may conduct instructional activities with controlled substances.

**10.5(6) *Conducting chemical analysis with controlled substances.*** A person or business registered to conduct chemical analysis with controlled substances listed in Schedules I through V may manufacture and import controlled substances for analytical or instructional activities; may distribute such substances to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3); may export such substances to persons in other countries performing chemical analysis or enforcing laws relating to controlled substances or drugs in those countries; and may conduct instructional activities with controlled substances.

**10.5(7) *Importing or exporting controlled substances.*** A person or business registered to import controlled substances listed in Schedules I through V may distribute any substances for which such registration was issued.

**657—10.6(124) Separate registrations for separate locations; exemption from registration.** A separate registration is required for each principal place of business or professional practice location where controlled substances are manufactured, distributed, imported, exported, dispensed, or collected for the purpose of disposal unless the person or business is exempt from registration pursuant to Iowa Code subsection 124.302(3), this rule, or federal regulations.

**10.6(1) *Warehouse.*** A warehouse where controlled substances are stored by or on behalf of a registered person or business shall be exempt from registration except as follows:

*a.* Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to registered locations other than the registered location from which the substances were delivered to the warehouse.

*b.* Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to persons exempt from registration pursuant to Iowa Code subsection 124.302(3).

**10.6(2) *Sales office.*** An office used by agents of a registrant where sales of controlled substances are solicited, made, or supervised shall be exempt from registration. Such office shall not contain controlled substances, except substances used for display purposes or for lawful distribution as samples, and shall not serve as a distribution point for filling sales orders.

**10.6(3) *Prescriber's office.*** An office used by a prescriber who is registered at another location and where controlled substances are prescribed but where no supplies of controlled substances are maintained shall be exempt from registration. However, a prescriber who practices at more than one office location where controlled substances are administered or otherwise dispensed as a regular part of the prescriber's practice shall register at each location wherein the prescriber maintains supplies of controlled substances.

**10.6(4) *Prescriber in hospital.*** A prescriber who is registered at another location and who treats patients and may order the administration of controlled substances in a hospital other than the prescriber's registered practice location shall not be required to obtain a separate registration for the hospital.

**10.6(5) *Affiliated interns, residents, or foreign physicians.*** An individual practitioner who is an intern, resident, or foreign physician may dispense and prescribe controlled substances under the registration of the hospital or other institution which is registered and by whom the registrant is employed provided that:

*a.* The hospital or other institution by which the individual practitioner is employed has determined that the practitioner is permitted to dispense or prescribe drugs by the appropriate licensing board;

*b.* Such individual practitioner is acting only in the scope of employment in the hospital or institution;

*c.* The hospital or other institution authorizes the intern, resident, or foreign physician to dispense or prescribe under the hospital registration and designates a specific internal code number, letters, or combination thereof which shall be appended to the institution's DEA registration number, preceded by a hyphen (e.g., AP1234567-10 or AP1234567-12); and

d. The hospital or institution maintains a current list of internal code numbers identifying the corresponding individual practitioner, available for the purpose of verifying the authority of the prescribing individual practitioner.

[ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.7 to 10.9** Reserved.

**657—10.10(124,147,155A) Inspection.** The board may inspect, or cause to be inspected, the establishment of an applicant or registrant. The board shall review the application for registration and other information regarding an applicant or registrant in order to determine whether the applicant or registrant has met the applicable standards of Iowa Code chapter 124 and these rules.

**657—10.11(124) Modification or termination of registration.** A registered individual or business may apply to modify a current registration as provided by this rule.

**10.11(1) Change of substances authorized.** Any registrant may apply to modify the substances authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, registration number, and the substances or schedules to be added to or removed from the registration and shall be signed by the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

**10.11(2) Change of address of registered location.**

a. *Individual practitioner, researcher, analytical laboratory, or teaching institution.* An entity registered under these classifications may apply to change the address of the registered location by submitting a written request to the board. The request shall include the registrant's name, current address, new address, telephone number, effective date of the address change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

b. *Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter.* An entity registered under these classifications shall apply to change the address of the registered location by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

**10.11(3) Change of registrant's name.**

a. *Individual practitioner, researcher, analytical laboratory, or teaching institution.* An entity registered under these classifications may apply to change the registrant's name by submitting a written request to the board. The request shall include the registrant's current name, the new name, address, telephone number, effective date of the name change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification. Change of name, as used in this paragraph, refers to a change of the legal name of the registrant and does not authorize the transfer of a registration issued to an individual practitioner or researcher to another individual practitioner or researcher.

b. *Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter.* An entity registered under these classifications shall apply to change the registrant name by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

**10.11(4) Change of ownership of registered business entity.** A change of immediate ownership of a pharmacy, hospital, care facility, manufacturer, distributor, analytical laboratory, teaching institution, importer, or exporter shall require the completion of an application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

**10.11(5) *Change of responsible individual.*** Any registrant, except an individual practitioner, a researcher, a hospital, or a pharmacy, may apply to change the responsible individual authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, the name and title of the current responsible individual and of the new responsible individual, the effective date of the change, and the registration number, and shall be signed by the new responsible individual. No fee shall be required for the modification.

*a. Individual practitioners and researchers.* Responsibility under a registration issued to an individual practitioner or researcher shall remain with the named individual practitioner or researcher. The responsible individual under such registration may not be changed.

*b. Pharmacies and hospitals.* The responsible pharmacist may execute a power of attorney for DEA order forms to change responsibility under the registration issued to the pharmacy or hospital. The power of attorney shall include the name, address, DEA registration number, and Iowa uniform controlled substances Act (CSA) registration number of the registrant. The power of attorney shall identify the current and new responsible individuals and shall authorize the new responsible individual to execute applications and official DEA order forms to requisition Schedule II controlled substances. The power of attorney shall be signed by both individuals, shall be witnessed by two adults, and shall be maintained by the registrant and available for inspection or copying by representatives of the board or other state or federal authorities.

**10.11(6) *Termination of registration.*** A registration issued to an individual shall terminate upon the death of the individual. A registration issued to an individual or business shall terminate when the registered individual or business ceases legal existence, discontinues business, or discontinues professional practice.

**657—10.12(124) Denial, modification, suspension, or revocation of registration.**

**10.12(1) *Grounds for suspension or revocation.*** The board may suspend or revoke any registration upon a finding that the registrant:

*a.* Has furnished false or fraudulent material information in any application filed under this chapter;

*b.* Has had the registrant's federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked;

*c.* Has been convicted of a public offense under any state or federal law relating to any controlled substance. For the purpose of this rule only, a conviction shall include a plea of guilty, a forfeiture of bail or collateral deposited to secure a defendant's appearance in court which forfeiture has not been vacated, or a finding of guilt in a criminal action even though entry of the judgment or sentence has been withheld and the individual has been placed on probation;

*d.* Has committed such acts as would render the registrant's registration under Iowa Code section 124.303 inconsistent with the public interest as determined by that section; or

*e.* Has been subject to discipline by the registrant's respective professional licensing board and the discipline revokes, suspends, or modifies the registrant's authority regarding controlled substances (including, but not limited to, limiting or prohibiting the registrant from prescribing or handling controlled substances). A certified copy of the record of licensee discipline or a copy of the licensee's surrender of the professional license shall be conclusive evidence.

**10.12(2) *Limited suspension or revocation.*** If the board finds grounds to suspend or revoke a registration, the board may limit revocation or suspension of the registration to the particular controlled substance with respect to which the grounds for revocation or suspension exist. If the revocation or suspension is limited to a particular controlled substance or substances, the registrant shall be given a new certificate of registration for all substances not affected by revocation or suspension; no fee shall be required for the new certificate of registration. The registrant shall deliver the old certificate of registration to the board.

**10.12(3) *Denial of registration or registration renewal.*** If upon examination of an application for registration or registration renewal, including any other information the board has or receives regarding the applicant, the board determines that the issuance of the registration would be inconsistent with the

public interest, the board shall serve upon the applicant an order to show cause why the registration should not be denied.

**10.12(4) Considerations in denial of registration.** In determining the public interest, the board shall consider all of the following factors:

- a. Maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels.
- b. Compliance with applicable state and local law.
- c. Any convictions of the applicant under any federal and state laws relating to any controlled substance.
- d. Past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion.
- e. Furnishing by the applicant of false or fraudulent material in any application filed under this chapter.
- f. Suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law.
- g. Any other factors relevant to and consistent with the public health and safety.

**10.12(5) Order to show cause.** Before denying, modifying, suspending, or revoking a registration, the board shall serve upon the applicant or registrant an order to show cause why the registration should not be denied, modified, revoked, or suspended. The order to show cause shall contain a statement of the basis therefor and shall call upon the applicant or registrant to appear before an administrative law judge or the board at a time and place not less than 30 days after the date of service of the order. The order to show cause shall also contain a statement of the legal basis for such hearing and for the denial, revocation, or suspension of registration and a summary of the matters of fact and law asserted. If the order to show cause involves the possible denial of registration renewal, the order shall be served not later than 30 days before the expiration of the registration. Proceedings to refuse renewal of registration shall not abate the existing registration, which shall remain in effect pending the outcome of the administrative hearing unless the board issues an order of immediate suspension pursuant to subrule 10.12(9).

**10.12(6) Hearing requested.** If an applicant or registrant who has received an order to show cause desires a hearing on the matter, the applicant or registrant shall file a request for a hearing within 30 days after the date of service of the order to show cause. If a hearing is requested, the board shall hold a hearing pursuant to 657—Chapter 35 at the time and place stated in the order and without regard to any criminal prosecution or other proceeding. Unless otherwise ordered by the board, an administrative law judge employed by the department of inspections and appeals shall be assigned to preside over the case and to render a proposed decision for the board's consideration.

**10.12(7) Waiver of hearing.** If an applicant or registrant entitled to a hearing on an order to show cause fails to file a request for hearing, or if the applicant or registrant requests a hearing but fails to appear at the hearing, the applicant or registrant shall be deemed to have waived the opportunity for a hearing unless the applicant or registrant shows good cause for such failure.

**10.12(8) Final board order when hearing waived.** If an applicant or registrant entitled to a hearing waives or is deemed to have waived the opportunity for a hearing, the executive director of the board may cancel the hearing and issue, on behalf of the board, the board's final order on the order to show cause.

**10.12(9) Order of immediate suspension.** The board may suspend any registration simultaneously with the service upon the registrant of an order to show cause why such registration should not be revoked or suspended if it finds there is an imminent danger to the public health or safety that warrants such action. If the board suspends a registration simultaneously with the service of the order to show cause upon the registrant, it shall serve an order of immediate suspension containing a statement of its findings regarding the danger to public health or safety upon the registrant with the order to show cause. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review thereof, under the provisions of the Iowa administrative procedure Act, unless sooner withdrawn by the board or dissolved by the order of the district court or an appellate court.

**10.12(10) *Disposition of controlled substances.*** If the board suspends or revokes a registration, the registrant shall promptly return the certificate of registration to the board. Also, upon service of the order of the board suspending or revoking the registration, the registrant shall deliver all affected controlled substances in the registrant's possession to the board or authorized agent of the board. Upon receiving the affected controlled substances from the registrant, the board or its authorized agent shall place all such substances under seal and retain the sealed controlled substances pending final resolution of any appeals or until a court of competent jurisdiction directs otherwise. No disposition may be made of the substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of proceeds of the sale with the court. Upon a revocation order's becoming final, all such controlled substances may be forfeited to the state.

**10.12(11) *Notifications.*** The board shall promptly notify the DEA and the Iowa department of public safety of all orders suspending or revoking registration and all forfeitures of controlled substances.

**657—10.13 and 10.14** Reserved.

**657—10.15(124,155A) *Security requirements.*** All applicants and registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances. In order to determine whether a person has provided effective controls against diversion, the board shall use the security requirements set forth in these rules as standards for the physical security controls and operating procedures necessary to prevent diversion.

**10.15(1) *Physical security.*** Physical security controls shall be commensurate with the schedules and quantity of controlled substances in the possession of the registrant in normal business operation. A registrant shall periodically review and adjust security measures based on rescheduling of substances or changes in the quantity of substances in the possession of the registrant.

*a.* Controlled substances listed in Schedule I shall be stored in a securely locked, substantially constructed cabinet.

*b.* Controlled substances listed in Schedules II through V may be stored in a securely locked, substantially constructed cabinet. However, pharmacies and hospitals may disperse these substances throughout the stock of noncontrolled substances in a manner so as to obstruct the theft or diversion of the controlled substances.

*c.* Controlled substances collected via an authorized collection program for the purpose of disposal shall be stored pursuant to federal regulations, which can be found at [http://deadiversion.usdoj.gov/drug\\_disposal/](http://deadiversion.usdoj.gov/drug_disposal/).

**10.15(2) *Factors in evaluating physical security systems.*** In evaluating the overall security system of a registrant or applicant necessary to maintain effective controls against theft or diversion of controlled substances, the board may consider any of the following factors it deems relevant to the need for strict compliance with the requirements of this rule:

- a.* The type of activity conducted;
- b.* The type, form, and quantity of controlled substances handled;
- c.* The location of the premises and the relationship such location bears to security needs;
- d.* The type of building construction comprising the facility and the general characteristics of the building or buildings;
- e.* The type of vault, safe, and secure enclosures available;
- f.* The type of closures on vaults, safes, and secure enclosures;
- g.* The adequacy of key control systems or combination lock control systems;
- h.* The adequacy of electric detection and alarm systems, if any;
- i.* The adequacy of supervision over employees having access to controlled substances, to storage areas, or to manufacturing areas;
- j.* The extent of unsupervised public access to the facility, including the presence and characteristics of perimeter fencing, if any;

k. The procedures for handling business guests, visitors, maintenance personnel, and nonemployee service personnel;

l. The availability of local police protection or of the registrant's or applicant's security personnel; and

m. The adequacy of the registrant's or applicant's system for monitoring the receipt, manufacture, distribution, and disposition of controlled substances.

**10.15(3) *Manufacturing and compounding storage areas.*** Raw materials, bulk materials awaiting further processing, and finished products which are controlled substances listed in any schedule shall be stored pursuant to federal laws and regulations.

[ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.16(124) Report of theft or loss.** A registrant shall report to the board and the DEA any theft or significant loss of controlled substances when the loss is attributable to other than inadvertent error. Thefts or other losses of controlled substances shall be reported whether or not the controlled substances are subsequently recovered or the responsible parties are identified and action taken against them.

**10.16(1) *Immediate notice to board.*** If the theft was committed by a registrant or licensee of the board, or if there is reason to believe that the theft was committed by a registrant or licensee of the board, the registrant from whom the controlled substances were stolen shall notify the board immediately upon discovery of the theft and shall identify to the board the registrant or licensee suspected of the theft.

**10.16(2) *Immediate notice to DEA.*** A registrant shall deliver notice, immediately upon discovery of a reportable theft or loss of controlled substances, to the Des Moines DEA field office via telephone, facsimile, or a brief written message explaining the circumstances of the theft or loss.

**10.16(3) *Timely report submission.*** Within 14 calendar days of discovery of the theft or loss, a registrant shall submit directly to the DEA a Form 106 or alternate required form via the DEA Web site at <http://www.deadiversion.usdoj.gov/>. A copy of the report that was completed and submitted to the DEA shall be immediately submitted to the board via facsimile, e-mail attachment, or personal or commercial delivery.

**10.16(4) *Record maintained.*** A copy of the report shall be maintained in the registrant's files for a minimum of two years following the date the report was completed.

[ARC 1787C, IAB 12/10/14, effective 1/14/15]

**657—10.17(124) Accountability of stock supply.** An individual who administers a controlled substance from a non-patient-specific, stock supply in an institutional setting shall personally document on a separate readily retrievable record system each dose administered, wasted, or returned to the pharmacy. Such documentation shall not be delegated to another individual. Wastage documentation shall include the signature or unique electronic signature or identification of a witnessing licensed health care practitioner.

Distribution records for non-patient-specific, floor-stocked controlled substances shall bear the following information:

1. Patient's name;
2. Prescriber who ordered drug;
3. Name of drug, dosage form, and strength;
4. Time and date of administration to patient and quantity administered;
5. Signature or unique electronic signature of individual administering controlled substance;
6. Returns to the pharmacy;
7. Waste, which is required to be witnessed and cosigned by another licensed health care practitioner.

[ARC 9912B, IAB 12/14/11, effective 1/18/12]

**657—10.18(124) Disposal of registrant stock.** Any persons legally authorized to possess controlled substances in the course of their professional practice or the conduct of their business shall dispose of such drugs pursuant to the procedures and requirements of this rule. Disposal records shall be maintained by the registrant.

**10.18(1) *Registrant stock supply.*** Pharmacy personnel, registrants, and registrant staff shall remove from current inventory and dispose of controlled substances by one of the following procedures.

*a.* The responsible individual shall utilize the services of a DEA-registered and Iowa-licensed disposal firm.

*b.* The board may authorize and instruct the registrant to dispose of the controlled substances in one of the following manners:

(1) By delivery to an agent of the board or to the board office;

(2) By destruction of the drugs in the presence of a board officer, agent, inspector, or other authorized individual; or

(3) By such other means as the board may determine to ensure that drugs do not become available to unauthorized persons.

**10.18(2) *Waste.*** Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient from a registrant's stock or emergency supply or resulting from drug compounding operations may be destroyed or otherwise disposed of by the registrant or a pharmacist in witness of one other licensed health care provider or a registered pharmacy technician 18 years of age or older pursuant to this subrule. A written record of the wastage shall be made and maintained by the registrant for a minimum of two years following the destruction or other disposal. The record shall include the signatures of the individual destroying or otherwise disposing of the waste controlled substance and of the witnessing licensed health care provider or registered pharmacy technician and shall identify the following:

*a.* The controlled substance wasted;

*b.* The date of destruction or other disposition;

*c.* The quantity or estimated quantity of the wasted controlled substance;

*d.* The source of the controlled substance, including identification of the patient to whom the substance was administered or the drug compounding process utilizing the controlled substance; and

*e.* The reason for the waste.

[ARC 0749C, IAB 5/29/13, effective 7/3/13; ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.19(124) Disposal of previously dispensed controlled substances.** A registrant may not dispose of previously dispensed controlled substances unless the registrant has modified its registration with DEA to administer an authorized collection program. A registrant shall not take possession of a previously dispensed controlled substance except for reuse for the same patient.

[ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.20** Reserved.

**657—10.21(124,126,155A) Prescription requirements.** All prescriptions for controlled substances shall be dated as of, and signed on, the day issued. Controlled substances prescriptions shall be valid for six months following date of issue. A prescription for a Schedule III, IV, or V controlled substance may include authorization to refill the prescription no more than five times within the six months following date of issue. A prescription for a Schedule II controlled substance shall not be refilled.

**10.21(1) *Form of prescription.*** All prescriptions shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and DEA registration number of the prescriber. All prescriptions issued by individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber's written or electronic signature. When an oral order is not permitted, or when a prescriber is unable to prepare and transmit an electronic prescription in compliance with DEA requirements for electronic prescriptions, prescriptions shall be written with ink, indelible pencil, or typed print and shall be manually signed by the prescriber. If the prescriber utilizes an electronic prescription application that meets DEA requirements for electronic prescriptions, the prescriber may electronically prepare and transmit a prescription for a controlled substance to a pharmacy that utilizes a pharmacy prescription application that meets DEA requirements for electronic prescriptions. A prescriber's agent may prepare a prescription for the review, authorization, and manual or electronic signature of the prescriber but the

prescribing practitioner is responsible for the accuracy, completeness, and validity of the prescription. An electronic prescription for a controlled substance shall not be transmitted to a pharmacy except by the prescriber in compliance with DEA regulations. A prescriber shall securely maintain the unique authentication credentials issued to the prescriber for utilization of the electronic prescription application and authentication of the prescriber's electronic signature. Unique authentication credentials issued to any individual shall not be shared with or disclosed to any other prescriber, agent, or individual. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by this rule.

**10.21(2) *Verification by pharmacist.*** The pharmacist shall verify the authenticity of the prescription with the individual prescriber or the prescriber's agent in each case when a written or oral prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient's agent is known to the pharmacist. The pharmacist shall verify the authenticity of the prescription with the individual prescriber or the prescriber's agent in any case when the pharmacist questions the validity of, including the legitimate medical purpose for, the prescription. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist's name or unique identifier.

**10.21(3) *Intern, resident, foreign physician.*** An intern, resident, or foreign physician exempt from registration pursuant to subrule 10.6(5) shall include on all prescriptions issued the hospital's registration number and the special internal code number assigned by the hospital in lieu of the prescriber's registration number required by this rule. Each prescription shall include the stamped or legibly printed name of the intern, resident, or foreign physician as well as the prescriber's signature.

**10.21(4) *Valid prescriber/patient relationship.*** Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or to oversee the patient's use of the controlled substance, a prescription shall lose its validity. A prescriber/patient relationship shall be deemed broken when the prescriber dies, retires, or moves out of the local service area or when the prescriber's authority to prescribe is suspended, revoked, or otherwise modified to exclude authority for the schedule in which the prescribed substance is listed. The pharmacist, upon becoming aware of the situation, shall cancel the prescription and any remaining refills. However, the pharmacist shall exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new prescription can be issued.

**10.21(5) *Schedule II prescriptions.*** With appropriate verification, a pharmacist may add information provided by the patient or patient's agent, such as the patient's address, to a Schedule II controlled substance prescription. A pharmacist shall never change the patient's name, the controlled substance prescribed except for generic substitution, or the name or signature of the prescriber. After consultation with the prescriber or the prescriber's agent and documentation of such consultation, a pharmacist may change or add the following information on a Schedule II controlled substance prescription:

- a. The drug strength;
- b. The dosage form;
- c. The drug quantity;
- d. The directions for use;
- e. The date the prescription was issued; and
- f. The prescriber's address or DEA registration number.

[ARC 9912B, IAB 12/14/11, effective 1/18/12]

#### **657—10.22(124) Schedule II emergency prescriptions.**

**10.22(1) *Emergency situation defined.*** For the purposes of authorizing an oral or facsimile transmission of a prescription for a Schedule II controlled substance listed in Iowa Code section 124.206, the term "emergency situation" means those situations in which the prescribing practitioner determines that all of the following apply:

- a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.

b. No appropriate alternative treatment is available, including administration of a drug that is not a Schedule II controlled substance.

c. It is not reasonably possible for the prescribing practitioner to provide a manually signed written prescription to be presented to the pharmacy before the pharmacy dispenses the controlled substance or the prescribing practitioner is unable to provide a DEA-compliant electronic prescription to the pharmacy before the pharmacy dispenses the controlled substance.

**10.22(2) Requirements of emergency prescription.** In the case of an emergency situation as defined in subrule 10.22(1), a pharmacist may dispense a controlled substance listed in Schedule II pursuant to a facsimile transmission or upon receiving oral authorization of a prescribing individual practitioner provided that:

a. The quantity prescribed and dispensed is limited to the smallest available quantity to meet the needs of the patient during the emergency period. Dispensing beyond the emergency period requires a written prescription manually signed by the prescribing individual practitioner or a DEA-compliant electronic prescription.

b. If the pharmacist does not know the prescribing individual practitioner, the pharmacist shall make a reasonable effort to determine that the authorization came from an authorized prescriber. The pharmacist shall record the manner by which the authorization was verified and include the pharmacist's name or unique identification.

c. The pharmacist shall prepare a temporary written record of the emergency prescription. The temporary written record shall consist of a hard copy of the facsimile transmission or a written record of the oral transmission authorizing the emergency dispensing. A written record is not required to consist of a handwritten record and may be a printed facsimile or a print of a computer-generated record of the prescription if the printed record includes all of the required elements for the prescription. If the emergency prescription is transmitted by the practitioner's agent, the record shall include the first and last names and title of the individual who transmitted the prescription.

d. If the emergency prescription is transmitted via facsimile transmission, the means of transmission shall not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the written prescription, and the hard-copy record of the facsimile transmission shall not be obscured or rendered illegible due to such security features.

e. Within seven days after authorizing an emergency prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of 657—10.21(124,126,155A), the prescription shall have written on its face "Authorization for Emergency Dispensing" and the date of the emergency order. The written prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the seven-day period. The written prescription shall be attached to and maintained with the temporary written record prepared pursuant to paragraph "c."

f. The pharmacist shall notify the board and the DEA if the prescribing individual fails to deliver a written prescription. Failure of the pharmacist to so notify the board and the DEA, or failure of the prescribing individual to deliver the required written prescription as herein required, shall void the authority conferred by this subrule.

[ARC 7636B, IAB 3/11/09, effective 4/15/09; ARC 9410B, IAB 3/9/11, effective 4/13/11; ARC 9912B, IAB 12/14/11, effective 1/18/12]

**657—10.23(124) Schedule II prescriptions—partial filling.** The partial filling of a prescription for a controlled substance listed in Schedule II is permitted as provided in this rule.

**10.23(1) Insufficient supply on hand.** If the pharmacist is unable to supply the full quantity called for in a prescription and makes a notation of the quantity supplied on the prescription record, a partial fill of the prescription is permitted. The remaining portion of the prescription must be filled within 72 hours of the first partial filling. If the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall so notify the prescriber. No further quantity may be supplied beyond 72 hours without a new prescription.

**10.23(2) Long-term care or terminally ill patient.** A prescription for a Schedule II controlled substance written for a patient in a long-term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units as provided by this subrule.

*a.* If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner prior to partially filling the prescription. Both the pharmacist and the practitioner have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient.

*b.* The pharmacist shall record on the prescription whether the patient is “terminally ill” or an “LTCF patient.” For each partial filling, the dispensing pharmacist shall record on the back of the prescription, or on another appropriate uniformly maintained and readily retrievable record, the date of the partial filling, the quantity dispensed, the remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

*c.* The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed. Schedule II prescriptions for patients in a LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

*d.* Information pertaining to current Schedule II prescriptions for patients in a LTCF or for patients with a medical diagnosis documenting a terminal illness may be maintained in a computerized system pursuant to rule 657—21.4(124,155A).

**657—10.24(124) Schedule II medication order.** Schedule II controlled substances may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.18(124,155A), as applicable.

**657—10.25(124) Schedule II—issuing multiple prescriptions.** An individual prescriber may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance pursuant to the provisions and limitations of this rule.

**10.25(1) Refills prohibited.** The issuance of refills for a Schedule II controlled substance is prohibited. The use of multiple prescriptions for the dispensing of Schedule II controlled substances, pursuant to this rule, ensures that the prescriptions are treated as separate dispensing authorizations and not as refills of an original prescription.

**10.25(2) Legitimate medical purpose.** Each separate prescription issued pursuant to this rule shall be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of the prescriber’s professional practice.

**10.25(3) Dates and instructions.** Each prescription issued pursuant to this rule shall be dated as of and manually signed by the prescriber on the day the prescription is issued. Each separate prescription, other than the first prescription if that prescription is intended to be filled immediately, shall contain written instructions indicating the earliest date on which a pharmacist may fill each prescription.

**10.25(4) Authorized fill date unalterable.** Regardless of the provisions of subrule 10.21(5), when a prescription contains instructions from the prescriber indicating that the prescription shall not be filled before a certain date, a pharmacist shall not fill the prescription before that date. The pharmacist shall not contact the prescriber for verbal authorization to fill the prescription before the fill date originally indicated by the prescriber pursuant to this rule.

**10.25(5) Number of prescriptions and authorized quantity.** An individual prescriber may issue for a patient as many separate prescriptions, to be filled sequentially pursuant to this rule, as the prescriber deems necessary to provide the patient with adequate medical care. The cumulative effect of the filling of each of these separate prescriptions shall result in the receipt by the patient of a quantity of the Schedule II controlled substance not exceeding a 90-day supply.

**10.25(6) Prescriber’s discretion.** Nothing in this rule shall be construed as requiring or encouraging an individual prescriber to issue multiple prescriptions pursuant to this rule or to see the prescriber’s patients only once every 90 days when prescribing Schedule II controlled substances. An individual

prescriber shall determine, based on sound medical judgment and in accordance with established medical standards, how often to see patients and whether it is appropriate to issue multiple prescriptions pursuant to this rule.

[ARC 8172B, IAB 9/23/09, effective 10/28/09]

**657—10.26** Reserved.

**657—10.27(124,155A) Facsimile transmission of a controlled substance prescription.** With the exception of an authorization for emergency dispensing as provided in rule 657—10.22(124), a prescription for a controlled substance may be transmitted via facsimile from a prescriber to a pharmacy as provided in rule 657—21.9(124,155A).

**10.27(1) Schedule II prescription.** A prescription for a Schedule II controlled substance may be transmitted via facsimile to the pharmacy only as provided in rules 657—21.12(124,155A) to 657—21.16(124,155A).

**10.27(2) Schedule III, IV, or V prescription.** A prescription for a Schedule III, IV, or V controlled substance may be transmitted via facsimile to the pharmacy only as provided in rule 657—21.9(124,155A).

[ARC 9912B, IAB 12/14/11, effective 1/18/12]

**657—10.28(124,155A) Schedule III, IV, or V refills.** No prescription for a controlled substance listed in Schedule III, IV, or V shall be filled or refilled more than six months after the date on which it was issued nor be refilled more than five times.

**10.28(1) Record.** Each filling and refilling of a prescription shall be entered on the prescription or on another uniformly maintained and readily retrievable record.

*a.* The following information shall be retrievable by the prescription number: the name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, the unique identification of the dispensing pharmacist for each refill, and the total number of refills authorized for that prescription.

*b.* If the pharmacist merely initials or affixes the pharmacist's unique identifier and dates the back of the prescription, it shall be deemed that the full face amount of the prescription has been dispensed.

**10.28(2) Oral refill authorization.** The prescribing practitioner may authorize additional refills of Schedule III, IV, or V controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

*a.* The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issuance of the original prescription.

*b.* The pharmacist who obtains the oral authorization records from the prescriber who issued the original prescription records on or with the original prescription the date, the quantity of each refill, the number of additional refills authorized, and the pharmacist's unique identification.

*c.* The quantity of each additional refill is equal to or less than the quantity authorized for the initial filling of the original prescription.

*d.* The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

**10.28(3) Automated data processing record system.** An automated data processing record system may be used for the storage and retrieval of Schedule III, IV, and V controlled substance prescription fill and refill information subject to the conditions and requirements of rules 657—21.4(124,155A) and 657—21.5(124,155A).

**657—10.29(124,155A) Schedule III, IV, or V partial fills.** The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible provided that each partial fill is recorded in the same manner as a refill. The total quantity dispensed in all partial fills shall not exceed the total quantity prescribed. No dispensing shall occur later than six months after the date on which the prescription was issued.

**657—10.30(124,155A) Schedule III, IV, and V medication order.** A Schedule III, IV, or V controlled substance may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124,155A), as applicable.

**657—10.31(124,155A) Dispensing Schedule V controlled substances without a prescription.** A controlled substance listed in Schedule V, which substance is not a prescription drug as determined under the federal Food, Drug and Cosmetic Act, and excepting products containing ephedrine, pseudoephedrine, or phenylpropanolamine, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

**10.31(1) Who may dispense.** Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

**10.31(2) Frequency and quantity.** Dispensing at retail to the same purchaser in any 48-hour period shall be limited to no more than one of the following quantities of a Schedule V controlled substance:

- a. 240 cc (8 ounces) of any controlled substance containing opium.
- b. 120 cc (4 ounces) of any other controlled substance.
- c. 48 dosage units of any controlled substance containing opium.
- d. 24 dosage units of any other controlled substance.

**10.31(3) Age of purchaser.** The purchaser shall be at least 18 years of age.

**10.31(4) Identification.** The pharmacist shall require every purchaser under this rule not known by the pharmacist to present a government-issued photo identification, including proof of age when appropriate.

**10.31(5) Record.** A bound record book (i.e., with pages sewn or glued to the spine) for dispensing of Schedule V controlled substances pursuant to this rule shall be maintained by the pharmacist. The book shall contain the name and address of each purchaser, the name and quantity of controlled substance purchased, the date of each purchase, and the name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the substance to the purchaser.

**10.31(6) Prescription not required under other laws.** No other federal or state law or regulation requires a prescription prior to distributing or dispensing a Schedule V controlled substance.

**657—10.32(124,155A) Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine without a prescription.** A product containing ephedrine, pseudoephedrine, or phenylpropanolamine, which substance is a Schedule V controlled substance and is not listed in another controlled substance schedule, may be dispensed or administered without a prescription by a pharmacist, pharmacist-intern, or pharmacy technician to a purchaser at retail pursuant to the conditions of this rule.

**10.32(1) Who may dispense.** Dispensing shall be by a licensed Iowa pharmacist, by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor, or by a registered pharmacy technician under the direct supervision of a pharmacist, except as authorized in 657—Chapter 100. This subrule does not prohibit, after the pharmacist, pharmacist-intern, or pharmacy technician has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by another pharmacy employee.

**10.32(2) Packaging of nonliquid forms.** A nonliquid form of a product containing ephedrine, pseudoephedrine, or phenylpropanolamine includes gel caps. Nonliquid forms of these products to be sold pursuant to this rule shall be packaged either in blister packaging with each blister containing no more than two dosage units or, if blister packs are technically infeasible, in unit dose packets or pouches.

**10.32(3) Frequency and quantity.** Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine,

pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

**10.32(4) *Age of purchaser.*** The purchaser shall be at least 18 years of age.

**10.32(5) *Identification.*** The pharmacist, pharmacist-intern, or pharmacy technician shall require every purchaser under this rule to present a current government-issued photo identification, including proof of age when appropriate. The pharmacist, pharmacist-intern, or pharmacy technician shall be responsible for verifying that the name on the identification matches the name provided by the purchaser and that the photo image depicts the purchaser.

**10.32(6) *Record.*** Purchase records shall be recorded in the real-time electronic pseudoephedrine tracking system (PTS) established and administered by the governor's office of drug control policy pursuant to 657—Chapter 100. If the real-time electronic repository is unavailable for use, the purchase record shall be recorded in an alternate format and submitted to the PTS as provided in 657—subrule 100.3(4).

*a. Alternate record contents.* The alternate record shall contain the following:

- (1) The name, address, and signature of the purchaser.
- (2) The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.
- (3) The date and time of the purchase.
- (4) The name or unique identification of the pharmacist, pharmacist-intern, or pharmacy technician who approved the dispensing of the product.

*b. Alternate record format.* The record shall be maintained using one of the following options:

- (1) A hard-copy record.
- (2) A record in the pharmacy's electronic prescription dispensing record-keeping system that is capable of producing a hard-copy printout of a record.
- (3) A record in an electronic data collection system that captures each of the data elements required by this subrule and that is capable of producing a hard-copy printout of a record.

*c. PTS records retrieval.* Pursuant to 657—subrule 100.4(6), the pharmacy shall be able to produce a hard-copy printout of transactions recorded in the PTS by the pharmacy for one or more specific products for a specified period of time upon request by the board or its representative or to such other persons or governmental agencies authorized by law to receive such information.

**10.32(7) *Notice required.*** The pharmacy shall ensure that the following notice is provided to purchasers of ephedrine, pseudoephedrine, or phenylpropanolamine products and that the notice is displayed with or on the electronic signature device or is displayed in the dispensing area and visible to the public:

“WARNING: Section 1001 of Title 18, United States Code, states that whoever, with respect to the logbook, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, shall be fined not more than \$250,000 if an individual or \$500,000 if an organization, imprisoned not more than five years, or both.”

[ARC 8892B, IAB 6/30/10, effective 9/1/10; ARC 3100C, IAB 6/7/17, effective 7/12/17]

**657—10.33(124,155A) Schedule II perpetual inventory in pharmacy.** Each pharmacy located in Iowa that dispenses Schedule II controlled substances shall maintain a perpetual inventory system for all Schedule II controlled substances pursuant to the requirements of this rule. All records relating to the perpetual inventory shall be maintained by the pharmacy and shall be available for inspection and copying by the board or its representative for a period of two years from the date of the record.

**10.33(1) *Record format.*** The perpetual inventory record may be maintained in a manual or an electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed.

**10.33(2) Information included.** The perpetual inventory record shall identify all receipts for and disbursements of Schedule II controlled substances by drug or by national drug code (NDC) number. The record shall be updated to identify each prescription filled and each shipment received. The record shall also include incident reports and reconciliation records pursuant to subrules 10.33(3) and 10.33(4).

**10.33(3) Changes to a record.** If a perpetual inventory record is able to be changed, the individual making a change to the record shall complete an incident report documenting the change. The incident report shall identify the specific information that was changed including the information before and after the change, shall identify the individual making the change, and shall include the date and the reason the record was changed. If the electronic record system documents within the perpetual inventory record all of the information that must be included in an incident report, a separate report is not required.

**10.33(4) Reconciliation.** The pharmacist in charge shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance on a periodic basis but no less frequently than annually. In case of any discrepancies between the physical inventory and the perpetual inventory, the pharmacist in charge shall determine the need for further investigation, and significant discrepancies shall be reported to the board pursuant to rule 657—10.16(124) and to the DEA pursuant to federal DEA regulations. Periodic reconciliation records shall be maintained and available for review and copying by the board or agents of the board for a period of two years from the date of the record. The reconciliation process may be completed using either of the following procedures or a combination thereof:

*a.* The dispensing pharmacist verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. If controlled substances are maintained on the patient care unit, the nurse or other responsible licensed health care provider verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. All discrepancies shall be reported to the pharmacist in charge. If any Schedule II controlled substances in the pharmacy's current inventory have been dispensed and verified in this manner within the year, and there are no discrepancies noted, no additional reconciliation action is required. A drug that has had no activity within the year shall be reconciled pursuant to paragraph "b" of this subrule.

*b.* A physical count of each Schedule II controlled substance stocked by the pharmacy shall be completed at least once each year, and that count shall be reconciled with the perpetual inventory record balance. The physical count and reconciliation may be completed over a period of time not to exceed one year in a manner that ensures that the perpetual inventory and the physical inventory of Schedule II controlled substances are annually reconciled. The individual performing the reconciliation shall record the date, the time, the individual's initials or unique identification, and any discrepancies between the physical inventory and the perpetual inventory. Any discrepancies between the physical inventory and the perpetual inventory shall be reported to the pharmacist in charge.

**657—10.34(124,155A) Records.** Every inventory or other record required to be kept under this chapter or under Iowa Code chapter 124 shall be kept by the registrant and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record except as otherwise required in these rules. Controlled substances records shall be maintained in a readily retrievable manner that establishes the receipt and distribution of all controlled substances. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department.

**10.34(1) Schedule I and II records.** Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the registrant.

**10.34(2) Schedule III, IV, and V records.** Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the required information is readily retrievable from the ordinary business records of the registrant.

**10.34(3) *Date of record.*** The date on which a controlled substance is actually received, imported, distributed, exported, disposed of, or otherwise transferred shall be used as the date of receipt, importation, distribution, exportation, disposal, or transfer.

**10.34(4) *Receipt and disbursement records.*** Each record of receipt or disbursement of controlled substances, unless otherwise provided in these rules or pursuant to federal law, shall include the following:

- a. The name of the substance;
- b. The strength and dosage form of the substance;
- c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from whom the substances were acquired;
- d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to whom the substances were distributed; and
- e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to whom the substances were distributed for disposal, if appropriate.

**10.34(5) *Dispensing records.*** Each record of dispensing of controlled substances to a patient or research subject shall include the following information:

- a. The name and address of the person to whom dispensed;
- b. The date of dispensing;
- c. The name of the substance;
- d. The quantity of the substance dispensed; and
- e. The name or unique identification of the individual who dispensed or administered the substance.

**10.34(6) *Ordering or distributing Schedule I or II controlled substances - DEA Form 222.*** Except as otherwise provided by subrule 10.34(7) and under federal law, a DEA Form 222 is required for each distribution of a Schedule I or II controlled substance. An order form may be executed only on behalf of the registrant named on the order form and only if the registrant's DEA and Iowa registrations for the substances being purchased have not expired or been revoked or suspended by the issuing agency.

a. Order forms shall be obtained, executed, and filled pursuant to DEA requirements. Each form shall be complete, legible, and properly prepared, executed, and endorsed and shall contain no alteration, erasure, or change of any kind.

b. The purchaser shall submit Copy 1 and Copy 2 of the order form to the supplier.

c. The purchaser shall maintain Copy 3 of the order form in the files of the registrant. Upon receipt of the substances from the supplier, the purchaser shall record on Copy 3 of the order form the quantity of each substance received, and the date of receipt, and shall initial each line identifying a substance received.

d. The supplier shall record on Copy 1 and Copy 2 of the order form the quantity of each substance distributed to the purchaser and the date on which the shipment is made. The supplier shall maintain Copy 1 of the order form in the files of the supplier and shall forward Copy 2 of the order form to the DEA district office.

e. Order forms shall be maintained separately from all other records of the registrant.

f. Each unaccepted, defective, or otherwise "void" order form and any attached statement or other documents relating to any order form shall be maintained in the files of the registrant.

g. If the registration of any purchaser of Schedule I or II controlled substances is terminated for any reason, or if the name or address of the registrant as shown on the registration is changed, the registrant shall return all unused order forms to the DEA district office.

**10.34(7) *Ordering or distributing Schedule I or II controlled substances - electronic ordering system.*** A registrant authorized to order or distribute Schedule I or II controlled substances via the DEA Controlled Substances Ordering System (CSOS) shall comply with the requirements of the DEA

relating to that system, including the maintenance and security of digital certificates, signatures, and passwords and all record-keeping and reporting requirements.

*a.* For an electronic order to be valid, the purchaser shall sign the electronic order with a digital signature issued to the purchaser or the purchaser's agent by the DEA.

*b.* An electronic order may include controlled substances that are not in Schedules I and II and may also include noncontrolled substances.

*c.* A purchaser shall submit an order to a specific wholesale distributor appropriately licensed to distribute in Iowa.

*d.* Prior to filling an order, a supplier shall verify the integrity of the signature and the order, verify that the digital certificate has not expired, check the validity of the certificate, and verify the registrant's authority to order the controlled substances.

*e.* The supplier shall retain an electronic record of every order, including a record of the number of commercial or bulk containers furnished for each item and the date on which the supplier shipped the containers to the purchaser. The shipping record shall be linked to the electronic record of the order. Unless otherwise provided under federal law, a supplier shall ship the controlled substances to the registered location associated with the digital certificate used to sign the order.

*f.* If an order cannot be filled for any reason, the supplier shall notify the purchaser and provide a statement as to the reason the order cannot be filled. When a purchaser receives such a statement from a supplier, the purchaser shall electronically link the statement of nonacceptance to the original electronic order. Neither a purchaser nor a supplier may correct a defective order; the purchaser must issue a new order for the order to be filled.

*g.* When a purchaser receives a shipment, the purchaser shall create a record of the quantity of each item received and the date received. The record shall be electronically linked to the original order and shall identify the individual reconciling the order. A purchaser shall, for each order filled, retain the original signed order and all linked records for that order for two years. The purchaser shall also retain all copies of each unfilled or defective order and each linked statement.

*h.* A supplier shall retain each original order filled and all linked records for two years. A supplier shall, for each electronic order filled, forward to the DEA within two business days either a copy of the electronic order or an electronic report of the order in a format specified by the DEA.

*i.* Records of CSOS electronic orders and all linked records shall be maintained by a supplier and a purchaser for two years following the date of shipment or receipt, respectively. Records may be maintained electronically or in hard-copy format. Records that are maintained electronically shall be readily retrievable from all other records, shall be easily readable or easily rendered into a readable format, shall be readily retrievable at the registered location, and shall be made available to the board, to the board's agents, or to the DEA upon request. Records maintained in hard-copy format shall be maintained in the same manner as DEA Form 222.

[ARC 8539B, IAB 2/24/10, effective 4/1/10; ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.35(124,155A) Physical count and record of inventory.** Responsibility for ensuring that a required inventory is timely completed shall rest with the registrant or, in the case of a registered business, shall rest with the owner of the business. A registrant or owner of a registered business may delegate the actual taking of any inventory. The person or persons responsible for taking the inventory shall sign the completed inventory record.

**10.35(1) Record and procedure.** Each inventory record, except the periodic count and reconciliation required pursuant to subrule 10.33(4), shall comply with the requirements of this subrule and shall be maintained for a minimum of two years from the date of the inventory.

*a.* Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date and at the time the inventory is taken.

*b.* Each inventory shall be maintained in a handwritten, typewritten, or electronically printed form at the registered location. An inventory of Schedule II controlled substances shall be maintained separately from an inventory of all other controlled substances.

c. Controlled substances shall be deemed to be on hand if they are in the possession of or under the control of the registrant. These shall include prescriptions prepared for dispensing to a patient but not yet delivered to the patient, substances maintained in emergency medical services programs or care facility emergency supplies, outdated or adulterated substances pending destruction, and substances stored in a warehouse on behalf of the registrant. Controlled substances obtained through an authorized collection program for the purpose of disposal shall not be examined, inspected, counted, sorted, inventoried, or otherwise handled.

d. A separate inventory shall be made for each registered location and for each independent activity registered except as otherwise provided under federal law.

e. The inventory shall be taken either prior to opening or following the close of business on the inventory date, and the inventory record shall identify either opening or close of business.

f. The inventory record, unless otherwise provided under federal law, shall include the following information:

- (1) The name of the substance;
- (2) The strength and dosage form of the substance;
- (3) The quantity of the substance; and
- (4) Information required of authorized collection programs pursuant to federal regulations for such collection programs.

g. For all substances listed in Schedule I or II, and for all solid oral and injectable hydrocodone-containing products, the quantity shall be an exact count or measure of the substance.

h. For all substances listed in Schedule III, IV, or V, except for hydrocodone-containing products identified in paragraph "g" herein, the quantity may be an estimated count or measure of the substance unless the container has been opened and originally held more than 100 dosage units. If the opened commercial container originally held more than 100 dosage units, an exact count of the contents shall be made. Liquid oral hydrocodone-containing products packaged in incremented containers shall be measured to the nearest increment; products packaged in nonincremented containers may be estimated to the nearest one-fourth container.

**10.35(2) Initial inventory.** A new registrant shall take an inventory of all stocks of controlled substances on hand on the date the new registrant first engages in the manufacture, distribution, or dispensing of controlled substances. If the registrant commences business or the registered activity with no controlled substances on hand, the initial inventory shall record that fact.

**10.35(3) Annual inventory.** After the initial inventory is taken, a registrant shall take a new inventory of all stocks of controlled substances on hand at least annually. The annual inventory may be taken on any date that is within one year or seven days after the date of the previous annual inventory.

**10.35(4) Change of ownership.** Both the current owner and the prospective owner shall be responsible for ensuring that an inventory of all controlled substances is timely completed whenever there is a change of ownership of any pharmacy or drug wholesaler licensed pursuant to Iowa Code section 155A.13 or 155A.17, respectively. The inventory shall be taken following the close of business the last day under terminating ownership and prior to opening for business the first day under the new ownership. The inventory shall serve as the ending inventory for the terminating owner as well as a record of beginning inventory for the new owner.

**10.35(5) Change of pharmacist in charge (PIC).** An inventory of all controlled substances shall be completed whenever there is a change of PIC. The inventory shall be taken following the close of business the last day of the terminating PIC's employment and prior to opening for business the first day of the new PIC's employment. A single inventory shall be sufficient if there is no lapse between employment of the terminating PIC and the new PIC.

**10.35(6) Change of registered location.** A registrant shall take an inventory of all controlled substances whenever there is a change of registered location. The inventory shall be taken following the close of business the last day at the location being vacated. This inventory shall serve as the ending inventory for the location being vacated as well as a record of beginning inventory for the new location.

**10.35(7) Discontinuing registered activity.** A registrant shall take an inventory of controlled substances at the close of business the last day the registrant is engaged in registered activities. If

the registrant is selling or transferring the remaining controlled substances to another registrant, this inventory shall serve as the ending inventory for the registrant discontinuing business as well as a record of additional or starting inventory for the registrant to whom the substances are transferred.

**10.35(8) *Newly controlled substances.*** On the effective date of the addition of a previously noncontrolled substance to any schedule of controlled substances, any registrant who possesses the newly controlled substance shall take an inventory of all stocks of the substance on hand. That initial inventory record shall be maintained with the most recent controlled substances inventory record. Thereafter, the newly controlled substance shall be included in each inventory made by the registrant. [ARC 1575C, IAB 8/20/14, effective 9/24/14; ARC 2408C, IAB 2/17/16, effective 3/23/16]

**657—10.36(124) Samples and other complimentary packages—records.** Complimentary packages and samples of controlled substances may be distributed to practitioners pursuant to federal and state law only if the person distributing the items leaves with the practitioner a specific written list of the items delivered.

**10.36(1) *Distribution record.*** The record form for the distribution of complimentary packages of controlled substances shall contain the following information:

- a. The name, address, and DEA registration number of the supplier;
- b. The name, address, and DEA registration number of the practitioner;
- c. The name, strength, and quantity of the specific controlled substances delivered; and
- d. The date of delivery.

**10.36(2) *Reports to the board.*** Any person who distributes controlled substances pursuant to this rule shall report all such distributions to the board. Reports shall:

- a. Include the information identified in subrule 10.36(1). Reports may consist of copies of those distribution records or may be computer-generated listings identifying those distributions.
- b. Be submitted as soon as practicable after distribution to the practitioner but no less often than once each calendar quarter.

**10.36(3) *Practitioner records.*** A practitioner who regularly administers or dispenses controlled substances shall keep records of the receipt and disbursement of such drugs, including complimentary packages and samples. Records shall be filed in a readily retrievable manner in accordance with federal requirements and shall be made available for inspection and copying by agents of the board or other authorized individuals for at least two years from the date of the record.

**657—10.37(124,126) Revision of controlled substances schedules.**

**10.37(1) *Application for exception.*** Any person seeking to have any compound, mixture, or preparation containing any depressant or stimulant substance listed in any of the schedules in Iowa Code chapter 124 excepted from the application of all or any part of that chapter may apply to the board for such exception.

- a. An application for an exception under this rule shall provide evidence that an exception has been granted under the federal Controlled Substances Act.
- b. The board shall permit any interested person to file written comments on or objections to the proposal for exception and shall designate the time during which such filings may be made. After consideration of the application and any comments on or objections to the proposal for exception, the board shall issue its findings on the application.

**10.37(2) *Designation of new controlled substance.*** The board may designate any new substance as a controlled substance to be included in any of the schedules in Iowa Code chapter 124 no sooner than 30 days following publication in the Federal Register of a final order so designating the substance under federal law. Designation of a new controlled substance under this subrule shall be temporary as provided in Iowa Code section 124.201, subsection 4.

**10.37(3) *Objection to designation of a new controlled substance.*** The board may object to the designation of any new substance as a controlled substance within 30 days following publication in the Federal Register of a final order so designating the substance under federal law. The board shall file objection to the designation of a substance as controlled, shall afford all interested parties an

opportunity to be heard, and shall issue the board's decision on the new designation as provided in Iowa Code section 124.201, subsection 4.

**657—10.38(124) Temporary designation of controlled substances.**

**10.38(1)** Amend Iowa Code subsection 124.204(9) by adding the following new paragraphs “g,” “h,” “i,” and “j”:

*g.* N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, (salts, and salts of isomers. Other names: AB-CHMINACA.

*h.* N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, (salts, and salts of isomers. Other names: AB-PINACA.

*i.* [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone, its optical, positional, and geometric isomers, (salts, and salts of isomers. Other names: THJ-2201.

*j.* N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide, its optical, positional, and geometric isomers, (salts, and salts of isomers. Other names: acetyl fentanyl.

**10.38(2)** Amend Iowa Code subsection 124.206(2), paragraph “a,” introductory paragraph, as follows:

*a.* Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextroprhan, nalbuphine, nalmefene, naloxegol, naloxone, and naltrexone, and their respective salts, but including the following:

[ARC 7906B, IAB 7/1/09, effective 6/22/09; ARC 8411B, IAB 12/30/09, effective 12/1/09; ARC 8989B, IAB 8/11/10, effective 7/21/10; ARC 9091B, IAB 9/22/10, effective 8/30/10; ARC 0893C, IAB 8/7/13, effective 7/9/13; ARC 1408C, IAB 4/2/14, effective 3/13/14; ARC 1787C, IAB 12/10/14, effective 1/14/15; ARC 2407C, IAB 2/17/16, effective 3/23/16]

**657—10.39(124,126) Excluded substances.** The Iowa board of pharmacy hereby excludes from all schedules the current list of “Excluded Nonnarcotic Products” identified in Title 21, CFR Part 1308, Section 22. Copies of the list of excluded products may be obtained by written request to the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

**657—10.40(124,126) Anabolic steroid defined.** Anabolic steroid, as defined in Iowa Code section 126.2, paragraph 2, includes any substance identified as such in Iowa Code section 124.208, paragraph 6, or in Iowa Code section 126.2, paragraph 2.

**657—10.41(124A) Designation of imitation controlled substances.** Rescinded ARC 2195C, IAB 10/14/15, effective 11/18/15.

These rules are intended to implement Iowa Code sections 124.201, 124.301 to 124.308, 124.402, 124.403, 124.501, 126.2, 126.11, 147.88, 155A.13, 155A.17, 155A.26, 155A.37, and 205.3.

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CHAPTER 11  
DRUGS IN EMERGENCY MEDICAL SERVICE PROGRAMS  
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 11]

**657—11.1(124,147A,155A) Definitions.** For the purpose of this chapter, the following definitions shall apply:

“*Adulterated*” means any drug or device that consists in whole or in part of any filthy, putrid, or decomposed substance.

“*Ambulance service*” means any privately or publicly owned service program that utilizes ambulances, including air transport vehicles, in order to provide patient transportation and emergency medical services.

“*Authorized prescriber*” means any provider who has prescriptive authority in the state of Iowa.

“*Board*” means the board of pharmacy.

“*Bureau*” means the Iowa department of public health, bureau of emergency and trauma services (BETS).

“*Controlled substance*” means any drug that is identified in Schedules I through V of Iowa Code chapter 124, the Iowa uniform controlled substances Act.

“*CSA registration*” means a registration issued by the board pursuant to Iowa Code chapter 124, the Iowa uniform controlled substances Act.

“*DEA*” means the U.S. Department of Justice, Drug Enforcement Administration.

“*DEA registration*” means a registration issued by the DEA pursuant to 21 CFR Part 1301.

“*Department*” means the Iowa department of public health.

“*Drug*” means a substance as defined in Iowa Code section 155A.3(13) but does not include nonmedicated intravenous solutions such as saline.

“*Emergency medical care provider*” means an emergency medical care provider as defined in 641—131.1(147A).

“*Emergency medical services*” or “*EMS*” means an integrated medical care delivery system to provide emergency and nonemergency medical care.

“*Emergency medical technician*” or “*EMT*” means any emergency medical technician or EMT as defined in 641—131.1(147A).

“*Medical direction*” means direction, advice, or orders provided, in accordance with written parameters and protocols, to emergency medical care personnel by a medical director, supervising physician, or physician designee.

“*Medical director*” means any physician licensed under Iowa Code chapter 148, 150, or 150A who shall be responsible for overall medical direction of the service program and who has completed a medical director workshop, sponsored by the department, within one year of assuming duties.

“*Medical director-based*” means that ownership of the drugs maintained in and used by the service program remains with the medical director.

“*Patient care report*” means a computerized or written report that documents the assessment and management of the patient by the emergency medical care provider.

“*Pharmacy-based*” means that ownership of the drugs maintained in and used by the service program remains with the pharmacy.

“*Physician*” means any individual licensed under Iowa Code chapter 148, 150, or 150A.

“*Physician assistant*” or “*PA*” means any individual licensed under Iowa Code chapter 148C.

“*Primary program site*” means the physical location from which the service program is operated and at which stock supplies of prescription drugs may be maintained and distributed to a program vehicle and a program substation.

“*Program substation*” means the physical location from which a service program is operated as a branch or extension of a primary program site, at which an emergency kit or supply of prescription drugs is maintained, and at which a stock supply of prescription drugs is not maintained.

“*Protocols*” means written direction and orders, consistent with the department’s standard of care, that are to be followed by an emergency medical care provider in emergency and nonemergency

situations. Protocols shall be approved by the service program's medical director and shall address the care of both adult and pediatric patients.

*"Responsible individual"* means the individual who maintains legal responsibility of the prescription drugs and devices. "Responsible individual" includes the medical director in a medical director-based service program or the pharmacist in charge in a pharmacy-based service program.

*"Service"* or *"service program"* means any medical care ambulance service or nontransport service that has received authorization from the department.

*"Service director"* means the individual who is responsible for the operation and administration of a service program.

*"Supervising physician"* means any physician licensed under Iowa Code chapter 148, 150, or 150A who supervises and is responsible for medical direction of emergency medical care personnel when such personnel are providing emergency medical care.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 0342C, IAB 10/3/12, effective 11/7/12; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.2(124,147A,155A) Responsibility.** Each service program shall appoint a service director at the primary program site and shall have a responsible individual who is responsible for ensuring that the management of all prescription drugs complies with federal and state laws and regulations. In service programs that maintain both a pharmacy-based service program agreement and a medical director-based service program agreement, the responsible individual for each service program agreement shall be responsible for ensuring the management of drugs under that individual's ownership. If more than one pharmacy enters into an agreement with a pharmacy-based service program, the pharmacist in charge at each pharmacy is responsible for the rules and laws pertaining to the specific prescription drugs, including controlled substances, that each pharmacy provides to the service program.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.3(124,147A,155A) Registration required.** In any service program which intends to provide services in or into Iowa that include the administration of controlled substances, the responsible individual shall ensure that each primary program site, regardless of location, is registered with the board pursuant to this rule. The current registration certificate shall be available at the primary program site for inspection and copying by the board, its representative, or any other authorized individual.

**11.3(1) Medical director-based service program.** In a medical director-based service program, CSA and DEA registrations shall be obtained for each primary program site. CSA and DEA registrations shall be obtained prior to procurement of any controlled substances for use in the service program. Separate registrations for program substations shall not be required. In a medical director-based service program, the CSA and DEA registrations shall be issued in the name of the service program, shall secondarily name the medical director, and shall be issued for the address of the service program's primary program site.

**11.3(2) Pharmacy-based service program.** In a pharmacy-based service program, the CSA registration shall be issued in the name of the service program and shall secondarily name the provider pharmacy. The CSA registration shall be issued for the address of the service program's primary program site and shall identify the pharmacist in charge of the provider pharmacy as the individual responsible for the controlled substances at the service program.

**11.3(3) Combination pharmacy-based and medical director-based service program.** In a service program that is a combination of pharmacy-based and medical director-based and both the pharmacy and medical director provide controlled substances, each provider of controlled substances shall maintain a CSA registration with the board as provided by this rule. A medical director-based program shall also maintain a federal DEA registration as provided by this rule.

**11.3(4) Change of address of registered primary program site.** A registrant may apply to change the address of the registered primary program site by submitting a written request as provided in 657—subrule 10.11(2). The board and the DEA shall be notified in writing prior to a change of address of a registered primary program site.

**11.3(5) Discontinuation of medical director in a medical director-based service program.** If a medical director intends to terminate a written agreement with a service program pursuant to rule

657—11.5(124,147A,155A), the medical director shall provide written notification to the board at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309, pursuant to 657—subrule 10.11(6), to cancel the registration, including the effective date of the termination of the agreement. The registration certificate shall be returned to the board no later than ten days following the effective date of the termination of the agreement.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.4(124,147A,155A) Written agreement.** A signed, written agreement for the service program shall be maintained at the primary program site and be available for inspection and copying by the board, its representative, or any other authorized individual.

**11.4(1) Pharmacy-based service programs.** An Iowa-licensed pharmacy may enter into an agreement with a service program located in the state. The agreement with the service program shall establish that the service program is operating as an extension of the pharmacy with respect to the prescription drugs the pharmacy provides to the service program. The agreement shall be signed by the pharmacist in charge and the service director at the primary program site. A copy of this agreement shall be maintained at both the pharmacy and the primary program site while the agreement is in effect. Nothing in this rule prohibits more than one pharmacy from entering into an agreement with a service program provided that each pharmacy complies with all rules and regulations for a pharmacy-based service program, including maintenance of all required records specific to each pharmacy's drugs.

**11.4(2) Medical director-based service programs.** An Iowa-licensed physician may enter into an agreement with a service program located in the state. The agreement shall be signed by the medical director and the service director and be maintained at the primary program site while the agreement is in effect. The agreement shall include an attestation that the medical director agrees to abide by these rules.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.5(124,147A,155A) Termination of agreement.** A written agreement may be terminated at the discretion of either the service program or the party or parties responsible for providing drugs to the service program. Written notification of such termination shall be provided to the other party at least 30 days prior to termination of the agreement.

**11.5(1) Pharmacy-based service programs.** Immediately upon discontinuation of a written agreement, all controlled substances shall be jointly inventoried by the pharmacist in charge of the pharmacy that owns the drugs and the service director or their respective designees. A record of this inventory shall be maintained at the pharmacy for two years from the date of the inventory and shall be available for inspection and copying by the board, its representative, or any other authorized individual. All drugs and devices that are the property of the pharmacy shall be immediately returned to the pharmacy.

**11.5(2) Medical director-based service programs.** Immediately upon discontinuation of a written agreement, all controlled substances shall be jointly inventoried by the medical director and the service director or their respective designees. A record of this inventory shall be maintained by the medical director for two years from the date of the inventory and shall be available for inspection and copying by the board, its representative, or any other authorized individual. All drugs and devices that are the property of the medical director shall be immediately returned to the medical director.

**11.5(3) Transfer of ownership.** If drugs in a service program are to be maintained under the ownership of a new pharmacy or medical director, such transfer of ownership shall be in compliance with 657—Chapter 10, 657—Chapter 17, and federal laws and regulations. Pursuant to rule 657—10.34(124,155A), the transfer of Schedule II controlled substances shall require an executed DEA Form 222.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 0342C, IAB 10/3/12, effective 11/7/12; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.6(124,147A,155A) Registration required.** Rescinded ARC 3101C, IAB 6/7/17, effective 7/12/17.

[ARC 9786B, IAB 10/5/11, effective 11/9/11]

**657—11.7** Reserved.

**657—11.8(124,147A,155A) Identification.** A log of employees who have access to prescription drugs and to records regarding procurement, storage, and administration of prescription drugs at the service program shall be maintained for two years and be available for inspection and copying by the board, its representative, or any other authorized individual. This log shall include each employee's printed name and signature, printed and signed initials or other unique identification used in service program records, and the employee's level of certification. A service program may maintain an electronic record of employee identification, including the employee's name, signature, unique identification used in the service program records, and level of certification. Such log shall be maintained at the primary program site for at least two years from the date of the employee's last date of employment with the service program and shall be available for inspection and copying by the board, its representative, or any other authorized individual.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.9** Reserved.

**657—11.10(124,147A,155A) Ownership of prescription drugs.** All prescription drugs obtained for use in a service program shall be owned either by a pharmacy or by the medical director of the service program.

**11.10(1) Pharmacy-based service programs.** If the drugs are owned by a pharmacy or more than one pharmacy pursuant to these rules, the service program shall be considered a pharmacy-based service program and shall comply with these rules as they pertain to a pharmacy-based service program.

**11.10(2) Medical director-based service programs.** If the drugs are owned by the medical director, the service program shall be considered a medical director-based service program and shall comply with these rules as they pertain to a medical director-based service program.

**11.10(3) Combination pharmacy-based and medical director-based service programs.** If the service program has entered into both pharmacy-based and medical director-based service program agreements, both the pharmacy and the medical director shall retain separate ownership of the prescription drugs supplied and shall comply with these rules as applicable. The primary program site shall maintain a list that identifies which prescription drugs are owned and supplied by each responsible individual.

**11.10(4) Transfer of ownership.** Any transfer of ownership of prescription drugs and devices in a service program shall be in compliance with 657—Chapter 10, 657—Chapter 17, and federal laws and regulations.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.11(124,147A,155A) Policies and procedures.**

**11.11(1)** The service director, the medical director, and the responsible individual shall develop, implement, and adhere to written policies and procedures for the operation and management of the service program with respect to prescription drugs and devices in accordance with these rules. These policies and procedures shall be available for inspection and copying by the board, its representative, or any other authorized individual. The policies and procedures shall be periodically reviewed by the responsible individual, the medical director, and the service director and shall identify the frequency of the review. Documentation of the review shall be maintained.

**11.11(2)** The policies and procedures shall address, at a minimum, the following:

*a.* Storage of drugs at the primary program site and any program substations, including appropriate temperature controls, temperature monitoring and response when drugs are exposed to extreme temperatures pursuant to rule 657—11.13(124,147A,155A).

*b.* Storage of drugs at the primary program site and any program substations, including adequate security to prevent diversion and unauthorized access to drugs and records pursuant to rule 657—11.13(124,147A,155A).

*c.* Protocols for administration of drugs pursuant to rule 657—11.14(124,147A,155A).

*d.* Administration of drugs outside the parameters of written protocols pursuant to rule 657—11.15(124,147A,155A).

*e.* Service program personnel matters including, but not limited to:

(1) Access to prescription drugs and records, identifying level of access based upon employee certification level and scope of practice.

(2) Authority to administer drugs based upon employee certification level and scope of practice.

(3) Authority to order, receive, and distribute prescription drugs and devices.

(4) Initial training and periodic review of the medication policies and procedures.

(5) Identification of registered nurses not employed by the service program who are authorized by the medical director pursuant to Iowa Code section 147A.12 and pursuant to rules of the board of nursing to provide emergency care under the service program's protocol.

*f.* Process for the return of drugs pursuant to rule 657—11.22(124,147A,155A).

*g.* Out-of-date and adulterated drugs pursuant to rule 657—11.23(124,147A,155A).

*h.* Drug and device recalls pursuant to rule 657—11.24(124,147A,155A).

*i.* Monthly inspections pursuant to rule 657—11.20(124,147A,155A).

*j.* Record retention as described in rule 657—11.34(124,147A,155A) and other applicable rules of the board.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 0342C, IAB 10/3/12, effective 11/7/12; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.12** Reserved.

**657—11.13(124,147A,155A) Storage.** Prescription drugs at primary program sites and program substations shall be stored in designated secure areas that are clean and free of debris, where temperature is appropriately controlled, and in a manner to protect identity and integrity.

**11.13(1) Temperature.** Each drug shall be stored within the temperature range required in the manufacturer labeling. The service program shall utilize a method to provide continuous temperature control or monitoring, such as a temperature indicator, which at a minimum identifies when the drugs have been exposed to extreme temperatures. The service program shall regularly, but at least weekly, verify and document verification that the drugs have not been exposed to extreme temperatures. Drugs that are subjected to extreme temperatures shall not be administered to patients and shall be quarantined and returned to the responsible individual for disposition. Extreme temperatures shall be defined as excessive heat greater than 40 degrees Celsius (104 degrees Fahrenheit) and, if the product requires protection from freezing temperatures, excessive cold less than -10 degrees Celsius (13 degrees Fahrenheit). Disposition of unusable drugs shall be in compliance with rule 657—11.32(124,147A,155A).

**11.13(2) Security.** The security of prescription drugs, records for such drugs, and patient records is the responsibility of the responsible individual and shall provide for the effective control against theft of, diversion of, or unauthorized access to drugs and records. Policies shall identify procedures that will utilize or require the signature of two service employees for each disbursement to ensure accountability for controlled substances.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.14(124,147A,155A) Protocols.** Every service program shall utilize department protocols as the standard of care. The service program medical director may authorize an alternative protocol provided the directives are within the EMS provider's scope of practice, are within acceptable medical practice, and have been filed with the department. Prescription drugs shall be administered pursuant only to a written protocol or oral order by an authorized prescriber. A copy of the current protocol shall be provided to and maintained by the responsible individual, the service director, the primary program site and each program substation and shall be available for inspection and copying by the board, its representative, or any other authorized individual.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.15(124,147A,155A) Administration of drugs beyond the limits of a written protocol.** Drugs may be administered beyond the limits of a written protocol provided that medical direction from an authorized prescriber has been obtained prior to administration. The authorization shall be recorded in the patient care report documenting the identity of the authorizing prescriber. If an agent of the authorized prescriber relayed the order, the identity of the prescriber's agent, including the agent's first and last names and title, shall also be recorded. The administration of a Schedule II controlled substance in a pharmacy-based service program shall be documented pursuant to rule 657—11.16(124,147A,155A). [ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.16(124,147A,155A) Administration of Schedule II controlled substances—pharmacy-based service program.** In a pharmacy-based service program, Schedule II controlled substances may be administered to patients under the care of a service program, including administration beyond the limits of a protocol when authorized pursuant to rule 657—11.15(124,147A,155A), provided that a signed order is delivered by the authorized prescriber to the pharmacy within seven days of the date administration was authorized. The signed order shall contain all of the prescription information required pursuant to Iowa Code section 155A.27. The patient care report may be accepted as the required signed order if the patient care report includes the required prescription information, including an original signature of the authorizing prescriber. [ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.17 and 11.18** Reserved.

**657—11.19(124,147A,155A) Patient care reports.** Patient care reports shall be maintained at the primary program site or the program substation as required by the bureau and rule 657—11.34(124,147A,155A). [ARC 9786B, IAB 10/5/11, effective 11/9/11]

**657—11.20(124,147A,155A) Prescription drugs in service programs.** Prescription drugs maintained by a service program shall be owned by an Iowa-licensed pharmacy or the service program's medical director.

**11.20(1) Pharmacy-based service programs.** The pharmacist in charge, the medical director, and the service director shall jointly develop, consistent with the service program's protocol, a list of drugs to be maintained for administration by the service program. The pharmacy shall maintain a current list of all prescription drugs including controlled substances that the pharmacy maintains at the primary program site and at any program substation.

*a. Replenishment.* The responsible individual, the service director, or designee may request that replenishment supplies of drugs be maintained at the primary program site provided that the pharmacy has been supplied with administration records justifying the order. Records of the administration of Schedule III, IV, and V controlled substances and noncontrolled prescription drugs provided to and maintained at the pharmacy shall include, at a minimum: the patient's name; the name, strength, dosage form, and quantity of the drug administered; and the date of administration. Records of the administration of Schedule II controlled substances provided to and maintained at the pharmacy shall consist of a written prescription including all of the prescription information required pursuant to Iowa Code section 155A.27 or the patient care report if the patient care report includes the required prescription information, including an original signature of the authorizing prescriber. A pharmacist shall verify the accuracy of every drug to be disbursed to the primary program site. Documentation of this verification shall be maintained within the pharmacy records.

*b. Replenishment using automated medication distribution system (AMDS).* A pharmacy utilizing an automated medication distribution system (AMDS) may authorize replenishment of the service program's drug supplies from the AMDS provided that a pharmacist verifies the drugs stocked in the AMDS component before the drugs are removed from the pharmacy. Service program personnel authorized to remove drugs from the AMDS for restocking the service program's supplies shall be assigned a unique identification and access code for the purpose of accessing the AMDS. Access by

authorized service program personnel shall be restricted to specific drug products authorized for use by the service program. A pharmacist shall, within 72 hours, review the access of and removal of drugs from the AMDS by service program personnel and shall maintain documentation of that review within the pharmacy records.

*c. Inspections.* The pharmacist in charge shall ensure the completion of a monthly inspection of all prescription drugs maintained by the pharmacy at the primary program site and any program substation. Inspection shall include the removal of outdated or adulterated drugs. All drugs removed from service program stock shall be returned to the pharmacy. Records of inspection shall be maintained for two years from the date of the inspection at the pharmacy. The pharmacist in charge may delegate the completion of the monthly inspection to another pharmacist, a pharmacist-intern, a certified pharmacy technician, or another designee of the pharmacist in charge.

**11.20(2) Medical director-based service programs.** The medical director and the service director shall jointly develop, consistent with the service program's protocol, a list of drugs to be maintained for administration by the service program. The medical director shall maintain a current list of all prescription drugs including controlled substances that the medical director maintains at the primary program site and at any program substation.

*a. Replenishment.* All drugs procured for administration in a medical director-based service program shall be obtained from an Iowa-licensed wholesaler, pharmacy, or authorized prescriber.

*b. Inspections.* The medical director shall ensure the completion of a monthly inspection of all prescription drugs maintained by the medical director at the primary program site and any program substation. Inspection shall include the removal of outdated or adulterated drugs. Records of inspection shall be maintained for two years from the date of the inspection at the primary program site or the program substation. The medical director may delegate the completion of the required inspections to the service director or other designee.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 0342C, IAB 10/3/12, effective 11/7/12; ARC 1307C, IAB 2/5/14, effective 3/12/14; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.21** Reserved.

**657—11.22(124,147A,155A) Return of drugs.** Drugs that have been removed from service program stock shall be returned to the responsible individual. In a pharmacy-based service program, drugs returned from the service program to the pharmacy may be used by the pharmacy for subsequent dispensing or administration provided the drugs are not outdated or adulterated. Records of the return of prescription drugs shall be maintained by the responsible individual for two years from the date of the return.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.23(124,147A,155A) Out-of-date drugs or devices.** Any drug or device bearing an expiration date shall not be administered beyond the expiration date of the drug or device. Outdated drugs or devices shall be removed from service program stock and quarantined until such drugs or devices are returned to the responsible individual for disposition.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.24(124,147A,155A) Product recall.** Each service program shall have a procedure for removal from service program stock all drugs or devices subject to a product recall. The procedure shall include action appropriate to the direction or requirements of the recall.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.25** Reserved.

**657—11.26(124,147A,155A) Controlled substances records.**

**11.26(1) Records maintained.** Every inventory or other record required to be maintained under this chapter, 657—Chapter 10, or Iowa Code chapter 124 shall be maintained at the primary program site or the program substation and by the pharmacy if the service program is pharmacy-based. All required

records shall be available for inspection and copying by the board, its representative, or any other authorized individual for at least two years from the date of such record. Controlled substances records shall be maintained in a readily retrievable manner. Schedule II controlled substances records shall be maintained separately from all other records of the registrant.

**11.26(2)** *Receipt and disbursement records in medical director-based service programs.* Any pharmacy or other authorized registrant that provides controlled substances for a medical director-based service program shall provide to the service program a record of the disbursement and maintain a record of the disbursement pursuant to rule 657—10.34(124,155A). The service program shall retain the record on which an authorized individual shall sign and record the actual date of receipt. The record shall include the following:

- a. The name of the substance;
- b. The strength and dosage form of the substance;
- c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from whom the substances were acquired;
- d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to whom the substances were distributed; and
- e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to whom the substances were distributed for disposal, if appropriate.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.27(124,147A,155A) Ordering Schedule II controlled substances—medical director-based service programs.** Except as otherwise provided by 657—subrule 10.34(7) and under federal law, a DEA Form 222, preprinted with the address of the primary program site, is required to be maintained at the primary program site for the acquisition of each supply of a Schedule II controlled substance. The order form shall be executed only by the medical director named on the order form or by an authorized signer designated pursuant to a properly executed power of attorney. A DEA Form 222 shall be dated and signed as of the date the order is submitted for filling. A medical director or authorized signer shall not pre-sign a DEA Form 222 for subsequent completion. All Schedule II order forms shall be maintained at the primary program site and shall be available for inspection and copying by the board, its representative, or any other authorized individual for a period of two years from the date of the record. [ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.28** Reserved.

**657—11.29(124,147A,155A) Schedule II controlled substances perpetual inventory.** Each service program located in Iowa that administers Schedule II controlled substances shall maintain a perpetual inventory for all Schedule II controlled substances pursuant to the requirements of this rule. All records relating to the perpetual inventory shall be maintained at the primary program site and shall be available for inspection and copying by the board, its representative, or any other authorized individual for a period of two years from the date of the record.

**11.29(1)** *Record.* The perpetual inventory record may be maintained in a hard-copy or electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed. A record entry, once recorded, shall not be changed; any adjustments or corrections shall require entry of a separate record as provided in subrule 11.29(3).

**11.29(2)** *Information included.* The perpetual inventory record shall identify all receipts and disbursements of Schedule II controlled substances by drug name or by National Drug Code (NDC), including each patient administration, wastage, and return of a drug to the responsible individual. The record of receipt shall also identify the source of the drug, the strength and dosage form, the quantity,

the date of receipt, and the name or unique identification of the individual verifying receipt of the drug. The disbursement record shall identify where or to whom the drug is disbursed or administered, the strength and dosage form, the quantity, the date of disbursement or administration, and the name or unique identification of the individual responsible for the disbursement. Receipts and disbursements shall be recorded in the perpetual inventory as soon as practicable but no later than 24 hours after the receipt, disbursement, or administration.

**11.29(3) *Adjustments or corrections to the record.*** Any adjustments or corrections made to the perpetual inventory shall include the identity of the person making the adjustment or correction and the reason for the adjustment or correction.

**11.29(4) *Reconciliation.*** The pharmacist in charge or designee in a pharmacy-based service program, or the medical director or designee in a medical director-based service program, shall be responsible for reconciling the perpetual inventory record of all Schedule II controlled substances with the physical inventory at least monthly. Any discrepancy shall be reported within 24 hours of the discovery to the responsible individual for investigation.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.30(124,147A,155A) Controlled substances annual inventory.** An accurate inventory shall be taken annually of all controlled substances maintained at the primary program site and program substations. Controlled substances in a pharmacy-based service program shall be included in the pharmacy's annual controlled substances inventory. The inventory record shall identify the drug name or National Drug Code (NDC) and the exact quantity under the control of the service program including drugs in replenishment stock and quarantined stock. The inventory record shall contain the date and time the inventory was taken and the printed name and signature of the individual or individuals responsible for the inventory record. Records of the inventory shall be maintained pursuant to rule 657—11.34(124,147A,155A).

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.31** Reserved.

**657—11.32(124,147A,155A) Disposition of controlled substances.** Disposition of controlled substances shall be pursuant to the requirements of this rule, rule 657—11.29(124,147A,155A), 657—Chapter 10, and federal regulations. Records shall be maintained at the primary program site and, if the service program is pharmacy-based, records shall be maintained at the pharmacy.

**11.32(1) *Outdated, adulterated, or unwanted supply.*** Controlled substances shall not be destroyed except as provided in subrule 11.32(2). Any drug that requires disposition shall be quarantined until the drug can be returned to the responsible individual. The responsible individual shall ensure the proper disposition of controlled substances according to the following procedures:

*a.* The responsible individual shall utilize the services of a DEA-registered and Iowa-licensed disposal firm (reverse distributor), or

*b.* The responsible individual shall utilize such other means determined and approved by the board.

**11.32(2) *Administration wastage.*** Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient may be destroyed or otherwise disposed of by the administering service program personnel, the medical director, or a pharmacist. Any wastage of a controlled substance shall be conducted in the presence of a responsible adult witness who is an authorized service program employee, a member of the professional or technician pharmacy staff, or a licensed health care professional. A written or electronic record of controlled substance wastage shall be created and maintained at the primary program site and, if the service program is pharmacy-based, at the pharmacy, for a minimum of two years following the disposition. The record shall include the signatures or other unique identification of the witness and of the individual destroying or otherwise disposing of the wastage of the controlled substance and shall identify the following:

*a.* The controlled substance wasted;

*b.* The date of destruction or other disposition;

- c. The quantity or estimated quantity of the wasted controlled substance;
  - d. The source of the controlled substance, including identification of the patient to whom the substance was administered; and
  - e. If either individual involved in the wastage is not identified in the service program identification log, the legibly printed first and last names and title of the individual.
- [ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.33(124,147A,155A) Report of loss or theft of controlled substance.** Upon suspicion of any loss or theft of a controlled substance, the service director shall immediately notify the responsible individual. The responsible individual shall provide notice and reporting as required in rule 657—10.16(124).

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

**657—11.34(124,147A,155A) Records.** If a service program includes a primary program site and one or more program substations, each record shall identify the specific location to which it applies. Records regarding service program substation activities, including drug supply and administration records, may be maintained at the primary program site but shall clearly identify the program substation to which the records apply. All records regarding prescription drugs and devices in a service program shall be maintained for two years from the date of the activity or record and be available for inspection and copying by the board, its representative, or any other authorized individual.

[ARC 9786B, IAB 10/5/11, effective 11/9/11; ARC 3101C, IAB 6/7/17, effective 7/12/17]

These rules are intended to implement Iowa Code chapter 147A and Iowa Code sections 124.301 and 155A.13.

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CHAPTER 37  
IOWA PRESCRIPTION MONITORING PROGRAM

**657—37.1(124) Purpose.** These rules establish a prescription monitoring program that compiles a central database of reportable prescriptions dispensed to patients in Iowa. An authorized health care practitioner may, but is not required to, access prescription monitoring program (PMP) information regarding the practitioner's patient to assist in determining appropriate treatment options and to improve the quality of patient care. The PMP is intended to provide a health care practitioner with a resource for information regarding a patient's use of controlled substances. This database will assist the practitioner in identifying any potential diversion, misuse, or abuse of controlled substances without impeding the appropriate medical use of controlled substances.

[ARC 7903B, IAB 7/1/09, effective 8/5/09]

**657—37.2(124) Definitions.** As used in this chapter:

*"Board"* means the Iowa board of pharmacy.

*"Controlled substance"* means a drug, substance, or immediate precursor in Schedules I through V set forth in Iowa Code chapter 124, division II.

*"Council"* means the PMP advisory council established pursuant to Iowa Code section 124.555 to provide oversight and to co-manage PMP activities with the board.

*"Database information"* or *"PMP information"* means information submitted to and maintained by the PMP database.

*"DEA number"* means the registration number issued to an individual or pharmacy by the U.S. Department of Justice, Drug Enforcement Administration (DEA) authorizing the individual or pharmacy to engage in the prescribing, dispensing, distributing, or procuring of a controlled substance.

*"Dispenser"* means a person who delivers to the ultimate user a substance required to be reported to the PMP database. "Dispenser" includes a pharmacy located outside the state of Iowa that is licensed by the board with a nonresident pharmacy license authorizing the pharmacy to dispense prescription drugs to patients physically located in Iowa. "Dispenser" does not include a person exempt from reporting pursuant to subrule 37.3(1).

*"Electronic health record system"* or *"EHRS"* means a real-time, patient-centered health record system that makes patient health information and other health care tools and resources readily and securely available to authorized providers in a digital format capable of being shared with other providers across one or more health care organizations or facilities.

*"Electronic pharmacy information system"* or *"e-pharmacy system"* means a real-time electronic patient prescription record system that includes, at a minimum, patient profiles and prescription dispensing information and that may enable shared access to included information by multiple pharmacies, such as a chain of pharmacies using the same e-pharmacy system.

*"Electronic system"* means an electronic health record system, an electronic pharmacy information system, or a health information exchange. "Electronic systems" refers to a combination of two or more of these types of systems.

*"Health care professional"* means a person who, by education, training, certification, or licensure, is qualified to provide and is engaged in providing health care to patients. "Health care professional" does not include clerical or administrative staff. "Health care professional," other than a licensed prescriber or pharmacist, may include, but is not limited to, a certified pharmacy technician or a registered technician trainee, a nurse, a certified medical assistant, or a pharmacist-intern.

*"Health information exchange"* or *"HIE"* means a system that allows health care professionals to appropriately access and securely share a patient's vital medical information and records as that electronic information is instantly updated and simultaneously available to each of the health care professionals across organizations, often within a region, community, or health care system.

*"National drug code"* or *"NDC number"* means the universal product identifier used in the United States to identify a specific human drug product.

“*Patient*” means the person or animal that is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed.

“*Patient's agent*” means a person legally authorized to make health care decisions or gain access to health care records on behalf of the patient for purposes of directing the patient’s care.

“*Patients rights committee*” or “*committee*” means the physician and pharmacist members of the council responsible for monitoring and ensuring protection and preservation of patients’ rights as provided in Iowa Code section 124.555(3)“e.”

“*PMP administrator*” means the board staff person or persons designated to manage and administer the PMP under the direction and oversight of the board and the council.

“*Practitioner*” means a prescriber or a pharmacist.

“*Practitioner's agent*” means a health care professional who is employed by or under the direct supervision of a PMP-registered practitioner and who is authorized by the practitioner to access PMP information as provided in subrule 37.4(1).

“*Prescriber*” means a licensed health care professional with the authority to prescribe prescription drugs including controlled substances.

“*Prescription monitoring program*” or “*PMP*” means the program established pursuant to these rules for the collection and maintenance of PMP information and for the provision of PMP information to authorized individuals, including health care providers, for use in treatment of their patients.

“*Prescription monitoring program database*” or “*PMP database*” means a centralized database of reportable controlled substance prescriptions dispensed to patients and includes data access logs, security tracking information, and records of each individual who requests PMP information.

“*Reportable prescription*” means the record of a Schedule II, III, or IV controlled substance dispensed by a pharmacy to a patient pursuant to a prescriber-authorized prescription. “Reportable prescription” does not include those records excluded in subrule 37.3(1).

“*Schedule II, III, and IV controlled substances*” means those substances that are identified and listed as Schedule II, III, or IV substances in Iowa Code sections 124.205 through 124.210 or in the federal Controlled Substances Act (21 U.S.C. Section 812).

[ARC 7903B, IAB 7/1/09, effective 8/5/09; ARC 0056C, IAB 4/4/12, effective 7/1/12; ARC 0242C, IAB 8/8/12, effective 1/1/13; ARC 3102C, IAB 6/7/17, effective 7/12/17]

**657—37.3(124) Requirements for the PMP.** Each dispenser, unless identified as exempt from reporting and who has applied for and been granted an exemption from reporting to the PMP pursuant to subrule 37.3(1), shall submit to the PMP administrator either a record of each reportable prescription dispensed during a reporting period or a zero report pursuant to subrule 37.3(5), as appropriate. A dispenser located outside the state of Iowa, unless identified as exempt from reporting and who has applied for and been granted an exemption from reporting to the PMP pursuant to subrule 37.3(1), shall submit to the PMP administrator either a record of each reportable prescription dispensed during a reporting period to a patient located in Iowa or a zero report pursuant to subrule 37.3(5), as appropriate.

**37.3(1) Exemptions.** The dispensing of a controlled substance as described in this subrule shall not be considered a reportable prescription. A dispenser engaged in the distribution of controlled substances solely pursuant to one or more of the practices identified in paragraph 37.3(1)“a,” 37.3(1)“b,” or 37.3(1)“c,” or that is not registered to handle controlled substances as described in paragraph 37.3(1)“d,” may apply for an exemption from reporting to the PMP. A dispenser claiming exemption pursuant to this subrule shall certify to the board, on a form provided by the board, the basis for exemption from reporting to the PMP. The PMP administrator is hereby authorized to approve or deny the pharmacy’s request for exemption from reporting to the PMP.

*a.* A licensed hospital pharmacy shall not be required to report the dispensing of a controlled substance for the purposes of inpatient hospital care, the dispensing of a prescription for a starter supply of a controlled substance at the time of a patient’s discharge from such a facility, or the dispensing of a prescription for a controlled substance in a quantity adequate to treat the patient for a maximum of 72 hours. A hospital pharmacy claiming exemption from reporting pursuant to this paragraph shall certify to the board that the hospital pharmacy dispenses only as provided by this paragraph.

*b.* A licensed pharmacy shall not be required to report the dispensing of a controlled substance for a patient residing in a long-term care facility or for a patient residing in an inpatient hospice facility. A pharmacy claiming exemption from reporting pursuant to this paragraph shall certify to the board that the pharmacy dispenses only to patients residing in a long-term care facility or to patients residing in an inpatient hospice facility.

*c.* A nonresident pharmacy that does not distribute controlled substances to patients located in Iowa shall not be required to report to the PMP. A nonresident pharmacy claiming exemption from reporting pursuant to this paragraph shall certify to the board that the nonresident pharmacy does not dispense controlled substances to patients located in Iowa.

*d.* A licensed pharmacy that does not handle controlled substances and that is not registered to handle controlled substances with the federal DEA shall not be required to report to the PMP. A pharmacy claiming exemption from reporting pursuant to this paragraph shall certify to the board that the pharmacy does not dispense controlled substances.

*e.* A prescriber or other authorized person who administers or dispenses a controlled substance, including samples of a controlled substance, for the purposes of outpatient care shall not be required to report such administration or dispensing. A prescriber shall not be required to submit a form or notification claiming exemption from reporting to the PMP. This exception shall not apply to a pharmacist who administers a controlled substance, as directed by the prescriber, pursuant to a prescription.

*f.* A wholesale distributor of a controlled substance shall not be required to report the wholesale distribution of such a substance. A wholesale distributor shall not be required to submit a form or notification claiming exemption from reporting to the PMP.

**37.3(2)** *Data elements.* The information submitted for each prescription shall include, at a minimum, the following items:

- a.* Dispenser DEA number.
- b.* Date the prescription is filled.
- c.* Prescription number.
- d.* Indication as to whether the prescription is new or a refill.
- e.* NDC number for the drug dispensed.
- f.* Quantity of the drug dispensed.
- g.* Number of days of drug therapy provided by the drug as dispensed.
- h.* Patient first and last names.
- i.* Patient address including street address, city, state, and ZIP code.
- j.* Patient date of birth.
- k.* Patient gender.
- l.* Prescriber DEA number.
- m.* Date the prescription was issued by the prescriber.
- n.* Method of payment.

**37.3(3)** *Reporting periods.* A record of each reportable prescription dispensed shall be submitted by each dispenser at least weekly. Records may be submitted with greater frequency than required by this subrule. Records of reportable prescriptions dispensed between Sunday and Saturday each week shall be submitted no later than the following Wednesday. However, a pharmacy that is currently submitting prescription dispensing records to another state's PMP on an alternative weekly reporting schedule may request authority to submit records to the Iowa PMP pursuant to that established schedule. The request shall be submitted in writing via e-mail, fax, or regular mail to the PMP administrator. The request shall identify the pharmacy by name, address, and Iowa pharmacy license number and shall define the alternative reporting period and the reason for the requested alternative reporting period. The PMP administrator is hereby authorized to approve or deny the pharmacy's alternative weekly reporting schedule.

**37.3(4)** *Transmission methods.* Prescription information shall be transmitted using one of the following methods:

- a.* Data upload to a reporting Web site via a secure Internet connection or by utilizing the secure FTP procedure. The PMP administrator or designee will provide dispensers with initial secure login and

password information. Dispensers will be required to register on the reporting Web site prior to initial data upload.

*b.* Electronic media including CD-ROM, DVD, or diskette, accompanied by a transmittal form identifying the dispenser submitting the electronic media, the number of prescription records included on the media, and the individual submitting the media as directed by the PMP administrator or designee.

*c.* If a dispenser does not have an automated record-keeping system capable of producing an electronic report as provided in this rule, the dispenser may submit prescription information on the industry standard universal claim form. The dispenser may complete and submit the claim form on the reporting Web site or, if the dispenser does not have Internet access, the completed paper claim form may be submitted as directed by the PMP administrator or designee.

*d.* Chain pharmacies and pharmacies under shared ownership may submit combined data transmissions on behalf of all facilities by utilizing the secure FTP procedure. Combined data transmissions shall identify the specific pharmacy that dispensed each individual prescription record included in the combined data transmission.

**37.3(5) Zero reports.** If a dispenser has not been identified as exempt from reporting to the PMP and the dispenser did not dispense any reportable prescriptions during a reporting period, the dispenser shall submit a zero report via the established reporting Web site or secure FTP procedure. The schedule identified in subrule 37.3(3) shall determine timely submission of zero reports.

[ARC 7903B, IAB 7/1/09, effective 8/5/09; ARC 0242C, IAB 8/8/12, effective 1/1/13; ARC 3102C, IAB 6/7/17, effective 7/12/17]

**657—37.4(124) Access to database information.** All information contained in the PMP database, including prescription information submitted for inclusion in the PMP database, communications or notifications to PMP users and dispensers via the database, and records of requests for PMP information, shall be privileged and strictly confidential and not subject to public or open records laws. The board, council, and PMP administrator shall maintain procedures to ensure the privacy and confidentiality of patients, prescribers, dispensers, practitioners, practitioners' agents, and patient information collected, recorded, transmitted, and maintained in the PMP database and to ensure that program information is not disclosed to persons except as provided in this rule.

**37.4(1) Prescribers and pharmacists.** A health care practitioner authorized to prescribe or dispense controlled substances may obtain PMP information regarding the practitioner's patient, or a patient seeking treatment from the practitioner, for the purpose of providing patient health care. A practitioner may authorize no more than six health care professionals to act as the practitioner's agents for the purpose of requesting PMP information regarding a practitioner's patients. A practitioner's agent shall be licensed, registered, certified, or otherwise credentialed as a health care professional in a manner that permits verification of the health care professional's credentials.

*a.* Prior to being granted access to PMP information, a practitioner or a practitioner's agent shall submit an individual request for registration and program access. The PMP administrator shall take reasonable steps to verify the identity of a practitioner or practitioner's agent and to verify a practitioner's or practitioner's agent's credentials prior to providing a practitioner or practitioner's agent with a secure login and initial password.

(1) A practitioner shall register via a secure Web site established by the board for that purpose.

(2) A practitioner's agent shall register for access to PMP information on behalf of the supervising practitioner by completing and submitting a hard-copy registration form, provided by the board, that requires the signatures of both the supervising practitioner and the practitioner's agent.

*b.* Each practitioner or practitioner's agent registered to access PMP information shall securely maintain and use the login and password assigned to the individual practitioner or practitioner's agent. Except in an emergency when the patient would be placed in greater jeopardy by restricting PMP information access to the practitioner or practitioner's agent, a registered practitioner shall not share the practitioner's secure login and password information and shall not delegate PMP information access to another health care practitioner or to an unregistered agent. A registered practitioner's agent shall not delegate PMP information access to another individual.

c. A practitioner or practitioner's agent may submit a request for PMP information via a secure Web site established by the board for that purpose. The requested information shall be provided to the requesting practitioner or practitioner's agent in a format established by the board and shall be delivered via the secure Web site.

d. A practitioner or practitioner's agent who requests and receives PMP information consistent with the requirements and intent of these rules may provide that information to another practitioner who is involved in the care of the patient who is the subject of the information. Information from the PMP database remains privileged and strictly confidential. Such disclosures among practitioners shall be consistent with these rules and federal and state laws regarding the confidentiality of patient information. The information shall be used for medical or pharmaceutical care purposes.

e. A practitioner or practitioner's agent shall not provide the patient with a copy of a report generated by the PMP. A patient may receive a report of the patient's own prescription history pursuant to subrule 37.4(4).

**37.4(2) *Regulatory agencies and boards.*** Professional licensing boards and regulatory agencies that supervise or regulate a health care professional or that provide payment for health care services shall be able to access information from the PMP database only pursuant to an order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause. The board may charge a fee for the preparation and release of PMP information and reports as provided in rule 657—37.5(124).

a. Prior to accepting and processing a request for PMP database information from the director or director's designee of a licensing board or other authorized regulatory agency, the director or director's designee shall complete and submit a hard-copy registration form, provided by the board, that requires the signatures of both the director and the director's designee, as appropriate. The PMP administrator shall take reasonable steps to verify the identity of the director or director's designee prior to providing a director or director's designee with a secure login and initial password.

b. A director of a licensing board with jurisdiction over a health care professional, or the director's designee, who seeks access to PMP information for an investigation shall submit to the PMP administrator in a format established by the board a written request via mail, e-mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

c. A director of a regulatory agency with jurisdiction over a health care professional or with jurisdiction over a person receiving health care services pursuant to one or more programs provided by the agency, or the director's designee, who seeks access to PMP information for an investigation shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, e-mail, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

d. The requested information shall be provided to the requesting director or director's designee in a format established by the board and shall be delivered via the secure Web site or by an alternate delivery method determined by the PMP administrator to be appropriate.

**37.4(3) *Law enforcement agencies.*** Local, state, and federal law enforcement or prosecutorial officials engaged in the administration, investigation, or enforcement of any state or federal law relating to controlled substances shall be able to access information from the PMP database by order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause. The board may charge a fee for the preparation and release of PMP information and reports as provided in rule 657—37.5(124).

a. Prior to accepting and processing a request for PMP database information from a law enforcement officer, the officer shall complete and submit a hard-copy registration form, provided by the board, that requires the signatures of both the officer and the officer's direct superior. The PMP administrator shall take reasonable steps to verify the identity of the officer and the officer's direct superior prior to providing the officer with a secure login and initial password.

b. A law enforcement officer shall submit to the PMP administrator in a format established by the board a written request via mail, e-mail, facsimile, or personal delivery. The request shall be signed by the requesting officer or the officer's superior. The request shall be accompanied by an order, subpoena, or warrant issued by a court or legal authority that requires a determination of probable cause and shall be processed by the PMP administrator.

c. A report identifying PMP information relating to the specific individual identified by the order, subpoena, or warrant shall be delivered to the law enforcement officer via the secure Web site or by an alternate delivery method determined by the PMP administrator to be appropriate.

**37.4(4) Patients.** A patient or the patient's agent may request and receive PMP information regarding prescriptions reported to have been dispensed to the patient.

a. A patient may submit a signed, written request for records of the patient's prescriptions dispensed during a specified period of time. The board shall provide the patient with a request form requiring identification of the patient by name, including any aliases used by the patient, and the patient's date of birth and gender. The request form shall also require any address where the patient resided during the time period of the request and the patient's current address and daytime telephone number. A patient may personally deliver the completed request to the PMP administrator or designee at the offices of the board located at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. The patient will be required to present current government-issued photo identification at the time of delivery of the request. A copy of the patient's identification and request shall be maintained in the records of the PMP.

b. A patient who is unable to personally deliver the request to the board offices may submit a request via mail or commercial delivery service. The request shall comply with all provisions of paragraph "a" above, and the signature of the requesting patient shall be witnessed and the patient's identity shall be attested to by a currently registered notary public. In addition to the notary's signature and assurance of the patient's identity, the notary shall certify a copy of the patient's government-issued photo identification and that certified copy shall be submitted with the written request. The request shall be submitted to the Iowa Board of Pharmacy at the address identified in paragraph "a."

c. In the case of a patient whose health care decisions have been legally transferred to the patient's agent, the patient's agent may submit a request on behalf of the patient pursuant to the appropriate procedure in paragraph "a" or "b." In addition to the patient's information, the patient's agent shall be identified by name, current address, and telephone number. In lieu of the patient's signature and identification, the patient's agent shall sign the request and the government-issued photo identification shall identify the patient's agent. The patient's agent shall include a certified copy of the legal document that transferred control over decisions regarding the patient's health care to the patient's agent.

d. A report prepared pursuant to this subrule shall be delivered to the patient or the patient's agent, as appropriate, by personal delivery or via mail or alternate secure delivery.

**37.4(5) Court orders and subpoenas.** The PMP administrator shall provide PMP information in response to court orders and county attorney or other subpoenas issued by a court upon a determination of probable cause. The board may charge a fee for the preparation and release of PMP information and reports as provided in rule 657—37.5(124).

**37.4(6) Statistical data.** The PMP administrator or designee may provide summary, statistical, or aggregate data to public or private entities for statistical, public research, public policy, or educational purposes. Prior to the release of any such data, the PMP administrator or designee shall remove any personal identifying information or verify that any personal identifying information that could be used to identify an individual patient, prescriber, dispenser, practitioner, or other person who is identified in the PMP information or data has been removed from the PMP information or data. The board may charge a fee for the preparation and release of statistical data as provided in rule 657—37.5(124).

**37.4(7) PMP administrator access.** Other than statistical data as described in subrule 37.4(6) and technical, error, and administrative function reports and information needed by PMP support staff to determine that records are received and maintained in good order or to review or resolve issues of reported or suspected erroneous data as provided in rule 657—37.7(124), any other reports concerning the information received from dispensers shall only be prepared at the direction of the board, the

council, or the PMP administrator. The board and the council may compile statistical reports from PMP information for use in determining the advisability of continuing the PMP and for use in preparing required reports to the governor and the legislature. The reports shall not include information that would identify any patient, prescriber, dispenser, practitioner, practitioner's agent, or other person who is identified in the PMP information or data.

**37.4(8) *Electronic health and pharmacy information systems.*** The board may contract with electronic health record systems, health information exchanges, and electronic pharmacy information systems to securely integrate into those electronic systems access to patient prescription histories and other PMP information available to authorized practitioners and practitioners' agents. Institutional users may be established to identify the facilities and contracted electronic systems and to facilitate secure access by the prescribing practitioners and pharmacists authorized to access PMP information by and through the electronic systems.

*a.* EHRs, HIE, and e-pharmacy system integration contracts or agreements shall ensure protection of confidential information contained in and received from the PMP.

*b.* EHRs, HIE, and e-pharmacy system integration contracts or agreements shall restrict access to PMP information to authorized practitioners and practitioner agents as provided by these rules except that individual user registration with the PMP may not be required if the identity of the specific individual receiving or requesting information from the PMP, including a record of the patient whose record is requested, is logged and maintained in an alternate record and is available to the PMP administrator upon request.

*c.* PMP and electronic system integration may require a separate contract or agreement with a third-party interface or translation service provider to facilitate integration of the PMP into the electronic system. The contract with the service provider shall provide that translation, transmission, or other data integration services provided under the contract are accomplished via a secure encrypted channel that ensures the confidentiality of all information exchanged between the PMP and the electronic system.

[ARC 7903B, IAB 7/1/09, effective 8/5/09; ARC 0056C, IAB 4/4/12, effective 7/1/12; ARC 3102C, IAB 6/7/17, effective 7/12/17]

**657—37.5(124) Fees.** The board may charge a fee and recover costs incurred for the provision of PMP information, including statistical data, except that no fees or costs shall be assessed to a dispenser for reporting to the PMP or to a practitioner or practitioner's agent for querying the PMP regarding a practitioner's patient. Any fees or costs assessed by the board shall be considered repayment receipts as defined in Iowa Code section 8.2.

[ARC 7903B, IAB 7/1/09, effective 8/5/09; ARC 3102C, IAB 6/7/17, effective 7/12/17]

**657—37.6(124) PMP information retained.** All dispenser records of prescriptions reported to the PMP shall be retained by the PMP for a period of four years following the date of the record. All records of access to or query of PMP information shall be retained by the PMP for a period of four years following the date of the record. At least semiannually, all PMP information identified as exceeding that four-year period shall be deleted from the PMP and discarded in a manner to maintain the confidentiality of the PMP information and data. Statistical data and reports from which all personally identifiable information has been removed or which do not contain personally identifiable information as provided in subrules 37.4(6) and 37.4(7) may be retained by the PMP for historical purposes.

[ARC 7903B, IAB 7/1/09, effective 8/5/09]

**657—37.7(124) Information errors.** Any person who believes that PMP information about that person is false or in error shall submit a written statement to the PMP administrator. The statement shall identify the information the person believes to be false or in error and the reason the individual believes the information to be false or in error. The PMP administrator may examine the information identified in the statement and may request the assistance of the board's compliance staff to determine whether or not the PMP information is accurate. Prior to initiating any action to correct, delete, or amend any PMP information, the PMP administrator shall submit the statement and the resulting report to the patients rights committee for review and approval of the recommended action. If correction, deletion, or amendment of any PMP information is authorized, that action shall be accomplished by the PMP

administrator within 72 hours of the committee's decision. The PMP administrator shall respond, in writing, to the person who submitted the statement charging that the PMP information was false or in error. The response shall identify the action approved by the committee.

[ARC 7903B, IAB 7/1/09, effective 8/5/09]

**657—37.8(124) Dispenser and practitioner records.** Nothing in these rules shall apply to records created or maintained in the regular course of business of a pharmacy or health care practitioner. All information, documents, or records otherwise available from pharmacies or health care practitioners shall not be construed as immune from discovery or use in any civil proceedings merely because the information contained in those records was reported to the PMP in accordance with these rules.

[ARC 7903B, IAB 7/1/09, effective 8/5/09]

**657—37.9(124) Prohibited acts.** The PMP administrator shall report to the licensing board of a dispenser, a practitioner, or a practitioner's agent any known violation of the confidentiality provisions or the reporting requirements of the law and these rules for which the dispenser, practitioner, or practitioner's agent is subject to disciplinary action.

**37.9(1) Confidentiality.** A pharmacy, pharmacist, practitioner, or practitioner's agent who knowingly fails to comply with the confidentiality provisions of the law or these rules or who delegates PMP information access to another individual, except as provided in paragraph 37.4(1) "b," is subject to disciplinary action by the appropriate professional licensing board. The PMP administrator or a member of the program staff who knowingly fails to comply with the confidentiality provisions of the law or these rules is subject to disciplinary action by the board. In addition to any disciplinary action or sanctions imposed by a professional licensing board, a pharmacy, pharmacist, practitioner, practitioner's agent, PMP administrator, or member of the PMP program staff who knowingly accesses, uses, or discloses program information in violation of Iowa law or these rules is subject to criminal prosecution as provided in Iowa Code section 124.558.

**37.9(2) Dispenser reporting.** A dispenser or a pharmacist who fails to comply with the reporting requirements of the law or these rules may be subject to disciplinary action by the board.

[ARC 7903B, IAB 7/1/09, effective 8/5/09; ARC 0056C, IAB 4/4/12, effective 7/1/12; ARC 3102C, IAB 6/7/17, effective 7/12/17]

These rules are intended to implement Iowa Code sections 124.550 to 124.558.

[Filed ARC 7903B (Notice ARC 7676B, IAB 4/8/09), IAB 7/1/09, effective 8/5/09]

[Filed ARC 0056C (Notice ARC 9921B, IAB 12/14/11), IAB 4/4/12, effective 7/1/12]

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CHAPTER 100  
IOWA REAL-TIME ELECTRONIC PSEUDOEPHEDRINE  
TRACKING SYSTEM

**657—100.1(124) Purpose and scope.** Iowa Code section 124.212B directs the governor's office of drug control policy to establish a real-time electronic repository to monitor and control the sale of Schedule V products that are not listed in another controlled substance schedule and that contain any detectible amount of pseudoephedrine, its salts, or optical isomers, or salts of optical isomers; ephedrine; or phenylpropanolamine. All pharmacies dispensing such products without a prescription shall electronically report all such sales to the repository. The real-time electronic repository shall be under the control of and administered by the governor's office of drug control policy. Both the governor's office of drug control policy and the board of pharmacy are directed to adopt rules relating to the real-time electronic repository and have jointly adopted these rules. These rules establish the pseudoephedrine tracking system (PTS).

[ARC 8893B, IAB 6/30/10, effective 9/1/10; ARC 3100C, IAB 6/7/17, effective 7/12/17]

**657—100.2(124) Definitions.** As used in this chapter:

*"Attempted purchase"* means a proposed transaction for the dispensing of a product that is entered by a dispenser into the electronic pseudoephedrine tracking system, which transaction is not completed because the system recommends that the transaction be denied pursuant to the quantity limits established in Iowa Code section 124.213.

*"Board"* means the board of pharmacy.

*"Dispenser"* means a licensed Iowa pharmacist, a registered pharmacist-intern under the direct supervision of a pharmacist preceptor, or a registered pharmacy technician under the direct supervision of a pharmacist, except as authorized in 657—Chapter 13.

*"Law enforcement officer"* means all of the following:

1. State police officer.
2. City or county police officer.
3. Sheriff or deputy sheriff.
4. State or public university safety and security officer.
5. Department of natural resources officer.
6. Certified or full-time peace officer of this or another state.
7. Federal peace officer.
8. Criminal analyst assigned to a law enforcement agency.
9. Probation or parole officer.

*"Office"* means the governor's office of drug control policy.

*"Product"* means a Schedule V drug product that is not listed in another controlled substance schedule and that contains any detectible amount of pseudoephedrine, its salts, or optical isomers, or salts of optical isomers; ephedrine; or phenylpropanolamine.

*"Pseudoephedrine tracking system"* or *"PTS"* means the real-time electronic repository established to monitor and control the sale of products and administered by the governor's office of drug control policy.

*"Purchaser"* means an individual 18 years of age or older who purchases or attempts to purchase a product.

[ARC 8893B, IAB 6/30/10, effective 9/1/10; ARC 0153C, IAB 6/13/12, effective 7/18/12; ARC 3100C, IAB 6/7/17, effective 7/12/17]

**657—100.3(124) Electronic pseudoephedrine tracking system (PTS).** Unless granted an exemption by the office pursuant to these rules, all pharmacies dispensing products as defined in rule 657—100.2(124) without a prescription are required to participate in the PTS pursuant to Iowa Code section 124.212B.

**100.3(1) Reporting elements.** The record of a completed purchase or attempted purchase of a product without a prescription shall contain the following:

- a. The name and address of the purchaser.

- b. A current government-issued photo identification number.
- c. The electronic signature of the purchaser. If a pharmacy is not able to secure or record an electronic signature, a hard-copy signature logbook shall be utilized and maintained by the pharmacy. Each record in the logbook shall include the purchaser's signature and shall identify the purchase by transaction number.
- d. Date and time of purchase.
- e. The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.
- f. The name or unique identification of the pharmacist, pharmacist-intern, or pharmacy technician who approved the dispensing of the product.

**100.3(2) *Frequency and quantity.*** Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

**100.3(3) *Denial of transactions and overrides.***

- a. If an individual attempts to purchase a product in violation of these rules, the PTS shall:
  - (1) Notify the dispenser at the time of sale; and
  - (2) Recommend that the dispenser deny the transaction.
- b. The PTS shall provide an override feature for use by a dispenser to allow completion of the sale. For security purposes and to ensure the integrity of the PTS, use of the override feature shall be restricted to authorized dispensers and may not be delegated to a pharmacy technician trainee or a pharmacy support person. A dispenser utilizing the override feature shall document the reason that, in the professional judgment of the dispenser, it is necessary to override the recommendation of the PTS to deny the transaction.

**100.3(4) *Availability of electronic PTS.*** If the electronic PTS is unavailable for use, the dispenser shall maintain a written record of each transaction pursuant to 657—subrule 10.32(6). The dispenser shall enter the information from the written record into the PTS within 72 hours of the time the PTS is again available and shall include in the electronic record that the record is a delayed entry.

[ARC 8893B, IAB 6/30/10, effective 9/1/10; ARC 0153C, IAB 6/13/12, effective 7/18/12; ARC 3100C, IAB 6/7/17, effective 7/12/17]

**657—100.4(124) Access to database information and confidentiality.** Information collected in the PTS is confidential unless otherwise ordered by a court or released by the office pursuant to state or federal law. Information may not be released except as provided by this rule.

**100.4(1) *PTS administrators.*** PTS administrators shall be provided access to the PTS for the purpose of searching and retrieving reports only by articulating reasonable suspicion or providing a case number or reference number for an ongoing investigation. PTS administrators shall also be provided information on purchasers directly from the PTS. This information may be sent directly to law enforcement officers pursuant to paragraph 100.4(2)“e” for purposes of investigation.

**100.4(2) *Law enforcement release.*** PTS reports may be provided to a law enforcement officer pursuant to rule 657—100.4(124).

a. A law enforcement officer shall register with the PTS prior to requesting reports. To ensure the identity of the officer and to maintain confidentiality of PTS information, the officer's identity shall be verified and registration shall be approved by the office or the administrator for the officer's agency.

b. Law enforcement officers shall be given direct access to all data from the PTS pursuant to the federal Combat Methamphetamine Epidemic Act and 21 CFR § 1314.45.

c. If a law enforcement officer requests PTS information directly from the PTS, the law enforcement officer shall enter the purpose of the request into the PTS and shall certify the request is part of the officer's official duties.

**100.4(3) *Statistical data.*** The PTS administrator, following establishment of confidentiality, may provide summary, statistical, or aggregate data to public or private entities for statistical, research, or educational purposes. Prior to release of any such data, the administrator shall remove any information

that could be used to identify an individual patient, dispenser, or other person who is the subject of or identified in the PTS information or data.

**100.4(4) Patients.** A patient may request and receive information regarding products reported to have been purchased by the patient.

*a.* A patient may submit a signed, written request for records of the patient's purchases and attempted purchases during a specified period of time. The request shall identify the patient by name, including any aliases used by the patient, and shall include the patient's date of birth and gender. The request shall also include any address where the patient resided during the time period of the request and the patient's current address and daytime telephone number. A patient may personally deliver the request to the PTS administrator or authorized staff member of the office located at Oran Pape State Office Building, 215 East 7th Street, Fifth Floor, Des Moines, Iowa 50319. The patient shall be required to present current government-issued photo identification at the time of delivery of the request. A copy of the patient's identification shall be maintained in the records of the PTS.

*b.* A patient who is unable to personally deliver the request to the office may submit a request via mail or commercial delivery service. The request shall comply with all provisions of paragraph "a" above, and the signature of the requesting patient shall be witnessed and the patient's identity shall be attested to by a currently registered notary public. In addition to the notary's signature and assurance of the patient's identity, the notary shall certify a copy of the patient's current government-issued photo identification, and that certified copy shall be submitted with the written request. The request shall be submitted to the governor's office of drug control policy at the address identified in paragraph 100.4(4) "a."

**100.4(5) Regulatory officers.** Regulatory agencies that supervise or regulate a health care practitioner shall be able to access information from the PTS only pursuant to an order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause. A director of a regulatory agency with jurisdiction over a practitioner, or the director's designee, who seeks access to PTS information for an investigation shall submit to the PTS administrator in a format established by the office a written request via mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

**100.4(6) Pharmacy administrators.** A pharmacy, an authorized employee of a pharmacy, or a licensed pharmacist shall be provided access to the stored PTS information only for the limited purpose of determining the sales made by the pharmacy. A pharmacy shall be able to print the pharmacy's sales records for any product during any specified period of time upon the request of the board or an agent of the board.

**100.4(7) Court orders and subpoenas.** The PTS administrator shall provide database information in response to a court order or a county attorney subpoena or other subpoena issued by a court upon a determination of probable cause.

[ARC 8893B, IAB 6/30/10, effective 9/1/10; ARC 9161B, IAB 10/20/10, effective 9/30/10; ARC 0153C, IAB 6/13/12, effective 7/18/12; ARC 3100C, IAB 6/7/17, effective 7/12/17]

**657—100.5(124) Violations.** Violations of provisions of these rules or Iowa Code section 124.212A, 124.212B, or 124.213 may subject the violator to criminal prosecution.

[ARC 8893B, IAB 6/30/10, effective 9/1/10; ARC 3100C, IAB 6/7/17, effective 7/12/17]

These rules are intended to implement Iowa Code sections 124.212, 124.212A, 124.212B, and 124.213.

[Filed ARC 8893B (Notice ARC 8666B, IAB 4/7/10), IAB 6/30/10, effective 9/1/10]

[Filed Emergency ARC 9161B, IAB 10/20/10, effective 9/30/10]

[Filed ARC 0153C (Notice ARC 0053C, IAB 3/21/12), IAB 6/13/12, effective 7/18/12]

[Filed ARC 3100C (Notice ARC 2858C, IAB 12/7/16), IAB 6/7/17, effective 7/12/17]



CHAPTER 71  
ASSESSMENT PRACTICES AND EQUALIZATION  
[Prior to 12/17/86, Revenue Department[730]]

**701—71.1(405,427A,428,441,499B) Classification of real estate.**

**71.1(1) Responsibility of assessors.** All real estate subject to assessment by city and county assessors shall be classified as provided in this rule. It shall be the responsibility of city and county assessors to determine the proper classification of real estate. There can be only one classification per property under this rule, except as provided for in paragraph 71.1(5) “b.” An assessor shall not assign one classification to the land and a different classification to the building or separate classifications to the land or separate classifications to the building. A building or structure on leased land is considered a separate property and may be classified differently than the land upon which it is located. The determination shall be based upon the best judgment of the assessor following the guidelines set forth in this rule and the status of the real estate as of January 1 of the year in which the assessment is made. The assessor shall classify property according to its present use and not according to its highest and best use. See subrule 71.1(9) for an exception to the general rule that property is to be classified according to its use. The classification shall be utilized on the abstract of assessment submitted to the department of revenue pursuant to Iowa Code section 441.45. See rule 701—71.8(428,441).

**71.1(2) Responsibility of boards of review, county auditors, and county treasurers.** Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall classify property as provided in this rule and adhere to the requirements of this rule.

**71.1(3) Agricultural real estate.**

*a. Generally.* Agricultural real estate shall include all tracts of land and the improvements and structures located on them which are in good faith used primarily for agricultural purposes except buildings which are primarily used or intended for human habitation as defined in subrule 71.1(4). Land and the nonresidential improvements and structures located on it shall be considered to be used primarily for agricultural purposes if its principal use is devoted to the raising and harvesting of crops or forest or fruit trees, the rearing, feeding, and management of livestock, or horticulture, all for intended profit. Agricultural real estate shall also include woodland, wasteland, and pastureland, but only if that land is held or operated in conjunction with agricultural real estate as defined in paragraph “a” or “b” of this subrule.

*b. Vineyards.* Beginning with valuations established on or after January 1, 2002, vineyards and any buildings located on a vineyard and used in connection with the vineyard shall be classified as agricultural real estate if the primary use of the land and buildings is an activity related to the production or sale of wine.

*c. Algae cultivation and production.* Beginning with valuations established on or after January 1, 2013, real estate used directly in the cultivation and production of algae for harvesting as a crop for animal feed, food, nutritionals, or biofuel production shall be classified as agricultural real estate if the real estate is an enclosed pond or land which contains a photobioreactor. Pursuant to 2013 Iowa Acts, House File 632, section 1, a photobioreactor is not attached to land upon which it sits and shall not be assessed and taxed as real property.

(1) Determining direct usage. To determine if real estate is used “directly” in the cultivation and production of algae, one must first ensure that the real estate is used to perform activities that cultivate and produce algae and is not used for activities that occur before or after the cultivation and production of algae. If the real estate is used to perform activities for the cultivation and production of algae, to be “directly” so used, the real estate must be used to perform activities that are integral and essential to the cultivation and production, as distinguished from activities that are incidental, merely convenient to, or remote from cultivation and production. The fact that real estate is used for activities that are essential or necessary to the cultivation and production of algae does not mean that the real estate is also “directly” used in production. Even if the real estate is used for activities that are essential or necessary

to the cultivation and production of algae, if the activities are far enough removed from the cultivation or production of algae, the real estate would not qualify for the agricultural designation.

(2) Examples. The following are nonexclusive examples of real estate which would not be directly used in the cultivation and production of algae:

1. Real estate that is used to store, assemble, or repair machinery and equipment that is used for cultivation and production of algae.
2. Real estate that is used in the management, administration, advertising, or selling of algae.
3. Real estate that is used in the management, administration, or planning of the cultivation and production of algae.
4. Real estate that is used for packaging of the algae which has been produced and cultivated.

**71.1(4) Residential real estate.** Residential real estate shall include all lands and buildings which are primarily used or intended for human habitation containing fewer than three dwelling units, as that term is defined in subparagraph 71.1(5)“a”(5), including those buildings located on agricultural land. Buildings used primarily or intended for human habitation shall include the dwelling as well as structures and improvements used primarily as a part of, or in conjunction with, the dwelling. This includes but is not limited to garages, whether attached or detached, tennis courts, swimming pools, guest cottages, and storage sheds for household goods. “Used in conjunction with” means that the structure or improvement is located on the same parcel, on contiguous parcels, or on a parcel directly across a street or alley as the building or structure containing the dwelling and when marketed for sale would be sold as a unit. Residential real estate located on agricultural land shall include only buildings as defined in this subrule. Buildings for human habitation that are used as commercial ventures, including but not limited to hotels, motels, rest homes, and structures containing three or more separate living quarters shall not be considered residential real estate. However, regardless of the number of separate living quarters, multiple housing cooperatives organized under Iowa Code chapter 499A and land and buildings owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be considered residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use for human habitation shall be classified as residential real estate regardless of who occupies the apartment. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

**71.1(5) Multiresidential real estate.** Multiresidential real estate shall include all parcels or portions of a parcel which are primarily used or intended for human habitation containing three or more separate dwelling units as well as structures and improvements used primarily as a part of, or in conjunction with, the dwelling units. For purposes of this rule, “used in conjunction with” means that the structure or improvement is located on the same parcel, on contiguous parcels, or on a parcel directly across a street or alley as the building or structure containing the dwelling units and when marketed for sale would be sold as a unit. Multiresidential real estate shall include mobile home parks, manufactured home communities, land-leased communities, and assisted living facilities. Multiresidential real estate shall exclude properties referred to in Iowa Code section 427A.1(8) or properties subject to valuation under Iowa Code section 441.21(2).

*a. Definitions.* For purposes of this subrule, the following definitions apply:

(1) “Mobile home park” means any land upon which three or more mobile homes, as defined in Iowa Code section 435.1, or manufactured homes, as defined in Iowa Code section 435.1, or a combination of such homes, are placed on developed spaces and operated as a for-profit enterprise with water, sewer, or septic, and electrical services available. “Mobile home park” does not include homes where the owner of the land is providing temporary housing for the owner’s employees or students.

(2) “Manufactured home community” means any site, lot, field, or tract of land under common ownership upon which ten or more occupied manufactured homes, as defined in Iowa Code section 435.1, are harbored, either free of charge or for revenue purposes, and shall include any building, structure, or enclosure used or intended for use as part of the equipment of the community.

“Manufactured home community” shall not be construed to include homes, buildings, or other structures temporarily maintained by any individual, educational institution, or company on their own premises and used exclusively to house their own labor or students. “Manufactured home community” means the same as “land-leased community” as defined in Iowa Code sections 335.30A and 414.28A.

(3) “Land-leased community” means any site, lot, field, or tract of land under common ownership upon which ten or more occupied manufactured homes are harbored, either free of charge or for revenue purposes, and shall include any building, structure, or enclosure used or intended for use as part of the equipment of the land-leased community. “Land-leased community” shall not be construed to include homes, buildings, or other structures temporarily maintained by any individual, educational institution, or company on their own premises and used exclusively to house their own labor or students.

(4) “Assisted living facility” means real estate that provides housing with services which may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living to three or more tenants in a physical structure which provides a homelike environment. “Assisted living facility” also includes a health care facility, as defined in Iowa Code section 135C.1, an elder group home, as defined in Iowa Code section 231B.1, a child foster care facility under Iowa Code chapter 237, or property used for a hospice program as defined in Iowa Code section 135J.1.

(5) “ Dwelling unit” means an apartment, group of rooms, or single room which is occupied as separate living quarters or, if vacant, is intended for occupancy as separate living quarters, in which a tenant can live and sleep separately from any other persons in the building. A vacant dwelling unit that does not have active utility services is not considered to be intended for occupancy.

*b. Dual classification.* Assessors shall use dual classification on parcels where the primary use of the parcel is commercial or industrial and a portion or portions of the parcel are used or intended for human habitation, regardless of the number of dwelling units. For the assessment year beginning January 1, 2015, a parcel where the primary use is multiresidential shall not receive a dual classification but instead shall be classified multiresidential for the entire parcel.

For assessment years beginning January 1, 2016, and after, assessors shall use dual classification on properties where the primary use of the parcel meets the requirements of the multiresidential classification and a portion or portions of the parcel meet the requirements of the commercial classification under subrule 71.1(6) or the industrial classification under subrule 71.1(7). If the primary use of a parcel is for human habitation and the parcel contains fewer than three separate dwelling units, it shall be classified as residential real estate under subrule 71.1(4).

The only permissible combinations of dual classifications are commercial and multiresidential or industrial and multiresidential. The assessor shall assign to that portion of the parcel that satisfies the requirements the classification of multiresidential property and to such other portions of the parcel the property classification for which such other portions qualify. The assessor shall maintain the valuation and assessment of property with a dual classification on one parcel record.

*c. Section 42 housing.* Property that has elected special valuation procedures under Iowa Code section 441.21(2) and is rented or leased to low-income individuals and families as authorized by Section 42 of the Internal Revenue Code shall not be classified as multiresidential property as required by 2014 Iowa Acts, House File 2466, section 3.

*d. Short-term leases.* A hotel, motel, inn or other building where rooms or dwelling units are usually rented for less than one month shall not be classified as multiresidential property.

**71.1(6) Commercial real estate.** Commercial real estate shall include all lands and improvements and structures located thereon which are primarily used or intended as a place of business where goods, wares, services, or merchandise is stored or offered for sale at wholesale or retail. Commercial realty shall also include hotels, motels, and property that is rented or leased to low-income individuals and families as authorized by Section 42 of the Internal Revenue Code and has not been withdrawn from Section 42 assessment procedures under Iowa Code section 441.21(2). Commercial real estate shall also include data processing equipment as defined in Iowa Code section 427A.1(1) “j,” except data processing equipment used in the manufacturing process. However, regardless of the number of separate living quarters or any commercial use of the property, single- and two-family dwellings, multiple housing cooperatives organized under Iowa Code chapter 499A, and land and buildings used primarily for human

habitation and owned and operated by organizations that have received tax-exempt status under Section 501(c)(3) of the Internal Revenue Code, if the rental income from the property is not taxed as unrelated business income under Iowa Code section 422.33(1A), shall be classified as residential real estate.

An apartment in a horizontal property regime (condominium) referred to in Iowa Code chapter 499B which is used or intended for use as a commercial venture, other than leased for human habitation, shall be classified as commercial real estate. Existing structures shall not be converted to a horizontal property regime unless building code requirements have been met.

**71.1(7) Industrial real estate.**

*a. Land and buildings.*

(1) Industrial real estate includes land, buildings, structures, and improvements used primarily as a manufacturing establishment. A manufacturing establishment is a business entity in which the primary activity consists of adding to the value of personal property by any process of manufacturing, refining, purifying, the packing of meats, or the combination of different materials with the intent of selling the product for gain or profit. Industrial real estate includes land and buildings used for the storage of raw materials or finished products and which are an integral part of the manufacturing establishment, and also includes office space used as part of a manufacturing establishment.

(2) Whether property is used primarily as a manufacturing establishment and, therefore, assessed as industrial real estate depends upon the extent to which the property is used for the activities enumerated in subparagraph 71.1(7) "a"(1). Property in which the performance of these activities is only incidental to the property's primary use for another purpose is not a manufacturing establishment. For example, a grocery store in which bakery goods are prepared would be assessed as commercial real estate since the primary use of the grocery store premises is for the sale of goods not manufactured by the grocery and the industrial activity, i.e., baking, is only incidental to the store premises' primary use. However, property which is used primarily as a bakery would be assessed as industrial real estate even if baked goods are sold at retail on the premises since the bakery premises' primary use would be for an industrial activity to which the retail sale of baked goods is merely incidental. See *Lichty v. Board of Review of Waterloo*, 230 Iowa 750, 298 N.W. 654 (1941).

Similarly, a facility which has as its primary use the mixing and blending of products to manufacture feed would be assessed as industrial real estate even though a portion of the facility is used solely for the storage of grain, if the use for storage is merely incidental to the property's primary use as a manufacturing establishment. Conversely, a facility used primarily for the storage of grain would be assessed as commercial real estate even though a part of the facility is used to manufacture feed. In the latter situation, the industrial use of the property — the manufacture of feed — is merely incidental to the property's primary use for commercial purposes — the storage of grain.

(3) Property used primarily for the extraction of rock or mineral substances from the earth is not a manufacturing establishment if the only processing performed on the substance is to change its size by crushing or pulverizing. See *River Products Company v. Board of Review of Washington County*, 332 N.W.2d 116 (Iowa Ct. App. 1982).

*b. Machinery.*

(1) Machinery includes equipment and devices, both automated and nonautomated, which is used in manufacturing as defined in Iowa Code section 428.20. See *Deere Manufacturing Co. v. Beiner*, 247 Iowa 1264, 78 N.W.2d 527 (1956).

(2) Machinery owned or used by a manufacturer but not used within the manufacturing establishment is not assessed as industrial real estate. For example, "X" operates a factory which manufactures building materials for sale. In addition, "X" uses some of these building materials in construction contracts. The machinery which "X" would primarily use at the construction site would not be used in a manufacturing establishment and, therefore, would not be assessed as industrial real estate.

(3) Machinery used in manufacturing but not used in or by a manufacturing establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963).

(4) Where the primary function of a manufacturing establishment is to manufacture personal property that is consumed by the manufacturer rather than sold, the machinery used in the manufacturing

establishment is not assessed as industrial real estate. See *Associated General Contractors of Iowa v. State Tax Commission*, 255 Iowa 673, 123 N.W.2d 922 (1963).

**71.1(8) Point-of-sale equipment.** As used in Iowa Code section 427A.1(1)“j,” the term “point-of-sale equipment” means input, output, and processing equipment used to consummate a sale and to record or process information pertaining to a sale transaction at the time the sale takes place and which is located at the counter, desk, or other specific point at which the transaction occurs. As used in this subrule, the term “sale” means the sale or rental of goods or services and includes both retail and wholesale transactions. Point-of-sale equipment does not include equipment used primarily for depositing or withdrawing funds from financial institution accounts.

**71.1(9) Housing development property.**

*a. Ordinances adopted or amended on or after January 1, 2011.*

(1) Adoption of ordinance by board of supervisors. A county board of supervisors may adopt an ordinance providing that property acquired and subdivided for development of housing on or after January 1, 2011, shall continue to be assessed for taxation in the manner it was assessed prior to the acquisition. Each lot shall continue to be taxed in the manner it was taxed prior to acquisition for housing until the lot is sold for construction or occupancy of housing or 5 years from the date of subdivision, whichever occurs first.

(2) Amendments to ordinance by board of supervisors. On or after July 27, 2011, the board of supervisors of a county may amend an ordinance adopted or otherwise made effective under 2011 Iowa Code Supplement section 405.1(1)“a” to extend the 5-year time period for a period of time not to exceed 5 years beyond the end of the original 5-year period established under 2011 Iowa Code Supplement section 405.1(1). Thus, the maximum special assessment time for ordinances adopted on or subsequent to January 1, 2011, is 10 years. An extension of an ordinance under 2011 Iowa Code Supplement section 405.1(1)“a” may apply to all or a portion of the property that was subject to the original ordinance.

(3) Amendments to ordinance by city council. A city council may adopt an ordinance, affecting all or a portion of the property located within the incorporated area of the city subject to the county ordinance adopted under 2011 Iowa Code Supplement section 405.1(1)“a,” extending the county ordinance not previously extended by the board of supervisors up to 5 years. An ordinance by a city council providing for an extension under 2011 Iowa Code Supplement section 405.1(3) shall be subject to the 5-year limitation under 2011 Iowa Code Supplement section 405.1(2). Thus, the maximum time to appeal an ordinance adopted on or subsequent to January 1, 2011, is 10 years if the city council amends an ordinance originally adopted by the county board of supervisors.

(4) Sale of lot; expiration of 5-year or extended period. Upon the sale of the lot for construction or occupancy for housing or upon the expiration of the 5-year or extended period, the property shall be assessed for taxation as residential or commercial multifamily property, whichever is applicable.

(5) Definition of “subdivide.” As used in both paragraphs 71.1(9)“a” and “b,” “subdivide” means to divide a tract of land into three or more lots.

*b. Ordinances adopted on or after January 1, 2004, but prior to January 1, 2011.*

(1) Ordinances adopted under 2011 Iowa Code Supplement sections 405.1(1) and 405.1(2), to the extent such ordinances affect the assessment of property subdivided for development of housing on or after January 1, 2004, but before January 1, 2011, shall remain in effect or otherwise be made effective, and such ordinances:

1. Adopted under 2011 Iowa Code Supplement section 405.1(1), applicable to counties with a population of less than 20,000, shall be extended, from a period of 5 years, to apply to a period of 10 years from the date of subdivision.

2. Adopted under 2011 Iowa Code Supplement section 405.1(2), applicable to counties with a population of 20,000 or more, shall be extended, from a period of 3 years, to apply to a period of 8 years from the date of subdivision.

Each lot shall continue to be taxed in the manner it was taxed prior to acquisition for housing until the lot is sold for construction or occupancy of housing, or 10 years pursuant to paragraph “1” above or 8 years pursuant to paragraph “2” above (or the extended period, if applicable) from the date of subdivision, whichever occurs first.

(2) Amendments to ordinance by board of supervisors. On or after July 27, 2011, the board of supervisors of a county may amend an ordinance adopted under 2011 Iowa Code Supplement section 405.1(1) or 405.1(2) to extend the 10- and 8-year periods, respectively, for a period of time not to exceed 5 years beyond the end of the 10- and 8-year periods established under 2011 Iowa Code Supplement section 405.1(1)“b.” Thus, the maximum special assessment time for ordinances adopted on or after January 1, 2004, but prior to January 1, 2011, for counties with a population of less than 20,000 shall be 15 years. For counties with a population of 20,000 or more, the maximum shall be 13 years.

(3) Amendments to ordinance by city council. A city council may adopt an ordinance, affecting all or a portion of the property located within the incorporated area of the city subject to the county ordinance adopted under 2011 Iowa Code Supplement sections 405.1(1) and 405.1(2), extending the county ordinances not previously extended by the board of supervisors up to 5 years. An ordinance by a city council providing for an extension under 2011 Iowa Code Supplement section 405.1(3) shall be subject to the 5-year limitation under 2011 Iowa Code Supplement section 405.1(2). Thus, the maximum time to appeal an ordinance adopted on or after January 1, 2004, but prior to January 1, 2011, for counties with a population of less than 20,000 shall be 15 years if the city council amends an ordinance originally adopted by the board of supervisors. For counties with a population of 20,000 or more, the maximum special assessment time shall be 13 years.

(4) Sale of lot. Upon the sale of the lot for construction or occupancy for housing or upon the expiration of the 10- or 8-year or extended period, the property shall be assessed for taxation as residential or commercial multifamily property, whichever is applicable.

**71.1(10) Assessment of platted lots.**

a. When a subdivision plat is recorded pursuant to Iowa Code chapter 354 on or after January 1, 2011, the individual lots within the subdivision plat shall not be assessed, in the aggregate, in excess of the total assessment of the land as acreage or unimproved property for 5 years after the recording of the plat or until the lot is actually improved with permanent construction, whichever occurs first. When an individual lot has been improved with permanent construction, the lot shall be assessed for taxation purposes as provided in Iowa Code chapters 428 and 441.

b. For subdivision plats recorded pursuant to Iowa Code chapter 354 (relating to division and subdivision of land) on or after January 1, 2004, but before January 1, 2011, the individual lots within the subdivision plat shall not be assessed, in the aggregate, in excess of the total assessment of the land as acreage or unimproved property for 8 years after the recording of the plat or until the lot is actually improved with permanent construction, whichever occurs first. When an individual lot has been improved with permanent construction, the lot shall be assessed for taxation purposes as provided in Iowa Code chapters 428 and 441.

c. 2011 Iowa Code Supplement section 441.72 does not apply to special assessment levies.

This rule is intended to implement Iowa Code sections 405.1, 427A.1, 428.4 and 441.22 and chapter 499B and Iowa Code Supplement section 441.21 as amended by 2002 Iowa Acts, House File 2584. [ARC 8559B, IAB 3/10/10, effective 4/14/10; ARC 0400C, IAB 10/17/12, effective 11/21/12; ARC 1196C, IAB 11/27/13, effective 1/1/14; ARC 1765C, IAB 12/10/14, effective 1/14/15; ARC 2146C, IAB 9/16/15, effective 10/21/15]

**701—71.2(421,428,441) Assessment and valuation of real estate.**

**71.2(1) Responsibility of assessor.** The valuation of real estate as established by city and county assessors shall be the actual value of the real estate as of January 1 of the year in which the assessment is made. New parcels of real estate created by the division of existing parcels of real estate shall be assessed separately as of January 1 of the year following the division of the existing parcel of real estate.

**71.2(2) Responsibility of other assessing officials.** Whenever local boards of review, county auditors, and county treasurers exercise assessment functions allowed or required by law, they shall follow the provisions of subrule 71.2(1) and rules 701—71.3(421,428,441) to 701—71.7(421,427A,428,441).

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

**701—71.3(421,428,441) Valuation of agricultural real estate.** Agricultural real estate shall be assessed at its actual value as defined in Iowa Code section 441.21 by giving exclusive consideration to its productivity and net earning capacity. In determining the actual value of agricultural real estate,

city and county assessors shall use the Iowa Real Property Appraisal Manual and any other guidelines issued by the department of revenue pursuant to Iowa Code section 421.17(18).

**71.3(1) Productivity.**

*a.* In determining the productivity and net earning capacity of agricultural real estate, the assessor shall also use available data from Iowa State University, the United States Department of Agriculture (USDA) National Agricultural Statistics Service (NASS), the USDA Farm Service Agency (FSA), the Iowa department of revenue, or other reliable sources. The assessor shall also consider the results of a modern soil survey, if completed. The assessor shall determine the actual valuation of agricultural real estate within the assessing jurisdiction and distribute such valuation throughout the jurisdiction so that each parcel of real estate is assessed at its actual value as defined in Iowa Code section 441.21.

*b.* In distributing such valuation to each parcel under paragraph 71.3(1)“*a*,” the assessor shall adjust non-cropland. The adjustment shall be applied to non-cropland with a corn suitability rating (CSR) that is greater than 50 percent of the average CSR for cropland for the county. The adjustment shall be determined for each county based upon the five-year average difference in cash rent between non-irrigated cropland and pasture land as published by NASS. The assessor may utilize the USDA FSA-published Common Land Unit digital data or other reliable sources in determining non-cropland. Counties shall implement the adjustments under this paragraph on or before the 2017 assessment year. The department of revenue may, in a case involving hardship, extend the implementation of the adjustments required under this paragraph to the 2019 assessment year. No extension of time shall be granted unless the county makes a written request to the department of revenue for such action.

*c.* A taxpayer may apply to the county for the adjustment to non-cropland under paragraph 71.3(1)“*b*” beginning with the 2014 assessment and until the county’s full implementation of this subrule. Upon application, and subsequent approval by the assessor, the county assessor shall adjust non-cropland as provided in paragraph 71.3(1)“*b*.” Once a taxpayer applies for the adjustment, and upon approval, the assessor shall make the adjustment to the assessment year for which the application was submitted and until the county’s full implementation of this subrule, without the need to reapply for the adjustment.

*d.* EXAMPLE. The following is an example of the calculation used to compute adjustment on land determined to be non-cropland with a CSR that is greater than 50 percent of the average CSR for cropland for the county:

Average county CSR rating for cropland	80 CSR
50% of average cropland CSR	40 CSR
Example of non-cropland soil 11b CSR rating	58 CSR
Non-cropland CSR points to be adjusted	$58 - 40 = 18$ CSR points
5-year average rent for non-irrigated cropland	\$163.60
5-year average rent for pasture land	\$48.30
Percent difference (rounded)	$1 - (\$48.30/\$163.60) = 70\%$
Apply the percent difference to points to be adjusted	$18 \text{ CSR points} \times (1 - .70) = 5.40$ adjusted CSR points
Adjusted CSR non-cropland	$40 + 5.40 = 45.40$ adjusted CSR points

**71.3(2) Agricultural factor.** In order to determine a productivity value for agricultural buildings and structures, assessors must make an agricultural adjustment to the market value of these buildings and structures by developing an “agricultural factor” for the assessors’ jurisdictions. The agricultural factor for each jurisdiction is the product of the ratio of the productivity and net earning capacity value per acre as determined under subrule 71.12(1) over the market value of agricultural land within the assessing jurisdiction. The resulting ratio is then applied to the actual value of the agricultural buildings and structures as determined under the Iowa Real Property Appraisal Manual prepared by the department. The agricultural factor must be applied uniformly to all agricultural buildings and structures in the assessing jurisdiction. As an example, if a building’s actual value is \$500,000 and the agricultural factor is 30 percent, the productivity value of that building is \$150,000. See *H & R Partnership v. Davis*

*County Board of Review*, 654 N.W.2d 521 (Iowa 2002). The 2007, 2008, and 2009 average of the market value of land will be used in determining the agricultural factor for assessment year 2011. A five-year market value average of land for years used to determine the productivity formula will be used to determine the agricultural factor for assessment year 2013 and subsequent assessment years.

**71.3(3) Classification.** Land classified as agricultural real estate includes the land beneath any dwelling and appurtenant structures located on that land and shall be valued by the assessor pursuant to rule 701—71.3(421,428,441). An assessor shall not value a part of the land as agricultural real estate and a part of the land as if it is residential real estate.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

[ARC 8542B, IAB 2/24/10, effective 3/31/10; ARC 9478B, IAB 4/20/11, effective 5/25/11; ARC 0770C, IAB 5/29/13, effective 7/3/13]

**701—71.4(421,428,441) Valuation of residential real estate.** Residential real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of residential real estate, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

**701—71.5(421,428,441) Valuation of commercial real estate.** Commercial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21. In determining the actual value of commercial real estate, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data available. In cases involving the valuation of owner-occupied commercial property, the data relating to the financial performance of the owner or the owner's business, including but not limited to its sales, revenue, expenses, or profits, shall not be considered relevant in determining the property's actual value.

**71.5(1) Property of long distance telephone companies.** The director of revenue shall assess the property of long distance telephone companies as defined in Iowa Code section 476.1D(10) which property is first assessed for taxation on or after January 1, 1996, in the same manner as commercial real estate.

**71.5(2) Low-income housing subject to Section 42 of the Internal Revenue Code.**

*a. Productive and earning capacity.* In assessing property that is rented or leased to low-income individuals and families as authorized by Section 42 of the Internal Revenue Code which limits the amount that the individual or family pays for the rental or lease of units in the property, the assessor shall use the productive and earning capacity from the actual rents received as a method of appraisal and shall take into account the extent to which that use and limitation reduces the market value of the property.

*b. Direct capitalization method.* The income approach to valuation shall be applied using the direct capitalization method. The assessor may use the discounted cash flow method as a test of the reasonableness of the results produced by the direct capitalization method. The direct capitalization method of the income approach involves dividing the Net Operating Income (NOI) on a cash basis by an overall capitalization rate to derive an indication of the value of the property for the assessment year.

In applying the direct capitalization method, the assessor shall develop a normalized measure of annual NOI based on the productive and earning capacity of the development utilizing (1) the actual rent schedule applicable for each of the available units as of January 1 of the year of assessment indicating the actual rent to be paid by the resident plus any Section 8 rental assistance or other direct cash rental subsidy provided to the resident by federal, state or local rent subsidy programs as limited pursuant to Section 42 of the Internal Revenue Code, (2) a normal vacancy/collection allowance, (3) the prior year's actual and current year's projected annual operating expenses associated with the property, excluding noncash items such as depreciation and amortization, but including property taxes and those actual costs expected to be incurred and paid as required by Internal Revenue Code Section 42 regulations, provisions,

and restrictions as applicable to the assessment year, and (4) an appropriate provision for replacement reserves.

If no separate line item is included for reserves for replacement in the historic income and expense data, then the maintenance and repair categories of the historic expense data must be itemized. For properties that have attained a normalized operating history, the NOI results of the prior three years (as represented in the statements variously named as the Income and Loss Statement, the Profit and Loss Statement, the Income Statement, the Actual to Budget Comparison Statement, Balance Sheet, or some name variation of these) may be used to provide the basis for determining the normalized NOI used for purposes of applying the direct capitalization method for the year of assessment, provided an appropriate replacement reserve is included in the NOI determination and provided any additional costs required as a result of Section 42 regulation or compliance changes for the assessment year are included as an operating expense in the NOI determination. In addition, the assessor may utilize the current year operating budget to develop a measure of NOI for the assessment year. The assessor, in developing the measure of annual NOI on a cash basis, shall not consider as income any potential rental income differential that could otherwise be received from the property if the rents were not limited pursuant to Section 42 of the Internal Revenue Code, any tax credit equity, any tax credit value, or other subsidized financing.

*c. Filing of reports.* It shall be the responsibility of the property owner to file income and expense data with the local assessor by March 1 of each year. The assessor may require the filing of additional information if deemed necessary.

*d. Capitalization rate.* The overall capitalization rate to be used in applying the direct capitalization method for a Section 42 property is developed through the band-of-investment technique. The capitalization rate will be calculated annually by the Iowa department of revenue and distributed to all Iowa assessors by March 1. The capitalization rate is a composite rate weighted by the proportions of total property investment represented by debt and equity. The capital structure weights equity at 80 percent and debt at 20 percent unless actual market capital structure can be verified to the assessor. The yield, or market rate of return, for equity is calculated using the capital asset pricing model (CAPM). The yield for debt is equivalent to the average yield on 25-year Treasury bonds referred to as the Treasury long-term average rate. An example of the band-of-investment technique to be utilized is as follows:

	<u>% to Total</u>	<u>Yield</u>	<u>Composite</u>
Equity	80%	11.05%	8.84%
Debt	20%	5.94%	1.19%
	<u>100%</u>		<u>10.03%</u>

*e. Capital asset pricing model.* The capital asset pricing model (CAPM) is utilized to develop the equity rate. The formula is:

$$R_e = B(R_m - R_f) + R_f$$

Where:

- $R_e$  = return on equity
- $B$  = beta
- $R_m$  = return on the market
- $R_f$  = risk-free rate of return
- $R_m - R_f$  = market-risk premium

The beta is assumed to be 1 which indicates the risk level to be consistent with the market as a whole. The risk-free rate is calculated by finding the average of the three-month and six-month Treasury bill. The return on the market is calculated by taking the average of the return on the market for the Merrill Lynch Universe and Standard and Poor's 500 or by reference to other published secondary sources.

*f. Properties under construction.* For Section 42 properties under construction, the assessor may value the property by applying the percentage of completion to the replacement cost new (RCN) as calculated from the Iowa Real Property Appraisal Manual and adding the fair market value of the land. Alternatively, projected income and expense data may be utilized if available.

*g. Negative or minimal NOI.* If the Section 42 property shows a negative or minimal net operating income (NOI), the indicator of value as set forth in these rules shall not be utilized.

*h. Eligibility withdrawn.* The property owner shall notify the assessor when property is withdrawn from Section 42 eligibility under the Internal Revenue Code. The notification must be provided by March 1 of the assessment year or the owner is subject to a penalty of \$500.

This rule is intended to implement Iowa Code sections 421.17, 428.4, 441.21 as amended by 2004 Iowa Acts, Senate File 2296, and 476.1D(10).

[ARC 3107C, IAB 6/7/17, effective 7/12/17]

**701—71.6(421,428,441) Valuation of industrial land and buildings.** Industrial real estate shall be assessed at its actual value as defined in Iowa Code section 441.21.

In determining the actual value of industrial land and buildings, city and county assessors shall use the appraisal manual issued by the department of revenue pursuant to Iowa Code subsection 421.17(18), and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21.

**701—71.7(421,427A,428,441) Valuation of industrial machinery.** Industrial machinery as referred to in Iowa Code section 427A.1(1)“e” shall include all machinery used in manufacturing establishments and shall be assessed as real estate even though such machinery might be assessed as personal property if not used in a manufacturing establishment.

In determining the actual value of industrial machinery assessed as real estate, the assessor shall give consideration to the “Industrial Machinery and Equipment Valuation Guide” issued by the department of revenue and any other relevant data available.

This rule is intended to implement Iowa Code sections 421.17, 427A.1, 428.4 and 441.21.

**701—71.8(428,441) Abstract of assessment.** Each city and county assessor shall submit annually to the department of revenue at the times specified in Iowa Code section 441.45 an abstract of assessment for the current year. The assessor shall use the form of abstract prescribed and furnished by the department and shall enter on the abstract all information required by the department. However, the department may approve the use of a computer-prepared abstract if the data is in essentially the same format as on the form prescribed by the department. The information entered on the abstract of assessment shall be reviewed and considered by the department in equalizing the valuations of classes of properties.

This rule is intended to implement Iowa Code sections 428.4 and 441.45.

[ARC 2657C, IAB 8/3/16, effective 9/7/16]

**701—71.9(428,441) Reconciliation report.** The assessor’s report of any revaluation required by Iowa Code section 428.4 shall be made on the reconciliation report prescribed and furnished by the department of revenue. The assessor shall enter on the report all information required by the department. The reconciliation report shall be a part of the abstract of assessment required by Iowa Code section 441.45 and shall be reviewed and considered by the department in equalizing valuations of classes of property.

This rule is intended to implement Iowa Code sections 428.4 and 441.45.

[ARC 2657C, IAB 8/3/16, effective 9/7/16]

**701—71.10(421) Assessment/sales ratio study.**

**71.10(1) Basic data.** Basic data shall be that submitted to the department of revenue by county recorders and city and county assessors on forms prescribed and provided by the department, information furnished by parties to real estate transactions, and information obtained by field investigations made by the department of revenue.

**71.10(2) Responsibility of recorders and assessors.** County recorders and city and county assessors shall complete the prescribed forms as required by Iowa Code subsection 421.17(6) and rule 701—79.3(428A) in accordance with instructions issued by the department. Assessed values entered on the prescribed form shall be those established as of January 1 of the year in which the sale takes place.

**71.10(3) Normal sales.** All real estate transfers shall be considered by the department of revenue to be normal sales unless there exists definite information which would indicate the transfer was not an arms-length transaction or is of an excludable nature as provided in Iowa Code section 441.21.

This rule is intended to implement Iowa Code section 421.17.

**701—71.11(441) Equalization of assessments by class of property.**

**71.11(1)** Commencing in 1977 and every two years thereafter, the department of revenue shall order the equalization of the levels of assessment of each class of property as provided in rule 701—71.12(441) by adding to or deducting from the valuation of each class of property, as reported to the department on the abstract of assessment and reconciliation report that is a part of the abstract, the percentage in each case as may be necessary to bring the level of assessment to its actual value as defined in Iowa Code section 441.21. Valuation adjustments shall be ordered if the department determines that the aggregate valuation of a class of property as reported on the abstract of assessment submitted by the assessor is at least 5 percent above or below the aggregate valuation for that class of property as determined by the department pursuant to rule 701—71.12(441). Equalization orders of the department shall be restricted to equalizing the aggregate valuations of entire classes of property among the several assessing jurisdictions. All classifications of real estate shall be applied uniformly throughout the state of Iowa.

**71.11(2)** Equalization percentage adjustments determined for residential realty located outside incorporated areas and not located on agricultural land shall apply to buildings located on agricultural land outside incorporated areas, which are primarily used or intended for human habitation, as defined in subrule 71.1(4).

Equalization percentage adjustments determined for residential realty located within incorporated cities and not located on agricultural land shall apply to buildings located on agricultural land within incorporated cities that are primarily used or intended for human habitation as defined in subrule 71.1(4).

This rule is intended to implement Iowa Code sections 441.21, 441.47, 441.48 and 441.49.  
[ARC 2657C, IAB 8/3/16, effective 9/7/16]

**701—71.12(441) Determination of aggregate actual values.**

**71.12(1) Agricultural real estate.**

*a. Use of income capitalization study.* The equalized valuation of agricultural realty shall be based upon its productivity and net earning capacity and shall be determined in accordance with the provisions of this subrule. Data used shall pertain to crops harvested during the five-year period ending with the calendar year in which assessments were last equalized. The equalized valuation of agricultural realty shall be determined for each county as follows:

(1) Computation of county acres. This information shall be obtained from the USDA National Agricultural Statistics Service.

1. Total acres in farms: Total acreage used for agricultural purposes.
2. Corn acres: Sum of corn acres harvested including silage, popcorn and acres planted for sorghum.
3. Oats and wheat acres: Sum of oats and wheat acres harvested.
4. Soybean acres: Soybean acres harvested.
5. Hay acres: All hay acres harvested.
6. Pasture acres: All pasture acres. Total pasture acres shall be determined by multiplying the total acres in farms reported by the USDA National Agricultural Statistics Service by the percentage which total pasture land as reported in the most recent U.S. Census of Agriculture bears to the total acreage in farmland also reported in the most recent U.S. Census of Agriculture. The amount of tillable and nontillable pasture acres shall be determined as follows:

1.	From the most recent U.S. Census of Agriculture obtain the following:		
	Cropland used only for pasture and grazing	_____	acres
	Woodland pasture	_____	acres
	Pasture land and rangeland (other than cropland and woodland pasture)	_____	acres
	TOTAL PASTURE LAND (total of above):	_____	acres
2.	Determine what percentage of the total pasture land is cropland used only for pasture:	_____	%
3.	Apply the percentage in "2" above to the 5-year average total acres of pasture as determined above to determine the pasture acres to be classified as tillable pasture. The remainder of the 5-year average shall be classified as nontillable pasture land.	_____	acres

7. Government programs: Determine the 5-year average acres participating in applicable government programs. Obtain data from the USDA Farm Service Agency, including but not limited to acreage devoted to the Payment-In-Kind (PIK), diverted and deficiency programs.

8. Other acres: The difference between the total acreage for land uses listed above and the total of all land in farms. Add the total of the corn, oats, soybeans, hay, tillable and nontillable pasture and diverted acres. Subtract this total from total acres in farms. The residual is classified as other acres.

(2) Computation of county yields. This information shall be obtained for each county from the USDA National Agricultural Statistics Service.

1. Corn yield (including silage): Number of bushels of corn harvested for grain per acre.
2. Oat yield (including wheat): Number of bushels of oats harvested per acre.
3. Soybean yield: Number of bushels per acre harvested.
4. Hay yield in tons: Number of tons per acre harvested.

(3) Computation of county gross income.

1. Corn: One-half of the 5-year average production multiplied by the 5-year average price received for corn.

2. Silage: One-half of the 5-year average number of acres devoted to the production of silage multiplied by the 5-year average production per acre for corn. The amount of production so determined shall be added to the 5-year average production for corn and included in the determination of the gross income for corn.

3. Soybeans: One-half of the 5-year average production multiplied by the 5-year average price received.

4. Oats: One-half of the 5-year average production of oats and wheat multiplied by the 5-year average price received for oats.

5. Price adjustment: For corn, soybeans, hay, and oats, the prices used shall be as obtained from the USDA National Agricultural Statistics Service and shall be adjusted to reflect any individual county price conditions prior to the 2007 crop year. For the 2007 crop year and later, the USDA National Agricultural Statistics Service district prices shall be used and shall be adjusted to reflect any individual county price conditions.

6. Government programs: Gross income shall be one-half of the 5-year average amount of cash payments or equivalent (such as PIK bushels) including but not limited to diverted, deficiency and PIK programs as reported by the USDA Farm Service Agency.

7. Hay: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to hay by the product obtained by multiplying one-fourth of the 5-year average hay yield by the 5-year average price received for all types of hay.

8. Tillable pasture: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to tillable pasture by the product obtained in “hay” above.

9. Nontillable pasture: Gross income shall be a cash rent amount determined by multiplying the 5-year average number of acres devoted to nontillable pasture by one-half the product obtained in “hay” above.

10. Other acres: Income shall be the product of the number of other acres multiplied by 17 percent of the net income per acre for all other land uses.

(4) Computation of county production costs. The following data and procedures shall be used to determine specific county production costs.

1. Basic average landlord production costs. Landlord production costs for corn, soybeans, oats, diverted acres, hay, tillable pasture, nontillable pasture, fertilizer costs, and facilities’ costs shall be obtained for each year from Iowa State University.

2. Production cost adjustment. The production costs for corn, soybeans, oats, and hay are adjusted for each county by multiplying the difference between the 5-year state average yield per acre and the 5-year county average yield per acre by the 5-year average facilities’ costs. If a county’s yield exceeds the state yield, production costs are increased by this amount. If a county’s yield is less than the state yield, production costs are reduced by this amount.

3. Fertilizer cost adjustment. The adjustment for fertilizer costs is determined as follows: Multiply the difference between the 5-year state average corn yield per acre and the 5-year county average corn yield per acre obtained from the USDA National Agricultural Statistics Service by the fertilizer cost amount per bushel determined by dividing the statewide average cost of landlord’s share of fertilizer cost per acre from Iowa State University by the statewide average corn yield per acre to produce the corn fertilizer cost per bushel adjustment. This amount is then multiplied by the 5-year county average corn acres determined in (2) above.

4. Expense adjustments. If a county’s 5-year average corn yield is greater than the state 5-year average corn yield, this amount is allowed as an additional expense. If the county’s average is less than the state average, this amount is an expense reduction.

5. Liability insurance cost adjustment. The 5-year average per acre cost of obtaining tort liability insurance shall be determined.

(5) Computation of county net income. From the total gross income, subtract the total expenses. Divide the resulting total by the total number of acres.

(6) Computation of dwelling adjustment factor. The amount determined in (5) above shall be reduced by 10.6 percent.

(7) Computation of county tax adjustment. Subtract the 5-year average per acre real estate taxes levied for land and structures including drainage and levee district taxes but excluding those levied against agricultural dwellings from the amount determined in (6) above. Taxes shall be the tax levied for collection during the 5-year period as reported by county auditors, and reduced by the amount of the agricultural land tax credit.

(8) Calculation of county valuation per acre. Divide the net income per acre ((7) above) for each county as determined above by the capitalization rate specified in Iowa Code section 441.21. The quotient shall be the actual per acre equalized valuation of agricultural land and structures for the current equalization year.

*b. Use of other relevant data.* The department of revenue may also consider other relevant data, including field investigations conducted by representatives of the department, to determine the level of assessment of agricultural real estate.

*c. Determination of value.* The aggregate actual value of agricultural real estate in each county shall be determined by multiplying the equalized per acre value by the number of acres of agricultural real estate reported on the abstract of assessment for the current year, adjusted where necessary by the results of any field investigations conducted by the department of revenue and any other relevant data available.

**71.12(2) Residential real estate outside and within incorporated cities.**

*a. Use of assessment/sales ratio study.*

(1) Basic data shall be that set forth in rule 701—71.10(421) refined by eliminating any sales determined to be abnormal or by adjusting the sales to eliminate the effects of factors that resulted in the determination that the sales were abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The department of revenue may also supplement the assessment/sales ratio study with appraisals made by department appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of residential real estate in each assessing jurisdiction. The department may consider sales and appraisal data for prior years if it is determined the use of the sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value.

(2) Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals that would indicate abnormal or unusual conditions or reporting discrepancies that would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

*b. Use of other relevant data.* The department of revenue may also consider other relevant data, including field investigations conducted by representatives of the department, to determine the level of assessment of residential real estate.

*c. Equalization appraisal selection procedures for residential real estate.* Residential properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the following manner:

(1) The department appraiser assigned to the jurisdiction shall determine a systematic random sequence of numbers equal to the number of appraisals required and document the following steps.

1. The department appraiser assigned to the jurisdiction shall compute the interval number by dividing the total number of improved properties in the classification to be sampled by the number of appraisals to be performed.

EXAMPLE: In this example, ten appraisals are needed with a total of 1,397 improved residential units. Dividing 1,397 by 10, 139.7 is arrived at, which is rounded down to 139. This is the interval number.

2. The selection of the first sequence number shall be accomplished by having an available disinterested person randomly select a number from one through the interval number.

EXAMPLE: In this example a number from 1 to 139 is to be selected. The person randomly selected number 20.

3. The department appraiser shall develop a systematic sequence of numbers equal to the number of appraisals required. Starting with the randomly selected number previously picked by the disinterested person, add the interval number to this number and to each resulting number until a systematic sequence of numbers is obtained.

EXAMPLE: In this example ten appraisals are needed, so a sequence of ten numbers must be developed. Starting with number 20 and adding the interval number of 139 to it, each resulting number provides the following systematic sequence: 20, 159, 298, 437, 576, 715, 854, 993, 1,132, 1,271.

(2) Number of improved properties.

County jurisdictions—Put the name of each city or township having improved units in the classification to be sampled into a hat. Draw each one out of the hat and record its name in the order of its draw. Likewise, record the respective number of improved units for each. Then consecutively number all the improved units and document the procedure.

## EXAMPLE:

City or Township	Number of Improved Residential Units	Code Numbers
Franklin Twp.	57	1-57
Pleasant View	160	58-217
Jackson Twp.	56	218-273
Johnston	300	274-573
Polk Twp.	110	574-683
Washington Twp.	114	684-797
Maryville	306	798-1103
Camden Twp.	110	1104-1213
Salem	184	1214-1397
Total	<u>1,397</u>	

(3) Determine the location of the improved properties selected for appraisal and document the procedure.

## EXAMPLE:

City or Township	Number of Improved Residential Units	Code Numbers	Sequence Number	Entry on Rolls
Franklin Twp.	57	1-57	20	20
Pleasant View	160	58-217	159	102
Jackson Twp.	56	218-273		
Johnston	300	274-573	298,437	25,164
Polk Twp.	110	574-683	576	3
Washington Twp.	114	684-797	715	32
Maryville	306	798-1103	854,993	57,196
Camden Twp.	110	1104-1213	1132	29
Salem	184	1214-1397	1271	58
Total	<u>1,397</u>			

1. The department appraiser shall locate the property to be appraised by finding the relationship between the sequence numbers and the code numbers and identify the property.

EXAMPLE: The first sequence number is 20. Since the improved residential properties in Franklin Township have been assigned code numbers 1 to 57, sequence number 20 is in that location.

To identify this property, examine the Franklin Township assessment roll book and stop at the twentieth improved residential entry.

Document the parcel number, owner's name, and legal description of this property.

2. The department appraiser shall appraise the property selected unless it is ineligible because of any of the following restrictions:

- Current year sale
- Partial assessment
- Prior equalization appraisal
- Tax-exempt
- Value established by court action
- Value is not more than \$10,000
- Building on leased land

3. The department appraiser shall determine a substitute property if the originally selected one is ineligible. In ascending order, select code numbers until an eligible property is found.

EXAMPLE: If code number 20 is ineligible, use code number 21 as a substitute. If code number 21 is ineligible, use code number 22, etc., until an eligible property is found.

If the procedure described in 71.12(2)“c”(3)“3” moves the substitute property to another city or township, select substitute code numbers in descending order until an eligible property is found.

If the procedure described in the previous paragraph moves the substitute property to a preceding city or township, go back to the procedure of 71.12(2)“c”(3)“3” even if it moves the substitute property to a subsequent city or township.

4. Select an alternate property for the originally selected property which also would be eligible. This is necessary because at the time of appraisal the property may be found to be ineligible due to one of the restrictions in 71.12(2)“c”(3)“2.” Alternate properties are selected by using the same procedure described in 71.12(2)“c”(3)“3.”

5. Follow procedures 71.12(2)“c”(3), items “1” to “4,” for each of the other originally selected sequence numbers.

**71.12(3) Multiresidential real estate.**

*a. Use of assessment/sales ratio study.*

(1) Basic data shall be that set forth in rule 701—71.10(421), refined by eliminating any sales determined to be abnormal or by adjusting same to eliminate the effects of factors that resulted in the determination that the sales were abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The department of revenue may also supplement the assessment/sales ratio study with appraisals made by department appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of multiresidential real estate in each assessing jurisdiction. The department may consider sales and appraisal data for prior years if it is determined the use of sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value.

(2) Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals that would indicate abnormal or unusual conditions or reporting discrepancies that would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

*b. Use of other relevant data.* The department of revenue may also consider other relevant data, including field investigations conducted by representatives of the department, to determine the level of assessment of multiresidential real estate.

*c. Equalization appraisal selection procedures for multiresidential real estate.* To the extent possible, multiresidential properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the manner outlined in paragraph 71.12(4)“c.”

The following restrictions shall render a property ineligible for the appraisal selection for multiresidential property:

Vacant building

Current-year sale

Partial assessment

Tax-exempt

Only one portion of a total property unit (example—a parking lot of a grocery store)

Value established by court action

Value is not more than \$10,000

**Building on leased land****71.12(4) Commercial real estate.***a. Use of assessment/sales ratio study.*

(1) Basic data shall be that set forth in rule 701—71.10(421), refined by eliminating any sales determined to be abnormal or by adjusting same to eliminate the effects of factors that resulted in the determination that the sales were abnormal. The basic data used shall be the assessment/sales ratio study conducted for sales taking place during the calendar year immediately preceding the year in which the equalization order is issued. The department of revenue may also supplement the assessment/sales ratio study with appraisals made by department appraisal personnel for the year immediately preceding the year in which the equalization order is issued. The assessment/sales ratio study including relevant appraisals, if any, shall be used to determine the aggregate actual valuation of commercial real estate in each assessing jurisdiction. The department may consider sales and appraisal data for prior years if it is determined the use of sales and appraisal data for the year immediately preceding the year in which the equalization order is issued is insufficient to determine market value. If such sales and appraisal data for prior years is used, consideration shall be given for any subsequent changes in either assessed value or market value. Properties receiving a dual classification with the primary use being commercial shall be included.

(2) Assessors shall provide any known facts or circumstances regarding reported sales transactions and department appraisals that would indicate abnormal or unusual conditions or reporting discrepancies that would necessitate exclusion or adjustment of sales or appraisals from the determination of aggregate actual values. Assessors shall provide those facts within 45 days of receipt from the department of information concerning sales and appraisal data proposed for assessment/sales ratio and equalization purposes.

*b. Use of other relevant data.* The department of revenue may also consider other relevant data, including field investigations conducted by representatives of the department, to determine the level of assessment of commercial real estate. The diverse nature of commercial real estate precludes the use of a countywide or citywide income capitalization study.

*c. Equalization appraisal selection procedures for commercial real estate.* Commercial properties to be appraised by department of revenue personnel for use in supplementing the assessment/sales ratio study shall be selected for each jurisdiction in the manner outlined below. Properties receiving a dual classification with the primary use being commercial shall be included.

(1) The department appraiser assigned to the jurisdiction shall determine a systematic random sequence of numbers equal to the number of appraisals required and document the following steps.

1. The department appraiser shall compute the interval number by dividing the total number of improved properties in the classification to be sampled by the number of appraisals to be performed.

EXAMPLE: In this example, ten appraisals are needed with a total of 397 improved commercial units. Dividing 397 by 10, 39.7 is arrived at, which is rounded down to 39. This is the interval number.

2. The selection of the first sequence number shall be accomplished by having an available disinterested person randomly select a number from one through the interval number.

EXAMPLE: In this example a number from 1 to 39 is to be selected. The person randomly selected number 2.

3. The department appraiser shall develop a systematic sequence of numbers equal to the number of appraisals required. Starting with the randomly selected number previously picked by the disinterested person, add the interval number to this number and to each resulting number until a systematic sequence of numbers is obtained.

EXAMPLE: In this example ten appraisals are needed, so a sequence of ten numbers must be developed. Starting with number 2 and adding the interval number of 39 to it, each resulting number provides the following systematic sequence: 2, 41, 80, 119, 158, 197, 236, 275, 314, 353.

(2) Number of improved properties.

1. City jurisdictions—Utilizing the assessment book or a computer printout which follows the same order as the assessment book, consecutively number all the improved units and document the procedure.

2. County jurisdictions—Put the name of each city or township having improved units in the classification to be sampled into a hat. Draw each one out of the hat and record its name in the order of its draw. Likewise, record the respective number of improved units for each. Then consecutively number all the improved units and document the procedure.

EXAMPLE:

City or Township	Number of Improved Commercial Units	Code Numbers
Franklin Twp.	4	1-4
Pleasant View	60	5-64
Jackson Twp.	9	65-73
Johnston	100	74-173
Polk Twp.	10	174-183
Washington Twp.	14	184-197
Maryville	106	198-303
Camden Twp.	10	304-313
Salem	84	314-397
Total	397	

(3) The department appraiser shall determine the location of the improved properties selected for appraisal and document the procedure.

EXAMPLE:

City or Township	Number of Improved Commercial Units	Code Numbers	Sequence Number	Entry on Rolls
Franklin Twp.	4	1-4	2	2
Pleasant View	60	5-64	41	37
Jackson Twp.	9	65-73		
Johnston	100	74-173	80,119,158	7,46,85
Polk Twp.	10	174-183		
Washington Twp.	14	184-197	197	14
Maryville	106	198-303	236,275	39,78
Camden Twp.	10	304-313		
Salem	84	314-397	314,353	1,40
Total	397			

1. The department appraiser shall locate the property to be appraised by finding the relationship between the sequence numbers and the code numbers and identify the property.

EXAMPLE: The first sequence number is 2. Since the improved commercial properties in Franklin Township have been assigned code numbers 1 to 4, sequence number 2 is in that location.

To identify this property, examine the Franklin Township assessment roll book and stop at the second improved commercial entry.

The department appraiser shall document the parcel number, owner's name, and legal description of this property.

2. The department appraiser shall appraise the property selected unless it is ineligible because of any of the following restrictions:

- Vacant building
- Current-year sale

Partial assessment  
 Prior equalization appraisal  
 Tax-exempt  
 Only one portion of a total property unit (example—a parking lot of a grocery store)  
 Value established by court action  
 Value is not more than \$10,000  
 Building on leased land

3. The department appraiser shall determine a substitute property if the originally selected one is ineligible. In ascending order, select code numbers until an eligible property is found.

EXAMPLE: If code number 2 is ineligible, use code number 3 as a substitute. If code number 3 is ineligible, use code number 4, etc., until an eligible property is found.

If the procedure described in 71.12(4)“c”(3)“3” moves the substitute property to a city or township, select substitute code numbers in descending order until an eligible property is found.

If the procedure described in the previous paragraph moves the substitute property to a preceding city or township, go back to the procedure of 71.12(4)“c”(3)“3” even if it moves the substitute property to a subsequent city or township.

4. Select an alternate property for the originally selected property which also would be eligible. This is necessary because at the time of appraisal the property may be found to be ineligible due to one of the restrictions in 71.12(4)“c”(3)“2.” Alternate properties are selected by using the same procedure described in 71.12(4)“c”(3)“3.”

5. Follow procedures 71.12(4)“c”(3), items “1” to “4,” for each of the other originally selected sequence numbers.

**71.12(5) Industrial real estate.** It is not possible to determine the level of assessment of industrial real estate by using accepted equalization methods. The lack of sales data precludes the use of an assessment/sales ratio study, the diverse nature of industrial real estate precludes the use of a countywide or citywide income capitalization study, and the limited number of industrial properties precludes the use of sample appraisals. The level of assessment of industrial real estate can only be determined by the valuation of individual parcels of industrial real estate. Any attempt to equalize industrial valuations by using accepted equalization methods would create an arbitrary result. However, under the circumstances set forth in Iowa Code subsection 421.17(10), the department may correct any errors in such assessments that are brought to the attention of the department, including errors related to property with a dual classification if the primary use of the property is from the industrial portions.

**71.12(6) Centrally assessed property.** Property assessed by the department of revenue pursuant to Iowa Code chapters 428 and 433 to 438, inclusive, is equalized internally by the department in the making of the assessments. Further, the assessments are equalized with the aggregate valuations of other classes of property as a result of actions taken by the department pursuant to rule 701—71.11(441).

**71.12(7) Miscellaneous real estate.** Since it is not possible to use accepted equalization methods to determine the level of assessment of mineral rights and interstate railroad and toll bridges, these classes of property shall not be subject to equalization by the department of revenue. However, under the circumstances set forth in Iowa Code section 421.17(10), the department may correct any errors in assessments which are brought to the attention of the department.

This rule is intended to implement Iowa Code sections 441.21, 441.47, 441.48 and 441.49.

[ARC 7726B, IAB 4/22/09, effective 5/27/09; ARC 9478B, IAB 4/20/11, effective 5/25/11; ARC 1765C, IAB 12/10/14, effective 1/14/15; ARC 2657C, IAB 8/3/16, effective 9/7/16]

**701—71.13(441) Tentative equalization notices.** Prior to the issuance of the final equalization order to each county auditor, a tentative equalization notice providing for proposed percentage adjustments to the aggregate valuations of classes of property as set forth in rule 701—71.12(441) shall be mailed to the county auditor whose valuations are proposed to be adjusted. The tentative equalization notice constitutes the ten days’ notice required by Iowa Code section 441.48.

This rule is intended to implement Iowa Code sections 441.47 and 441.48.

**701—71.14(441) Hearings before the department.**

**71.14(1) *Protests.*** Written or oral protest against the proposed percentage adjustments as set forth in the tentative equalization notice issued by the department of revenue shall be made only on behalf of the affected assessing jurisdiction. The protests shall be made only by officials of the assessing jurisdiction, including, but not limited to, an assessing jurisdiction's city council or board of supervisors, assessor, or city or county attorney. An assessing jurisdiction may submit a written protest in lieu of making an oral presentation before the department, or may submit an oral protest supported by written documentation. Protests against the adjustments in valuation contained in the tentative equalization notices shall be limited to a statement of the error or errors complained of and shall include such facts as might lead to their correction. No other factors shall be considered by the department in reviewing the protests. Protests and hearings on tentative equalization notices before the department are excluded from the provisions of the Iowa Administrative Procedure Act governing contested case proceedings.

**71.14(2) *Conduct of hearing.*** The department shall schedule each hearing so as to allow the same amount of time within which each assessing jurisdiction can make its presentation. During the hearing each assessing jurisdiction shall be afforded the opportunity to present evidence relevant to its protest. The division administrator for the property tax division shall act as the department's representative. The department's representative shall preside at the hearing, which shall be held at the time and place designated by the department or such other time and place as may be mutually agreed upon by the department and the protesting assessing jurisdiction.

This rule is intended to implement Iowa Code section 441.48.  
[ARC 2657C, IAB 8/3/16, effective 9/7/16]

**701—71.15(441) Final equalization order and appeals.**

**71.15(1) *Issuance of final equalization order.*** After the tentative equalization notice has been issued and an opportunity for a hearing described in rule 701—71.14(441) has been afforded, the department of revenue shall issue a final equalization order by mail to the county auditor. The order shall specify any percentage adjustments in the aggregate valuations of any class of property to be made effective for the county as of January 1 of the year in which the order is issued. The final equalization order shall be issued on or before October 1 unless for good cause it cannot be issued until after October 1. The final equalization order shall be implemented by the county auditor.

**71.15(2) *Appeal of final equalization order.*** The city or county officials of the affected county or assessing jurisdiction may appeal a final equalization order to the director of revenue by filing a notice of appeal with the clerk of the hearings section of the department of revenue. The notice of appeal must be filed or postmarked not later than ten days after the date the final equalization order is issued.

*a. Form of appeal.* The notice of appeal shall be in writing and in the same format as provided in 701—subrule 7.8(6).

- (1) The notice of appeal shall substantially state in separate numbered paragraphs the following:
  1. The county or assessing jurisdiction;
  2. The date on which the final equalization order was issued;
  3. The portion of the equalization order being appealed;
  4. A clear and concise assignment of each and every error;
  5. A clear and concise statement of the facts upon which the affected county or assessing jurisdiction relies as sustaining the assignment of error;
  6. The relief requested;
  7. The signature of the city or county officials bringing the appeal, or their representative, along with the address to which all subsequent correspondence, notice or papers shall be served or mailed.

(2) A county or assessing jurisdiction may amend its notice of appeal at any time prior to the commencement of the evidentiary hearing. The department may request that the county or assessing jurisdiction amend the notice of appeal for clarification.

*b. Filing of notice of appeal.* The notice of appeal must either be delivered to the department by electronic means or by United States Postal Service or a common carrier, by ordinary, certified, or registered mail, directed to the attention of the clerk of the hearings section at P.O. Box 14457, Des

Moines, Iowa 50319, or be personally delivered to the clerk of the hearings section or served on the clerk of the hearings section by personal service during business hours. For the purpose of mailing, a notice of appeal is considered filed on the date of the postmark. If a postmark date is not present on the mailed article, then the date of receipt of protest will be considered the date of mailing. Any document, including a notice of appeal, is considered filed on the date personal service or personal delivery to the office of the clerk of the hearings section is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

*c. Answer.* The department of revenue shall file an answer with the clerk of the hearings section within 30 days after the filing of the pleading responded to, unless attacked by motion as provided in 701—subrule 7.17(5), and then the answer shall be filed within 30 days after the date on which the fact finder issues a ruling on the motion. The department may amend its answer at any time prior to the commencement of the evidentiary hearing.

*d. Docketing.* Appeals shall be assigned a docket number as provided in rule 701—7.10(17A). Records consisting of the case name and the corresponding docket number assigned to the case must be maintained by the clerk of the hearings section. The records of each case shall also include each action and each act done, with the proper dates as follows:

- (1) The title of the appeal;
- (2) Brief statement of the date of the final equalization order, the property tax classification affected, and the relief sought;
- (3) The manner and time of service of notice of appeal;
- (4) The appearance of all parties;
- (5) Notice of hearing, together with manner and time of service; and
- (6) The decision of the director or administrative law judge or other disposition of the case and the date.

*e. Hearing.* Rules 701—7.14(17A) through 701—7.22(17A) shall apply to any hearing or proceeding regarding the appeal of a final equalization order to the director of revenue.

This rule is intended to implement Iowa Code chapter 17A and sections 441.48 and 441.49.  
[ARC 2657C, IAB 8/3/16, effective 9/7/16]

#### **701—71.16(441) Alternative method of implementing equalization orders.**

##### **71.16(1) Application for permission to use an alternative method.**

*a.* A request by an assessing jurisdiction for permission to use an alternative method of applying the final equalization order must be made in writing to the department of revenue within ten days from the date the county auditor receives the final equalization order. The written request shall include the following information:

- (1) Facts evidencing the need to use an alternative method of implementing the final equalization order. Such facts shall clearly show that the proposed method is essential to ensure compliance with the provisions of Iowa Code section 441.21.
- (2) The exact methods to be employed in implementing the requested alternative method for each class of property.
- (3) The specific method of notifying affected property owners of the valuation changes.
- (4) Evidence that the alternative method will result in an aggregate property class valuation adjustment equivalent to that prescribed in the department's final equalization order.

*b.* The department of revenue shall review each written request for an alternative method and shall notify the assessing jurisdiction of acceptance or rejection of the proposed method by October 15. The assessing jurisdiction shall immediately inform the county auditor of the department's decision. The county auditor shall include a description of any approved alternative method in the required newspaper publication of the final equalization order. In those instances where the approved alternative method

includes individual property owner notification, the publication shall not be considered proper notice to the affected property owners.

**71.16(2) *Implementation of alternative method.*** If an alternative method is approved by the department of revenue, any individual notification of property owners shall be completed by the assessor by not later than October 25.

**71.16(3) *Appeal by property owners.*** If an alternative method is approved by the department of revenue, the special session of the local board of review to hear equalization protests shall be extended to November 30. In such instances, protests may be filed up to and including November 4.

This rule is intended to implement Iowa Code section 441.49.  
[ARC 2657C, IAB 8/3/16, effective 9/7/16]

#### **701—71.17(441) Special session of boards of review.**

**71.17(1) *Grounds for protest.*** The only ground for protesting to the local board of review reconvened in special session pursuant to Iowa Code section 441.49 is that the application of the department's final equalization order results in a value greater than that permitted under Iowa Code section 441.21.

**71.17(2) *Authority of board of review.*** When in special session to hear protests resulting from equalization adjustments, the local board of review shall only act upon protests for those properties for which valuations have been increased as a result of the application of the department of revenue's final equalization order.

The local board of review may adjust valuations of those properties it deems warranted, but under no circumstance shall the adjustment result in a value less than that which existed prior to the application of the department's equalization order. The local board of review shall not adjust the valuation of properties for which no protests have been filed.

**71.17(3) *Report of board of review.*** In the report to the department of revenue of action taken by the local board of review in special session, the board of review shall report the aggregate valuation adjustments by class of property as well as all other information required by the department of revenue to determine if such actions may have substantially altered the equalization order.

**71.17(4) *Meetings of board of review.*** If the final equalization order does not increase the valuation of any class of property, the board of review is not required to meet during the special session. If the final equalization order increases the valuation of one or more classes of property but no protests are filed by the times specified in Iowa Code section 441.49, the board of review is not required to meet during the special session.

This rule is intended to implement Iowa Code sections 421.17(10) and 441.49.  
[ARC 2657C, IAB 8/3/16, effective 9/7/16]

**701—71.18(441) Judgment of assessors and local boards of review.** Nothing stated in these rules should be construed as prohibiting the exercise of honest judgment, as provided by law, by the assessors and local boards of review in matters pertaining to valuing and assessing of individual properties within their respective jurisdictions.

This rule is intended to implement Iowa Code sections 441.17 and 441.35.

#### **701—71.19(441) Conference boards.**

**71.19(1) *Establishment and abolition of office.***

*a.* As referred to in Iowa Code section 441.1, the term "federal census" includes any special census conducted by the Bureau of the Census of the U.S. Department of Commerce as well as the Bureau's decennial census.

*b.* Within 60 days of receiving the certified results of a federal census indicating the population of a city having its own assessor has fallen below 10,000, the city council of the city shall repeal the ordinance providing for its own assessor.

*c.* Whenever the office of city assessor is abolished, all moneys in the assessment expense fund and the special appraiser fund shall be transferred to the appropriate accounts in the county assessor's office, and all equipment and supplies shall be transferred to the county assessor's office. Employees of the city assessor's office may, at the discretion of the county assessor, become employees of the county

assessor. However, any deputy assessor of the city may not be appointed a deputy county assessor unless certified as eligible for appointment pursuant to Iowa Code sections 441.5 and 441.10.

**71.19(2) Membership.**

*a. County conference boards.* A county conference board consists of the county board of supervisors, the mayor of each incorporated city in the county whose property is assessed by the county assessor, and one member of the board of directors of each high school district in the county, provided the member is a resident of the county. Members representing school districts serve one-year terms, and the board of directors each year must notify the clerk of the conference board of its representative on the conference board. A member of the board of directors of a school district may serve on the county conference board even though the member lives in a city having its own assessor (1978 O.A.G. 466).

*b. City conference boards.* A city conference board consists of the county board of supervisors, the city council, and the entire board of directors of each school district whose property is assessed by the city assessor.

**71.19(3) Voting.**

*a.* Votes on matters before a conference board shall be by units as provided in Iowa Code section 441.2. At least two members of each voting unit must be present in order for the unit to cast a vote (1960 O.A.G. 226). In the event the vote of the members of a voting unit ends in a tie, that unit shall not cast a vote on the particular matter before the conference board.

*b.* If a member of a conference board is absent from a meeting, the member's vote may not be cast by another person, except that a mayor pro tem as provided in Iowa Code section 372.14(3) may vote for the mayor when the mayor is absent from or unable to perform official duties.

This rule is intended to implement Iowa Code section 441.2.

**701—71.20(441) Board of review.**

**71.20(1) Membership.**

*a. Occupation of members.* One member of the county board of review must be actively engaged in farming as that member's primary occupation. However, it is not necessary for a board of review to have as a member one licensed real estate broker and one registered architect or person experienced in the building and construction field if the person cannot be located after a good faith effort to do so has been made by the conference board (1966 O.A.G. 416). In determining eligibility for membership on a board of review, a retired person is not considered to be employed in the occupation pursued prior to retirement, unless that person remains in reasonable contact with the former occupation, including some participation in matters associated with that occupation.

*b. Residency of members.* A person must be a resident of the assessor jurisdiction served to qualify for appointment as a member of the board of review. However, a member changing assessing jurisdiction residency after appointment to the board may continue to serve on the board until the member's current term of office expires.

*c. Term of office.* The term of office of members of boards of review shall be for six years and shall be staggered as provided in Iowa Code section 441.31. In the event of the death, resignation, or removal from office of a member of a board of review, the conference board or city council shall appoint a successor to serve the unexpired term of the previous incumbent.

*d. Membership on other boards.* A member of a board of review shall not at the same time serve on either the conference board or the examining board, or be an employee of the assessor's office (1948 O.A.G. 120, 1960 O.A.G. 226).

*e. Number of members.* A conference board or city council may at any time change the composition of a board of review to either three or five members. To reduce membership from five members to three members, the conference board or city council shall not appoint successors to fill the next two vacancies which occur (1970 O.A.G. 342). To increase membership from three members to five members, the conference board or city council shall appoint two additional members whose initial terms shall expire at such times so that no two board members' terms expire at the end of the same year. Also, the conference board or city council may increase the membership of the board of review by an additional two members if it determines that a large number of protests warrant the emergency

appointments. If the board of review has ten members, not more than four additional members may be appointed by the conference board. The terms of the emergency members will not exceed two years.

*f. Removal from office.* A member of a board of review may be removed from office by the conference board or city council but only after specific charges have been filed by the conference board or city council.

*g. Appointment of members.* Members of a county board of review shall be appointed by the county conference board. Members of a city board of review shall be appointed by the city conference board in cities with an assessor or by the city council in cities without an assessor. A city without an assessor can only have a board of review if the population of the city is 75,000 or more. A city with a population of more than 125,000 may appoint a city board of review or request the county conference board to appoint a ten-member county board of review.

**71.20(2) Sessions of boards of review.**

*a.* It is mandatory that a board of review convene on May 1 and adjourn no later than May 31 of each year. However, if either date falls on a Saturday, Sunday, or legal holiday, the board of review shall convene or adjourn on the following Monday.

*b.* Extended session. If a board of review determines it will be unable to complete its work by May 31, it may request that the director of revenue extend its session up to July 15. The request must be signed by a majority of the membership of the board of review and must contain the reasons the board of review cannot complete its work by May 31. During the extended session, a board of review may perform the same functions as during its regular session unless specifically limited by the director of revenue.

*c.* Special session. If a board of review is reconvened by the director of revenue pursuant to Iowa Code section 421.17, the board of review shall perform those functions specified in the order of the director of revenue and shall perform no other functions.

**71.20(3) Actions initiated by boards of review.**

*a.* Internal equalization of assessments. A board of review in reassessment years as provided in Iowa Code section 428.4 has the power to equalize individual assessments as established by the assessor, but cannot make percentage adjustments in the aggregate valuations of classes of property (1966 O.A.G. 416). In nonreassessment years, a board of review can adjust the valuation of an entire class of property by adjusting all assessment by a uniform percentage. Nothing contained in this rule shall restrict the director from exercising the responsibilities set forth in Iowa Code section 421.17.

*b.* Omitted assessments. A board of review may assess for taxation any property which was not assessed by the assessor, including property which the assessor determines erroneously is not subject to taxation by virtue of enjoying an exempt status (*Talley v. Brown*, 146 Iowa 360, 125 N.W. 248 (1910)).

*c.* Notice to taxpayers. If the value of any property is increased by a board of review or a board of review assesses property not previously assessed by the assessor, the person to whom the property is assessed shall be notified by regular mail of the board's action. The notification shall state that the taxpayer may protest the action by filing a written protest with the board of review within five days of the date of the notice. After at least five days have passed since notifying the taxpayer, the board of review shall meet to take final action on the matter, including the consideration of any protest filed. However, if the valuations of all properties within a class of property are raised or lowered by a uniform percentage in a nonreassessment year, notice to taxpayers shall be provided by newspaper publication as described in Iowa Code section 441.35 and in the manner specified in Iowa Code section 441.36.

**71.20(4) Appeals to boards of review.**

*a.* A board of review may act only upon written protests which have been filed with the board of review between April 2 and April 30, inclusive. In the event April 30 falls on a Saturday or Sunday, protests filed the following Monday shall be considered to have been timely filed. Protests postmarked by April 30 or the following Monday if April 30 falls on a Saturday or Sunday shall also be considered to have been timely filed. All protests must be in writing and signed by the taxpayer or the taxpayer's authorized agent. A written request for an oral hearing must be made at the time of filing the protest and may be made by checking the appropriate box on the form prescribed by the department of revenue. Protests may be filed for previous years if the taxpayer discovers that a mathematical or clerical error

was made in the assessment, provided the taxes have not been fully paid or otherwise legally discharged. The protester may combine on one form assessment protests on parcels separately assessed if the same grounds are relied upon as the basis for protesting each separate assessment. If an oral hearing is requested on more than one of the protests, the person making the combined protests may request that the oral hearings be held consecutively. A board of review may allow protests to be filed in electronic format. Protests transmitted electronically are subject to the same deadlines as written protests.

*b.* Grounds for protest. Taxpayers may protest to a board of review on one or more of the grounds specified in Iowa Code section 441.37. The grounds for protest and procedures for considering protests are as follows:

(1) The assessment is not equitable when compared with those of similar properties in the same assessing district. If this ground is a basis for the protest, the protest must contain the legal descriptions and assessments of the comparable properties. The comparable properties selected by the taxpayer must be located within the same assessing district as the property for which the protest has been filed (*Maytag Co. v. Partridge*, 210 N.W.2d 584 (Iowa 1973)). In considering a protest based upon this ground, the board of review should examine carefully all information used to determine the assessment of the subject property and the comparable properties and determine that those properties are indeed comparable to the subject property. It is the responsibility of the taxpayer to establish that the other properties submitted are comparable to the subject property and that inequalities exist in the assessments (*Chicago & N. W. Ry. Co. v. Iowa State Tax Commission*, 257 Iowa 1359, 137 N.W.2d 246(1965)).

(2) The property is assessed at more than its actual value as defined in Iowa Code section 441.21. If this ground is used, the taxpayer must state both the amount by which the property is overassessed and the amount considered to be the actual value of the property.

(3) The property is not assessable and should be exempt from taxation. If using this ground, taxpayers must state the reasons why it is felt the property is not assessable.

(4) There is an error in the assessment. An error in the assessment would most probably involve erroneous mathematical computations or errors in listing the property. The improper classification of property also constitutes an error in the assessment. If this ground is used, the taxpayer's protest must state the specific error alleged.

A board of review must determine:

1. If an error exists, and
2. How the error might be corrected.

(5) There is fraud in the assessment. If this ground of protest is used, the taxpayer's protest must state the specific fraud alleged, and the board of review must first determine if there is validity to the taxpayer's allegation. If it is determined there is fraud in the assessment, the board of review shall take action to correct the assessment and report the matter to the director of revenue.

(6) There has been a change of value of real estate since the last assessment. The board of review must determine that the value of the property as of January 1 of the current year has changed since January 1 of the previous reassessment year. This is the only ground upon which a protest pertaining to the valuation of a property can be filed in a year in which the assessor has not assessed or reassessed the property pursuant to Iowa Code section 428.4. In a year subsequent to a year in which a property has been assessed or reassessed pursuant to Iowa Code section 428.4, a taxpayer cannot protest to the board of review based upon actions taken in the year in which the property was assessed or reassessed (*James Black Dry Goods Co. v. Board of Review for City of Waterloo*, 260 Iowa 1269, 151 N.W.2d 534 (1967); *Commercial Merchants Nat'l Bank and Trust Co. v. Board of Review of Sioux City*, 229 Iowa 1081, 296 N.W. 203 (1941)).

*c.* Disposition of protests. After reaching a decision on a protest, the board of review shall give the taxpayer written notice of its decision. The notice shall contain the following information:

- (1) The valuation and classification of the property as determined by the board of review.
- (2) If the protest was based on the ground the property was not assessable, the notice shall state whether the exemption is allowed and the value at which the property would be assessed in the absence of the exemption.
- (3) The specific reasons for the board's decision with respect to the protest.

(4) That the board of review's decision may be appealed to the district court within 20 days of the board's adjournment or May 31, whichever date is later. If the adjournment date is known, the date shall be stated on the notice. If the adjournment date is not known, the notice shall state the date will be no earlier than May 31. Notice of the appeal shall be served on the chairperson, presiding officer, or clerk of the board of review after the written notice of appeal has been filed with the clerk of district court.

This rule is intended to implement Iowa Code sections 441.31 to 441.37 and Iowa Code Supplement section 441.38 as amended by 2006 Iowa Acts, House File 2794.  
[ARC 2707C, IAB 9/14/16, effective 10/19/16]

**701—71.21(421,17A) Property assessment appeal board.** This rule applies to appeals filed before January 1, 2015, in which the property assessment appeal board has jurisdiction to hear appeals from the action of a local board of review. Appeals filed on or after January 1, 2015, are governed by 701—Chapter 126.

**71.21(1) Establishment, membership, and location of the property assessment appeal board.**

a. A statewide property assessment appeal board is created for the purpose of establishing a consistent, fair, and equitable property assessment appeal process. The statewide property assessment appeal board is established within the department of revenue. The board's principal office shall be in the office of the department of revenue.

b. The property assessment appeal board shall consist of three members appointed by the governor and subject to confirmation by the senate. The members shall be appointed to staggered six-year terms beginning initially on January 1, 2007, and ending as provided in Iowa Code section 69.19. Members' subsequent terms shall begin and end as provided in Iowa Code section 69.19. The governor shall appoint from the members a chairperson, subject to confirmation by the senate, of the board to a two-year term. Vacancies on the board shall be filled for the unexpired portion of the term in the same manner as regular appointments are made.

Each member of the property assessment appeal board shall be qualified by virtue of at least two years' experience in the area of government, corporate, or private practice relating to property appraisal and property tax administration. Two members of the board shall be certified real property appraisers and one member shall be an attorney practicing in the area of state and local taxation or property tax appraisals. No more than two members of the board may be from the same political party as that term is defined in Iowa Code section 43.2.

c. The property assessment appeal board shall organize by appointing a secretary who shall take the same oath of office as the members of the board. The board may employ additional personnel as it finds necessary. All personnel employed by the board shall be considered state employees and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

**71.21(2) Powers and duties of the board.** The property assessment appeal board shall:

a. Review any final decision, finding, ruling, determination, or order of a local board of review relating to assessment protests, valuation, or application of an equalization order.

b. Affirm, reverse, or modify a final decision, finding, ruling, determination, or order of a local board of review.

c. Order the payment or refund of property taxes in a matter over which the board has jurisdiction.

d. Grant other relief or issue writs, orders, or directives that the board deems necessary or appropriate in the process of disposing of a matter over which the board has jurisdiction.

e. Subpoena documents and witnesses and administer oaths.

f. Adopt administrative rules pursuant to Iowa Code chapter 17A for the administration and implementation of its powers, including rules for practice and procedure for protests filed with the board, the manner in which hearings on appeals of assessments shall be conducted, filing fees to be imposed by the board, and for the determination of the correct assessment of property which is the subject of an appeal.

g. Adopt administrative rules pursuant to Iowa Code chapter 17A necessary for the preservation of order and the regulation of proceedings before the board, including forms or notice and the service thereof, which rules shall conform as nearly as possible to those in use in the courts of this state.

*h.* If an appeal to district court is taken from the action of the property assessment appeal board, notice of appeal shall be served as an original notice on the secretary of the board after the written notice of appeal has been filed with the clerk of district court.

**71.21(3) General counsel.** The property assessment appeal board shall employ a competent attorney to serve as its general counsel, and assistants to the general counsel as it finds necessary for the full and efficient discharge of its duties. The general counsel is the attorney for, and legal advisor of, the board. The general counsel or an assistant to the general counsel shall provide the necessary legal advice to the board in all matters and shall represent the board in all actions instituted in a court challenging the validity of a rule or order of the board. The general counsel shall devote full time to the duties of the office. During employment as general counsel to the board, the counsel shall not be a member of a political committee, contribute to a political campaign, participate in a political campaign, or be a candidate for partisan political office. The general counsel and assistants to the general counsel shall be considered state employees and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV.

**71.21(4) Compensation.** The members of the property assessment appeal board shall receive a salary set by the governor within a range established by the general assembly. The members of the board shall be considered state employees for purposes of salary and benefits and are subject to the merit system provisions of Iowa Code chapter 8A, subchapter IV. Members of the board and any employees of the board, when required to travel in the discharge of official duties, shall be paid their actual and necessary expenses incurred in the performance of their duties.

**71.21(5) Applicability and scope.** These subrules set forth herein govern the proceedings for all cases in which the property assessment appeal board (board) has jurisdiction to hear appeals from the action of a local board of review. For the purpose of these subrules, the following definitions shall apply:

“*Appellant*” means the party filing the notice of appeal with the secretary of the property assessment appeal board.

“*Board*” means the property assessment appeal board as created by Iowa Code section 421.1A and governed by Iowa Code chapter 17A and section 441.37A.

“*Department*” means the Iowa department of revenue.

“*Local board of review*” means the board of review as defined by Iowa Code section 441.31.

“*Party*” means each person or entity named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

“*Presiding officer*” means the chairperson, member or members of the property assessment appeal board who preside over an appeal of proceedings before the property assessment appeal board.

“*Secretary*” means the secretary for the property assessment appeal board.

**71.21(6) Appeal and jurisdiction.** Notice of appeal confers jurisdiction for the board. The procedure for appeals and parameters for jurisdiction are as follows:

*a.* Jurisdiction is conferred upon the board by written notice of appeal given to the secretary. The written notice of appeal shall include a petition setting forth the basis of the appeal and the relief sought. The written notice of appeal shall be filed with the secretary within 20 calendar days after the date of adjournment of the local board of review or May 31, whichever is later. Appeals postmarked within this time period shall also be considered to have been timely filed. The appellant may appeal the action of the board of review relating to protests of assessment, valuation, or the application of an equalization order. No new grounds in addition to those set out in the protest to the local board of review can be pleaded, but additional evidence to sustain those grounds may be introduced. The appeal is a contested case.

*b.* Notice of appeal may be delivered in person, mailed by first-class mail, delivered to an established courier service for immediate delivery, or e-mailed to the board at [paab@iowa.gov](mailto:paab@iowa.gov).

*c.* For an appeal filed by e-mail to be timely, it must be received by the board by 11:59 p.m. on the last day for filing as established within the time period set forth in paragraph 71.21(6) “*a.*”

**71.21(7) Form of appeal.** The notice of appeal shall include:

- a.* The appellant’s name, mailing address, e-mail address, and telephone number;
- b.* The address of the property being appealed and its parcel number;
- c.* A copy of the letter of disposition by the local board of review;
- d.* A short and plain statement of the claim showing that the appellant is entitled to relief;

- e. The relief sought; and
- f. If the party is represented by an attorney or designated representative, the attorney or designated representative's name, mailing address, e-mail address, and telephone number.

**71.21(8) Scope of review.** The board shall determine anew all questions arising before the local board of review which relate to the liability of the property to assessment or the amount thereof. There shall be no presumption as to the correctness of the valuation of the assessment appealed from. The burden of proof is on the appellant; however, when the appellant offers competent evidence by at least two disinterested witnesses that the market value of the property is less than the market value determined by the assessor, the burden of proof thereafter shall be upon the party seeking to uphold the valuation.

**71.21(9) Notice to local board of review.** The secretary shall mail a copy of the appellant's written notice of appeal and petition to the local board of review whose decision is being appealed. Notice to all affected taxing districts shall be deemed to have been given when written notice is provided to the local board of review.

**71.21(10) Certification by local board of review.**

a. *Initial certification.* Within 21 days after notice of appeal is given, the local board of review shall certify to the board the original notice of assessment if any, the petition to the board of review, and a copy of the board of review's letter of disposition.

The local board of review shall also submit to the board in writing the name, address, telephone number, and e-mail address of the attorney representing the local board of review before the board. The local board of review may request additional time to certify a copy of its record to the board by submitting a request in writing or by e-mail to the board at [paab@iowa.gov](mailto:paab@iowa.gov).

b. *Full record certification prior to hearing.* At least 21 calendar days prior to the contested case hearing, the local board of review shall certify to the board the complete property record card for the subject property, the protest hearing minutes of the local board of review kept pursuant to Iowa Code chapter 21, and any information provided to or considered by the local board of review as part of the protest. The local board of review shall also send a copy of the full record to the opposing party.

**71.21(11) Docketing.** Appeals shall be assigned consecutive docket numbers. Records consisting of the case name and the corresponding docket number assigned to the case shall be maintained by the secretary. The records of each case shall also include each action and each act done, with the proper dates as follows:

- a. The title of the appeal including jurisdiction and parcel identification number;
- b. Brief statement of the grounds for the appeal and the relief sought;
- c. Postmarked date of the local board of review's letter of disposition;
- d. The manner and date/time of service of notice of appeal;
- e. Date of notice of hearing;
- f. Date of hearing; and
- g. The decision by the board, or other disposition of the case, and date thereof.

**71.21(12) Appearances.** Any party may appear and be heard on its own behalf, or by its designated representative. A designated representative shall file a notice of appearance with the board for each case in which the representative appears for a party. Filing a motion or pleadings on behalf of a party shall be equivalent to filing a notice of appearance. A designated representative who is not an attorney shall also file a power of attorney. When acting as a designated representative on behalf of a party, the designated representative acknowledges that the representative has read and will abide by the board's rules.

**71.21(13) Service and filing of papers.** After the notice of appeal and petition have been filed, all motions, pleadings, briefs, and other papers shall be served upon each of the parties of record contemporaneously with their filing with the board.

a. *Service on a party—how and when made.* The parties may agree to exchange the certified record, motions, pleadings, briefs, exhibits, and any other papers with each other electronically or via any other means. All documents are deemed served at the time they are delivered in person to the opposing party; delivered to an established courier service for immediate delivery; mailed by first-class mail, so long as there is proof of mailing; or sent electronically if the parties have agreed to service by such means.

*b. Filing with the board—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the board; delivered to an established courier service for immediate delivery; mailed by first-class mail, so long as there is proof of mailing; or sent by e-mail as permitted by the applicable subrules of this rule.

(1) For most filings in a docket made with the board, only an original is required.

(2) For exhibits and other documents to be introduced at hearing, three copies are required. For a nonoral submission, only one copy is required.

(3) The board or presiding officer may request additional copies.

*c. Proof of mailing.* Proof of mailing includes: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Property Assessment Appeal Board and to the names and addresses of the parties listed below by depositing the same in a (United States post office mailbox with correct postage properly affixed).

(Date)

(Signature)

**71.21(14) Motions.** No technical form for motions is required. All prehearing motions shall be in writing, shall be filed with the secretary and shall contain the reasons and grounds supporting the motion. The board shall act upon such motions as justice may require. Motions based on matters which do not appear of record shall be supported by affidavit. Any party may file a written response to a motion no later than 10 days from the date the motion is filed, unless the time period is extended or shortened by the board or presiding officer. The presiding officer may schedule oral argument on any motion.

*a.* Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least 10 days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by the board or presiding officer.

*b.* Motions for summary judgment. Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment must be filed and served no later than 90 days after service of the notice of appeal, unless good cause is shown for a later filing. Good cause may include, but is not limited to, information the moving party obtains through discovery. Any party resisting the motion shall file and serve a resistance within 20 days, unless otherwise ordered by the board or presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than 30 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to subrule 71.21(34).

**71.21(15) Authority of board to issue procedural orders.** The board may issue preliminary orders regarding procedural matters. The secretary shall mail copies of all procedural orders to the parties.

**71.21(16) Members participating.** Each appeal may be considered by one or more members of the board, and the chairperson of the board may assign members to consider appeals. If the appeal is considered by less than the full membership of the board, the determination made by such members shall be forwarded to the full board for approval, rejection, or modification. Decisions shall affirm, modify, or reverse the decision, order, or directive from which an appeal was made. In order for the decision to be valid, a majority of the board must concur on the decision on appeal.

**71.21(17) Notice of hearing.** Unless otherwise designated by the board, the hearing shall be held in the hearing room of the board. All hearings are open to the public. If a hearing is requested, the secretary shall mail a notice of hearing to the parties at least 30 days prior to the hearing. The parties may jointly waive the 30-day notice by following the provisions of subrule 71.21(18). The notice of hearing shall contain the following information:

- a. A statement of the date, time, and place of the hearing;
- b. A statement of legal authority and jurisdiction under which the hearing is to be held;
- c. A reference to the particular sections of the statutes and rules involved;
- d. That the parties may appear and present oral arguments;
- e. That the parties may submit evidence and briefs;
- f. That the hearing will be electronically recorded by the board;
- g. That a party may obtain a certified court reporter for the hearing at the party's own expense;
- h. That audio visual aids and equipment are to be provided by the party intending to use them;
- i. A statement that, upon submission of the appeal, the board will take the matter under advisement. A letter of disposition will be mailed to the parties; and
- j. A compliance notice required by the Americans with Disabilities Act (ADA).

**71.21(18) Waiver of 30-day notice.** The parties to the appeal may jointly waive the 30-day written notice requirement for a hearing. The waiver must be in writing or by e-mail to [paab@iowa.gov](mailto:paab@iowa.gov) and signed by the parties or their designated representatives. By waiving notice, the parties acknowledge they are ready to proceed with the hearing. The parties will be contacted when a hearing date is available but notice for said date may be less than 30 days. The parties will have the right to accept or reject the hearing date.

**71.21(19) Transcript of hearing.** All hearings shall be electronically recorded. Any party may provide a certified court reporter at the party's own expense. Any party may request a transcription of the hearing. The board reserves the right to impose a charge for copies and transcripts.

**71.21(20) Continuance.** Any hearing may be continued for "good cause." Requests for continuance prior to the hearing shall be in writing or by e-mail to [paab@iowa.gov](mailto:paab@iowa.gov) and promptly filed with the secretary of the board immediately upon "the cause" becoming known. An emergency oral continuance may be obtained from the board or presiding officer based on "good cause" and at the discretion of the board or presiding officer. In determining whether to grant a continuance, the board or presiding officer may consider:

- a. Prior continuances;
- b. The interests of all parties;
- c. The likelihood of informal settlement;
- d. The existence of an emergency;
- e. Any objection;
- f. Any applicable time requirements;
- g. The existence of a conflict in the schedules of counsel, parties, or witnesses;
- h. The timeliness of the request; and
- i. Other relevant factors, including the existence of a scheduling order.

**71.21(21) Telephone proceedings.** The board or presiding officer may conduct a telephone conference in which all parties have an opportunity to participate to resolve preliminary procedural motions. Other proceedings, including contested case hearings, may be held by telephone. The board will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when the location is chosen.

**71.21(22) Disqualification of board member.** A board member or members must, on their own motion or on a motion from a party in the proceeding, withdraw from participating in an appeal if there are circumstances that warrant disqualification.

a. A board member or members shall withdraw from participation in the making of any proposed or final decision in an appeal before the board if that member is involved in one of the following circumstances:

- (1) Has a personal bias or prejudice concerning a party or a representative of a party;
- (2) Has personally investigated, prosecuted, or advocated in connection with the appeal, the specific controversy underlying that appeal, or another pending factually related matter, or a pending factually related controversy that may culminate in an appeal involving the same parties;

(3) Is subject to the authority, direction, or discretion of any person who has personally investigated, prosecuted, or advocated in connection with that matter, the specific controversy underlying the appeal, or a pending factually related matter or controversy involving the same parties;

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

(5) Has a personal financial interest in the outcome of the appeal or any other significant personal interest that could be substantially affected by the outcome of the appeal;

(6) Has a spouse or relative within the third degree of relationship who:

1. Is a party to the appeal, or an officer, director or trustee of a party;

2. Is a lawyer in the appeal;

3. Is known to have an interest that could be substantially affected by the outcome of the appeal;

or

4. Is likely to be a material witness in the appeal; or

(7) Has any other legally sufficient cause to withdraw from participation in the decision making in that appeal.

*b. Motion for disqualification.* If a party asserts disqualification on any appropriate ground, including those listed in paragraph “a,” the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.11. The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification, but must establish the grounds by the introduction of evidence into the record.

If a majority of the board determines that disqualification is appropriate, the board member shall withdraw. If a majority of the board determines that withdrawal is not required, the board shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and a stay as provided under 701—Chapter 7.

*c. The term “personally investigated” means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term “personally investigated” does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person’s investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other functions of the board, including fact gathering for purposes other than investigation of the matter which culminates in an appeal. Factual information relevant to the merits of an appeal received by a person who later serves as presiding officer or a member of the board shall be disclosed if required by Iowa Code section 17A.11 and this rule.*

*d. Withdrawal.* In a situation where a presiding officer or any other board member knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

**71.21(23) Consolidation and severance.** The board or presiding officer may determine if consolidation or severance of issues or proceedings should be performed in order to efficiently resolve matters on appeal before the board.

*a. Consolidation.* The presiding officer may consolidate any or all matters at issue in two or more appeal proceedings where:

(1) The matters at issue involve common parties or common questions of fact or law;

(2) Consolidation would expedite and simplify consideration of the issues involved; and

(3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

*b. Severance.* The presiding officer may, for good cause shown, order any appeal proceedings or portions of the proceedings severed.

**71.21(24) Withdrawal.** An appellant may withdraw the appeal prior to the hearing. Such a withdrawal of an appeal must be in writing or by e-mail to [paab@iowa.gov](mailto:paab@iowa.gov) and signed by the appellant or the appellant’s designated representative. Unless otherwise provided, withdrawal shall be with

prejudice and the appellant shall not be able to refile the appeal. Within 20 days of the board granting a withdrawal of appeal, the appellant may make a motion to reopen the file and rescind the withdrawal based upon fraud, duress, undue influence, or mutual mistake.

**71.21(25) Prehearing conference.** An informal conference of parties may be ordered at the discretion of the board or presiding officer or at the request of any party for any appropriate purpose. Any agreement reached at the conference shall be made a part of the record in the manner directed by the board or presiding officer.

**71.21(26) Scheduling orders.**

*a. When required.* For appeals involving properties classified commercial or industrial and assessed at \$2 million or more, a scheduling order shall be sent to the parties to set dates for discovery, designation of witnesses, filing of motions, exchange of evidence, and a contested case hearing. In any other appeal, the parties may jointly enter a scheduling order or the board may, on its own motion, issue a scheduling order. The dates established in a scheduling order under this subrule shall supersede any dates set forth in other subrules of this rule.

*b. Prehearing conference.* A party may request a prehearing conference to resolve scheduling issues.

*c. Modification.* The parties may jointly agree to modify a scheduling order. If one party seeks to modify a scheduling order, the party must show good cause for the modification.

*d. Failure to comply.* A party that fails to comply with a scheduling order shall be required to show good cause for failing to comply with the order and that the other party is not substantially prejudiced. Failing to comply with a scheduling order may result in sanctions including, but not limited to, the exclusion of evidence or dismissal of the appeal.

**71.21(27) Hearing procedures.** A party to the appeal may request a hearing, or the appeal may proceed without a hearing. The local board of review may be present and participate at such hearing. Hearings may be conducted by the board or by one or more of its members.

*a. Authority of presiding officer.* The presiding officer presides at the hearing and may rule on motions, require briefs, issue a decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

*b. Representation.* Parties to the appeal have the right to participate or to be represented in all hearings. Any party may be represented by an attorney or by a designated representative.

*c. Participation in hearing.* The parties to the appeal have the right to introduce evidence relevant to the grounds set out in the protest to the local board of review. Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

*d. Decorum.* The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

*e. Conduct of the hearing.* The presiding officer shall conduct the hearing in the following manner:

(1) The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

(2) The parties shall be given an opportunity to present opening statements;

(3) The parties shall present their cases in the sequence determined by the presiding officer;

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

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

**71.21(28) Discovery.**

*a. Discovery procedure.* Discovery procedures applicable in civil actions under the Iowa Rules of Civil Procedure are available to parties in cases before the board. Unless lengthened or shortened by these rules, the board or presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

*b. Discovery motions.* Prior to filing any motion related to discovery, parties shall make a good-faith effort to resolve discovery disputes without the involvement of the board or presiding officer. Any motion related to discovery shall allege that the moving party has made a good-faith attempt to resolve the discovery issues involved with the opposing party. Opposing parties shall be given the opportunity to respond within 10 days of the filing of the motion unless the time is shortened by order of the board or presiding officer. The board or presiding officer may rule on the basis of the written motion and any response or may have a hearing or other proceedings on the motion.

*c. Admissibility of evidence.* Evidence obtained in discovery may be used in the case proceeding if that evidence would otherwise be admissible in that proceeding.

**71.21(29) Subpoenas.**

*a. Issuance of Subpoena for Witness.*

(1) An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In absence of good cause for permitting later action, a request for subpoena must be received at least 10 days before the scheduled hearing.

(2) Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

*b. Issuance of Subpoena for Production of Documents.*

(1) An agency subpoena shall be issued to a party on request. The request shall be in writing and include the name, address, and telephone number of the requesting party. In absence of good cause for permitting later action, a request for subpoena must be received at least 20 days before the scheduled hearing.

(2) Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas.

*c. Motion to quash or modify.* Upon motion, the board or presiding officer may quash or modify a subpoena for any lawful reason in accordance with the Iowa Rules of Civil Procedure.

**71.21(30) Evidence.**

*a. Admissibility.* The presiding officer shall rule on admissibility of evidence and may take official notice of facts in accordance with all applicable requirements of law.

*b. Stipulations.* Stipulation of facts by the parties is encouraged. The presiding officer may make a decision based on stipulated facts.

*c. Scope of admissible evidence.* Evidence in the proceeding shall be confined to the issues contained in the notice from the board prior to the hearing, unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. Admissible evidence is that which, in the opinion of the board, is determined to be material, relevant, or necessary for the making of a just decision. Irrelevant, immaterial or unduly repetitious evidence may be excluded. A finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Hearsay evidence is admissible. The rules of privilege apply in all proceedings before the board.

*d. Exhibits, exhibit and witness lists, and briefs.* The party seeking admission of an exhibit must provide an opposing party with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents to be used as evidence, exhibit lists, and a list of witnesses intended to be called at hearing shall be served on the opposing party at least 21 calendar days prior to the hearing, unless the time period is extended or shortened by the board or presiding officer or the parties have entered a scheduling order under subrule 71.21(26). All exhibits and briefs admitted into evidence shall be appropriately marked and be made part of the record. The appellant shall mark exhibits with consecutive numbers. The appellee shall mark exhibits with consecutive letters.

*e. Objections.* Any party may object to specific evidence or may request limits on the scope of examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which the objection is based. The objection, the ruling on the objection, and the reasons

for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

*f. Offers of proof.* Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

**71.21(31) Settlements.** Parties to a case may propose to settle all or some of the issues in the case at any time prior to the issuance of a final decision. A settlement of an appeal shall be jointly signed by the parties, or their designated representatives, and filed in writing or by an electronic copy e-mailed to [paab@iowa.gov](mailto:paab@iowa.gov). The board will not approve settlements unless the settlement is reasonable in light of the whole record, consistent with law, and in the public interest. Board adoption of a settlement constitutes the final decision of the board on issues addressed in the settlement.

**71.21(32) Records access.**

*a. Location of record.* A request for access to a record should be directed to the custodian.

*b. Office hours.* Open records shall be made available during all customary office hours, which are 8 a.m. to 4:30 p.m. Monday through Friday excluding holidays.

*c. Request for access.* Requests for access to open records may be made in writing, in person, by e-mail, or by telephone. Requests shall identify the particular records sought by name or description in order to facilitate the location of the record. Mail, e-mail, and telephone requests shall include the name, address, and telephone number of the person requesting the information. A person shall not be required to give a reason for requesting an open record.

*d. Response to requests.* Access to an open record shall be provided promptly upon request unless the size or nature of the request makes prompt access infeasible. If the size or nature of the request for access to an open record requires time for compliance, the custodian shall comply with the request as soon as feasible. Access to an open record may be delayed for one of the purposes authorized by Iowa Code section 22.8(4) or 22.10(4). The custodian shall promptly give notice to the requester of the reason for any delay in access to an open record and an estimate of the length of that delay and, upon request, shall promptly provide that notice to the requester in writing. The custodian of a record may deny access by members of the public to the record only on the grounds that such a denial is warranted under Iowa Code sections 22.8(4) and 22.10(4), or that it is a confidential record, or that its disclosure is prohibited by a court or board order. Access by members of the public to a confidential record is limited by law and, therefore, may generally be provided only in accordance with the applicable provisions of law.

*e. Security of record.* No person may, without permission from the secretary, search or remove any record from board files. Examination and copying of board records shall be supervised by the secretary. Records shall be protected from damage and disorganization.

*f. Copying.* A reasonable number of copies of an open record may be made in the board's office. If photocopy equipment is not available, the custodian shall permit examination of the record and shall arrange to have copies promptly made elsewhere.

*g. Fees.*

(1) When charged. The board may charge fees in connection with the examination or copying of records only if the fees are authorized by law. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

(2) Copying and postage costs. Price schedules for published materials and for photocopies of records supplied by the board are available from the custodian. Copies of records may be made by or for members of the public on board photocopy machines or from electronic storage systems at cost as determined and made available by the custodian. When the mailing of copies of records is requested, the actual costs of such mailing may also be charged to the requester.

(3) Supervisory fee. An hourly fee may be charged for actual board expenses in supervising the examination and copying of requested records when the supervision time required is in excess of one hour. The custodian shall provide the hourly fees to be charged for supervision of records during

examination and copying. That hourly fee shall not be in excess of the hourly wage of a board clerical employee who ordinarily would be appropriate and suitable to perform this supervisory function.

(4) Advance deposits.

1. When the estimated total fee chargeable under this paragraph exceeds \$25, the custodian may require a requester to make an advance payment to cover all or a part of the estimated fee.

2. When a requester has previously failed to pay a fee chargeable under this paragraph, the custodian may require advance payment of the full amount of any estimated fee before the custodian processes a new request from that requester.

**71.21(33) Motion to reopen records.** The board or presiding officer, on the board's or presiding officer's own motion or on the motion of a party, may reopen the record for the reception of further evidence. A motion to reopen the record may be made anytime prior to the issuance of a final decision.

**71.21(34) Rehearing and reconsideration.**

a. *Application for rehearing or reconsideration.* Any party to a case may file an application for rehearing or reconsideration of the final decision. The application for rehearing or reconsideration shall be filed within 20 days after the final decision in the case is issued.

b. *Contents of application.* Applications for rehearing or reconsideration shall specify the findings of fact and conclusions of law claimed to be erroneous, with a brief statement of the alleged grounds of error. Any application for rehearing or reconsideration asserting that evidence has arisen since the final order was issued as a ground for rehearing or reconsideration shall present the evidence by affidavit that includes an explanation of the competence of the person to sponsor the evidence and a brief description of the evidence sought to be included.

c. *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

d. *Requirements for objections to applications for rehearing or reconsideration.* An answer or objection to an application for rehearing or reconsideration must be filed within 14 days of the date the application was filed with the board, unless otherwise ordered by the board.

e. *Disposition.* Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

**71.21(35) Dismissal.** If a party fails to appear or participate in an appeal hearing after proper service of notice, the presiding officer may dismiss the appeal unless a continuance is granted for good cause. If an appeal is dismissed for failure to appear, the board shall have no jurisdiction to consider any subsequent appeal on the appellant's protest.

**71.21(36) Waivers.**

a. In response to a request, or on its own motion, the board may grant a waiver from a rule adopted by the board, in whole or in part, as applied to a specific set of circumstances, if the board finds, based on clear and convincing evidence, that:

(1) The application of the rule would pose an undue hardship on the person for whom the waiver is requested;

(2) The waiver would not prejudice the substantial rights of any person;

(3) The provisions of the rule subject to a petition for waiver are not specifically mandated by statute or another provision of law; and

(4) Substantially equal protection of public health, safety, and welfare will be afforded by means other than that prescribed in the rule for which the waiver is requested.

b. Persons requesting a waiver may submit their request in writing. The waiver request must state the relevant facts and reasons the requester believes will justify the waiver, if the reasons have not already been provided to the board in another pleading.

c. Grants or denials of waiver requests shall contain a statement of the facts and reasons upon which the decision is based. The board may condition the grant of the waiver on such reasonable

conditions as appropriate to achieve the objectives of the particular rule in question. The board may at any time cancel a waiver upon appropriate notice and opportunity for hearing.

**71.21(37) Appeals of board decisions.** A party may seek judicial review of a decision rendered by the board by filing a written notice of appeal with the clerk of the district court where the property is located within 20 days after the letter of disposition of the appeal by the board is mailed to the appellant. Iowa Code chapter 17A applies to judicial review of the board's final decision. The filing of the petition does not itself stay execution or enforcement of the board's final decision. The board may grant a stay on appropriate terms or other temporary remedies during the pendency of judicial review.

**71.21(38) Stays of agency actions.** Any party to a contested case proceeding may petition the board for a stay or other temporary remedies pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy. In determining whether to grant a stay, the board or presiding officer shall consider the factors listed in Iowa Code section 17A.19(5) "c." A stay may be vacated by the board upon application of any other party.

**71.21(39) Time requirements.** Time shall be computed as provided in Iowa Code section 4.1(34).

**71.21(40) Judgment of the board.** Nothing in this rule should be construed as prohibiting the exercise of honest judgment, as provided by law, by the board in matters pertaining to valuation and assessment of individual properties.

This rule is intended to implement Iowa Code sections 421.1, 421.1A as amended by 2013 Iowa Acts, Senate File 295, division VI, 421.2, 441.37A as amended by 2013 Iowa Acts, Senate File 295, division VI, 441.38 and 441.49 and chapter 17A.

[ARC 9877B, IAB 11/30/11, effective 1/4/12; ARC 1306C, IAB 2/5/14, effective 3/12/14; ARC 1496C, IAB 6/11/14, effective 5/20/14; ARC 2108C, IAB 8/19/15, effective 9/23/15]

#### **701—71.22(428,441) Assessors.**

**71.22(1) Conflict of interest.** An assessor shall not act as a private appraiser, or as a real estate broker or option agent in the jurisdiction in which serving as assessor (1976 O.A.G. 744).

##### **71.22(2) Listing of property.**

*a.* Forms. Assessors may design and use their own forms in lieu of those prescribed by the department of revenue provided that the forms contain all information contained on the prescribed form, are not substantially different from the prescribed form, and are approved by the director of revenue.

*b.* Assessment rolls. Assessment rolls must be prepared in duplicate for each property in a reassessment year as defined in Iowa Code section 428.4. However, the copy of the roll does not have to be issued to a taxpayer unless there is a change in the assessment or the taxpayer requests the issuance of the duplicate copy.

*c.* Whenever a date specified in Iowa Code chapter 441 falls on a Saturday, Sunday, or legal holiday, the action required to be completed on or before that date shall be considered to have been timely completed if performed on or before the following day which is not a Saturday, Sunday, or holiday.

*d.* Buildings erected or improvements made by a person other than the owner of the land on which they are located are to be assessed to the owner of the buildings or improvements. Unpaid taxes are a lien on the buildings or improvements and not a lien on the land on which they are located.

**71.22(3) Notice of protest.** If a protest or appeal is filed with the board of review, property assessment appeal board, or district court against the assessment of property valued at \$5 million or more, the assessor shall provide notice to the school district in which the property is located within ten days of the filing of the protest or the appeal, as applicable.

This rule is intended to implement Iowa Code chapter 428 and Iowa Code chapter 441 as amended by 2006 Iowa Acts, House File 2797.

**701—71.23(421,428,441) Valuation of multiresidential real estate.** Multiresidential real estate shall be assessed at a percent of its actual value as defined in Iowa Code section 441.21. In determining the actual value of multiresidential real estate, city and county assessors shall use the appraisal manual issued

by the department of revenue pursuant to Iowa Code section 421.17(18) as well as a locally conducted assessment/sales ratio study, an analysis of sales of comparable properties, and any other relevant data.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21 as amended by 2013 Iowa Acts, Senate File 295.

[ARC 1765C, IAB 12/10/14, effective 1/14/15]

**701—71.24(421,428,441) Valuation of dual classification property.** Real estate with a dual classification of commercial/multiresidential or industrial/multiresidential shall be assessed at its actual value as defined in Iowa Code section 441.21.

**71.24(1) Allocation of dual classification values.** The assessor shall value as a whole properties that have portions classified as multiresidential and portions classified as commercial or industrial using the methodology found in rule 701—71.23(421,428,441). After the assessor has assigned a value to the property, the value shall be allocated between the two classes of property based on the appropriate appraisal methodology. The assessor shall allocate land value proportionately by class.

**71.24(2) Notice of valuation.** The valuation notice issued pursuant to Iowa Code section 441.23 shall include a breakdown of the valuation by class for the current year and the prior year.

**71.24(3) Protest of assessment.** The valuation and assessment of property with a dual classification shall be considered one assessment, and any protest of assessment brought under Iowa Code section 441.37 or subsequent appeal must be made on the entire assessment. Protests of assessments on the valuation of only one class of property are not permitted. The board of review shall review the valuation in total as both classifications are subject to the board's adjustment in any review proceeding. Likewise, any tribunal or court reviewing the board's decision shall base its review on the entire assessment.

This rule is intended to implement Iowa Code sections 421.17, 428.4 and 441.21 as amended by 2013 Iowa Acts, Senate File 295.

[ARC 1765C, IAB 12/10/14, effective 1/14/15]

**701—71.25(441,443) Omitted assessments.**

**71.25(1) Property subject to omitted assessment.**

*a. Land and buildings.* An omitted assessment can be made only if land or buildings were not listed and assessed by the assessor. The failure to list and assess an entire building is an omission for which an omitted assessment can be made even if the land upon which the building is located has been listed and assessed. See *Okland v. Bilyeu*, 359 N.W.2d 412 (Iowa 1984). However, the failure to consider the value added as a result of an improvement made does not constitute an omission for which an omitted assessment can be made if the building or land to which the improvement was made has been listed and assessed.

*b. Previously exempt property.* Property which has been erroneously determined to be exempt from taxation may be restored to taxation by the making of an omitted assessment. See *Talley v. Brown*, 146 Iowa 360, 125 N.W. 243 (1910). An omitted assessment is also made to restore to taxation previously exempt property which ceases to be eligible for an exemption.

**71.25(2) Officials authorized to make an omitted assessment.**

*a. Local board of review.* A local board of review may make an omitted assessment of property during its regular session only if the property was not listed and assessed as of January 1 of the current assessment year. For example, during its regular session which begins May 1, 1986, a local board of review may make an omitted assessment only of property that was not assessed by the assessor as of January 1, 1986. During that session, the board of review could not make an omitted assessment for an assessment year prior to 1986.

*b. County auditor and local assessor.* The county auditor and local assessor may make an omitted assessment. However, no omitted assessment can be made by the county auditor or local assessor if taxes based on the assessment year in question have been paid or otherwise legally discharged. For example, if a tract of land was listed and assessed and taxes levied against that assessment have been paid or legally discharged, no omitted assessment can be made of a building located upon that tract of land even though the building was not listed and assessed at the time the land was listed and assessed. See *Okland v. Bilyeu*, 359 N.W.2d 412, 417 (Iowa 1984).

*c. County treasurer.* The county treasurer may make an omitted assessment within two years from the date the tax list which should have contained the assessment should have been delivered to the county treasurer. For example, for the 1999 assessment year, the tax list is to be delivered to the county treasurer on or before June 30, 2000. Thus, the county treasurer may make an omitted assessment for the 1999 assessment year at any time on or before June 30, 2002. The county treasurer may make an omitted assessment of a building even if taxes levied against the land upon which the building is located have been paid or legally discharged. See *Okland v. Bilyeu*, 359 N.W.2d 412, 417 (Iowa 1984). The county treasurer may not make an omitted assessment if the omitted property is no longer owned by the person who owned the property on January 1 of the year the original assessment should have been made.

*d. Department of revenue.* The department of revenue may make an omitted assessment of any property assessable by the department at any time within two years from the date the assessment should have been made.

This rule is intended to implement Iowa Code chapter 440 and sections 443.6 through 443.15 as amended by 1999 Iowa Acts, chapter 174.

[ARC 2657C, IAB 8/3/16, effective 9/7/16]

### **701—71.26(441) Assessor compliance.**

**71.26(1)** The assessor shall determine the value of real property in accordance with rules adopted by the department of revenue and in accordance with forms and guidelines contained in the Iowa Real Property Appraisal Manual prepared by the department. The assessor may use an alternative manual to value property if it is a unique type of property not covered in the manual prepared by the department.

**71.26(2)** If the department finds that an assessor is not in compliance with the rules of the department relating to valuation of property or has disregarded the forms and guidelines contained in the real property appraisal manual, the department shall notify the assessor and each member of the conference board for that assessing jurisdiction. The notice shall be mailed by restricted certified mail and shall specify the areas of noncompliance and the steps necessary to achieve compliance. The notice shall also inform the assessor and conference board that if compliance is not achieved, a penalty may be imposed.

**71.26(3)** The conference board shall respond to the department within 30 days of receipt of the notice of noncompliance. The conference board may respond to the notice by asserting that the assessor is in compliance with the rules, guidelines, and forms of the department or by informing the department that the conference board intends to submit a plan of action to achieve compliance. If the conference board responds to the notification by asserting that the assessor is in compliance, a hearing before the director of revenue shall be held on the matter within 60 days of receipt of the notice of noncompliance. The director's decision is subject to judicial review in accordance with Iowa Code chapter 17A. If it is agreed that the assessor is not in compliance, the conference board shall submit a plan of action within 60 days of receipt of the notice of noncompliance.

**71.26(4)** The plan of action shall contain a time frame under which compliance shall be achieved, which shall be no later than January 1 of the following assessment year. The plan shall contain the signature of the assessor and of the chairperson of the conference board. The department shall review the plan to determine whether the plan is sufficient to achieve compliance. Within 30 days of receipt of the plan, the department shall notify the assessor and the chairperson of the conference board that it has accepted the plan or that it is necessary to submit an amended plan of action.

**71.26(5)** By January 1 of the assessment year following the calendar year in which the plan of action was submitted to the department, the conference board shall submit a report to the department verifying that the plan was followed and compliance has been achieved. The department may conduct a field inspection to ensure that the assessor is in compliance. By January 31, the department shall notify the assessor and the conference board, by restricted certified mail, either that compliance has been achieved or that the assessor remains in noncompliance. If the department determines that the assessor remains in noncompliance, the department shall take steps to withhold up to 5 percent of the reimbursement payment authorized in Iowa Code section 425.1 until the department determines that the assessor is in compliance.

**71.26(6)** If the conference board disputes the determination of the department, the chairperson of the conference board may appeal the determination to the director of revenue under 701—Chapter 7.

This rule is intended to implement Iowa Code section 441.21.

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<sup>1</sup> Amendments nullified by 2000 Iowa Acts, SJR 2005, editorially removed IAC Supplement 7/12/00 pursuant to Iowa Code section 17A.6(3).

CHAPTER 405  
SALVAGE

**761—405.1(321) Applicability.** This chapter supplements 761—Chapter 400. It applies to salvage motor vehicles and foreign motor vehicles brought into Iowa that are or were salvage, rebuilt or junked. This chapter applies only to motor vehicles subject to registration except that owners of vehicles with a gross vehicle weight rating of 30,000 pounds or more are not required to submit a salvage theft examination certificate to convert a salvage title to a regular title.

**761—405.2(321) Definitions.**

“*Authorized vehicle recycler*” means a person licensed under Iowa Code chapter 321H.

“*Iowa salvage title*” means an Iowa salvage certificate of title.

“*Junking certificate*” means an Iowa junking certificate.

“*New motor vehicle dealer*” means a dealer licensed under Iowa Code chapter 322 to sell new motor vehicles.

“*Previous owner*” as used in Iowa Code section 321.24 means the last titled owner.

“*Regular foreign title*” means a certificate of title issued by a foreign jurisdiction that allows the vehicle to be driven or moved upon a highway.

“*Regular Iowa title*” means an Iowa certificate of title that is not a salvage title.

**761—405.3(321) Salvage title.**

**405.3(1) *Face of title.*** Except for vehicles with a gross vehicle weight rating of 30,000 pounds or more, the following shall be stamped in red ink on the face of an Iowa salvage title: SALVAGE—CANNOT BE REGISTERED WITHOUT A SALVAGE THEFT EXAMINATION CERTIFICATE OR AN INSURER’S CERTIFICATION.

**405.3(2) *Assignment.*** An Iowa or a foreign salvage title may be assigned only as provided in Iowa Code subsection 321.52(4). Except as provided in subrule 405.3(3), the transferee to whom an Iowa or a foreign salvage title is assigned shall apply for a new Iowa salvage title within 30 days after the date of assignment unless, within this time period, application for a regular title is made or a junking certificate is obtained.

**405.3(3) *Reassignment.*** Reassignment of an Iowa or a foreign salvage title by a licensed new motor vehicle dealer or by an authorized vehicle recycler is allowed, and the dealer or recycler is not required to obtain a new Iowa salvage title upon assignment of an Iowa or a foreign salvage title to the dealer or recycler, provided a vacant reassignment space is available on the title. If all reassignment spaces on an Iowa or a foreign salvage title assigned to the dealer or recycler have been used, the dealer or recycler shall obtain a new Iowa salvage title in accordance with subrule 405.3(2). The following shall be stamped on the dealer reassignment portion of Iowa salvage titles: ONLY NEW MOTOR VEHICLE DEALERS OR RECYCLERS MAY REASSIGN THIS TITLE.

**405.3(4) *Registration fees.***

*a.* An Iowa salvage title may be obtained without payment of the current registration fees or any delinquent registration fees or registration penalties. If the registration fees are delinquent at the time of issuance of an Iowa salvage title, no additional penalty shall accrue after issuance.

*b.* Any registration fees or registration penalties due at the time of issuance of an Iowa salvage title, together with the current registration fees if not already paid, shall be paid upon issuance of a regular title. However, a dealer is not required to pay current registration fees to obtain a regular title for a vehicle held for resale or trade. See rule 761—400.27(321,322) for any exceptions.

**405.3(5) *Plates.*** Registration plates shall not be assigned when an Iowa salvage title is issued.  
[ARC 9048B, IAB 9/8/10, effective 10/13/10]

**761—405.4 and 405.5** Reserved.

**761—405.6(321) Iowa salvage title required.**

**405.6(1) *Wrecked or salvage vehicle.*** A vehicle rebuilder or a person engaged in the business of buying, selling, or exchanging vehicles of a type required to be registered in this state upon acquisition of a wrecked or salvage vehicle shall obtain an Iowa salvage title or a junking certificate for the vehicle except as provided in subrule 405.3(3).

*a.* A wrecked or salvage vehicle is a damaged motor vehicle that:

- (1) Has repair costs exceeding 50 percent of its fair market value before it became damaged, and
- (2) Had a fair market value of \$500 or more before it became damaged.

*b.* Fair market value is the average retail value found in the National Automobile Dealers Association (NADA) Official Used Car Guide. If there is no value available, the office of vehicle services shall determine the fair market value upon request. The address is: Office of Vehicle Services, Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278.

**405.6(2) *Insurer.*** An insurer upon acquisition of a motor vehicle as a result of a settlement with the motor vehicle owner arising out of damage to or unrecovered theft of the motor vehicle shall obtain an Iowa salvage title for the motor vehicle.

**405.6(3) *Application.*** Application for an Iowa salvage title shall be made within 30 days after the date of assignment to the transferee.

**761—405.7(321) Converting salvage title to regular title.**

**405.7(1) *General application procedure.***

*a.* To obtain a regular title, the owner in whose name the salvage title is issued or assigned shall pay the appropriate fees and surrender the following when applying for the regular title:

- (1) The salvage title.
- (2) The salvage theft examination certificate issued in the applicant's name. However, a salvage theft examination certificate is not required if the vehicle has a gross vehicle weight rating of 30,000 pounds or more. See rule 761—405.15(321) for salvage theft examination.

*b.* A regular title and registration receipt issued pursuant to this subrule shall bear the designation "prior salvage."

**405.7(2) *Insurer's certification.*** An insurer who has title pursuant to Iowa Code subsection 321.52(4) may submit an insurer's certification in lieu of a salvage theft examination certificate.

*a.* The insurer's certification shall:

- (1) Include the name and address of the insurance company and the VIN, year and make of the salvage titled vehicle.
- (2) Include a statement by the insurer certifying that the retail cost of repairs for all damages to the vehicle is less than \$3000.
- (3) Be dated and signed by an authorized representative of the insurer.

*b.* The insurer's certification is not transferable if the insurer assigns the salvage title to another person.

*c.* A regular title and registration receipt issued pursuant to this subrule is not required to have a designation of "prior salvage." However, the title and registration receipt shall bear any designation to be carried forward, as explained in rule 761—405.10(321).

**761—405.8(321) Foreign vehicles.**

**405.8(1) *Definitions.*** The following definitions apply to foreign titles and the designations shown on them.

*"Junked"* means the vehicle is damaged or dismantled and is prohibited from ever again being driven upon a highway.

*"Rebuilt"* means the vehicle had been designated as salvage but had the designation removed, and the vehicle is permitted to be driven and moved upon a highway. Also, a designation of "salvage" on a regular foreign title means that the vehicle is rebuilt.

*"Salvage"* means the vehicle is damaged and shall not be registered to be driven or moved upon a highway until it is no longer designated as salvage.

**405.8(2) Foreign title with rebuilt designation.** If the prior title for a vehicle is a foreign title indicating that the vehicle was rebuilt, the Iowa title and registration receipt issued from the foreign title shall contain the designation of “rebuilt” together with the two-letter abbreviation of the name of the jurisdiction that issued the foreign title.

EXCEPTION: If a records check indicates that the vehicle was previously titled in Iowa with a designation of “prior salvage,” the prior salvage designation takes precedence and shall be carried forward to the Iowa title and registration receipt.

**405.8(3) Converting foreign salvage title to Iowa title.** If the prior title for a vehicle is a foreign title indicating that the vehicle is salvage, a regular Iowa title shall not be issued for the vehicle unless an Iowa salvage title is first issued. After an Iowa salvage title is issued for the vehicle, a regular Iowa title may be obtained pursuant to rule 761—405.7(321).

EXCEPTION 1: As provided in subrule 405.3(3), a licensed new motor vehicle dealer or an authorized vehicle recycler is not required to obtain an Iowa salvage title upon assignment of a foreign salvage title to the dealer or recycler, provided a vacant reassignment space is available on the title.

EXCEPTION 2: As provided in Iowa Code section 321.24(5), an owner who surrenders a foreign salvage title and obtains a salvage theft examination pursuant to Iowa Code section 321.52(4) “b” within 30 days of the date the owner was assigned the foreign salvage title is not required to first obtain an Iowa salvage title.

**405.8(4) Salvage titled vehicle leaving and reentering Iowa.** If a vehicle leaves Iowa with an Iowa salvage title and reenters Iowa with a regular foreign title, a regular Iowa title may be issued without a salvage theft examination. The regular Iowa title and registration receipt issued from the foreign title will be designated:

- a. “Prior salvage” if the foreign title does not indicate that the vehicle was rebuilt.
- b. As specified in subrule 405.8(2) if the foreign title indicates that the vehicle was rebuilt.

**405.8(5) Designation carried forward.** If a vehicle leaves Iowa with a regular Iowa title and reenters Iowa with a regular foreign title, the foreign title does not indicate that the vehicle was rebuilt and a records check indicates that the vehicle had a designation listed in paragraphs 405.10(1) “a” to “e,” that designation shall be carried forward to the Iowa title and registration receipt issued from the foreign title.

**405.8(6) Foreign title with flood, fire, vandalism or theft designation.** If the prior title for a vehicle is a foreign title indicating that the vehicle was damaged by flood, fire or vandalism or is a recovered stolen vehicle and another designation is not required under this rule or rule 761—405.10(321), the Iowa title and registration receipt issued from the foreign title shall contain, as applicable, the designation of “flood,” “fire,” “vandalism” or “theft.”

**405.8(7) Foreign title with a lemon buy-back designation.** See rule 761—405.10(321).

**405.8(8) Junking certificate.**

a. An Iowa junking certificate shall be issued if:

- (1) The prior title for a vehicle is a foreign title indicating that the vehicle was junked, regardless of any other designation on the title.
- (2) A records check for a vehicle with a foreign title indicates that the vehicle had previously been issued an Iowa junking certificate.

b. This subrule applies to all vehicles subject to Iowa titling laws.

[ARC 3108C, IAB 6/7/17, effective 7/12/17]

**761—405.9(321) Records check.** Before a title is issued in Iowa, a computer records check may be made. The purpose of the records check is to:

**405.9(1)** Determine if the vehicle ever had or should have had a “prior salvage,” “rebuilt,” “damage over 50 percent,” “flood,” “fire,” “vandalism,” “theft,” “lemon buy-back,” or equivalent designation(s) on a previous title. If such a designation is or should have been on a previous title, the Iowa title to be issued shall contain the designation required by this chapter.

**405.9(2)** Determine if the vehicle is or was ever a wrecked or salvage vehicle as defined in Iowa Code section 321.52. If a vehicle is a wrecked or salvage vehicle, an Iowa salvage title shall be issued.

If the vehicle was a wrecked or salvage vehicle, the Iowa title to be issued shall contain the appropriate designation required by this chapter.

**405.9(3)** Determine if the vehicle should have been or was ever junked as defined in subrule 405.8(1). If the vehicle should have been or was ever junked, an Iowa junking certificate shall be issued.

**761—405.10(321) Designations.**

**405.10(1)** The following designations for a vehicle shall be used on Iowa titles and registrations receipts and shall be carried forward to all subsequent Iowa titles and registration receipts issued for the vehicle, unless otherwise specified:

*a.* Prior salvage. This designation supersedes other designations. When a designation of “prior salvage” is required pursuant to rule 761—405.7(321), it replaces any other designation.

*b.* Rebuilt together with a two-letter abbreviation of the name of a foreign jurisdiction. When this designation is required pursuant to subrule 405.8(2), it replaces any other designation except a “prior salvage” designation.

*c.* Damage over 50 percent. As required by Iowa Code section 321.69, a designation of “damage over 50 percent” shall be used when the seller or the buyer indicates on the damage disclosure statement that the person has knowledge that the motor vehicle sustained damage for which the cost of the repair exceeded 50 percent of the fair market value before the motor vehicle became damaged. This designation replaces any other designation except “prior salvage” or “rebuilt.”

*d.* Flood, fire, vandalism or theft. The most recent designation applies. Unless superseded by a “prior salvage,” “rebuilt,” or “damage over 50 percent” designation, a designation of “flood,” “fire,” “vandalism” or “theft” shall be used as specified in subrule 405.8(6) and supersedes a “lemon buy-back” designation.

*e.* Lemon buy-back. Unless superseded by a “prior salvage,” “rebuilt,” “damage over 50 percent,” “flood,” “fire,” “vandalism” or “theft” designation, a designation of “lemon buy-back” shall be used:

(1) When a certificate of title is issued to a manufacturer of a motor vehicle pursuant to Iowa Code section 322G.12.

(2) When the prior certificate of title for a motor vehicle is a foreign title indicating that the vehicle was returned to the manufacturer pursuant to Iowa Code chapter 322G or a law of another state similar to Iowa Code chapter 322G.

**405.10(2)** An Iowa salvage title will be issued with a designation of “salvage” unless a designation listed in subrule 405.10(1) is required.

**761—405.11 to 405.14** Reserved.

**761—405.15(321) Salvage theft examination.** Except for foreign salvage titles assigned to licensed new motor vehicle dealers or authorized vehicle recyclers, a salvage theft examination may only be conducted on a vehicle with an Iowa salvage title. The vehicle shall not be examined until it has been completely repaired, except for minor body parts such as trim, body marking or paint.

**405.15(1) General procedure.**

*a.* A salvage theft examination shall be conducted by a peace officer who has been specially certified, and recertified when required, by the Iowa law enforcement academy to perform salvage theft examinations.

(1) To arrange for a salvage theft examination by an investigator from the department of transportation, the applicant shall contact the office of motor vehicle enforcement. The address is: Office of Motor Vehicle Enforcement, Department of Transportation, P.O. Box 10473, Des Moines, Iowa 50306-0473.

(2) To arrange for a salvage theft examination by any other authorized peace officer, the applicant shall contact the local law enforcement agency for instructions.

*b.* The owner of the vehicle may drive the vehicle to and from the examination location by completing the permit section located on the affidavit of salvage vehicle repairs form.

(1) The affidavit shall state that the vehicle is reasonably safe for operation and shall list the parts that have been replaced on the vehicle. The affidavit must be signed by the owner or the owner's authorized agent.

(2) To be valid, the permit to drive the vehicle to and from the examination location must be signed by the owner or owner's authorized agent.

*c.* The owner of the vehicle must be present for the examination or certify, on the affidavit of salvage vehicle repairs, the name of the person who will be representing the owner at the examination.

*d.* The owner or owner's representative, when appearing with the vehicle for the examination, shall submit to the peace officer for review the salvage title or a certified copy of the salvage title; the affidavit of salvage vehicle repairs; and, pursuant to subrules 405.15(3) and 405.15(4), bills of sale for all component parts replaced.

*e.* The owner or owner's representative shall electronically make payment for the salvage theft examination at the time the examination is scheduled, and the fee collected shall be distributed in accordance with Iowa Code section 321.52(4) "c."

*f.* If the vehicle passes the salvage theft examination, the peace officer shall complete a salvage theft examination certificate on a form prescribed by the department. The form shall be distributed as follows:

(1) The white copy shall be mailed with the \$10 to the office of vehicle services at the Des Moines address.

(2) The canary copy shall be given to the owner or the owner's representative. This copy must be surrendered when applying for title.

(3) The pink copy shall be retained by the examining officer for three years for verification purposes.

*g.* Reserved.

*h.* The peace officer shall return the salvage title or the certified copy of the salvage title, the permit to drive section, if applicable, on the affidavit of salvage vehicle repairs, and the bills of sale to the owner or the owner's representative.

**405.15(2) *Affidavit of salvage vehicle repairs form and salvage theft examination certificate.***

*a.* The affidavit of salvage vehicle repairs form may be obtained from the office of motor vehicle enforcement at the Des Moines address, any local enforcement agency with officers certified to conduct salvage theft examinations or any local county treasurer's office.

*b.* The salvage theft examination certificate shall be a controlled form and furnished by the department.

*c.* The owner of the vehicle may obtain a duplicate copy of the salvage theft examination certificate upon written request to the issuing officer or agency.

*d.* The salvage theft examination certificate is not transferable.

**405.15(3) *Bill of sale.*** A bill of sale is a document from the seller to the buyer containing the name, address and telephone number of the seller, a description and identification number of the component part and, if applicable, the vehicle identification number (VIN) of the vehicle from which it was removed.

**405.15(4) *Component part.*** For salvage theft examinations, the definition of component part as found in Iowa Code section 321.1 shall apply.

[ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 3108C, IAB 6/7/17, effective 7/12/17]

These rules are intended to implement Iowa Code sections 321.24, 321.52, 321.69 and 322G.12.

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[Filed ARC 3108C (Notice ARC 2989C, IAB 3/29/17), IAB 6/7/17, effective 7/12/17]

CHAPTER 450  
MOTOR VEHICLE EQUIPMENT

[Appeared as Ch 1, Department of Public Safety, 1973 IDR; amended January 1975 IDR Supplement]  
[Prior to 6/3/87, Transportation Department[820]—(07,E)Ch 1]

**761—450.1(321) Safety standards for motor vehicle equipment.** Rescinded IAB 7/10/02, effective 8/14/02.

**761—450.2(321) Equipment requirements for specially constructed, reconstructed, street rod, and replica motor vehicles, other than motorcycles and motorized bicycles.** The following standards are minimum requirements for constructing and equipping specially constructed, reconstructed, street rod, and replica motor vehicles other than motorcycles and motorized bicycles.

**450.2(1) Definitions.** The definitions in Iowa Code section 321.1 and rule 761—400.16(321) are hereby made part of this chapter.

**450.2(2) Application.** As outlined in rule 761—400.16(321), the applicant shall submit the required application forms and exhibits to the county treasurer. The vehicle and ownership documents shall be examined by the department. If the department determines that the motor vehicle complies with this rule, that the integral parts and components have been identified as to ownership, and that the application forms have been completed properly, the department shall assign an identification number to the vehicle and certify that the motor vehicle is eligible for titling and registration. If the frame or unibody specified on an application for a specially constructed, reconstructed, street rod, or replica motor vehicle is designated “not for highway use,” the application shall not be approved. The exchange of compatible body parts does not constitute a specially constructed, reconstructed, street rod, or replica motor vehicle. The removal, addition, or substitution of reconstructed motor vehicle parts modifies the vehicle’s external appearance so that it does not reflect the original make or manufacturer model for that model.

**450.2(3) Defroster and defogging device.** Every closed motor vehicle shall be equipped with a device capable of defogging or defrosting the windshield area.

**450.2(4) Door latches.** Every motor vehicle that is equipped with doors leading directly into a compartment that contains one or more seating accommodations shall be equipped with mechanically actuated door latches which firmly and automatically secure the door when pushed closed and which allow each door to be opened from the inside by the actuation of a convenient lever, handle or other nonelectric device. Interior handles must be visible.

**450.2(5) Floor pan.** Every motor vehicle shall be equipped with a floor pan under the entire passenger-carrying compartment. The floor pan shall support the weight of the number of occupants that the vehicle is designed to carry. The floor pan shall be so constructed that it prevents the entry of exhaust fumes.

**450.2(6) Glazing.**

*a. Windshields.* Every motor vehicle shall be equipped with a laminated safety glass windshield that complies with and bears the approval marking of the American National Standards Institute (ANSI) Z 26.1 Standard. The windshield shall be in such a position that it affords continuous horizontal frontal protection to the driver and front seat occupants. The minimum vertical height of the unobstructed windshield glass shall be 6 inches. This paragraph does not preclude the use of a windshield that can be folded down to a horizontal position, provided that the windshield can be firmly fastened in both the vertical and horizontal positions.

*b. Side and rear glass.* Side and rear glass is not required in motor vehicles. If present, however, this glass must be either laminated or tempered safety glass bearing the approval of the ANSI Z 26.1 Standard.

**450.2(7) Driver visibility.** Each motor vehicle shall provide the driver with a minimum outward horizontal vision capability of 90 degrees each side of a vertical plane passing through the fore and aft centerline of the vehicle. This plane of vision may be interrupted by window framing and windshield door support posts not exceeding 4 inches in width at each side location.

**450.2(8) Hood latches.** If a motor vehicle is equipped with a front-opening hood, that hood shall be equipped with a primary and secondary latching system to hold the hood in a closed position.

**450.2(9) Instruments and controls.** Each motor vehicle shall be equipped with:

- a. An operating speedometer calibrated to indicate “miles per hour.”
- b. An operating odometer calibrated to indicate “total miles driven.”
- c. A steering wheel circular or nearly circular in shape, having an outside diameter of not less than 13 inches.
- d. An accelerator control system that returns the engine throttle to an idle position automatically when the driver removes the actuating force from the accelerator control.

**450.2(10) Brakes.**

a. Every motor vehicle shall be equipped with brakes acting upon all wheels. The service brakes must be capable of meeting or exceeding the stopping requirements of Iowa Code section 321.431. If necessary, the braking system may be tested by a road test on a public roadway by an officer of the motor vehicle division of the department.

b. Every motor vehicle shall be equipped with a parking brake operating on at least two wheels applied with required effectiveness despite exhaustion of any source of energy or leakage of any kind in the service brake system. The parking brake shall meet the requirements of Iowa Code sections 321.430 and 321.431.

**450.2(11) Rearview mirror.** Every motor vehicle shall be equipped with two rearview mirrors, each having substantial unit magnification. One shall be mounted on the inside of the vehicle in such a position that it affords the driver a clear view to the rear. The other shall be mounted on the outside of the vehicle on the driver’s side in such a position that it affords the driver a clear view to the rear. When an inside mirror does not give a clear view to the rear, a right-hand outside mirror shall be required in lieu thereof. The mirror mounting shall provide a stable support for the mirror, and shall provide for mirror adjustment by tilting in both horizontal and vertical directions. Each mirror shall have a minimum of 10 square inches of reflective surface.

**450.2(12) Seat belts.** Every motor vehicle shall be equipped with at least a Type I (lap belt) seat belt for the driver and each passenger seating position. The belts at each location shall comply with DOT Motor Vehicle Safety Standard No. 209, and shall be firmly anchored to the vehicle body.

**450.2(13) Seating.** All bench-type and individual seats in motor vehicles shall be firmly anchored to structural components or body parts.

**450.2(14) Fenders and mud flaps.** Rescinded IAB 9/8/10, effective 10/13/10.

**450.2(15) Bumpers.** Rescinded IAB 9/8/10, effective 10/13/10.

**450.2(16) Exhaust system.** Every motor vehicle shall have an exhaust system meeting the following requirements:

a. The system shall be free of leaks, including the exhaust manifold (or headers), piping forward of the muffler, the muffler(s), and tail piping.

b. Exhaust fumes shall be emitted to the extremity of the vehicle, behind the rear wheels, or to the extremity of the vehicle within 6 inches in front of the rear wheels. Exhaust fumes from trucks, other than enclosed vans, may be emitted to the rear of that part of the vehicle designed for and normally used for carrying the driver and passengers.

c. Each exhaust system must be equipped with a muffler that prevents excessive noise.

d. No part of the exhaust system shall pass through any area of the vehicle that is used as a passenger-carrying compartment, and shall be so constructed that persons entering the vehicle cannot make contact with the exhaust system.

e. All exterior side exhaust pipes must be fully shielded and any vertical truck exhaust stacks shall be shielded to the top of the cab.

**450.2(17) Frame.** Every vehicle shall be equipped with a frame consisting of wall box tubing, round tubing, wall channel or unitized construction capable of supporting the vehicle, its load and the torque produced by the power source.

**450.2(18) Fuel system.** Every motor vehicle shall have a fuel system in which all components are securely fastened with fasteners designed for this purpose, including the tank, tubing, hoses, clamps, etc. The filler from the system shall be located in a position not within the passenger-carrying

compartment, and shall be capped. The system shall be leakproof, and fuel lines shall be positioned so as not to come in contact with high temperature surfaces or moving parts.

**450.2(19) *Steering and suspension.***

a. Every motor vehicle shall have no parts extending below the wheel rims in their lowest position, except for tires and electrical grounding devices designed for this purpose.

b. The steering system shall remain unobstructed when turned from lock to lock.

c. The steering wheel shall have no less than two turns and no more than six turns when turning the road wheels from lock to lock.

d. While in a sharp turn at a speed between 5 and 15 MPH, release of the steering wheel shall result in a distinct tendency for the vehicle to increase its turning radius.

e. No motor vehicle shall be constructed so that the weight on any axle is less than 20 percent of the gross weight of the vehicle and load.

f. Motor vehicles shall be equipped with a damping device at each wheel location providing a minimum relative motion between the unsprung axle and the chassis of plus or minus 2 inches.

g. When each corner of the vehicle is depressed and released the damping device shall stop vertical body motion within two cycles.

h. There shall be no heating or welding on coil springs, leaf springs, or torsion bars.

**450.2(20) *Tires.*** Tires shall comply with Iowa Code section 321.440. Each tire shall have a load-bearing capacity in keeping with the size and weight of the vehicle.

**450.2(21) *Lighting and electrical system.*** Each motor vehicle shall be equipped with approved lighting devices in sufficient number, type, and locations to meet the requirements of Iowa Code sections 321.384 to 321.423, including headlamps, rear lamps, license plate lamp, rear reflectors, parking lamps, stop lamps, turn signals, and high-low beam indicator. In addition, every motor vehicle shall be equipped with:

a. A driver-controlled switch capable of selecting high and low beams (dimmer switch).

b. A motor vehicle more than 40 inches in width shall be equipped with turn signal lamps and have a manually operated switch controlled by the driver that shall cause the turn signal lamps to function. This switch shall be self-canceling.

c. A horn that shall be electrically actuated, and shall emit a sound clearly audible from a distance of 200 feet. The horn shall be actuated with a switch easily accessible to the driver when operating the vehicle.

d. All wiring shall be done in an orderly and workmanlike fashion, with no wiring in contact with high temperature surfaces or moving parts.

e. Headlamps shall be in a plane that is perpendicular to a vertical plane through the longitudinal centerline of the vehicle. The headlamps shall be mounted not less than 24 inches, nor more than 54 inches, above the road surface when measured to the headlamp center.

f. A tail lamp or lamps shall be mounted on the rear of the motor vehicle or vehicle, exhibiting a red light plainly visible from a distance of 500 feet to the rear. The tail lamp or lamps shall be mounted not less than 15 inches, nor more than 72 inches, above the roadway.

g. All original lamps and lighting equipment provided on the motor vehicle by the manufacturer shall be maintained in working condition or shall be replaced with equivalent equipment.

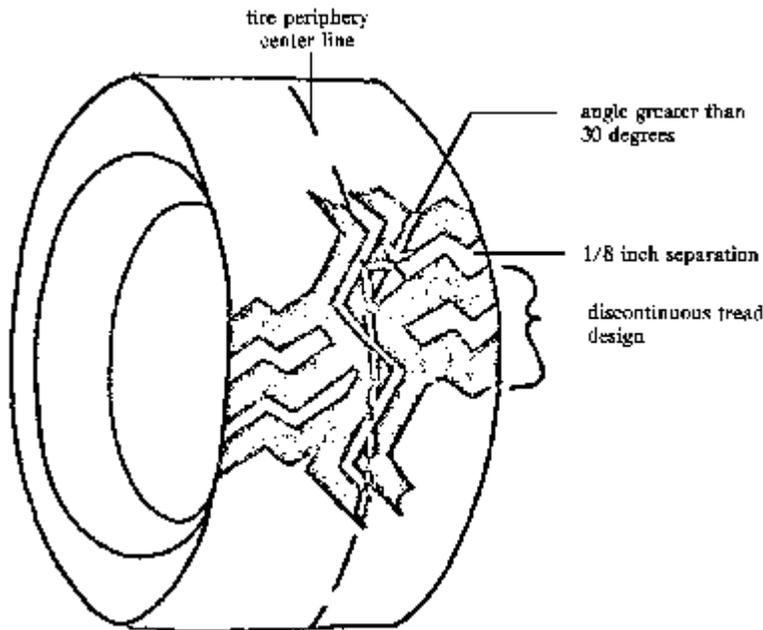
This rule is intended to implement Iowa Code section 321.23.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

**761—450.3(321) Mud and snow tire.** A mud and snow tire is a tire that is designed to provide additional starting, stopping and driving traction in mud and snow. The tread design shall have ribs, lugs, blocks or knobs which are discontinuous and have a minimum separation of one-eighth of an inch between the ribs, lugs, blocks or knobs. A substantial portion of the rib, lug, block or knob edge in the design of the tread shall be at an angle greater than 30 degrees to the periphery centerline. A mud and snow tire must comply with the tire restrictions expressed in Iowa Code section 321.440.

A tire labeled “Mud and Snow” or any contraction using the letters “M” and “S,” such as “MS,” “M/S,” “M-S” or “M & S” shall be considered a mud and snow tire.

A representation of the distinguishing features of a mud and snow tire is pictured below.



This rule is intended to implement Iowa Code subsection 321.236(12).

**761—450.4(321) Minimum requirements for constructing and equipping specially constructed or reconstructed motorcycles or motorized bicycles.** Minimum requirements for constructing and equipping specially constructed or reconstructed motorcycles or motorized bicycles as defined in Iowa Code section 321.1 are as follows:

**450.4(1) Application.** As outlined in rule 761—400.16(321), the applicant shall submit the required application forms and exhibits to the county treasurer. The vehicle and ownership documents shall be examined by the department. If the department determines that the motor vehicle complies with this rule, that the integral parts and components have been identified as to ownership, and that the application forms have been completed properly, the department shall assign an identification number to the vehicle and certify that the motor vehicle is eligible for titling and registration. If the frame specified on an application for a specially constructed or reconstructed motorcycle or motorized bicycle is designated “not for highway use,” the application shall not be approved. The exchange of compatible body parts does not constitute a specially constructed or reconstructed motorcycle or motorized bicycle. The removal, addition, or substitution of a reconstructed motorcycle or motorized bicycle part modifies the vehicle’s external appearance so that it does not reflect the original make or manufacturer model. EXEMPTION: The conversion of a manufactured motorcycle from two wheels to three-wheel operation by the addition or substitution of a bolt-on conversion kit shall not constitute a reconstructed motorcycle.

**450.4(2) Upgrade pulls—minimum speed.** No motor vehicle or combination of vehicles which cannot proceed up a 3 percent grade, on dry concrete pavement, at a minimum speed of 20 miles per hour, shall be operated upon the highways of this state.

**450.4(3) Engine.** Rescinded IAB 9/8/10, effective 10/13/10.

**450.4(4) Frame/chassis.** A motorcycle or motorized bicycle frame/chassis, including the suspension components and engine mountings, shall be of sufficient strength, capable of supporting the combined weight of all vehicle components and riders for which the vehicle was designed.

**450.4(5) Front end assembly.**

a. *Trail (extended fork measured in inches)*. No reconstructed or specially constructed motorcycle or motorized bicycle shall have the front fork so extended as to place the center of the front wheel axle farther than 36 inches from a vertical plane through the steering axis.

b. *Rake (extended fork measured in degrees)*. No reconstructed or specially constructed motorcycle or motorized bicycle shall have the front fork so extended as to exceed a 45-degree angle between the fork assembly and a vertical plane through the steering axis.

c. *Extensions*. No reconstructed or specially constructed motorcycle or motorized bicycle shall be equipped with extension slugs. However, one-piece extension tubes and springer units, if approved, are acceptable.

d. *Wheelbase*. No reconstructed or specially constructed motorcycle or motorized bicycle shall have an overall wheelbase, measured from the center of the front axle to the center of the rear axle, of less than 40 inches.

e. *Motorcycle front end geometry*. A representation of the front end geometry of a motorcycle is depicted in the Appendix to this rule.

**450.4(6) Brakes**. Every motorcycle and motorized bicycle shall be equipped with at least a rear brake. If the vehicle is also equipped with a front brake, all control cables, lines and hoses shall be located and secured so as not to become pinched between the fork and frame members when the wheel is turned completely to the left or right. Brake-actuating devices shall be in a readily accessible location, unencumbered by vehicle components. A suitable mechanism shall be provided for the purpose of automatically returning the actuating devices to a normal position upon release.

**450.4(7) Tires, wheels, rims**. Motorcycle tires shall be of pneumatic design with a minimum width of two and twenty-five hundredths inches and designed for highway use. Wheel rim diameters shall not be less than 10 inches and rims shall otherwise comply with applicable federal standards.

**450.4(8) Steering and suspension**.

a. *Stability*. Motorcycle or motorized bicycle steering and suspension shall provide the operator with the means of safely controlling vehicle direction.

b. *Wheel alignment*. The rear wheel of a two-wheel motorcycle or motorized bicycle shall track behind the front wheel within 1 inch with both wheels in a vertical plane when the vehicle is operating on a straight course. On a three-wheel motorcycle or motorized bicycle, the two wheels mounted on the rear axle shall have a wheel track distance not less than 30 inches and the midpoint of the rear wheel track distance shall be within 1 inch of the front wheel track when the vehicle is proceeding on a straight course.

c. *Steering*.

(1) The steering head shall be provided with a bearing or similar device that will allow the steering shaft to turn freely in rotational motion only. All handlebar-mounted control cables, wires, lines and hoses shall be located and secured so as not to become pinched between the fork and frame members when the wheel is turned completely to the right or the left.

(2) A steering wheel may be used on a three-wheel reconstructed or specially constructed motorcycle or motorized bicycle provided:

1. The steering wheel is circular or nearly circular in shape, having an outside diameter of not less than 13 inches.

2. The steering wheel shall have no less than two turns and no more than six turns when the road wheels are turned from lock to lock.

d. *Handlebars*. Handlebars shall be of sturdy construction, adequate in size (length) to provide proper leverage for steering, and capable of withstanding a minimum force of 100 pounds applied to each hand grip in any direction. The handlebars shall provide a minimum distance of 18 inches between grips after final assembly.

e. *Hand grips*. Motorcycles or motorized bicycles shall have handlebars equipped with hand grips of nonslip design or material.

*f. Suspension.* Motorcycles or motorized bicycles shall be equipped with a suspension system, and the suspension system shall be applicable to at least the front wheel. The suspension system(s) shall be designed for the purpose of maximum vehicle stability.

**450.4(9) Fuel system.** All fuel system components, including the tank, pump, tubing, hoses, clamps, etc., shall be securely fastened to the motorcycle or motorized bicycle so as not to interfere with vehicle operation and be leakproof when the vehicle is in its normal operating attitude. Fuel lines and tank shall be positioned in a manner so as to prevent their contact with the engine head, manifold, exhaust system, or other high temperature surfaces or moving components. The fuel system shall be adequately vented and provided with a fuel shutoff valve located between the fuel supply and the engine.

**450.4(10) Exhaust system.** Motorcycles or motorized bicycles with an internal combustion engine shall be equipped with an exhaust system incorporating a muffler or other mechanical device for the purpose of reducing engine noise. Cutouts and bypasses in the exhaust system are prohibited. The system shall be leakproof and all components shall be securely attached to the vehicle and located so as not to interfere with the operation of the motorcycle or motorized bicycle. Shielding shall be provided to prevent inadvertent contact with the exhaust system by the operator and/or passenger during normal operations.

**450.4(11) Mirrors.** Every motorcycle and motorized bicycle shall be equipped with at least one mirror of unit magnification, securely affixed to the handlebar and capable of adjustment within a range that will reflect an image that includes at least the horizon and the road surface to the rear of the motorcycle or motorized bicycle. The mirror shall consist of a minimum reflective surface of 10 square inches. All mirrors shall be regular in shape (circular, oval, rectangular, or square) and shall not contain sharp edges or projections capable of producing injury.

**450.4(12) Fenders.** Rescinded IAB 9/8/10, effective 10/13/10.

**450.4(13) Seat or saddle.** A seat or saddle securely attached to the vehicle shall be provided for the use of the operator. The seat or saddle shall not be less than 20 inches above a level road surface when measured to the lowest point on top of the seat or saddle cushion with the driver seated in a driving position. The seat or saddle adjustment locking device shall prevent relative movement of the seat from its selected and secured position under all normal vehicle operating conditions.

**450.4(14) Horn.** Every motorcycle and motorized bicycle shall be equipped with at least one horn. The horn shall be electrically operated and shall operate from a control device located on the handlebar. When operated the horn shall be audible for at least 200 feet.

**450.4(15) Speedometer and odometer.** Every motorcycle and motorized bicycle shall be equipped with a properly operating speedometer and odometer calibrated in miles per hour and miles respectively and shall be fully illuminated when the headlamp(s) is activated.

**450.4(16) Lighting equipment.** Every motorcycle and motorized bicycle shall be equipped with at least one headlamp but not more than two, mounted securely. Headlamp(s) shall be mounted not less than 24 inches, nor more than 54 inches, above the level road surface. A headlight beam indicator light shall be located within the operator's field of vision and illuminated automatically when the high beam of the headlamp is actuated. Every motorcycle and motorized bicycle shall be equipped with a tail and brake light assembly and a license plate light. All original lamps and lighting equipment provided on the motor vehicle by the manufacturer shall be maintained in working condition or shall be replaced with equivalent equipment.

**450.4(17) Footrest.** Every motorcycle shall be equipped with two footrests, one on each side of the vehicle and shall be provided for each designated seating position. Footrests shall be located so as to provide reasonable accessibility. Footrests shall be able to fold upward if they protrude beyond the side of the motorcycle's fixed items. Every motorized bicycle shall be equipped with either two footrests or two pedals, one on each side of the vehicle, to provide reasonable accessibility.

**450.4(18) Highway bars.** If a motorcycle or motorized bicycle is so equipped, highway bars (alternate footrests) shall be located at a maximum distance of 26 inches from the foot controls and shall not interfere with the operation of the foot controls.

This rule is intended to implement Iowa Code section 321.23.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3108C, IAB 6/7/17, effective 7/12/17]

**761—450.5(321)** Rescinded IAB 3/26/97, effective 4/30/97.

**761—450.6(321) Safety requirements for the movement of implements of husbandry on a roadway.** The following standards are minimum safety requirements for the movement of implements of husbandry on a roadway.

**450.6(1) Towing standard.** No power unit operated by a retail seller or manufacturer shall tow more than one implement of husbandry, except those implements of husbandry that are not self-propelled and are capable of being towed in tandem, from the manufacturer to the retail seller, from the retail seller to the farm purchaser, or from the manufacturer to the farm purchaser.

**450.6(2) Equipment standards.**

*a. Braking.* The towing unit or self-propelled implement of husbandry operated upon a highway shall be equipped with a braking device(s) which can control the movement of and stop the vehicle(s). When the vehicle is traveling 20 miles per hour, the braking device shall be adequate to stop the vehicle or vehicles within 30 feet if the gross weight is less than 5000 pounds and 50 feet if the gross weight is 5000 pounds or more.

*b. Rearview mirror.* The towing vehicle or self-propelled implement of husbandry shall be equipped with a rearview mirror that reflects to the operator a view of the highway for a distance of at least 200 feet to the rear of the vehicle(s). The rearview mirror equipment standard may be met by the use and installation of a temporary rearview mirror.

*c. Lighting.* The towing or towed vehicle, the rearmost implement of husbandry being towed in tandem, or a self-propelled implement of husbandry shall be equipped with at least one rear taillight which exhibits a red light plainly visible from a distance of 500 feet to the rear. The rear taillight equipment standard may be met by the use and installation of a temporary rear taillight. If an implement of husbandry is being towed by a vehicle which is equipped with brake lights, the towed unit must also have brake lights, constructed and located on the implement of husbandry so as to give a signal of intention to stop. The light shall be red or yellow in color. The signal shall be plainly visible in normal sunlight and at night from a distance of 100 feet to the rear and may be met by the use and installation of a temporary light.

*d. Turn signal.* The towing or towed vehicle, the rearmost implement of husbandry being towed in tandem, or a self-propelled implement of husbandry shall be equipped with a turn-signal device that operates in conjunction with or separately from the rear taillight. The signal shall be plainly visible and understandable from a distance of 100 feet to the rear. The turn-signal device equipment standard may be met by the use and installation of a temporary turn-signal device.

*e. Tires.* Pneumatic tires shall not be used if any part of the ply or cord is exposed; if there is any bump, bulge, or separation; if there is a tread design depth of less than one-sixteenth inch; if there is marking “not for highway use” or “unsafe for highway use.”

*f. Warning devices.* A towing vehicle or self-propelled implement of husbandry shall be equipped with flares, red reflectors or reflective triangles if operated after sunset and before sunrise.

*g. Drawbar.* When one vehicle is towing another vehicle, the drawbar shall be of sufficient strength to pull the weight towed and shall be fastened to the frame of the towing unit so as to prevent sidesway. In addition to the principal connection there shall be a safety chain which shall be fastened so it is capable of holding the towed vehicle if the principal connection fails.

This rule is intended to implement Iowa Code section 321.383.

[ARC 3108C, IAB 6/7/17, effective 7/12/17]

**761—450.7(321) Front windshields, windows or sidewings.**

**450.7(1) Prohibition.** Pursuant to Iowa Code subsection 321.438(2), a person shall not operate on the highway a motor vehicle equipped with a front windshield, a side window to the immediate right or left of the driver (front side window) or a sidewing forward of and to the left or right of the driver (front sidewing) which is excessively dark or reflective.

**450.7(2) Standard of transparency.** “Excessively dark or reflective” means that the windshield, front side window or front sidewing does not meet a minimum standard of transparency of 70 percent light transmittance.

**450.7(3) Dark window exemption.**

a. Effective July 4, 2012, no exemption shall be granted from the minimum standard of transparency set forth in subrule 450.7(2).

b. A motor vehicle fitted with a front windshield, a front side window or a front sidewing with less than 70 percent but not less than 35 percent light transmittance before July 4, 2012, may continue to be maintained and operated with a front windshield, a front side window or a front sidewing with less than 70 percent but not less than 35 percent light transmittance on or after July 4, 2012, so long as the vehicle continues to be used for the transport of a passenger or operator who obtained Form 432020, which documented a medical need for such reduced transparency, and was signed by the person’s physician before July 4, 2012. Form 432020 must be carried at all times in the vehicle to which the exemption applies. At such time as the vehicle is no longer used for the transport of the passenger or operator who is the subject of Form 432020, the exemption expires and may not be renewed. The owner of the vehicle to which the exemption applied must return the vehicle to conformance with the minimum standard of transparency set forth in subrule 450.7(2) within 60 days of expiration of the exemption.

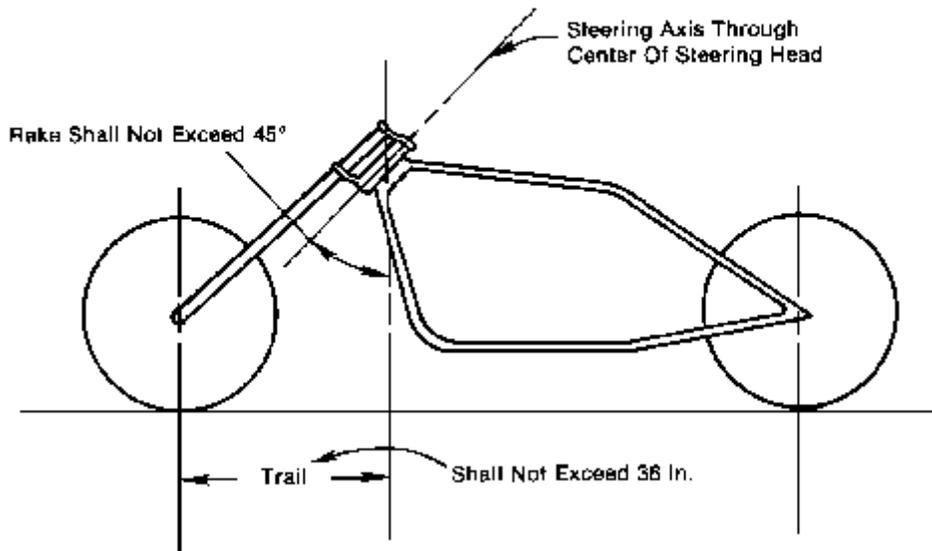
c. “Physician” as used in this rule means a person licensed under Iowa Code chapter 148, 151 or 154.

This rule is intended to implement Iowa Code section 321.438.  
[ARC 0136C, IAB 5/30/12, effective 7/4/12]

APPENDIX TO RULE  
761—450.2(321)  
Rescinded IAB 9/8/10, effective 10/13/10

APPENDIX TO RULE  
761—450.4(321)

**MOTORCYCLE FRONT END GEOMETRY**



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[Filed emergency 8/8/90—published 9/5/90, effective 8/10/90]  
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[Filed 11/29/95, Notice 10/25/95—published 12/20/95, effective 1/24/96]  
[Filed 3/5/97, Notice 1/29/97—published 3/26/97, effective 4/30/97]  
[Filed 10/28/98, Notice 8/26/98—published 11/18/98, effective 12/23/98]

[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]

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[Filed ARC 0136C (Notice ARC 0068C, IAB 4/4/12), IAB 5/30/12, effective 7/4/12]

[Filed ARC 3108C (Notice ARC 2989C, IAB 3/29/17), IAB 6/7/17, effective 7/12/17]

CHAPTER 22  
EMPLOYER RECORDS AND REPORTS

[Prior to 9/24/86, Employment Security [370] Ch 2]

[Prior to 3/12/97, Job Service Division [345] Ch 2]

**871—22.1(96) Records to be kept by the employer.**

**22.1(1)** Each employing unit having employment performed for it shall maintain records to show the information hereinafter indicated. Such records shall be kept in such form and manner that it will be possible from an inspection thereof to obtain the facts necessary to determine what remuneration was made by the employing unit and what remuneration is reportable to the department. Such records shall be open to inspection and be subject to be copied by the department and its authorized representatives at any reasonable time. Such records shall be kept for a period of five years after the calendar year in which the remuneration to which they relate was paid or, if not paid, was due.

**22.1(2)** Such records shall show with respect to each employee, unless the department has ruled that the particular service does not constitute employment:

- a.* Name of worker.
- b.* Social security account number.
- c.* Date on which employee was hired, rehired, or returned to work after a temporary layoff, and the date separated from work and the reason therefor.
- d.* Scheduled hours except for workers without a fixed schedule of hours, such as those working outside of the employer's establishment in such a manner that the employer has no definite knowledge of their working hours.
- e.* Total wages paid for employment in each period and the date of payment. For all pay periods ending in each quarter show separately: money wages, the cash value of other remuneration such as any special payment for services such as wages in lieu of notice, bonuses, gifts, prizes, and the nature of payments such as accounts paid to employees as allowance or reimbursement for traveling and other business expenses, and the amounts of such expenditures actually incurred and accounted for by the employees.
- f.* The state or states in which the services are performed; and if any of such services are performed outside of this state and are not incidental to the service within the state, the base of operations (or if there is no base of operations then the place from which such services are directed or controlled) and the residence (by state), and the name of the county in Iowa in which services were performed.
- g.* When the pay period covers services performed both in covered employment and in excluded work, show the hours and wages for covered employment under the Iowa employment security law, hereinafter referred to as the "Act," and also show hours and wages for excluded work.
- h.* The physical work site at which each employee worked during each pay period which includes the twelfth of each month. If an employee worked at more than one work site, the work site at which the majority of the work was performed should be the one of record.

**22.1(3)** Such payroll records may be preserved by the employer in an electronic format, provided the employer is willing to provide access to such records as may be required by the department.

**22.1(4)** Maintenance of records by out-of-state employing units. Any employing unit having its principal place of business outside of Iowa shall maintain payroll records in this state with respect to wages paid to employees who perform some service in this state; provided, however, that an out-of-state employing unit may, with the approval of the department, maintain such payroll records outside the state upon its understanding that it will, when requested so to do, furnish the department with a true and correct copy of such payroll records. Failure to maintain said records in Iowa as required may result in estimated reports and payroll listings being made by the department. See 871—subrule 23.59(2).

This rule is intended to implement Iowa Code section 96.11(6) "a."  
[ARC 3116C, IAB 6/7/17, effective 7/12/17]

**871—22.2(96) Reports.** Each employing unit shall make such reports at such times as the department may require, and shall comply with the instructions printed upon any report form issued by the department pertaining to the preparation and return of such report.

This rule is intended to implement Iowa Code section 96.11(1).

**871—22.3(96) Filing of Employer's Contribution and Payroll Report, 65-5300 and Employer's Payroll Continuation Sheet, 60-0103.**

**22.3(1)** Each employer shall, by the due date, file a 65-5300, Employer's Contribution & Payroll Report, for each quarter listing wages paid with respect to all the employer's business maintained within this state computed in accordance with the Iowa Code and these rules.

**22.3(2)** Failure to receive report forms shall not relieve the employer from responsibility for filing required forms on or before the due date or to pay any contribution due.

**22.3(3)** A copy of each such report shall be preserved by each such employer for a period of at least five years from the end of the calendar year in which the report was due.

**22.3(4)** Employer to file report even when no payroll. Every qualified or subject employer is required to send in an Employer's Contribution and Payroll Report, Form 65-5300, each quarter. Even though an employer finds that for some particular quarter no contributions are due, or they have no employees during the period covered, a report must be filed with the department.

**22.3(5)** Combined reports, leased employees, and concurrently employed individuals.

*a.* Consolidated or combined reports of parent and subsidiary corporations or other employing units, whether or not the employing units are related, shall not be allowed.

*b.* Employees of parent and subsidiary corporations or other employing units, whether or not they are related, shall be reported on the quarterly reports of the employing unit for which the services are performed regardless of which employing unit actually issues the employees' paychecks.

*c.* Leased employees:

(1) Except as described in subparagraphs (2), (3), (4), and (5) below, individuals leased from an employee leasing company, by the client of the employee leasing company, shall be considered to be employed by the client and shall be reported on the quarterly reports of the client, at the contribution rate of the client, unless and until it is shown to the satisfaction of the department that the individuals are and will continue to be under the exclusive direction and control of the employee leasing company, both under a written contract and in fact.

In order for a contract to be considered evidence that individuals are the employees of the employee leasing company it shall:

1. Specify the service to be performed by the individuals, on behalf of the employee leasing company, for the client.

2. Specify the fee the client must pay for this service. The fee must be large enough to cover the actual cost of the individuals' wages and fringe benefits plus provide a reasonable profit on the service performed for the client.

3. Specify that the employee leasing company has the exclusive right to determine the number of individuals needed to provide the service for the client and to direct and control the individuals in the performance of the service.

4. Specify that the employee leasing company has the exclusive right to hire, fire, discipline, and reassign any of the individuals to another position or to another client without the consent of the client.

(2) If an individual is leased to fill a temporary need from a company whose business is primarily to provide workers to fill temporary needs, the individual shall be considered to be the employee of the leasing company as long as a written contract is in place.

(3) If an individual is a truck driver leased from a company that leases truck tractors with drivers to trucking companies, the individual shall be considered to be the employee of the leasing company unless and until it is shown to the satisfaction of the department that the trucking company has the exclusive right to hire, fire, discipline, reassign, and direct and control the services performed by the individual, both under a written contract and in fact.

(4) If an individual leased from an employee leasing company is a corporate officer of the client, the individual shall always be considered the employee of the client and not the employee of the leasing company.

(5) If an individual leased from an employee leasing company holds an exempt relationship, as defined in Iowa Code section 96.19(18)“g”(5), with the client, the individual shall not be considered to be an employee of either the client or the leasing company unless an election to cover the individual has been filed and approved in accordance with Iowa Code section 96.8(3)“b.”

*d.* Concurrently employed individuals.

(1) Except as described in subparagraph (2) below, individuals who perform services concurrently for more than one employing unit, whether or not the employing units are related, shall be considered as working for each of the employing units and shall be reported on the quarterly reports of each of the employing units. Each of the employing units shall be required to pay contributions on the wages attributable to that employing unit up to the taxable wage base limit for each calendar year.

(2) An individual who concurrently performs services as a corporate officer for two or more related corporations and who is paid through a common paymaster that is one of the related corporations may be treated as working for only the common paymaster at the discretion of the related corporations.

**22.3(6)** Each Form 65-5300, Employer’s Contribution & Payroll Report, shall include:

*a.* The social security number, name (last name first), and total wages paid to each employee during the calendar quarter. All corrections to previous reports must be submitted on Form 68-0061, Employer’s Wage Adjustment Report. All employees’ wages will be reported by the reporting unit under which the work was performed. See rules 871—23.3(96) through 871—23.6(96).

*b.* The sum of the total and taxable wages paid to all employees during the calendar quarter. If reported electronically, the sum of the total and taxable wages will be computed for the employer. The electronic system will compute the taxable wages for each employee. If the employer is claiming taxable wages reported to another state, the amount claimed and the state that the wages were reported to will be listed.

*c.* The amount of contribution due for the calendar quarter. If the report is filed electronically, the system will compute and enter the contribution due.

*d.* The amount of interest due, if any, for the calendar quarter. If the report is filed electronically, the system will compute and enter the interest due.

*e.* The amount of penalty due, if any, for the calendar quarter. If the report is filed electronically, the system will compute and enter any penalty due.

*f.* The total amount of contribution, interest and penalty due for the calendar quarter. If the report is filed electronically, the system will compute and enter the total amount due.

*g.* Rescinded IAB 5/5/10, effective 6/9/10.

*h.* The amount of net remittance due for the calendar quarter; however, if the amount of net remittance due is less than \$1, the employer need not submit payment. If the report is filed electronically, the system will compute and enter the net remittance due.

*i.* The total number of employees listed on the report. If the report is filed electronically, the system will compute and enter the total number of employees on the report.

*j.* The amount of extraordinary pay which was paid to the employees during the calendar quarter for each reporting unit.

*k.* The total number of employees paid wages during the pay periods which include the twelfth day of each month of the calendar quarter for each reporting unit.

*l.* The number of the county in which the reporting unit is located if only one business activity is conducted at only one worksite during the calendar quarter; however, if the same business activity is conducted at more than one worksite or if different business activities are conducted at one or more worksites, the employer shall also be required to complete and return the Form 65-5519, Multiple Worksite Report, which shall include for each worksite the total number of employees paid wages during the pay periods which include the twelfth day of each month of the calendar quarter and the total wages paid during the calendar quarter. The system will compute and enter taxable wages if the report is filed electronically.

(1) The total number of employees paid wages during the pay periods which include the twelfth day of each month of the calendar quarter for all worksites as reported on the Form 65-5519, Multiple Worksite Report, should equal the total number of employees reported for that month on the Form 65-5300, Employer's Contribution & Payroll Report.

(2) The total wages paid to all employees at all worksites as reported on the Form 65-5519, Multiple Worksite Report, should equal the total wages reported on the Form 65-5300, Employer's Contribution & Payroll Report.

(3) It could be possible for wages to be reported for a worksite without corresponding employment being reported in any of the months during the quarter because wages paid are reportable for the full 13-week period in the calendar quarter, while employment is reportable on the Form 65-5300, Employer's Contribution & Payroll Report, when such employment occurs during the pay periods which include the twelfth day of any month in the calendar quarter.

*m.* The reason (seasonal change, labor dispute, layoff, recall, worksite opening, or worksite closing) for the increase or decrease in total employment during the calendar quarter.

*n.* Rescinded IAB 3/5/03, effective 4/9/03.

*o.* The signature, written or electronic, of the owner, responsible officer, or authorized agent of the employer certifying that the information given is true and correct to the best of the signer's knowledge and belief, the date the report was submitted and the telephone number.

*p.* Such other schedules or reports as may be required, duly completed in all substantial respects on such forms and in accordance with such instructions as the department may provide or approve.

This rule is intended to implement Iowa Code sections 96.7, 96.11(6), 96.11(11) and 96.19(17).  
[ARC 8711B, IAB 5/5/10, effective 6/9/10]

#### **871—22.4(96) Reporting of earnings data by secure file transfer.**

**22.4(1)** The employer may submit an electronic file in lieu of Form 65-5300, Employer's Contribution & Payroll Report. Authorization for this reporting method will be given if the employer meets the specification requirements to be compatible with the department's computer capabilities. Such specifications will be furnished upon request.

**22.4(2)** The electronic file submitted will contain all of the employer information, wage information, and labor market information required when filing using the Form 65-5300, Employer's Contribution & Payroll Report. If this method of filing is selected, all wages must be filed using this method. The report will not be considered filed until all worksite reporting units have filed. All corrections to previous reports submitted to the department must be listed and submitted on Form 68-0061, Employer's Wage Adjustment Report.

**22.4(3)** The director shall annually designate the number of wage lines per report that will require the report be filed electronically.

This rule is intended to implement Iowa Code section 96.11(6) "a."  
[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—22.5(96) Filing of quarterly report forms by newly subject or covered employers.** Any employing unit which becomes an employer subject to this chapter within any calendar quarter other than by a voluntary election of the employing unit shall file reports for each calendar quarter on Form 65-5300, Employer's Contribution and Payroll Report. Reports shall include all wages paid during the current quarter as well as separate quarterly reports for wages paid in prior quarters of the same calendar year. The first quarterly reports of that employer shall be due on the last day of the calendar month following the close of the calendar quarter in which the employing unit becomes subject to the Code and shall be considered delinquent if not submitted and paid by that date. Any employer filing a voluntary election for coverage must begin filing reports in the quarter the employer's election is effective.

This rule is intended to implement Iowa Code sections 96.7(1), 96.14(1), 96.14(2) and 96.8(3).

**871—22.6(96) Employer changing status, address or name required to file report.** Any employer who terminates business for any reason whatsoever, or transfers or sells all or a substantial part of the assets of the organization, trade or business to another, or changes the trade name of such business or

address thereof shall, within ten days after such termination, transfer, or change of name or address, give notice in writing to the department of that fact. The employer shall set forth in such notice the former name, address of the business, the new name, telephone number and address, the name of any new owner, and the employer's own name, telephone number and present address. Such notification shall be on Form 60-0111, Employer's Notice of Change, or on Form 65-5313, Employer's Delinquency Notice.

This rule is intended to implement Iowa Code sections 96.11 and 96.8(4).

**871—22.7(96) Exempt employing units and exempt employment.**

**22.7(1)** Any employing unit having workers performing services for it which it considers exempt from this Act shall file a Form 68-0192, Questionnaire for Determining Status of Workers, along with supporting exhibits and documents (i.e., contract, statements from employer and claimant) so that a decision can be made as to whether or not such service is in fact exempt from the provisions of this Act.

**22.7(2)** Any employing unit which has established its status as an organization exempt under this Act or that certain employment performed for it is not subject to contributions shall immediately notify the department of any changes in the character of its organization, the purposes and manner of its operation or the changed manner in which employment theretofore determined to be exempt by the department is performed.

**22.7(3)** Whenever an employing unit claims that any employment is not employment under this Act, the burden shall be on the employer to prove the exemption claimed.

This rule is intended to implement Iowa Code section 96.19(18) "f."

**871—22.8(96) Subject employers.**

**22.8(1)** Requesting determination of status. Whenever an employing unit is in doubt as to whether or not an individual is an employee, or is engaged in employment subject to the Act, the employing unit shall submit a statement of all relevant facts to the department for a determination as to the status under the Act of such individual or employment on Form 68-0192, Questionnaire for Determining Status of Workers, information for use in obtaining a ruling from the department as to whether or not a worker is an employee for the purposes of the Act.

**22.8(2)** Notification of status. The department shall maintain a separate account for each employer and shall notify the employer by mailing a Form 65-5308, Notice of Employer Status and Liability, to the last-known address. This notice will advise the employer of:

- a. The effective subjectivity date.
- b. The date of the determination (last day of quarter in which subjectivity occurred). See rule 871—22.5(96).
- c. The assigned industry code.
- d. The section of the law under which the employer was found liable.
- e. The federal identification number (if available).
- f. The workforce development unemployment insurance account number.
- g. The contribution rate for that year and preceding four years, if applicable.
- h. Whether the account was established new, reestablished or placed on an inactive status.

**22.8(3)** For the specific procedure and requirements for perfecting an appeal of an employer liability determination see rules 871—23.52(96) to 871—23.56(96).

This rule is intended to implement Iowa Code section 96.7(4).

**871—22.9(96) Employing units required to file report to determine liability.**

**22.9(1)** Each employing unit engaged in doing business in the state of Iowa January 1, 1936, or after, shall file a report to determine liability with the department on a form supplied by the department, Form 60-0126, Report to Determine Liability, setting forth the names and addresses of the owners of the business, or if a corporation, association, or joint stock company or limited liability company, the names and addresses of its officers or members. Each employing unit must show its principal place of business, the nature of its business, the number of individuals whom it customarily hires to perform services for it, the place or places where such services are performed, the time when such business was

begun, the number of weeks in the year for which it is customary to operate such business and such other information as may be required by such form.

**22.9(2)** Each employing unit which shall hereafter begin business in the state of Iowa in any manner whatsoever whether by succession to a business already being operated, by starting a new business, or otherwise, shall, within 30 days after beginning such business, inform the department of that fact, request the forms referred to in 22.9(1) and make and file the report required of all employing units by said rule.

This rule is intended to implement Iowa Code section 96.11(1).

**871—22.10(96) Report of a Partnership on Change in Partners.**

**22.10(1)** *Change in partnership.* In any case in which a partnership consisting of two or more partners adds to or deletes a partner or partners and is not required by the Internal Revenue Service to obtain a new federal identification number after such addition or deletion of partner or partners, the partnership shall notify the department of such change by filing a Form 68-0234, Report of a Partnership on Change in Partners, within ten days from the date the change occurred. The department will subsequently correct the partnership account to reflect this change.

**22.10(2)** *Reporting requirement.* If, after the change in partners, the partnership is required to obtain a new federal identification number by the Internal Revenue Service, or if there has been a change of ownership as described in Iowa Code section 96.19(18) “b” or a change of ownership as described in rule 871—23.28(96), then the old partnership shall notify the department by filing Form 60-0111, Employer’s Notice of Change, within ten days from the date the change occurred. The new partnership shall notify the department by filing Form 60-0126, Report to Determine Liability, within ten days from the date the change occurred.

This rule is intended to implement Iowa Code section 96.11(6).

**871—22.11(96) Employer account.**

**22.11(1)** The department shall maintain one account for each employer (or single legal entity). An employer who has more than one establishment or business shall be considered to be one employing unit entitled to one account and a single experience rate. If an establishment or business owned by an employer is a separate legal entity in its own right (i.e., a subsidiary corporation), it will be considered to be a separate employer and must have an experience rate based on its own experience. When an already covered employer acquires another establishment or business, the employer will have a separate account number with a separate experience rate for the acquired business only if that business retains its character as a separate legal entity. If the acquired business is merged with that of the employer so that they become a single legal entity under the law, the successor is not entitled to separate rates for each establishment or business.

**22.11(2)** Each employer shall report all wages paid and pay all contributions into the unemployment account maintained by the department. The title of the employer’s account shall be the name of the individual, partnership, corporation, association or other organization constituting the employing unit, and may contain the trade name used by the employing unit. Where the employing unit is a fiduciary agent or legal representative, the title of the account shall be the name of the fiduciary or legal representative and the official title.

**22.11(3)** Each employer’s account shall be assigned a number and, unless the system of numbering accounts is changed, the number identifying an employer’s account shall not be changed.

**22.11(4)** Establishment defined. As used in this rule, “establishment” means an economic unit, generally at a single physical location, where business is conducted, or where services or industrial operations are performed, or from which employees are dispatched.

This rule is intended to implement Iowa Code sections 96.7(2) “a”(1) and 96.19(17).

[ARC 871IB, IAB 5/5/10, effective 6/9/10]

**871—22.12(96) Reporting units.** Any employer having two or more separate establishments will file those establishments as separate reporting units. Additionally at the employer’s discretion, the employer may establish reporting units to report according to function within the business. When filing a Form

65-5300, Employer's Contribution & Payroll Report, by paper, all reporting units will be listed on a separate page and will all be submitted together. When filing a Form 65-5300, Employer's Contribution & Payroll Report, by electronic means, the individual reporting units may be filed separately by the reporting units when authorized but the complete account report is not submitted until all reporting units are completed. Maintaining current status for the reporting units will be the employer's responsibility. If any reporting units are deleted or added, the department shall be notified within ten working days from the date of change.

This rule is intended to implement Iowa Code sections 96.7(2) "a" and 96.19(6).  
[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—22.13(96) Procedure to be followed by an employer wishing to have an active reporting unit coded for notice of claim for unemployment benefit mailing.**

**22.13(1)** Any employing unit reporting under an assigned account and having one or more reporting units in the state of Iowa may request in writing or electronically the assignment of a reporting unit number which will be assigned for the specific purpose of mailing Form 65-5317, Notice of Claim Filing, to the reporting unit so that responsible personnel at that location can make a timely protest on Form 65-5317 if the employment separation was for a disqualifiable reason. Those accounts so wishing may request in writing that all unemployment insurance material other than Form 65-5317, Notice of Claim Filing, be sent to the home office or regional accounting office. All such requests must be from a responsible financial or operating officer of the firm and shall indicate:

- a. Full trade name and address of each location to be coded.
- b. The full employer name and address of the home office or financial office where all unemployment insurance material other than Form 65-5317 is to be sent.

**22.13(2)** It will be permissible to accept this information over the telephone by qualified personnel of the field audit section providing the employer makes known all of the above requested information and the person receiving this information notes the date it was received, the time it was received, who telephoned the information to the department, and the name and telephone number of a responsible party that can be contacted if further verification is needed with respect to the location coding procedure. Field audit section personnel receiving this classified information by telephone will accordingly note this and make it a matter of permanent record.

This rule is intended to implement Iowa Code section 96.6(2).  
[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—22.14(96) Notification by employer of employee's rights.** Each employer shall post and maintain in places readily accessible to individuals in its employ printed notices or posters, Form 60-0160, informing employees of their potential rights to benefits under the employment security law and providing general instructions as to what the employees shall do and where the employees shall go to obtain these benefits. Copies of these printed notices or posters may be obtained from the department, upon request, without cost to the employer.

This rule is intended to implement Iowa Code section 96.11(2).

**871—22.15(96) 940 certification.**

**22.15(1)** Upon request, the department shall furnish to the Internal Revenue Service a certification of an employer's account for a particular year. Certification requests may be on an individual basis or may be part of a bulk yearly certification. Such certification will include the employer's state account number, yearly taxable payroll, contribution rate, contributions paid prior to January 31 of the next succeeding year, and the date and amount of contributions after January 31 of the next succeeding year.

**22.15(2)** In addition to the information certified in subrule 22.15(1), yearly certification shall include:  
a. Employers who filed a federal unemployment tax return (Form 940) that did not file with the department.

*b.* Employers who filed returns with the department but not with the Internal Revenue Service except governmental employers and employers that department records indicate to be 501(c)(3) nonprofit organizations.

This rule is intended to implement Iowa Code sections 96.11(1) and 96.11(6) “c”(2).

**871—22.16(96) Transmittal.**

**22.16(1)** *Effect of postmark date.*

*a.* When the due date for filing reports and paying contributions falls on Saturday, Sunday or a legal holiday it is sufficient compliance with the law if reports and contributions are postmarked on or before midnight of the next succeeding business day following such Saturday, Sunday or legal holiday.

*b.* Contributions, if mailed, shall be deemed to have been paid on the date of mailing as indicated by the postmark on the cover thereof. If no postmark date on the cover, the date received by the department shall be deemed date of payment.

**22.16(2)** Reserved.

This rule is intended to implement Iowa Code sections 96.7(1) and 96.14(2).

**871—22.17(96) Procedures of field auditors.**

**22.17(1)** Field auditors are to provide a cost-effective method of promoting employers’ understanding of employer rights and responsibilities under Iowa unemployment insurance laws.

**22.17(2)** The department, through duly appointed field auditors, may examine an employer’s records at any time, subject to the limitations of 871—22.1(96), to determine compliance with Iowa Code chapter 96.

**22.17(3)** The department has enforcement authority. An employer, when requested to produce records by an auditor, must make the records available within and at a reasonable time to the auditor. If an employer does not comply with the auditor’s request to produce records, a subpoena duces tecum may be served on the employer to appear before the auditor with the records in accordance with Iowa Code section 96.11, subsections 8 and 9.

**22.17(4)** The department, through duly appointed field auditors, may perform a systematic audit of an employer’s records as authorized by Iowa Code section 96.11, subsection 7, and as mandated by the United States Department of Labor. In addition to the provisions of subrules 22.17(1) to 22.17(3), the following provisions apply to systematic audits:

*a.* The employer is to be given reasonable notice of the intent to audit, and a preaudit interview is to be conducted with the employer or a designated representative.

*b.* The records required, if maintained, may include individual pay records, Internal Revenue Service Forms W-2 and 1099, cash disbursement journal, check register, chart of accounts, general ledger, balance sheet, profit and loss statement, federal and state tax returns and other records to the extent they relate to possible hidden or misclassified wages.

*c.* To verify the existence of the business, the auditor may require a visit to the business premises or to see other evidence of legitimate business activity.

*d.* To verify the correct business entity is listed on department files, the auditor may examine various employer business licenses, legal documents or other tax returns.

*e.* To verify the reporting of all workers reportable to the department under Iowa Code chapter 96, questionable entries will be investigated and documented. Under rule 871—22.7(96) if the employer disagrees with the audit decision on coverage of a worker, the auditor may require the employer to complete Form 68-0192, Job Service Questionnaire For Determining Status of Workers. In any disputed case, the auditor is to be granted access to records as necessary to determine the remuneration paid for any given calendar quarter.

*f.* To verify proper employer posting to department reports, a detailed audit of check stubs, weekly time cards, or other maintained source documents will be made and documented for at least one worker for at least one quarter. The detailed audit may be more comprehensive at the discretion of the auditor or if discrepancies are found.

*g.* Employer records will be compared and reconciled to amounts reported to the department on contribution and payroll reports and audit findings documented.

*h.* Discrepancies will be resolved or explained, and report adjustments prepared as necessary.

*i.* The audit will cover four calendar quarters; however, if material errors are found, the audit may be expanded to cover prior or subsequent years subject to limitations of subrule 22.1(1). The auditor will review and correct similar errors in a minimum of a year prior to and after the audited year.

*j.* Additional amounts due will be calculated and collected, including applicable interest and penalties, or an explanation will be given. The employer may be required to submit a payment plan.

*k.* When the audit is completed, the audit will be discussed with the employer or a representative designated by the employer. The employer will be furnished copies of any wage adjustments, supplemental reports or delinquent reports prepared by the auditor. An audit report with all worksheets, adjustments and reports will be retained by Iowa workforce development.

**22.17(5)** There are several other reasons department representatives may make employer contacts and demands under authority of this rule. Any of these activities may be expanded into a systematic compliance audit as described in subrule 22.17(4) upon approval of the duly authorized representative of the department.

*a.* An auditor may request to examine business records to determine the date employment began and the date the employing unit became subject to Iowa Code chapter 96.

(1) To determine if an employing unit is to be a covered employer and if an individual, or class of individuals, are employees whose remuneration would be subject to contributions, the auditor will examine employment contracts and related documents.

(2) If it is determined that the employing unit is to be a covered employer, the auditor will examine legal documents such as leases, purchase contracts, partnership agreements, articles of incorporation, limited liability operating agreements and stock records to determine ownership of the business, to establish responsibility for filing reports and paying contributions, and to assist in the determination of the unemployment insurance tax rate.

(3) If liability is determined, the payroll/remuneration records may be examined to establish the correct amount of covered wages and the period to which they belong. Reports will be completed and the correct amount of contribution, penalty and interest due will be computed and collection action will be initiated.

*b.* When an unemployment insurance claim is filed, an auditor may request to examine the records of an employer to establish the claimant's rights to benefits under Iowa Code chapter 96. Form 68-0192, Job Insurance Questionnaire For Determining Status of Workers, and supporting documents may be required in contested cases. If the department determines that the claimant is an employee, the records will be examined to determine the correct amount of wages paid to the claimant and the period to which the wages apply.

*c.* When an employer fails or refuses to file a report, the auditor may examine the records to determine the correct amount of wages that should be reported, prepare the report, compute and collect contributions, penalty, and interest due. Should records not be made available, the auditor may estimate the wages paid and amounts due pursuant to 871—subrule 23.59(2).

*d.* When an employer is delinquent in paying contributions due, the auditor may examine records including cash accounts, accounts receivable, real and personal property accounts, accounts payable, notes payable, installment contracts and mortgages payable to determine the employer's equity in the assets on which a lien may be filed and judgment obtained.

**22.17(6)** When a temporary writ of injunction has been filed by the department, pursuant to Iowa Code section 96.16, against an employer because of the employer's failure or refusal to file a required report or to pay assessed contributions, penalty, and interest, a field auditor shall have the right to inspect the enjoined business premises during reasonable hours and interview any interested parties having knowledge of or being involved with the enjoined employer to ensure that such enjoined employer and all

of the employer's agents, servants, employees, and assigns are observing the conditions of the temporary writ of injunction.

This rule is intended to implement Iowa Code sections 96.7(1), 96.7(3), 96.8(1), 96.11(1), 96.11(6) "a," 96.11(7), 96.14, 96.16 and 96.20(3).

[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—22.18(96) Agents and other practitioners or firms representing employers in unemployment insurance matters.**

**22.18(1)** An agent, tax practitioner, accounting firm, attorney or any other firm or individual that represents or intervenes on behalf of an employer in any unemployment insurance matter shall have on file with the department:

- a. A power of attorney, or
- b. A letter of authorization from the employer, or
- c. An electronic designation of authority from the employer.

**22.18(2)** The foregoing documents shall contain the following information:

- a. Employer's full legal name, address and account number.
- b. Employer doing business as (DBA) or trade name if any.
- c. Legal name, address, telephone number and federal employer identification number (FEIN) of the agent or firm representing the employer.

d. Employer's E-mail address.

e. Address of the designated agent.

f. Roles that the agent or firm is authorized to perform for the employer.

g. Signature of the employer.

**22.18(3)** Rescinded IAB 3/5/03, effective 4/9/03.

This rule is intended to implement Iowa Code section 96.11(7).

[ARC 8711B, IAB 5/5/10, effective 6/9/10]

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CHAPTER 24  
CLAIMS AND BENEFITS

[Prior to 11/17/75, Ch 3]

[Prior to 9/24/86, Employment Security[370]]

[The filed emergency amendments were rescinded and the amendments to  
Chapter 4 were adopted following Notice, 12/31/86 IAB, effective 2/4/87]

[Prior to 3/12/97, Job Service Division [345] Ch 4]

**871—24.1(96) Definitions.** Unless the context otherwise requires, the terms used in these rules shall have the following meaning. All terms which are defined in Iowa Code chapter 96 shall be construed as they are defined in Iowa Code chapter 96.

**24.1(1) Additional claim.** An application for determination of eligibility filed on an established claim which follows a period of employment.

**24.1(2) Administrative office (state).** Same as central office.

**24.1(3) Agent state.** The state in which a worker claims benefits against another (liable) state through the facilities of the state employment security agency. See also liable state.

**24.1(4) Reserved.**

**24.1(5) Annual benefit amount.** See maximum annual benefits under benefits.

**24.1(6) Appeals.** See rule 871—26.1(96).

*a. Administrative appeal.* A request for a review by an appeals authority of a state employment security agency's determination on a claim for benefits, on a status report, or on an employer's contribution rate, or a request for a review by a higher appeals authority of a decision made by a lower appeals authority.

*b. Employment appeal board of the department of inspections and appeals.* The employment appeal board of the department of inspections and appeals is established to hear and decide disputed claims. The employment appeal board of the department of inspections and appeals will consist of three members appointed by the governor with the approval of two-thirds of the members of the senate. One member will represent the general public, one member will represent employers, and one member will represent employees.

This subrule is intended to implement Iowa Code section 96.6(4).

**24.1(7) Applicant.** Any individual applying for work at a workforce development center.

**24.1(8) and 24.1(9) Reserved.**

**24.1(10) Average weekly wages.** See wages.

**24.1(11) Base period.** The period of time in which the amount of wages paid to an individual in insured work which determines an individual's eligibility for, and the amount and duration of, benefits. The base period consists of the first four of the last five completed calendar quarters immediately preceding the calendar quarter in which the individual's claim for benefits is effective with the following exception. The department shall exclude three or more calendar quarters from the individual's base period in which the individual received workers' compensation or indemnity insurance benefits and substitute consecutive calendar quarters immediately preceding the base period in which the individual did not receive workers' compensation or indemnity insurance benefits. This exception applies under the following conditions:

*a.* The individual did not work in and receive wages from insured work for three calendar quarters of the base period, or

*b.* The individual did not work in and receive wages from insured work for two calendar quarters and lacked qualifying wages from insured work to establish a valid claim for benefits during another quarter of the base period.

**24.1(12) Base period employer and chargeable employer.**

*a. Base period employer.* An employer who paid wages for employment to a claimant during the claimant's base period or an employer who is responsible for an individual's wages pursuant to Iowa Code section 96.3, subsection 5, pertaining to workers' compensation benefits.

*b. Chargeable employer.* An employer who had base period wages accruing to the employer's account due to an employer liability determination.

**24.1(13) Benefit amount.**

*a. Maximum weekly benefit amount.* The highest weekly benefit amount provided in a state employment security law.

*b. Minimum weekly benefit amount.* The lowest weekly benefit amount for a week of total unemployment provided in a state employment security law.

*c. Weekly benefit amount.* The full amount of benefits a claimant is entitled to receive for a week of total unemployment.

**24.1(14) Benefit decision.** The decision reached by a lower or higher appeals authority with respect to an appealed claim. See also benefit determination, under determination.

**24.1(15) Benefit determination.** See determination.

**24.1(16) Benefit eligibility conditions.** Statutory requirements which must be satisfied by an individual with respect to each week of unemployment before benefits can be received.

**24.1(17) Benefit formula.** The combination of mathematical factors specified in the state employment security law as the basis for computing an individual's weekly benefit amount and maximum benefit amount.

*a. Annual wage formula.* A benefit formula which uses the claimant's total wages in insured work for a one-year period for computing the claimant's maximum benefit amount.

*b. High quarter formula.* A benefit formula which uses, for determining a claimant's weekly benefit amount, the quarter of the base period in which the claimant's wages in insured work were highest.

**24.1(18) Benefits.** Money payments to an individual with respect to unemployment.

*a. Regular benefits.* Benefits payable to an individual under this or any other state law (including benefits payable to federal civilian employees and ex-servicemembers pursuant to 5 U.S.C., chapter 85) other than extended benefits.

*b. Extended benefits.* Benefits payable to an individual (including benefits payable to federal civilian employees pursuant to 5 U.S.C., chapter 85) for weeks of unemployment which begin in an extended benefit period, which is a period when extended benefits are paid in this state.

**24.1(19) Benefit wages.** See wages.

**24.1(20) Benefit year.** That period to which the limitation of maximum duration of benefits is applicable, a year or approximately a year.

**24.1(21) Benefit year, individual.** The benefit year is a period of 365 days (366 in a leap year) beginning with and including the starting date of the benefit year. The starting date of the benefit year is always on Sunday and is the Sunday of the current week in which the claimant first files a valid claim unless the claim is backdated as allowed under paragraph 24.2(1) "h."

**24.1(22) Calendar week.** See week.

**24.1(23) Central office.** The state administrative office of the division of unemployment insurance services of the department of workforce development.

**24.1(24) Reserved.**

**24.1(25) Claim.** A request for benefit payment; also used to mean any notice filed by an individual to establish insured status or a notice filed by an individual to inform the administrative agency of the individual's unemployment.

*a.* A claim may be filed under any one or more of the following programs:

- (1) The state program of unemployment insurance (UI),
- (2) The federal program of unemployment compensation for federal employees (UCFE) established by Title V of the United States Code, and
- (3) The federal program of unemployment compensation for ex-military personnel (UCX) established by Title V of the United States Code.

*b.* Unless otherwise specified, the term claim as used in the following definitions is applicable equally to each of the three programs.

(1) *Additional UI, UCFE, or UCX claim.* A notice filed at the beginning of a second or subsequent series of claims within a benefit year, when a break in job attachment has occurred since the last claim was filed, concerning which state procedures require that separation information be obtained.

(2) *Additional claim.* An application for determination of eligibility filed on an established claim which follows a period of employment.

(3) *Additional interstate claim.* A claim filed by an interstate claimant within the benefit year of a liable state in which insured status has already been established, after a break in the continuity of filing continued interstate claims, or to establish a new series of claims against that liable state from a new agent state.

(4) *Appealed claim.* See appeal, administrative.

(5) *Combined wage claim.* A claim filed under the interstate wage combining plans. See interstate agreement.

(6) *Compensable claim.* A request for benefit payment which certifies the completion of a week of total or partial unemployment to satisfy a claim benefit for a compensable week.

(7) *Contested claim.* A claim which has been protested by an employer, the department or an interested party regarding the claimant's right to benefits.

(8) *Continued claim.* A continued claim is a request for benefit payment. A continued claim is a compensable claim. It is an electronic, oral or written application which certifies to the completion of a week of total unemployment or partial employment to claim benefits for a compensable week.

(9) *Initial claim.* An application for a determination of eligibility for benefits which determination sets forth the weekly benefit amount and duration of benefits for a benefit year.

(10) *Initial interstate claim.* A new or an additional interstate claim.

(11) *Interstate claim.* A claim filed in one state (agent state) against another state (liable state).

(12) *Intrastate claim.* A claim filed in the state of residence against wages earned in that state or by an interstate commuter.

(13) *Mail claim.* A claim filed by mail.

(14) *New claim.* An application for the establishment of a benefit year.

(15) *New interstate claim.* The first interstate claim filed by a claimant against a liable state which serves as a request for determination of insured status.

(16) *New intrastate extended benefits claim.* The first intrastate claim filed for extended benefits in a new extended benefits period by a claimant in state having extended benefits provisions in its law. Each time such provisions become effective it is considered a new extended benefit period. Such first claims will include those which become effective, without any break in the benefit series, for the week following the week in which regular benefits are exhausted or are terminated by the end of the benefit year.

(17) *New UI, UCFE, or UCX claim.* A request for determination of insured status for purposes of establishing a new benefit year.

(18) *Reopened claim.* The first continued claim in a second or subsequent series of claims in a benefit year when no additional claim is reportable. An application for determination of eligibility for benefits and which certifies to the beginning date of a period of unemployment which falls within a benefit year previously established for which a continued claim or claims may be filed and which follows a break in a claim series previously established, due to illness, disqualification, unavailability, or failure to report for any reason other than reemployment.

(19) *Subsequent benefit year claim.* A new claim with an effective date for a subsequent benefit year which immediately follows the last week of the individual's previous benefit year. The individual is notified by mail of the transition between the benefit years and is requested to provide the department with the information which has changed from the previous benefit year's claim for benefits.

(20) *Transitional claim.* A new claim dated as of any date in the seven-day period immediately following a week benefits were claimed.

(21) *Valid UI, UCFE or UCX claim.* A new claim on which a determination has been made that the individual has met the wage or employment requirements (and, under some laws, other eligibility conditions) to establish a benefit year.

(22) *Voice response continued claim.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.1(26) Claimant.**

a. An individual who has filed a request for determination of insured status or a new claim, or,  
b. An individual who has filed an initial claim unless the claim is found to be invalid or the benefit year has expired.

c. Courtesy claimant. See transient claimant.

d. Transient claimant. A transient claimant is defined as one who is moving from place to place and who indicates to the agent-state local office that the stay will be only temporarily in the area served by that office. Unlike a visiting claimant, a transient claimant does not have the intrastate claim forms and instructions from the regular reporting local office. Refer to subrule 24.23(36).

e. Visiting claimant. A visiting claimant is one who has received permission from the regular reporting office to report temporarily to a local office of another state and who has been furnished intrastate claim forms on which to file claims.

**24.1(27) Reserved.**

**24.1(28) Claim series.** A series of claims filed for continuous weeks of unemployment or for a period of unemployment during which the lapse in compensability or in reporting is deemed by the state insufficient to interrupt the series.

**24.1(29) Compensable claim.** See claim.

**24.1(30) Compensable week.** See week.

**24.1(31) Compensation.** Same as benefits.

**24.1(32) Contested claim.** See claim.

**24.1(33) Continued claim.** See claim.

**24.1(34) Covered employment.** Same as insured work.

**24.1(35) Covered worker.** An individual who has earned wages in insured work.

**24.1(36) Day.** The period of time between any midnight and the midnight following.

**24.1(37) Department.** The chief executive officer of the department of workforce development is the director who shall be appointed by the governor with the approval of two-thirds of the members of the senate. It shall be the duty of the director to administer Iowa Code chapter 96.

**24.1(38) Determination.**

a. *Benefit determination.* A decision with respect to a request for determination of insured status, a notice of unemployment, or a claim for benefits.

b. *Coverage determination.* A determination as to whether an employing unit is a subject employer and whether service performed for it constitutes employment as defined under a state employment security law. See status determination.

c. *Determination of insured status.* A determination as to whether an individual meets the employment requirements necessary for the receipt of benefits; and, if so, such individual's weekly benefit amount and maximum benefit amount.

d. *Initial determination.* The first determination with respect to a claim or a request for determination of insured status.

e. *Monetary determination.* Same as determination of insured status.

f. *Nonmonetary determination.* A determination as to whether a claimant is barred from receiving benefits for reasons other than those affecting the claimant's insured status.

g. *Reconsidered determination.* Same as redetermination.

h. *Redetermination.* A determination made with respect to a claimant after reconsideration by the initial determining authority.

i. *Status determination.* A determination as to whether an employing unit whose status is not known is a subject employer.

**24.1(39) Disqualification provisions.** Those provisions of a state employment security law that set forth the conditions that bar an individual from receiving benefits for a specified period or cancel or reduce the individual's benefits or credits.

**24.1(40) Duration of benefits.** The number of weeks for which benefits are paid or payable for total unemployment in a benefit year. Because there may be deductible wages and other compensation,

duration is often described in terms of the total amount of benefits arrived at by multiplying the weekly benefit amount by the number of weeks of total unemployment.

*a. Actual duration.* The number of full weeks of benefits received by an individual, or the equivalent thereof expressed in terms of dollars.

*b. Maximum duration.* The highest number of weeks of total unemployment for which benefits are payable to any individual in a benefit year under a state employment security law.

**24.1(41) Earnings limit.** An amount equal to the weekly benefit amount plus \$15.

**24.1(42) Eligibility requirements.** Same as benefit eligibility conditions.

**24.1(43) Employment interview.** A conversation between an applicant and an interviewer directed toward obtaining and recording information pertinent to classification and selection, and giving information pertinent to job seeking.

**24.1(44) Employment office.** An office maintained by the department of workforce development in accordance with Iowa Code sections 96.12 and 96.25.

**24.1(45) Employment security administration fund.** See funds.

**24.1(46) Employment security law.** A body of law which establishes a free public employment service, or a system of unemployment insurance, or both and which may also establish other systems compensating for wage loss, such as temporary disability insurance in Iowa Code chapter 96.

**24.1(47) Employment security program.** The federal-state program comprising public employment services and unemployment insurance.

**24.1(48) Fact-finding interview.** A face-to-face or telephonic discussion between interested parties and a department representative for the purpose of obtaining from the claimant a statement containing information on a specific eligibility or disqualification issue. This differs from an eligibility review interview in that a specific issue must exist as a result of a statement made by either the claimant, the liable state, an employer, or the staff of the department.

**24.1(49) First UI, UCFE, or UCX payment.** A payment issued to a claimant for the first compensable week of unemployment in a benefit year.

**24.1(50) Full-time week.** See week.

**24.1(51) Funds.**

*a. Administrative funds.* Funds made available from federal, state, local and other sources to meet the cost of state employment security administration.

*b. Contingency fund.* An amount of money appropriated by Congress to meet certain unpredictable increases in costs of administration by the state employment security agencies arising from increases in workload or other specified causes.

*c. Special employment security contingency fund.* A contingency fund established pursuant to Iowa Code section 96.13(3) into which all interest, fines, and penalties are paid.

*d. Employment security administration fund.* A special fund in the state treasury, established by state law, in which are deposited moneys granted by the manpower administration and monies from other sources, for the purpose of paying the cost of administering the state employment security program.

*e. Title V funds.* Funds appropriated by Congress to pay unemployment insurance benefits under Title V of the United States Code to federal, civilian and military employees.

*f. Unemployment fund.* A special fund established under a state employment security law for the receipt and management of contributions and the payment of unemployment account, clearing account, and unemployment trust fund account.

*g. Unemployment trust fund.* A fund established in the treasury of the United States which contains all moneys deposited with the treasury by state employment security agencies to the credit of their unemployment fund accounts and by the railroad retirement board to the credit of the railroad unemployment insurance account.

**24.1(52) Handbook.** The handbook for interstate claims-taking provided by the Employment and Training Administration of the United States Department of Labor.

**24.1(53) High quarter formula.** See benefit formula.

**24.1(54) to 24.1(56) Reserved.**

**24.1(57) Individual base period.** See base period.

**24.1(58)** *Individual benefit year.* See benefit year.

**24.1(59)** *Initial claim.* See claim.

**24.1(60)** *Initial determination.* See determination.

**24.1(61)** *Insured unemployment.* Unemployment during a given week for which benefits are claimed under the state employment security program, the unemployment compensation for federal employees program, the unemployment compensation for veterans program, or the railroad unemployment insurance program.

**24.1(62)** *Insured work.* Employment, as defined in a state employment security law, performed for a subject employer, or federal employment as defined in the Social Security Act.

**24.1(63)** *Insured worker.* An individual who has had sufficient insured work in such individual's base period to meet the employment requirements for receipt of benefits under a state employment security law.

**24.1(64)** *Interstate agreement.*

*a. Interstate benefit payment plan.* The plan under which each state acts as an agent for every other state in taking claims for individuals who are not in the state in which they earned their base period wages.

*b. Interstate reciprocal coverage agreement.* An administrative interstate agreement, permitted under most state employment security laws, which provides for the election of coverage of services under specified conditions which may or may not constitute an exception to the mandatory coverage provisions of the state law.

*c. Wage-combining agreements.* An interstate agreement which allows workers who lack qualifying wages in any one state, or who qualify for less than maximum benefits in one or more states, to qualify or to increase benefits by combining wages from all states.

**24.1(65)** *Interstate claim.* See claim.

**24.1(66)** *Interstate claimant.* An individual who files a claim for benefits in an agent state on the basis of employment covered by the employment security law of a liable state.

**24.1(67)** *Benefit rights information.* Information provided to a claimant for the purpose of explaining the claimant's rights and responsibilities under the law. Such information may be given on a group basis or on an individual basis or the information may be provided electronically.

**24.1(68)** *Office.*

*a. Unemployment insurance service center.* A full-time office staffed with workforce development staff to provide unemployment insurance services to the public.

*b. Workforce development center.* A full-time office staffed with workforce development personnel to provide unemployment insurance or job placement service to the public.

**24.1(69)** *Lag quarter.* The completed quarter between a claimant's base period and the quarter which includes the beginning date of such claimant's benefit year.

**24.1(70)** *Layoffs.* See separations.

**24.1(71)** *Liable state.* Any state against which a worker claims benefits through the facilities of a workforce development center or the job service division of another (agent) state. See also agent state.

**24.1(72)** *Mail claim.* See continued claims.

**24.1(73)** *Mass separation.* The separation from a given employing unit of a large number of workers at approximately the same time and for a reason common to all such workers.

**24.1(74)** *Mass separation notice.* A report of a mass separation sent to the local workforce development center by an employer, stating the number of workers separated and listing their names and other required data. Such a notice serves as a substitute for individual separation notices.

**24.1(75)** *Maximum benefit amount.* The maximum total amount of benefits an individual may receive during the individual's benefit year.

**24.1(76)** *Maximum benefits.* The maximum total amount of benefits payable to a claimant during the claimant's benefit year.

**24.1(77)** *Maximum weekly benefit amount.* See benefit amount.

**24.1(78)** *Microfiche.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.1(79)** *Military separations.* See separations.

- 24.1(80)** *Minimum weekly benefit amount.* See benefit amount.
- 24.1(81)** *Month.* The time beginning with any day of one month to the corresponding day of the next month, or if there is no corresponding day, then through the last day of the next month.
- 24.1(82)** *Multistate worker.* An individual who performs service for one employer in more than one state.
- 24.1(83)** *New claim.* See claim.
- 24.1(84)** *Noncovered employment.* Excluded employment, or employment for an employer below the size-of-firm coverage requirements of the state employment security law.
- 24.1(85)** *Notice of separation.* A report submitted by an employer at the time when a worker is separated from employment, on which the employer indicates the dates of the last day worked, the separation date and the reason the worker was separated.
- 24.1(86)** *Odd job earnings.* Any earnings which a claimant may have during a week of unemployment as a result of temporary work with an employing unit other than the claimant's regular employing unit.
- 24.1(87)** *Opening.* A single job for which a workforce development center has on file a request to select and refer an applicant or applicants.
- 24.1(88)** *Outstanding job order request.* An active request for referral of one or more applicants to fill one or more job openings in a single occupational classification; also, the record of such request.
- 24.1(89)** *Clearance order.* Rescinded IAB 8/6/03, effective 9/10/03.
- 24.1(90)** *Partial benefits.* Benefits payable to an individual for a week of partial unemployment.
- 24.1(91)** *Partial earnings allowance.* The amount of earnings that are disregarded in calculating a claimant's benefit for a week.
- 24.1(92)** *Partial unemployment.* See week of unemployment.
- 24.1(93)** *Part-time worker.* A person engaged in, or available only for, part-time work.
- 24.1(94)** *Placement.* An acceptance by an employer of a person for a job as a direct result of workforce development center activities, provided the employment office has completed all of the following four steps: receipt of an order, prior to referral; selection of the person to be referred without designation by the employer of any particular individual or group of individuals; referral; and verification from a reliable source, preferably the employer, that a person referred has been hired by the employer and has entered on the job.
- 24.1(95)** Reserved.
- 24.1(96)** *Qualifying employment.* The amount of insured work which an individual must have had within a specified period in order to be an insured worker. See also benefit eligibility conditions.
- 24.1(97)** *Qualifying wages.* See wages.
- 24.1(98)** *Quits.* See separations.
- 24.1(99)** *Railroad unemployment insurance account.* An account, established pursuant to the Railroad Unemployment Insurance Act, maintained in the federal unemployment trust fund for the payment of benefits provided in that Act.
- 24.1(100)** *Readout.* Printed data from the claimant database or other types of records stored in the computer.
- 24.1(101)** *Reciprocal coverage agreement.* See interstate agreements.
- 24.1(102)** *Reconsidered determination.* Same as redetermination—see determination.
- 24.1(103)** *Referee appeals.* See appeal, administrative. (Administrative law judge)
- 24.1(104)** *Referral.* The act of arranging to bring to the attention of an employer (or another workforce development center) the qualifications of an applicant who is available for a job opening on file for which the applicant has been selected by a workforce development center.
- 24.1(105)** *Registration.* The process of applying for work through an office of the department of workforce development.
- 24.1(106)** *Report to determine liability.* Same as status report.
- 24.1(107)** *Reporting requirements.* The rules of procedures of the department of workforce development concerning the frequency and time of required reporting by claimants.

**24.1(108) *Renewal.*** The transfer from the inactive to the active file of the application of an applicant who is again considered to be available for referral to job openings.

**24.1(109) *Request for determination of insured status.*** A request by an individual for a determination of insured status.

**24.1(110) *Selection.*** The process of choosing a qualified applicant for referral to a job by carefully analyzing and comparing employer requirements with applicant interests and abilities.

**24.1(111) *Self-employment.***

**24.1(112) *Self-filing (of claim).*** The partial or complete filling out of a claim form or request for determination of insured status by the claimant.

**24.1(113) *Separations.*** All terminations of employment, generally classifiable as layoffs, quits, discharges, or other separations.

*a. Layoffs.* A layoff is a suspension from pay status initiated by the employer without prejudice to the worker for such reasons as: lack of orders, model changeover, termination of seasonal or temporary employment, inventory-taking, introduction of laborsaving devices, plant breakdown, shortage of materials; including temporarily furloughed employees and employees placed on unpaid vacations.

*b. Quits.* A quit is a termination of employment initiated by the employee for any reason except mandatory retirement or transfer to another establishment of the same firm, or for service in the armed forces.

*c. Discharge.* A discharge is a termination of employment initiated by the employer for such reasons as incompetence, violation of rules, dishonesty, laziness, absenteeism, insubordination, failure to pass probationary period.

*d. Other separations.* Terminations of employment for military duty lasting or expected to last more than 30 calendar days, retirement, permanent disability, and failure to meet the physical standards required.

**24.1(114) *Short-time placement.*** A placement in a job which the employer expects to involve work in each of three days or less, whether or not consecutive.

**24.1(115) *Social security number.*** The identification number assigned to an individual by the Social Security Administration under the Social Security Act.

**24.1(116) *Status determination.*** See determination.

**24.1(117) *Supplemental benefit payment.*** A payment issued for the sole purpose of adjusting an underpayment for one or more previous weeks.

**24.1(118) *Taxable wages.*** See wages.

**24.1(119) *Total unemployment.*** See week of unemployment.

**24.1(120)** Reserved.

**24.1(121) *Transient.*** A claimant who is moving from place to place and who indicates to the agent-state area claims office that such claimant will be only temporarily in the area served by the area office.

**24.1(122) *Unemployment fund.*** See funds.

**24.1(123) *Unemployment trust fund.*** See funds.

**24.1(124) *Unemployment trust fund account.*** See accounts.

**24.1(125) *Valid claim.*** See claim.

**24.1(126) *Verification.*** The determination from a reliable source, preferably the employer, whether an applicant referred by a workforce development center has been hired by the employer and has entered on the job. In the case of applicants referred to seasonal agricultural openings, verification is considered complete when it is confirmed that a referred worker has been hired, even though confirmation of the worker's entry on the job may be lacking.

**24.1(127) *Visiting claimant.*** A claimant who files claims against such claimant's home state through some extension of that state's intrastate claims procedures.

**24.1(128) *Wage combining agreement.*** See interstate agreement.

**24.1(129) *Wage credits.*** Wages earned in insured work.

**24.1(130) *Wages.*** Average weekly wages.

*a.* For an individual worker, the result obtained by dividing the individual's total wages in a specified period either by the total number of weeks in the period or by the number of weeks for which wages were payable to the individual during the period.

*b.* For a group of workers, the result obtained by dividing the total wages for one or more quarters by the number of weeks in the period, and then dividing by the average monthly employment during the period.

**24.1(131) *Qualifying wages.*** The amount of wages a worker must have earned in insured work within a specified period in order to be an insured worker. See also benefit eligibility conditions.

**24.1(132) *Taxable wages.*** Wages subject to contribution under a state employment security law, or wages subject to tax under the federal Unemployment Tax Act.

**24.1(133)** Reserved.

**24.1(134) *Weekly indemnity insurance benefits.*** Payment for nonoccupational illness or injury pursuant to a benefit plan implemented by an employer.

**24.1(135) *Week.*** A seven-day period beginning at 12:01 a.m. on Sunday and terminating at midnight on the following Saturday.

*a. Calendar week.* A period of seven consecutive days usually ending at Saturday midnight, used by some state employment security agencies as a unit in the measurement of employment or unemployment.

*b. Compensable week.* A week for which benefits have been claimed.

*c. Full-time week.* The number of hours or days per week currently established by schedule, custom, or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

**24.1(136) *Weekly benefit amount.*** See benefit amount, or,

**24.1(137) *Weekly benefit amount.*** The compensation payable to an individual, with respect to employment, under the employment security law of any state.

**24.1(138) *Week of unemployment.*** A week in which an individual performs less than full-time work for any employing unit if the wages payable with respect to such week are less than a specified amount (usually the weekly benefit amount), or,

**24.1(139) *Week of unemployment.*** A week during which an individual performs no work and earns no wages, except as indicated and has earnings which do not exceed the earnings limit.

*a. Week of partial unemployment.* A week in which an individual worked less than the regular full-time hours for such individual's regular employer, because of lack of work, and earned less than the weekly benefit amount (plus the partial earnings allowance, if any, in the state's definition of unemployment) but more than the partial earnings allowance, so that, if eligible for benefits, the claimant received less than such claimant's full weekly benefit amount plus \$15.

*b. Week of part total unemployment.* A week of otherwise total unemployment during which an individual has odd jobs or subsidiary work with earnings in excess of the amount specified in the state law as allowable without resulting in a reduction in the individual's benefit payment.

*c. Week of total unemployment.* A week in which an individual performs no work and earns no wages.

**24.1(140) *Workload.*** The measure of the volume of work for each functional area of the state agency; i.e., the number of contribution (payroll) reports processed, the number of claims taken, the number of applications for employment.

This rule is intended to implement Iowa Code sections 96.3(5), 96.3(7), 96.4(3), 96.5(5) "c," 96.6, 96.7(2) "a"(2), 96.11, 96.19(16), and 96.23.  
[ARC 3116C, IAB 6/7/17, effective 7/12/17]

#### **871—24.2(96) Procedures for workers desiring to file a claim for benefits for unemployment insurance.**

**24.2(1)** Section 96.6 of the employment security law of Iowa states that claims for benefits shall be made in accordance with such rules as the department prescribes. The department of workforce development accordingly prescribes:

a. Following separation from work, any individual, in order to establish a benefit year during which the individual may receive benefits because of unemployment shall report in person to the nearest workforce development center which takes claims and shall file an initial claim for benefits and register for work.

(1) An individual may file an initial claim for unemployment benefits by telephone, in person or other means prescribed by the department or may call the service center during regular business hours. Claims filed in accordance with this rule shall be deemed filed as of Sunday of the week in which the claim is filed.

(2) Reserved.

b. The procedure for filing an initial claim. An individual, following a separation from work, shall report in person at the nearest workforce development center with the individual's social security number, and the individual shall register for work and file a claim for benefits on the Form 60-0330, Application for Job Placement Assistance and/or Job Insurance, prescribed by the department and shall provide, in addition to other requested information, the following information:

- (1) The name and complete mailing address of such individual's last employing unit or employer;
- (2) The location of the last job;
- (3) Last day of work;
- (4) The reason for separation from work;
- (5) That such individual is unemployed;
- (6) That the individual registers for work;
- (7) The individual's last job occupation;

(8) Number, name and relationship of any dependents claimed. As used in this subparagraph, "dependent" is defined as: spouse, son or daughter of the claimant, or a dependent of either; stepson or stepdaughter; foster child or child for whom claimant is a legal guardian; brother, sister, stepbrother, stepsister; father or mother of claimant, stepfather or stepmother of the claimant; son or daughter of a brother or sister of the claimant (nephew or niece); brother or sister of the father or mother of the claimant (uncle or aunt); son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the claimant; an individual who lived in the claimant's home as a member of the household for the whole year; cousin.

A "spouse" is defined as an individual who does not earn more than \$120 in gross wages in one week. The reference week for this monetary determination shall be the gross wages earned by the spouse in the calendar week immediately preceding the effective date of the claim.

A "dependent" means an individual who has been or could have been claimed for the preceding tax year on the claimant's income tax return or will be claimed for the current income tax year. The same dependent shall not be claimed on two separate monetarily eligible concurrent established benefit years. An individual cannot claim a spouse as a dependent if the spouse has listed the claimant as a dependent on a current claim.

(9) The option of filing for continued benefits by using the voice response continued claim system or by other means designated by the department.

(10) Such other information as required by the form.

c. All claimants on an initial claim shall state that they are registered for work and shall list their principal occupation. The claims taker will then assign a group code to the claimant to control the type of registration that is made. Code assignments will be based on all facts obtained at the time of the claim filing. The group codes are:

(1) Group "1" claimants are workers who have a definite attachment to a specific employer or trade and have reasonable employment prospects in a reasonable period of time. These claimants will be registered for work.

(2) Group "2" claimants are those individuals who do not otherwise meet the qualification for group "1," "3," "4," "5," or "6" under this section. Group "2" claimants may also include the following: claimants who were employed in demand occupations; irregular employment record (in reference to occupation); delay in claim filing; moved to address remote from labor market or transportation problems; unfavorable job prospects because of recent arrival in locality; farming

activities; self-employment assuming otherwise eligible; students or prospective students; pensioners; domestic care or problems; previous fraud or overpayment record; physical impairment or poor health which would limit employability; personal or other restrictions (wages, hours, travel).

(3) Group “3” claimants are workers who are employed on a reduced workweek or temporarily unemployed for a period, verified by the department, of four consecutive weeks or less, due to a plant shutdown, vacation, inventory, lack of work or emergency from the individual’s regular “employer.” This group pertains only to those individuals who worked full-time and will again work full-time if the individual’s employment, although temporarily suspended, has not been terminated. After a period of temporary unemployment, claimants in this group are reviewed for placement in group “1,” “2,” “5” or “6.”

(4) Group “4” claimants are those individuals who have left employment in lieu of exercising their right to bump or oust a fellow employee with less seniority or priority from the fellow employee’s job. Group “4” claimants with an individual benefit year starting prior to July 1, 1984, shall be able to work, available for work and have the search for work provisions of Iowa Code section 96.4(3) waived. Group “4” claimants with an individual benefit year starting on or after July 1, 1984, shall have only the search for work provision of Iowa Code section 96.4(3) and the disqualification provision for failure to apply for or to accept suitable work of Iowa Code section 96.5(3) waived. The group “4” code shall not apply to weeks claimed under the extended benefit or federal supplemental compensation programs.

(5) Group “5” claimants are those individuals who are members of unions, trades, or professionals having their own placement facilities. Claimants assigned to this group will be registered for work. A paid-up membership is acceptable as evidence of membership in such an organization. Loss of membership shall result in an assignment to group “2.”

(6) Group “6” claimants are those individuals whose occupations are of a nature that utilize résumés or who are normally unable, due to factors such as occupation, distance, etc., to make in-person contacts for employment.

(7) Nothing in this rule shall be construed as prohibiting an authorized representative of the department from requiring claimants for unemployment insurance benefits to avail themselves of workforce development center referral and counseling services if deemed beneficial and necessary to obtain prompt reemployment, nor shall anything in this rule be construed to deny referral or counseling service to claimants for unemployment insurance benefits.

*d.* Reserved.

*e.* In order to maintain continuing eligibility for benefits during any continuous period of unemployment, an individual shall report as directed to do so by an authorized representative of the department. If the individual has moved to another locality, the individual may register and report in person at a workforce development center at the time previously specified for the reporting.

The method of reporting shall be weekly if a voice response continued claim is filed, unless otherwise directed by an authorized representative of the department. An individual who files a voice response continued claim will have the benefit payment automatically deposited weekly in the individual’s account at a financial institution or be paid by the mailing of a warrant on a biweekly basis.

In order for an individual to receive payment by direct deposit, the individual must provide the department with the appropriate bank routing code number and a checking or savings account number.

The department retains the ultimate authority to choose the method of reporting and payment.

*f.* After the initial claim has been filed, the claimant will receive from the local office or the administrative office a Form 65-5318, which is a notice of the action taken on the claim, and if such claimant is eligible for benefits this notice will state the date on which the benefit year will begin, the amount per week, and the maximum amount for which the claimant is eligible.

*g.* No continued claim for benefits shall be allowed until the individual claiming benefits has completed a voice response continued claim or claimed benefits as otherwise directed by the department. The weekly voice response continued claim shall be transmitted not earlier than noon of the Saturday of the weekly reporting period and, unless reasonable cause can be shown for the delay, not later than close of business on the Friday following the weekly reporting period.

An individual claiming benefits using the weekly voice continued claim system shall personally answer and record such claim on the system unless the individual is disabled and has received prior approval from the department.

The individual shall set forth the following:

- (1) That the individual continues the claim for benefits;
- (2) That except as otherwise indicated, during the period covered by the claim the individual was unemployed, earned no wages and received no benefits, was able to work and available for work;
- (3) That the individual indicates the number of employers contacted for work;
- (4) That the individual knows the law provides penalties for false statements in connection with the claim;
- (5) That the individual has reported any job offer received during the period covered by the claim;
- (6) Other information required by the department.

*h.* Effective starting date for the benefit year.

(1) Filing for benefits shall be effective as of Sunday of the current calendar week in which, subsequent to the individual's separation from work, an individual files a claim for benefits.

(2) The claim may be backdated prior to the first day of the calendar week in which the claimant does report and file a claim for the following reasons:

1. The failure of the department to recognize the expiration of the claimant's previous benefit year;
2. The claimant filed an interstate claim against another state which has been determined as ineligible.

(3) When the benefit year expires on any day but Saturday, the effective date of the new claim is the Sunday of the current week in which the claim is filed even though it may overlap into the old benefit year up to six days. However, backdating shall not be allowed at the change of a calendar quarter if the backdating would cause an overlap of the same quarter in two base periods. When the overlap situation occurs, the effective date of the new claim may be postdated up to six days. If the claimant has benefits remaining on the old claim, the claimant may be eligible for benefits for that period by extending the old benefit year up to six days.

*i.* An individual shall be entitled to partial benefits for any week of less than full-time work, provided the wages earned during such week are less than the individual's weekly benefit earning limit, plus \$15. If the individual has been placed on reduced employment the individual may be entitled to partial benefits, and should file a claim in accordance with the instructions pertaining to the partial claims procedure.

*j.* Reserved.

*k.* Any individual who is disqualified for benefits because of the individual's failure to report as directed to file a claim following the date specified may appeal to the department for the right to establish good cause for failure to report because of extraordinary circumstances. A representative of the department may deny the request and the decision may be appealed to an administrative law judge for a hearing and decision on the merits. If the petition is allowed the petitioner shall be allowed to file a claim for and receive full benefits for each week for which such claim is filed, if otherwise eligible.

**24.2(2)** Filing a claim for unemployment insurance benefits (not applicable to interstate claims).

*a.* A notice of claim filing, which includes the name and social security number of the individual claiming benefits, shall be sent to each base period employer on record and the last employer if different than the base period employer unless the separation issue has previously been adjudicated.

*b.* Even though the claims taker may believe that the claimant cannot meet the eligibility conditions required by statute, the claims taker shall in no instance refuse to accept a claim from any unemployed individual. If the claimant elects to file a claim, even though the claimant's eligibility may be questionable, the claim shall be accepted without hesitation. The claimant must provide adequate proof of identification such as a driver's license, car registration, or union membership card or supply personally identifying information.

*c.* If a claim was filed in a previous quarter and was determined not eligible because of no wage records, or lack of qualifying earnings, a benefit year has not been established and a new claim will be taken. A new claim should not be taken if the claimant previously has filed an ineligible claim in the

same quarter unless the claimant insists on filing after being advised of ineligibility. The claims taker shall explain to the claimant that another claim filed in the same quarter would also be determined as ineligible because additional wage credits (if any) would not be available until a subsequent quarter. The claimant should be advised to file a new claim during the first full week of the next calendar quarter.

*d.* If the check of the files does not disclose a previous claim and the claimant states that a claim has not been filed during the past year, a new claim shall be taken.

*e.* Partially unemployed claims.

(1) A partially unemployed individual shall file a claim for benefits in the same manner as an initial claim for unemployment insurance.

(2) Reporting wages. A partially unemployed individual shall report all wages which are earned for each week benefits are claimed.

(3) A claimant in a continuous reporting status, employed with the same employer, may exceed the claimant's weekly benefit amount plus \$15 for four consecutive weeks before the individual is required to file an additional claim for benefits.

**24.2(3)** Filing a claim for unemployment insurance benefits (interstate only).

*a.* Initial interstate claims. The filing of an initial interstate claim shall conform to all requirements of this rule with the exception of the initial claim form. Both agent and liable states shall use the Initial Interstate Claim, Form 61-1000(IB-1), unless otherwise directed by the Interstate Handbook.

*b.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.2(4)** Cancellation of unemployment insurance claim.

*a.* A request for cancellation of an unemployment insurance claim may be made by the individual in writing and be directed to the Unemployment Insurance Service Center, Department of Workforce Development, P.O. Box 10332, Des Moines, Iowa 50306. The statement must include the specific reason for the request and contain as much pertinent information as possible so that a decision can be made.

*b.* A cancellation request which is the result of employer coercion or intimidation shall be denied and the employer could be subjected to serious misdemeanor charges.

*c.* Cancellation requests within the ten-day protest period. The claims section, upon review of the timely request and before payment is made, may cancel the claim for the following reasons:

(1) The individual found employment or returned to regular employment within the protest period.

(2) Cancellation would allow the individual to refile at the change of a calendar quarter to obtain an increase in the weekly or maximum benefit amount or the individual would receive more entitlement from another state.

(3) The individual filed a claim in good faith under the assumption of being separated and no actual separation occurred.

(4) The individual did not want to establish a benefit year because of eligibility for a low weekly or maximum benefit amount.

*d.* Other valid reasons for cancellation whether or not ten-day protest period has expired.

(1) The individual has an unexpired unemployment insurance claim in another state and is eligible for a remaining balance of benefits.

(2) The individual received erroneous information regarding entitlement or eligibility to unemployment insurance benefits from an employee of the department.

(3) The individual has an unexpired railroad unemployment insurance claim with a remaining benefit balance which was filed prior to the unemployment insurance claim.

(4) The individual exercises the option to cancel a combined wage claim within the ten days allowed by federal regulation.

(5) The individual has previously filed a military claim in another state or territory. Wages erroneously assigned to Iowa must be deleted and an interstate claim must be filed.

(6) Federal wages have previously been assigned to another state or territory or are assignable to another state or territory under federal regulation. Federal wages erroneously assigned to Iowa must be deleted and the appropriate type of claim filed.

(7) The Iowa wages are erroneous and are deleted and the wages from one other state were used, the claim shall be canceled and the wages returned to the transferring state.

*e.* If a claim is canceled and becomes final with no appeal being filed, a valid claim with Iowa as the paying state shall not be reestablished with the same effective date.

*f.* Voiding a claim. If it is determined a claim has been filed under an incorrect social security number, the claim shall be voided rather than canceled.

*g.* All unemployment insurance claims canceled shall be clearly identified as such and the administrative record of the individual's file shall be destroyed three years after final action.

This rule is intended to implement Iowa Code sections 96.3(3), 96.3(4), 96.4(1), 96.4(3), 96.5(1) "h," 96.5(3), 96.6(1), 96.6(2), 96.15, 96.16, 96.19(4), 96.19(24), and 96.20.  
[ARC 3116C, IAB 6/7/17, effective 7/12/17]

#### **871—24.3(96) Social security number needed for filing.**

**24.3(1)** The claims taker must have the social security number of the claimant. The correct social security number is essential in the processing of the claim. Therefore, if the claimant has a social security card, the number must be taken from that card or be provided by the claimant. If the claimant has two or more social security numbers, the claim shall be held until the claimant ascertains which number is correct.

**24.3(2)** When a claimant does not have a social security card and no other record of the claimant's social security number is available the claims taker shall advise the claimant that the number may be available from the claimant's employer.

**24.3(3)** In all such instances, the claims taker shall take the claim and hold it pending receipt of the social security number for a period not to exceed 30 days. If no number is provided by the claimant within 30 days, the claims taker shall submit the claim without a number. Such claims will be determined as ineligible (no wage credits).

**24.3(4)** and **24.3(5)** Rescinded IAB 8/6/03, effective 9/10/03.

**24.3(6)** The department will assist the claimant in every reasonable manner so that the claim may be processed in the shortest possible time.

#### **871—24.4(96) Benefit rights information.**

**24.4(1)** *Intrastate benefits.* Benefit rights information is provided to each individual filing an initial claim for benefits to explain those provisions in the law and rules which govern the individual's monetary eligibility, rights and responsibilities under Iowa's unemployment insurance program. The benefit rights information may be given by an individual or group type interview or by telephone or electronically. A Form 70-6200, Facts About Unemployment Insurance, will be provided which explains the individual's rights, benefits, and responsibilities under Iowa's unemployment insurance program.

**24.4(2)** *Interstate benefits.* Benefit rights information is not required for each individual who files an initial claim for interstate benefits. Claimants will be advised to contact the liable state which will provide additional information explaining the individual's rights, benefits, and responsibilities under the liable state's unemployment insurance program.

**24.4(3)** *Federal benefits.* Rescinded IAB 8/6/03, effective 9/10/03.

#### **871—24.5(96) Mass separation—definition and procedure.**

**24.5(1)** *Mass separation.* A mass separation is a layoff of all or a large number of workers, either permanently, indefinitely, or for a specific duration by one or more employers in the same area, at approximately the same time, and for the same common reason.

*a.* The special procedures for mass claim filing may be applied by the department, and the procedures may include taking claims at a designated site or utilizing an electronic mass claim entry form.

*b.* If other facilities must be obtained for a mass layoff, the order of precedence for obtaining such facilities will be as follows:

- (1) Interested employer involved.
- (2) Bona fide union which represents the workers.
- (3) Public facility (i.e., courthouse, city hall).

**24.5(2) Cooperation of employers.** To enable workforce development centers to make the preliminary arrangements for mass claim taking, the major employers in the area should notify the local office in advance, as soon as they know that a mass separation will take place. The workforce development center shall provide the information to legal counsel for the unemployment insurance services bureau so that the mass claim separation can be coordinated between the affected parties. This information should include:

- a. The number of workers to be separated.
- b. The date of separation and, if staggered, the number on each date.
- c. Reason for layoff.
- d. Its probable duration.
- e. If recall is anticipated, the date it will begin and, if staggered, the number to be recalled on each date.
- f. Rescinded IAB 8/6/03, effective 9/10/03.
- g. Reserved.
- h. If the layoff is for vacation or inventory purposes, the employer shall follow the vacation pay procedure in rules 871—24.16(96) and 871—24.17(96).

**24.5(3) Methods of mass claim taking.** The department may adopt a plan, which is based on the employer's workers, the circumstances and the size of the layoff.

**24.5(4) Announced mass separation.** If a mass separation occurs about which the department of workforce development has not been advised in advance in sufficient time to preschedule claimants, then the claimants will be advised of the alternative methods to file their claims as quickly as possible. The department will develop a plan to provide service to the claimants as quickly as possible under the circumstances.

This rule is intended to implement Iowa Code section 96.6(1).

#### **871—24.6(96) Profiling for reemployment services.**

**24.6(1)** The department of workforce development and the department of economic development will jointly provide a program which consists of profiling claimants and providing reemployment services.

**24.6(2)** Profiling is a systematic procedure used to identify claimants who, because of certain characteristics, are determined to be permanently separated and most likely to exhaust benefits. Such claimants may be referred to reemployment services.

**24.6(3)** Reemployment services may include, but are not limited to, the following:

- a. An assessment of the claimant's aptitude, work history, and interest.
- b. Employment counseling regarding reemployment approaches and plans.
- c. Job search assistance and job placement services.
- d. Labor market information.
- e. Job search workshops or job clubs and referrals to employers.
- f. Résumé preparation.
- g. Other similar services.

**24.6(4)** As part of the initial intake procedure, each claimant shall be required to provide the information necessary for profiling and evaluation of the likelihood of needing reemployment assistance.

**24.6(5)** The referral of a claimant and the provision of reemployment services is subject to the availability of funding and limitations of the size of the classes.

**24.6(6)** A claimant shall participate in reemployment services when referred by the department unless the claimant establishes justifiable cause for failure to participate or the claimant has previously completed such training or services. Failure by the claimant to participate without justifiable cause shall disqualify the claimant from the receipt of benefits until the claimant participates in the reemployment services.

a. Justifiable cause for failure to participate is an important and significant reason which a reasonable person would consider adequate justification in view of the paramount importance of reemployment to the claimant.

b. Reserved.

This rule is intended to implement Iowa Code section 96.4(7).

**871—24.7(96) Workers' compensation or indemnity insurance exclusion and substitution.**

**24.7(1)** An individual who has received workers' compensation under Iowa Code chapter 85 during a healing period or temporary total disability benefits or indemnity insurance benefits for an extended period of time and has insufficient wage credits in the base period may qualify for unemployment insurance benefits. Under specific circumstances as described below, the department shall exclude certain quarters in the base period and substitute three or more consecutive calendar quarters immediately preceding the base period which were prior to the workers' compensation or indemnity insurance benefits.

**24.7(2)** An individual may receive workers' compensation during a healing period or temporary total disability benefits or indemnity insurance benefits until the individual returns to work or is medically capable of returning to employment substantially similar to the employment in which the employee was engaged at the time of injury.

**24.7(3)** The department shall make an initial determination of eligibility for unemployment insurance benefits. If the individual has no wage records or lacks qualifying wage requirements, the department shall substitute three or more calendar quarters of the base period with those three or more consecutive calendar quarters immediately preceding the base period in which the individual did not receive workers' compensation benefits or indemnity insurance benefits. The qualifying criteria for substituting quarters in the base period are that the individual:

a. Must have received workers' compensation benefits under Iowa Code chapter 85 or indemnity insurance benefits for which an employer is responsible during the excluded quarters, and

b. Did not work in and receive wages from insured work for:

(1) Three or more calendar quarters in the base period, or

(2) Two calendar quarters and lacked qualifying wages from insured work during another quarter of the base period.

**24.7(4)** Subject to the provisions of subrule 24.7(3), the department shall use the following criteria for allowances and disqualifications.

a. *Allowances.* When the allowance criteria are met, the department shall always exclude and substitute at least three quarters of the base period if the individual received workers' compensation or indemnity insurance benefits in:

(1) Four base period quarters with no earnings in at least two of the quarters and the individual lacks qualifying earnings, the department will exclude and substitute all four quarters of the base period.

(2) Three no earnings base period quarters, with or without earnings in the fourth quarter, the fourth quarter remains in the base period and the department will exclude and substitute only three quarters in the base period.

b. *Disqualifications.* The request for retroactive substitution of base period quarters shall be denied if the individual received workers' compensation or indemnity insurance benefits in:

(1) At least three base period quarters but the individual is currently monetarily eligible with an established weekly and maximum benefit amount.

(2) At least three base period quarters and the individual has base period wages in three or more of the base period quarters, but the claim lacks qualifying earnings.

(3) Less than three base period quarters.

**24.7(5)** The individual shall be requested to complete the Affidavit and Questionnaire, Form 60-0286, which requests the following information:

a. Individual's name and social security number.

b. Name of employer responsible for the workers' compensation benefits or the indemnity insurance benefits.

c. Names of employers and periods worked for the period preceding the workers' compensation or the indemnity insurance pay period.

*d.* Name of the workers' compensation or indemnity insurance carrier or, if self-insured, the name of the employer.

*e.* Specify whether the wages determined to be in the individual's base period were or were not received for working in insured work during the base period.

**24.7(6)** The department will mail the redetermined initial claim to the individual. When the claim for benefits is determined to be monetarily eligible for payment, the employer responsible for the workers' compensation or the indemnity insurance benefits shall be notified of the redetermination and shall be responsible for the charges on the redetermined claim which are solely due to wage credits considered to be in the individual's base period due to the exclusion and substitution of calendar quarters. The employer responsible for the workers' compensation or indemnity insurance benefits shall have the right to protest as provided in rule 871—24.8(96).

**871—24.8(96) Notifying employing units of claims filed, requests for wage and separation information, and decisions made.**

**24.8(1)** Mailing of a notice of the filing of an initial claim or a request for wage and separation information to employing units.

*a.* The Form 65-5317, Notice of Claim, and the Form 68-0221, Request for Wage and Separation Information, shall be addressed to:

(1) The address or addresses as requested by the employing unit and agreed to by the department;  
or

(2) The business office of the employing unit where the records of the individual's employment are maintained; or

(3) The employing unit's place of business where the individual claiming benefits was most recently employed.

*b.* A notice of the filing of an initial claim or a request for wage and separation information shall be mailed to an owner, partner, executive officer, departmental manager or other responsible employee of the employing unit or to an agent designated to represent the employing unit in unemployment insurance matters.

(1) An agent who has been authorized to represent an employing unit in unemployment insurance matters may be furnished information from the files of the department to the extent designated in the authorization and in the same manner and to the same extent that the information would be furnished to the employing unit.

(2) The appointment of an agent to act for the employing unit and to receive documents and reports in no way abrogates the right of department representatives to deal directly with the employing unit when it appears that this will best serve the interest of the parties.

**24.8(2)** Responding by employing units to a notice of the filing of an initial claim or a request for wage and separation information and protesting the payment of benefits.

*a.* The employing unit which receives a Form 65-5317, Notice of Claim, or a Form 68-0221, Request for Wage and Separation Information, must, within ten days of the date of the notice or request, submit to the department wage or separation information that affects the individual's rights to benefits, including any facts which disclose that the individual separated from employment voluntarily and without good cause attributable to the employer or was discharged for misconduct in connection with employment.

*b.* The employing unit may protest the payment of benefits if the protest is postmarked within ten days of the date of the notice of the filing of an initial claim. In the event that the tenth day falls on a Saturday, Sunday or holiday, the protest period is extended to the next working day of the department. If the employing unit has filed a timely report of facts that might adversely affect the individual's benefit rights, the report shall be considered as a protest to the payment of benefits.

*c.* If the employing unit protests that the individual was not an employee and it is subsequently determined that the individual's name was changed, the employing unit shall be deemed to have not been properly notified and the employing unit shall again be provided the opportunity to respond to the notice of the filing of the initial claim.

*d.* The employing unit has the option of notifying the department under conditions which, in the opinion of the employing unit, may disqualify an individual from receiving benefits. The notification may be made by mail using Form 60-0154, Notice of Separation, or by telephone using a telephone number designated by the department.

(1) The Notice of Separation, Form 60-0154, must be postmarked or received before or within ten days of the date that the Notice of Claim, Form 65-5317, was mailed to the employer. In the event that the tenth day falls on Saturday, Sunday or holiday, the protest period is extended to the next working day of the department. If a claim for unemployment insurance benefits has not been filed, the Notice of Separation may be accepted at any time.

(2) Rescinded IAB 2/10/99, effective 3/17/99.

**24.8(3)** Completing and signing of forms by an employing unit which may affect the benefit rights of an individual.

*a.* A notice of separation, and any response by an employing unit or its authorized agent to a notice of the filing of an initial claim or a request for wage and separation information, shall be accomplished by properly completing the form or computerized format provided by the department.

*b.* A notice of separation, and any paper response by an employing unit or its authorized agent to a notice of the filing of an initial claim or a request for wage and separation information, shall be executed by the employing unit on the form provided by the department under the signature of an individual proprietor, a partner, an executive officer, a department manager or other responsible employee who handles employee information, or who has direct knowledge of the reasons for the individual's separation from employment or by completing the computerized form designated by the department.

*c.* Failure by an employing unit or its authorized agent to properly complete or sign any form provided by the department relating to the adjudication of a claim shall result in the return of the form to the employing unit or its authorized agent for proper completion or signature; however, an extension of any notice or response period to allow for the return of the form shall not be granted.

*d.* Failure by an employing unit or its authorized agent to timely submit any notice or response requested by the department shall result in the department representative's making a determination of the individual's rights to benefits based on the information available.

**24.8(4)** Mailing of determinations, redeterminations and decisions to employing units.

*a.* An employing unit which has filed a timely response or protest to the notice of the filing of an initial claim shall be notified in writing of the determination as to the individual's rights to benefits. If an employing unit of the individual has submitted timely information affecting the individual's rights to benefits, including facts which disclose that the individual voluntarily quit without good cause attributable to the employing unit or was discharged for misconduct in connection with employment, the employing unit shall be notified in writing of the department's decision as to the cause of termination of the individual's employment.

*b.* Any notice of determination or decision shall contain a statement setting forth the employing unit's right of appeal.

*c.* Determinations as to an individual's right to benefits, decisions as to the cause of termination of the individual's employment, decisions as to an employing unit's experience record and correspondence related thereto shall be sent to:

(1) The address of the employing unit to which the notice of the filing of an initial claim was mailed; or

(2) The address requested by the employing unit on the document filed with the department in response or protest to the notice of the filing of an initial claim;

(3) If the employing unit in its response or protest to the notice of the filing of an initial claim furnishes the address of an agent for the employing unit and requests that further documents and correspondence be sent to the agent, the department representative shall comply, provided there is on file with the department an approved authorization (power of attorney) designating the agent to represent the employing unit.

**871—24.9(96) Determination of benefit rights.****24.9(1) Monetary determinations.**

a. When an initial claim for benefits is filed, the department shall mail to the individual claiming benefits a Form 65-5318, Iowa Monetary Record, which is a statement of the individual's weekly benefit amount, total benefits, base period wages, and other data pertinent to the individual's benefit rights.

b. The monetary record shall constitute a final decision unless newly discovered facts which affect the validity of the original determination or a written request for reconsideration is filed by the individual within ten days of the date of the mailing of the monetary record specifying the grounds of objection to the monetary record.

c. If newly discovered facts are obtained by the department or a written request for reconsideration is filed by the individual and is timely, an unemployment insurance representative shall examine the facts or the written request for reconsideration and shall promptly issue a redetermination or transfer the written request to an administrative law judge. The redetermination of the monetary record shall constitute a final decision unless a written appeal to an administrative law judge is filed by the individual within ten days of the date of the mailing of the redetermination specifying the grounds of objection to the redetermined monetary record. For the purposes of this paragraph, if the newly discovered facts obtained by the department would result in a change of the individual's maximum benefit amount of \$25 or less, the department representative is not required to issue a redetermination unless a redetermination is requested by the individual, the employer, or a representative of another state or federal agency responsible for the administration of an unemployment insurance law.

d. For the purposes of this subrule, the appeal period is extended to the next working day of the department in the event that the tenth day falls on a Saturday, Sunday, or holiday. Also, failure of an individual to properly complete and sign any document relating to the adjudication of a claim shall result in the return of the document to the individual for proper completion or signature; however, an extension of the appeal period to allow for the return of the documents shall not be granted.

**24.9(2) Nonmonetary determinations.**

a. When a protest of an initial claim for benefits is filed, the department shall mail to the individual claiming benefits, and the most recent or any other base period employing unit, either a Form 60-0186 (manually generated) or a Form 65-5323 (computer generated), Unemployment Insurance Decision, which affects the individual's right to benefits.

b. The interested parties shall be afforded the opportunity to present facts and evidence in person or by telephone at an informational fact-finding interview scheduled by the department. An interested party, at the party's expense and with the party's equipment, may tape (video or audio) the proceedings. All participants must be informed of the taping of the interview. The taping of the interview must not be disruptive or distracting in nature.

c. Each of these decisions of the unemployment insurance representative shall constitute a final decision unless there are newly discovered facts which affect the validity of the original decision or a written request for reconsideration is filed by the individual, or the most recent or any other base period employing unit, within ten days of the date of the mailing of the decision specifying the grounds of objection to the decision.

d. If newly discovered facts are obtained by the department or a written request for reconsideration is timely filed by the individual, or the most recent or any other base period employing unit, an unemployment insurance representative shall examine the newly discovered facts or the written request for reconsideration and shall promptly issue a redetermination or transfer the written request to an administrative law judge. The redetermination of the decision shall constitute a final decision unless a written appeal to an administrative law judge is filed by the individual, or the most recent or any other base period employing unit, within ten days of the date of the mailing of the redetermination specifying the grounds for objection to the redetermined decision.

e. For the purposes of this subrule, the protest period is extended to the next working day of the department in the event that the tenth day falls on a Saturday, Sunday or holiday. Also, failure by an individual or an employing unit to properly complete or sign any document relating to the adjudication of a claim shall result in the return of the document to the individual or employing unit for proper completion

or signature; however, an extension of the protest period to allow for the return of the document shall not be granted.

**871—24.10(96) Employer and employer representative participation in fact-finding interviews.**

**24.10(1)** “Participate,” as the term is used for employers in the context of the initial determination to award benefits pursuant to Iowa Code section 96.6, subsection 2, means submitting detailed factual information of the quantity and quality that if unrebutted would be sufficient to result in a decision favorable to the employer. The most effective means to participate is to provide live testimony at the interview from a witness with firsthand knowledge of the events leading to the separation. If no live testimony is provided, the employer must provide the name and telephone number of an employee with firsthand information who may be contacted, if necessary, for rebuttal. A party may also participate by providing detailed written statements or documents that provide detailed factual information of the events leading to separation. At a minimum, the information provided by the employer or the employer’s representative must identify the dates and particular circumstances of the incident or incidents, including, in the case of discharge, the act or omissions of the claimant or, in the event of a voluntary separation, the stated reason for the quit. The specific rule or policy must be submitted if the claimant was discharged for violating such rule or policy. In the case of discharge for attendance violations, the information must include the circumstances of all incidents the employer or the employer’s representative contends meet the definition of unexcused absences as set forth in 871—subrule 24.32(7). On the other hand, written or oral statements or general conclusions without supporting detailed factual information and information submitted after the fact-finding decision has been issued are not considered participation within the meaning of the statute.

**24.10(2)** “A continuous pattern of nonparticipation in the initial determination to award benefits,” pursuant to Iowa Code section 96.6, subsection 2, as the term is used for an entity representing employers, means on 25 or more occasions in a calendar quarter beginning with the first calendar quarter of 2009, the entity files appeals after failing to participate. Appeals filed but withdrawn before the day of the contested case hearing will not be considered in determining if a continuous pattern of nonparticipation exists. The division administrator shall notify the employer’s representative in writing after each such appeal.

**24.10(3)** If the division administrator finds that an entity representing employers as defined in Iowa Code section 96.6, subsection 2, has engaged in a continuous pattern of nonparticipation, the division administrator shall suspend said representative for a period of up to six months on the first occasion, up to one year on the second occasion and up to ten years on the third or subsequent occasion. Suspension by the division administrator constitutes final agency action and may be appealed pursuant to Iowa Code section 17A.19.

**24.10(4)** “Fraud or willful misrepresentation by the individual,” as the term is used for claimants in the context of the initial determination to award benefits pursuant to Iowa Code section 96.6, subsection 2, means providing knowingly false statements or knowingly false denials of material facts for the purpose of obtaining unemployment insurance benefits. Statements or denials may be either oral or written by the claimant. Inadvertent misstatements or mistakes made in good faith are not considered fraud or willful misrepresentation.

This rule is intended to implement Iowa Code section 96.3(7) “b” as amended by 2008 Iowa Acts, Senate File 2160.

**871—24.11(96) Eligibility review program.**

**24.11(1)** *Purpose.* The eligibility review program is used to accelerate the individual’s return to work and systematically review the individual’s efforts toward the same goal.

**24.11(2)** *Individuals requiring an eligibility review.*

*a.* Selected individuals claiming intrastate benefits and interstate benefits shall be required to complete the eligibility review Form 60-0232 at times determined by the department after they have filed an initial or additional claim.

*b.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.11(3) Eligibility review form.** Form 60-0232 contains information relating to eligibility and availability furnished by and to the individual, instructions and advice on reemployment that is given to the individual and the results of the individual's job search efforts.

*a.* The Eligibility Review Form 60-0232 encourages individuals to record information that bears directly on reemployment prospects and continued eligibility data.

*b.* It should conserve benefit funds through early identification of individuals who are restricting their availability.

*c.* It assures that job-ready individuals receive maximum exposure to available jobs by a workforce development center.

**24.11(4) Eligibility review procedure.**

*a.* After an individual has claimed a number of weeks of intrastate benefits as designated by the department, the workforce development center shall receive a computer selected list of individuals claiming benefits. The list shall be retained in the workforce development center so work search assistance and reemployment services can be provided as needed by the claimant.

*b.* No eligibility review will be performed on an individual unless monetary and nonmonetary eligibility are established.

*c.* An Eligibility Review Questionnaire shall be mailed or provided to the individual.

*d.* A copy of the Eligibility Review Questionnaire shall be sent to the workforce development center only on an individual who is in an active status at the time of its printing. If the individual fails to respond to the Eligibility Review Questionnaire within the designated period of time printed on the questionnaire, the workforce development center shall issue a Form 60-0131, Notice to Report. If the individual does not respond after this action has been taken, the department must issue an appropriate failure to report decision and lock the claim to prevent payment.

*e.* In cases of illness, injury or pregnancy, an unemployment insurance representative shall determine when and if a personal appearance shall be conducted. The representative shall be responsible for determining continuing eligibility or noneligibility of the individual based on the information obtained on the Form 60-0141, Request for Medical Report, or the facts presented during the interview. If the representative believes an additional Form 60-0141 may be needed, the representative shall initiate the request in the regular manner. Special attention shall be given to work search, i.e., number of contacts, types of contacts and the available job market information.

*f.* Before an administrative law judge can rule on a disqualification for failure to report at an Iowa workforce development center as directed, there must be evidence to show that the individual was required to report for an interview.

*g.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.11(5) Scheduling first eligibility review interview.** Individuals shall be scheduled for an eligibility review interview if:

They are in demand occupations and still unemployed; it appears that they need help in finding work or their eligibility is suspect.

**24.11(6) Eligibility Review Form 60-0232.**

*a.* The Eligibility Review Form shall be completed by the individual. This form documents the information provided by the individual. The unemployment insurance representative reviews the information to determine if there are any disqualifying issues that need to be reviewed by conducting an interview in the local office or by telephone. If the interview is conducted by telephone, the individual may waive the opportunity for an in-person interview. The form also contains the individual's work search plan and the unemployment insurance representative's advice and instruction to the individual concerning eligibility requirements and work search plans.

*b.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.11(7) Conducting the first eligibility review interview.**

*a.* All available evidence must be examined to detect potentially disqualifying issues.

*b.* The individual's need for advice, assistance or instructions must be determined and conveyed to the individual.

c. The interview as recorded on the form must convey to the individual the requirements that must be satisfied to maintain eligibility insofar as work search and availability are concerned.

d. This advice, assistance or instruction constitutes an understanding and agreement between the individual and the unemployment insurance representative at the conclusion of the interview regarding the individual's willingness and ability to eliminate any barriers to obtaining reemployment which otherwise would result in referral for adjudication.

e. The individual shall be advised of what constitutes an acceptable effort to obtain reemployment in accordance with state policy considering local labor market information and the individual's occupation.

f. The final objective of the interview is to determine whether a subsequent interview is needed. This shall be based on expected return to work date, job openings in area, local labor market conditions, etc.

**24.11(8) Eligibility Review Statistics, Form 68-0150.** Rescinded IAB 8/6/03, effective 9/10/03.

This rule is intended to implement Iowa Code sections 96.4(3) and 96.6(1).

**871—24.12** Reserved.

**871—24.13(96) Deductible and nondeductible payments.**

**24.13(1) Procedures for deducting payments from benefits.** Any payment defined under subrules 24.13(2) and 24.13(3) made to an individual claiming benefits shall be deducted from benefits in accordance with the following procedures until the amount is exhausted; however, vacation pay which is deductible in the manner prescribed in rule 871—24.16(96) shall be deducted first when paid in conjunction with other deductible payments described in this rule unless otherwise designated by the employer: The individual claiming benefits is required to designate the last day paid which may indicate payments made under this rule. The employer is required to designate on the Form 65-5317, Notice of Claim, the amount of the payment and the period to which the amount applies. If the individual or the employer does not designate the period to which the amount of the payment applies, and the unemployment insurance representative cannot otherwise determine the period, the unemployment insurance representative shall determine the week or weeks following the effective date of the claim to which the amount of the payment applies by dividing the amount of the payment by the individual's average weekly wage during the highest earnings quarter of the individual's base period. The amount of any payment under subrule 24.13(2) shall be deducted from the individual's weekly benefit amount on the basis of the formula used to compute an individual's weekly benefit payment as provided in rule 871—24.18(96). The amount of any payment under subrule 24.13(3) shall be fully deducted from the individual's weekly benefit amount on a dollar-for-dollar basis.

**24.13(2) Deductible payments from benefits.** The following payments are considered as wages and are deductible from benefits on the basis of the formula used to compute an individual's weekly benefit payment as provided in rule 871—24.18(96):

a. *Holiday pay.* However, if the actual entitlement to the holiday pay is subsequently not paid by the employer, the individual may request an underpayment adjustment from the department.

b. *Commissions.* However, the commission payment is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

c. *Incentive pay.* However, the incentive payment is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

d. *Strike pay.* However, the strike pay is only deductible when it is a payment received for services rendered and the individual is otherwise eligible for benefits.

e. *Remuneration other than cash.* The cash value of all remuneration payable in any medium other than cash, board, rent, housing, lodging, meals, or similar advantage, is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

f. *Stand-by pay.* When an individual is paid to hold oneself in readiness for a call to specific work for an employer but is not called, since the work is given to another, the payment is stand-by pay which is

deductible from benefits when earned by the individual during the period when the individual is claiming benefits.

*g. Tips or gratuity.* However, the amount of the tips or gratuity is only deductible when based on service performed by the individual during the period in which the individual is also claiming benefits.

**24.13(3) Fully deductible payments from benefits.** The following payments are considered as wages; however, such payments are fully deductible from benefits on a dollar-for-dollar basis:

*a. Wage interruption insurance payment.* Any insurance payment received or due from wage interruption insurance because of fire, disaster, etc.

*b. Excused personal leave.* Excused personal leave, also referred to as casual pay or random pay, is personal leave with pay granted to an employee for absence from the job because of personal reasons. It shall be treated as vacation and be fully deductible in the manner prescribed in rule 871—24.16(96).

*c. Wages in lieu of notice, separation allowance, severance pay and dismissal pay.*

*d. Workers' compensation, temporary disability only.* The payment shall be fully deductible with respect to the week in which the individual is entitled to the workers' compensation for temporary disability, and not to the week in which such payment is paid.

*e. Pension, retirement, annuity, or any other similar periodic payment made under a plan maintained and contributed to by a base period or chargeable employer.* An individual's weekly benefit amount shall only be reduced by that portion of the payment which is the same percentage as the percentage contribution of the base period or chargeable employer to the plan.

**24.13(4) Nondeductible payments from benefits.** The following payments are not considered as wages and are not deductible from benefits:

*a. Self-employment income.* However, the individual must meet the benefit eligibility requirements of Iowa Code section 96.4(3).

*b. Bonuses.* The bonus payment is only nondeductible when based on service performed by the individual before the period in which the individual is also claiming benefits.

*c. Remuneration for work performed by the individual claiming benefits in exchange for county relief in the form of groceries, rent, etc.*

*d. Payment for unused sick leave.*

*e. National guard duty pay.* This includes reserve unit drill pay for any branch of the armed service.

*f. Supplemental unemployment benefit plans approved by the department.* See 871—subrule 23.3(1), paragraph "e," for criteria and employer procedure for obtaining department approval.

*g. Pension to the blind.*

*h. Payment for terminal leave.* Any payment received by military personnel for unused leave upon discharge.

*i. Compensation for military service-connected disability from the Department of Veterans Affairs.*

*j. Payments to the surviving spouse of a regular or disability pension based on the work of the deceased spouse.*

*k. Deferred wage compensation.* Remuneration received by the individual for wages earned in a period prior to the individual's claim for benefits shall not be deductible during the period in which the individual is claiming benefits.

*l. Witness and jury fees.* These fees are reimbursement for expenses and are not considered as wages.

*m. Supplemental security income.* This payment is nondeductible because it is financed by income taxes and not social security taxes and is based on need factors such as age, mental or physical disability, and personal income, and not on previous employment.

*n. Federal social security benefit and social security disability payments.*

This rule is intended to implement Iowa Code sections 96.3(3), 96.5, 96.5(5), 96.11(1), and 96.19(38).

[ARC 1367C, IAB 3/5/14, effective 4/9/14]

**871—24.14 and 24.15** Reserved.

**871—24.16(96) Vacation pay.**

**24.16(1)** If the employer properly notifies the department within ten days after the notification of the filing of the claim that an amount of vacation pay, either paid or owed, is to be applied to a specific vacation period, a sum equal to the wages of the individual for a normal workday shall be applied to the first and each subsequent workday of the designated vacation period until the amount of the vacation pay is exhausted. For the purposes of this rule, rule 871—24.13(96), and rule 871—24.17(96), the term “vacation pay” shall include paid time off and annual leave payments.

**24.16(2)** If the employer makes the original designation of the vacation period in a timely manner, the employer may extend the vacation period by designating the period of the extension in writing to the department before the period of extension begins.

**24.16(3)** If the employer fails to properly notify the department within ten days after the notification of the filing of the claim that an amount of vacation pay, either paid or owed, is to be applied to a specific vacation period, the entire amount of the vacation pay shall be applied to the one-week period starting on the first workday following the last day worked as defined in subrule 24.16(4). However, if the individual does not claim benefits after layoff during the normal employer workweek immediately following the last day worked, then the entire amount of the vacation pay shall not be deducted from any week of benefits.

**24.16(4)** Unless otherwise specified by the employer, the amount of the vacation pay shall be converted by the department to eight hours for a normal workday and five workdays for a normal workweek.

This rule is intended to implement Iowa Code section 96.5(7).  
[ARC 1367C, IAB 3/5/14, effective 4/9/14]

**871—24.17(96) Vacation pay procedure.**

**24.17(1)** Employer notice specified vacation or holiday pay only. The Form 65-5317, Notice of Claim, the Form 62-2048, Request for Federal Wage and Separation Information, and the Form 62-2049, Request for Wage and Separation Information on Federal Employment Additional Claim, which are returned by the employer for the purpose of notification of vacation pay, shall be used as notification to the department that vacation pay is applicable. The Forms 65-5317, 62-2048, and 62-2049 received in the administrative office shall be routed to the appropriate office for the following action:

*a.* Upon receipt of the vacation information, the unemployment insurance representative shall compare the amount of vacation reported by the employer with the computer record. If the computer record shows any discrepancies with the vacation information provided by the employer that would affect the claimant’s eligibility for unemployment insurance benefits for any week claimed, the claimant shall be afforded the opportunity to present facts and evidence, which may include an informational fact-finding interview scheduled by the department. The unemployment insurance representative may afford the employer the opportunity to present additional facts and evidence after ascertaining such from the claimant. If the employer is afforded such an opportunity to provide additional facts and evidence, the unemployment insurance representative shall also afford the claimant the opportunity to present additional facts and evidence.

*b.* After affording the claimant an opportunity to present facts and evidence regarding the receipt of vacation pay, and potentially affording the employer and the claimant an opportunity to provide additional facts and evidence, the representative shall consider all information submitted by the interested parties and issue to the employer and the claimant the appropriate decision concerning the vacation pay. The unemployment insurance representative shall then check the current status of the claim on the computer record to ascertain if any weeks have been reported.

*c.* If the computer record shows that the claimant has not reported or claimed for some or all of the weeks indicated for the vacation period, the unemployment insurance representative shall take no further action on the weeks not claimed.

*d.* The claimant shall be instructed to only report vacation pay applicable to the first week. The claimant shall also be instructed that vacation pay designated by the employer in excess of one week may result in an overpayment of benefits.

**24.17(2)** Reserved.

This rule is intended to implement Iowa Code section 96.5(7).  
[ARC 3116C, IAB 6/7/17, effective 7/12/17]

**871—24.18(96) Wage-earnings limitation.** An individual who is partially unemployed may earn weekly a sum equal to the individual's weekly benefit amount plus \$15 before being disqualified for excessive earnings. If such individual earns less than the individual's weekly benefit amount plus \$15, the formula for wage deduction shall be a sum equal to the individual's weekly benefit amount less that part of wages, payable to the individual with respect to that week and rounded to the nearest dollar, in excess of one-fourth of the individual's weekly benefit amount.

This rule is intended to implement Iowa Code sections 96.3, 96.4 and 96.19(38).

**871—24.19(96) Determination and review of benefit rights.**

**24.19(1)** Claims for benefits shall be promptly determined by the department on the basis of such facts as it may obtain. Notice of such determination shall be promptly given to each claimant and to any employer whose employment relationship with the claimant, or the claimant's separation therefrom, involves actual or potential disqualifying issues relevant to the determination. Such notice to the claimant shall advise of the weekly benefit amount, duration of benefits, wage records, other data pertinent to benefit rights, and if disqualified, the time of and reason for such disqualification. If a claimant is ineligible, such claimant shall be advised of such ineligibility and the reason therefor. Each notice of benefit determination which the department is required to furnish to the claimant shall, in addition to stating the decision and its reasons, include a notice specifying the claimant's appeal rights. The notice of appeal rights shall state clearly the place and manner for taking an appeal from the determination and the period within which an appeal may be taken. Unless the claimant or any such other party entitled to notice, within ten days after such notification was mailed to such claimant's last-known address, files with the department a written request for a review of or an appeal from such determination, such determination shall be final.

**24.19(2)** Each interested party will be afforded the opportunity to have a fact-finding interview by telephone regarding matters which are scheduled for a hearing. An interested party may request an in-person fact-finding interview as a reasonable accommodation under the federal Americans with Disabilities Act of 1990, as amended, or the Iowa Civil Rights Act of 1965, as amended. The department shall reserve the right to call any interested party in for an in-person fact-finding interview.

**24.19(3)** Upon receiving a written request for review or, on its own initiative and on the basis of the facts as it may have in its possession or may acquire, the claims section may affirm, modify, or reverse the prior decision, or refer the claim to an administrative law judge. The claimant or any other party filing the request for review shall be promptly notified of the decision or referral. Unless the claimant or any other party files an appeal within ten days after the date of mailing, the latter decision shall be final and benefits shall be paid or denied in accordance therewith.

[ARC 3116C, IAB 6/7/17, effective 7/12/17]

**871—24.20 and 24.21** Reserved.

**871—24.22(96) Benefit eligibility conditions.** For an individual to be eligible to receive benefits the department must find that the individual is able to work, available for work, and earnestly and actively seeking work. The individual bears the burden of establishing that the individual is able to work, available for work, and earnestly and actively seeking work.

**24.22(1) Able to work.** An individual must be physically and mentally able to work in some gainful employment, not necessarily in the individual's customary occupation, but which is engaged in by others as a means of livelihood.

*a. Illness, injury or pregnancy.* Each case is decided upon an individual basis, recognizing that various work opportunities present different physical requirements. A statement from a medical practitioner is considered prima facie evidence of the physical ability of the individual to perform the

work required. A pregnant individual must meet the same criteria for determining ableness as do all other individuals.

*b. Interpretation of ability to work.* The law provides that an individual must be able to work to be eligible for benefits. This means that the individual must be physically able to work, not necessarily in the individual's customary occupation, but able to work in some reasonably suitable, comparable, gainful, full-time endeavor, other than self-employment, which is generally available in the labor market in which the individual resides.

**24.22(2) Available for work.** The availability requirement is satisfied when an individual is willing, able, and ready to accept suitable work which the individual does not have good cause to refuse, that is, the individual is genuinely attached to the labor market. Since, under unemployment insurance laws, it is the availability of an individual that is required to be tested, the labor market must be described in terms of the individual. A labor market for an individual means a market for the type of service which the individual offers in the geographical area in which the individual offers the service. Market in that sense does not mean that job vacancies must exist; the purpose of unemployment insurance is to compensate for lack of job vacancies. It means only that the type of services which an individual is offering is generally performed in the geographical area in which the individual is offering the services.

*a. Shift restriction.* The individual does not have to be available for a particular shift. If an individual is available for work on the same basis on which the individual's wage credits were earned and if after considering the restrictions as to hours of work, etc., imposed by the individual there exists a reasonable expectation of securing employment, then the individual meets the requirement of being available for work.

*b. Job test.* The best method of testing availability for work is an offer of work or job test. If a job test is not possible because of lack of a suitable offer, the active search for work is relied on and conclusions are likely to be based entirely on the fact that the individual did or did not make a search, without regard to the fact that the individual's personal efforts had little probability of success.

*c. Intermittent employment.* An individual cannot restrict employability to only temporary or intermittent work until recalled by a regular employer.

*d. Jury duty.* The individual is considered available for work while serving on jury duty because time spent in jury service is not a personal service performed under a contract of hire in an employment situation but is a public duty required by law. Jury duty does not render the individual as employed and ineligible for benefits even though it may involve the individual full-time. Witness and jury fees will be considered as reimbursement for expenses and not as wages.

*e. Company employment office.* The department is not bound by a union/company contract that requires the individual to report at the company employment office. The individual is an independent agent seeking work, and may be found available, if an otherwise diligent search of work is made.

*f. Part-time worker, student—other.* Part-time worker shall mean any individual who has been in the employ of an employing unit and has established a pattern of part-time regular employment which is subject to the employment security tax, and has accrued wage credits while working in a part-time job. If such part-time worker becomes separated from this employment for no disqualifiable reason, and providing such worker has reasonable expectation of securing other employment for the same number of hours worked, no disqualification shall be imposed under Iowa Code section 96.4(3). In other words, if an individual is available to the same degree and to the same extent as when the wage credits were accrued, the individual meets the eligibility requirements of the law.

*g. Work release program while incarcerated.* For those individuals incarcerated in jail, the work release program usually does not meet the availability requirements of Iowa Code section 96.4(3); but the department will review any situation concerning an individual incarcerated in a jail, who can meet the able to work, availability for work, and actively seeking work requirements of Iowa Code section 96.4(3).

*h. Available for part of week.* Each case must be decided on its own merits. Generally, if the individual is available for the major portion of the workweek, the individual is considered to be available for work.

*i. On-call workers.*

(1) Substitute workers (i.e., post office clerks, railroad extra board workers), who hold themselves available for one employer and who do not accept other work, are not available for work within the meaning of the law and are not eligible for benefits.

(2) Substitute teachers. The question of eligibility of substitute teachers is subjective in nature and must be determined on an individual case basis. The substitute teacher is considered an instructional employee and is subject to the same limitations as other instructional employees. As far as payment of benefits between contracts or terms and during customary and established periods of holiday recesses is concerned, benefits are denied if the substitute teacher has a contract or reasonable assurance that the substitute teacher will perform service in the period immediately following the vacation or holiday recess. An on-call worker (includes a substitute teacher) is not disqualified if the individual is able and available for work, making an earnest and active search for work each week, placing no restrictions on employment and is genuinely attached to the labor market.

(3) An individual whose wage credits earned in the base period of the claim consist exclusively of wage credits by performing on-call work, such as a banquet worker, railway worker, substitute school teacher or any other individual whose work is solely on-call work during the base period, is not considered an unemployed individual within the meaning of Iowa Code section 96.19(38) "a" and "b." An individual who is willing to accept only on-call work is not considered to be available for work.

*j. Leave of absence.* A leave of absence negotiated with the consent of both parties, employer and employee, is deemed a period of voluntary unemployment for the employee-individual, and the individual is considered ineligible for benefits for the period.

(1) If at the end of a period or term of negotiated leave of absence the employer fails to reemploy the employee-individual, the individual is considered laid off and eligible for benefits.

(2) If the employee-individual fails to return at the end of the leave of absence and subsequently becomes unemployed the individual is considered as having voluntarily quit and therefore is ineligible for benefits.

(3) The period or term of a leave of absence may be extended, but only if there is evidence that both parties have voluntarily agreed.

*k. Effect of religious convictions on Sabbath day work.* An individual is considered as available for work if the precepts of the individual's religion prohibit work on the Sabbath. An individual who refuses to work on the Sabbath designated by the individual's religion, because of conscientious observance of the Sabbath as a matter of religious conviction, is also deemed to have good cause for refusing the work.

*l. Available for work.* To be considered available for work, an individual must at all times be in a position to accept suitable employment during periods when the work is normally performed. As an individual's length of unemployment increases and the individual has been unable to find work in the individual's customary occupation, the individual may be required to seek work in some other occupation in which job openings exist, or if that does not seem likely to result in employment, the individual may be required to accept counseling for possible retraining or a change in occupation.

*m. Restrictions and reasonable expectation of securing employment.* An individual may not be eligible for benefits if the individual has imposed restrictions which leave the individual no reasonable expectation of securing employment. Restrictions may relate to type of work, hours, wages, location of work, etc., or may be physical restrictions.

*n. Corporate officers.* To be considered available, the corporation officer must meet the same tests of availability as are met by other individuals. The individual must be desirous of other work, be free from serious limitations and be seriously searching for work. The reported efforts of a corporate officer to seek work should be studied to distinguish those directed toward obtaining work for the officer as an individual and those directed to obtaining work or business for the corporation. Any effort to obtain business for the corporation to perform is a service to the corporation and is not evidence of the individual's own availability for work.

*o. Lawfully authorized work.* An individual who is not lawfully authorized to work within the United States will be considered not available for work.

**24.22(3)** *Earnestly and actively seeking work.* Mere registration at a workforce development center does not establish that the individual is earnestly and actively seeking work. It is essential that the

individual personally and diligently search for work. It is difficult to establish definite criteria for defining the words earnestly and actively. Much depends on the estimate of the employment opportunities in the area. The number of employer contacts which might be appropriate in an area of limited opportunity might be totally unacceptable in other areas. When employment opportunities are high an individual may be expected to make more than the usual number of contacts. Unreasonable limitations by an individual as to salary, hours or conditions of work can indicate that the individual is not earnestly seeking work. The department expects each individual claiming benefits to conduct themselves as would any normal, prudent individual who is out of work.

*a. Basic requirements.* An individual shall be ineligible for benefits for any period for which the department finds that the individual has failed to make an earnest and active search for work. The circumstances in each case are considered in determining whether an earnest and active search for work has been made. Subject to the foregoing, applicable actions of the following kind are considered an earnest and active search for work if found by the department to constitute a reasonable means of securing work by the individual, under the facts and circumstances of the individual's particular situation:

(1) Making application with employers as may reasonably be expected to have openings suitable to the individual.

(2) Registering with a placement facility of a school, college, or university if one is available in the individual's occupation or profession.

(3) Making application or taking examination for openings in the civil service of a governmental entity with reasonable prospects of suitable work for the individual.

(4) Responding to appropriate "want ads" for work which appears suitable to the individual if the response is made in writing or in person or electronically.

(5) Any other action which the department finds to constitute an effective means of securing work suitable to the individual.

(6) No individual, however, is denied benefits solely on the ground that the individual has failed or refused to register with a private employment agency or at any other placement facility which charges the job-seeker a fee for its services. However, an individual may count as one of the work contacts required for the week an in-person contact with a private employment agency.

(7) An individual is considered to have failed to make an effort to secure work if the department finds that the individual has followed a course of action designed to discourage prospective employers from hiring the individual in suitable work.

*b. Number of employer contacts.* It is difficult to determine criteria in which earnestly and actively may be interpreted. Much depends on the estimate of employment opportunities in the area. The number of employer contacts which might be appropriate in an area of limited opportunities might be totally unacceptable in another area of unlimited opportunities. The number of contacts that an individual must make is dependent upon the condition of the local labor market, the duration of benefit payments, a change in the individual's characteristics, job prospects in the community, and other factors as the department deems necessary.

*c. Union and professional employees.* Members of unions or professional organizations who normally obtain their employment through union or professional organizations are considered as earnestly and actively seeking work if they maintain active contact with the union's business agent or with the placement officer in the professional organization. A paid-up membership must be maintained if this is a requirement for placement service. The trade, profession or union to which the individual belongs must have an active hiring hall or placement facility, and the trade, profession or union must be the source customarily used by employers in filling their job openings. Registering with the individual's union hiring or placement facility is sufficient except that whenever all benefit rights to regular benefits are exhausted and Iowa is in an extended benefit period or similar program such as the federal supplemental compensation program, individuals must also actively search for work; mere registration at a union or reporting to union hiring hall or registration with a placement facility of the individual's professional organization does not satisfy the extended benefit systematic and sustained effort to find work, and additional work contacts must be made.

*d. Week-to-week disqualification.* Active search for work disqualifications are to be made on a week-to-week basis and are not open-end disqualifications.

*e. Seniority rights.* An individual who fails to exercise seniority rights to replace another employee with less seniority has the work search requirement waived during a period of regular benefits. This waiver does not apply to the individual who is receiving extended benefits or similar federal program benefits.

*f. Search for work.*

(1) The Iowa law specifies that an individual must earnestly and actively seek work. This is interpreted to mean that a registration for work at a workforce development center or state employment service office in itself does not meet the requirements of the law. Nor is it interpreted to mean that every individual must make a fixed number of employer contacts each week to establish eligibility. The number of contacts that an individual must make is dependent upon the condition of the local labor market, the duration of benefit payments, a change in claimant characteristics, job prospects in the community, and such other factors as the department deems relevant.

(2) The individual is referred to suitable work, when possible, to those employers who have outstanding requests with the department of workforce development for referrals. The individual must meet the minimum lawful requirements of the employer. The individual applies to and obtains the signatures of the employer so designated on the form provided, unless the employer refuses to sign the form. The individual must return the form to the department as directed. The individual's failure to obtain the signature of designated employers, who have not refused to sign the form, disqualifies the individual from future benefits until requalified by earning ten times the weekly benefit amount.

(3) The group assignment of individuals is used, to a certain extent, in determining which ones are required to make personal applications for work. Other factors, however, such as the condition of the local labor market, the duration of benefit payments, and a change in claimant characteristics, are also taken into consideration on a weekly basis.

(4) Individuals receiving partial benefits are exempt from making personal applications for work, in any week they have worked and received wages from their regular employer. Individuals involved in hiring hall practices must keep in weekly touch with the business agent of that union in which they maintain membership. All other individuals must make contacts with such frequency as the department considers advisable, after considering job prospects in the community, the condition of the labor market and any other factors which may have a bearing on the individual's reemployment. A sincere effort must be made to find a job. A contact made merely for the sake of complying with the law is not good enough.

*g. Reverse referral.* A reverse referral is defined as an employer hiring only through the department of workforce development and all individuals applying for employment with the employer are referred to the department. An individual may use the department as work contacts during a week with the employer's name and the workforce development employee's name listed as the individual contacted. The workforce development center must be contacted in person by the individual to utilize each reverse referral registration job contact.

*h. Job search assistance.* Job search assistance classes, including reemployment services, which are sponsored by the department of workforce development and attended by the individual during a week may be counted as one of the individual's work search contacts for that week.

This rule is intended to implement Iowa Code section 96.4(3).

[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—24.23(96) Availability disqualifications.** The following are reasons for a claimant being disqualified for being unavailable for work.

**24.23(1)** An individual who is ill and presently not able to perform work due to illness.

**24.23(2)** An individual presently in the hospital is deemed not to meet the availability requirements of Iowa Code section 96.4(3) and benefits will be denied until a change in status and the individual can meet the eligibility requirements. Such individual must renew the claim at once if unemployed.

**24.23(3)** If an individual places restrictions on employability as to the wages and type of work that is acceptable and when considering the length of unemployment, such individual has no reasonable

expectancy of securing work, such individual will be deemed not to have met the availability requirements of Iowa Code section 96.4(3).

**24.23(4)** If the means of transportation by an individual was lost from the individual's residence to the area of the individual's usual employment, the individual will be deemed not to have met the availability requirements of the law. However, an individual shall not be disqualified for restricting employability to the area of usual employment. See subrule 24.24(7).

**24.23(5)** Full-time students devoting the major portion of their time and efforts to their studies are deemed to have no reasonable expectancy of securing employment except if the students are available to the same degree and to the same extent as they accrued wage credits they will meet the eligibility requirements of the law.

**24.23(6)** If an individual has a medical report on file submitted by a physician, stating such individual is not presently able to work.

**24.23(7)** Where an individual devotes time and effort to becoming self-employed.

**24.23(8)** Where availability for work is unduly limited because of not having made adequate arrangements for child care.

**24.23(9)** Reserved.

**24.23(10)** The claimant requested and was granted a leave of absence, such period is deemed to be a period of voluntary unemployment and shall be considered ineligible for benefits for such period.

**24.23(11)** Failure to report as directed to workforce development in response to the notice which was mailed to the claimant will result in the claimant being deemed not to meet the availability requirements.

**24.23(12)** If a claimant is in jail or prison, such claimant is not available for work.

**24.23(13)** Rescinded IAB 8/6/03, effective 9/10/03.

**24.23(14)** An individual is deemed not available for work because such individual cannot be contacted by the department for referral to possible employment.

**24.23(15)** Where a claimant has demanded a wage in excess of the wages most commonly paid in such claimant's locality for the suitable work the individual is seeking.

**24.23(16)** Where availability for work is unduly limited because a claimant is not willing to work during the hours in which suitable work for the claimant is available.

**24.23(17)** Work is unduly limited because the claimant is not willing to work the number of hours required to work in the claimant's occupation.

**24.23(18)** Where the claimant's availability for work is unduly limited because such claimant is willing to work only in a specific area although suitable work is available in other areas where the claimant is expected to be available for work.

**24.23(19)** Availability for work is unduly limited because the claimant is not willing to accept work in such claimant's usual occupation and has failed to establish what other types of work that can and will be performed at the wages most commonly paid in the claimant's locality.

**24.23(20)** Where availability for work is unduly limited because the claimant is waiting to be recalled to work by a former employer or waiting to go to work for a specific employer and will not consider suitable work with other employers.

**24.23(21)** Rescinded IAB 8/6/03, effective 9/10/03.

**24.23(22)** Where a claimant does not want to earn enough wages during the year to adversely affect receipt of federal old-age benefits (social security).

**24.23(23)** The claimant's availability for other work is unduly limited because such claimant is working to such a degree that removes the claimant from the labor market.

**24.23(24)** When a claimant is receiving from the Veterans Administration an educational assistance allowance under the War Orphans Educational Assistance Act of 1956, which is disqualifying under the Social Security Act.

**24.23(25)** If the claimant is out of town for personal reasons for the major portion of the workweek and is not in the labor market.

**24.23(26)** Where a claimant is still employed in a part-time job at the same hours and wages as contemplated in the original contract for hire and is not working on a reduced workweek basis different from the contract for hire, such claimant cannot be considered partially unemployed.

**24.23(27)** Failure to report on a claim that a claimant made any effort to find employment will make a claimant ineligible for benefits during the period. Mere registration at the workforce development center does not establish that a claimant is able and available for suitable work. It is essential that such claimant must actively and earnestly seek work.

**24.23(28)** A claimant will be ineligible for benefits because of failure to make an adequate work search after having been previously warned and instructed to expand the search for work effort.

**24.23(29)** Failure to work the major portion of the scheduled workweek for the claimant's regular employer.

**24.23(30)** Failure to attend the major portion of the scheduled workweek for department approved training.

**24.23(31)** Where the claimant spent the major portion of the period traveling while relocating.

**24.23(32)** The claimant is ineligible for benefits because no search for work was made during the period such claimant was on vacation unless the provisions of Iowa Code section 96.19(38) "c" are met.

**24.23(33)** Where the claimant left employment prior to a scheduled date of layoff when such claimant could have remained in employment during this period. No disqualification may be imposed in accordance with Iowa Code section 96.5(1) "g" for the period subsequent to the date of the scheduled layoff if such claimant is otherwise eligible. The claimant will be disqualified for the period between the last day worked and the date of the scheduled layoff because of voluntary unemployment.

**24.23(34)** Where the claimant is not able to work due to personal injury.

**24.23(35)** Where the claimant is not able to work and is under the care of a medical practitioner and has not been released as being able to work.

**24.23(36)** Rescinded IAB 8/6/03, effective 9/10/03.

**24.23(37)** An individual shall be deemed to have failed to make an effort to secure work if the individual has followed a course of action designed to discourage prospective employers from hiring such individual in suitable work.

**24.23(38)** Rescinded IAB 8/6/03, effective 9/10/03.

**24.23(39)** Where the work search or the Eligibility Review Form has been deliberately falsified for the purpose of obtaining unemployment insurance benefits. The general guide for disqualifications for falsification of work search is listed below. It is intended to be used as a guide only and is not a substitute for the personal subjective judgment of the representative because each case must be decided on its own merits. The administrative penalty recommended for falsification is:

- a. First offense—six weeks penalty.
- b. Second offense—nine weeks penalty.
- c. Third offense—total disqualification for the remainder of the benefit year plus consideration of the possibility of filing fraud charges depending on the circumstances.

**24.23(40)** Reserved.

**24.23(41)** The claimant became temporarily unemployed, but was not available for work with the employer that temporarily laid the claimant off. The evidence must establish that the claimant had a choice to work, and that the willingness to work would have led to actual employment in suitable work during the weeks the employer temporarily suspended operations.

This rule is intended to implement Public Law 96-499, Iowa Code sections 96.4(3), 96.5(1), 96.6(1), 96.19(38) "c" and 96.29.

**871—24.24(96) Failure to accept work and failure to apply for suitable work.** Failure to accept work and failure to apply for suitable work shall be removed when the individual shall have worked in (except in back pay awards) and been paid wages for insured work equal to ten times the individual's weekly benefit amount, provided the individual is otherwise eligible.

**24.24(1) Bona fide offer of work.**

a. In deciding whether or not a claimant failed to accept suitable work, or failed to apply for suitable work, it must first be established that a bona fide offer of work was made to the individual by personal contact or that a referral was offered to the claimant by personal contact to an actual job opening

and a definite refusal was made by the individual. For purposes of a recall to work, a registered letter shall be deemed to be sufficient as a personal contact.

*b.* Upon notification of a job opening for a claimant, a representative of the department shall notify the claimant of the job referral. If the claimant fails to respond without good cause, the claimant shall be disqualified until such time as the claimant contacts the local workforce development center or unemployment insurance service center.

**24.24(2)** *Job within claimant's capabilities.*

*a.* The job offered must be within the claimant's physical capabilities and not require any undue physical skill or particular training which the claimant does not already possess. As the period of unemployment lengthens, work which might originally have been unsuitable may become suitable.

*b.* If the claimant, separated for lack of work, fails to accept work offered by the employer on recall or fails to apply for work when directed by a representative of the department, such failure shall constitute a refusal of suitable work. In such a situation said claimant shall be disqualified for failure to apply for or accept an offer to work until such time as the individual shall have worked in (except in back pay awards) and been paid wages for insured work equal to ten times the individual's weekly benefit amount, provided the individual is otherwise eligible.

**24.24(3)** *Each case decided on its own merits.* Based upon the facts found by the department through investigation it shall then be determined whether the work was suitable and whether the claimant has good cause for refusal. Each case shall be determined on its own merits as established by the facts. A reason constituting good cause for refusal of suitable work may nevertheless disqualify such claimant as being not available for work.

**24.24(4)** *Work refused when the claimant fails to meet the benefit eligibility conditions of Iowa Code section 96.4(3).* Before a disqualification for failure to accept work may be imposed, an individual must first satisfy the benefit eligibility conditions of being able to work and available for work and not unemployed for failing to bump a fellow employee with less seniority. If the facts indicate that the claimant was or is not available for work, and this resulted in the failure to accept work or apply for work, such claimant shall not be disqualified for refusal since the claimant is not available for work. In such a case it is the availability of the claimant that is to be tested. Lack of transportation, illness or health conditions, illness in family, and child care problems are generally considered to be good cause for refusing work or refusing to apply for work. However, the claimant's availability would be the issue to be determined in these types of cases.

**24.24(5)** *Bumping rights to a job.* A claimant who fails to exercise seniority rights to bump a less senior employee is eligible for benefits and the provision pertaining to the search for work is waived during a period of regular unemployment insurance benefits. This waiver of the search for work does not apply to a claimant who is receiving extended benefits.

**24.24(6)** *Claimant physically unable to perform job.* A medical certification from a medical practitioner must be submitted to support the claimant's statement that work offered is not suitable because of the claimant's physical condition.

**24.24(7)** *Gainfully employed outside of area where job is offered.* Two reasons which generally would be good cause for not accepting an offer of work would be if the claimant were gainfully employed elsewhere or the claimant did not reside in the area where the job was offered.

**24.24(8)** *Refusal disqualification jurisdiction.* Both the offer of work or the order to apply for work and the claimant's accompanying refusal must occur within the individual's benefit year, as defined in subrule 24.1(21), before the Iowa Code subsection 96.5(3) disqualification can be imposed. It is not necessary that the offer, the order, or the refusal occur in a week in which the claimant filed a weekly claim for benefits before the disqualification can be imposed.

**24.24(9)** Reserved.

**24.24(10)** *Distance to new job.* Without a prior specific agreement between the employer and employee the employee's refusal to follow the employer to a distant new job site shall not be reason for a refusal disqualification.

**24.24(11) *Bulletin board notice of work.*** A bulletin board notice for employees to work during a plant shutdown shall not constitute an offer of work by the company. Such offer of work must be by personal contact to the employee.

**24.24(12) *Claimant discourages prospective employers.*** When a claimant willfully follows a course of action designed to discourage a prospective employer from hiring such claimant, the claimant shall be deemed to have refused suitable work as contemplated by the statute.

**24.24(13) *Claimant moved to another state.*** A claimant who moves to another state shall not be subject to disqualification for refusal to return to a previously held job.

**24.24(14) *Employment offer from former employer.***

*a.* The claimant shall be disqualified for a refusal of work with a former employer if the work offered is reasonably suitable and comparable and is within the purview of the usual occupation of the claimant. The provisions of Iowa Code section 96.5(3) “*b*” are controlling in the determination of suitability of work.

*b.* The employment offer shall not be considered suitable if the claimant had previously quit the former employer and the conditions which caused the claimant to quit are still in existence.

**24.24(15) *Suitable work.*** In determining what constitutes suitable work, the department shall consider, among other relevant factors, the following:

*a.* Any risk to the health, safety and morals of the individual.

*b.* The individual’s physical fitness.

*c.* Prior training.

*d.* Length of unemployment.

*e.* Prospects for securing local work by the individual.

*f.* The individual’s customary occupation.

*g.* Distance from the available work.

*h.* Whether the work offered is for wages equal to or above the federal or state minimum wage, whichever is higher.

*i.* Whether the work offered meets the percentage criteria established for suitable work which is determined by the number of weeks which have elapsed following the effective date of the most recent new or additional claim for benefits filed by the individual.

*j.* Whether the position offered is due directly to a strike, lockout, or other labor dispute.

*k.* Whether the wages, hours or other conditions of employment are less favorable for similar work in the locality.

*l.* Whether the individual would be required to join or resign from a labor organization.

**24.24(16) *Disabled accessibility to job.*** A job offer shall not be suitable if a disabled individual has no access to a building or its facilities.

This rule is intended to implement Iowa Code sections 96.3(3), 96.4(2), 96.4(3), 96.5(1), 96.5(3), 96.6(1), 96.11(1), 96.16, 96.19(38), and 96.29.

**871—24.25(96) *Voluntary quit without good cause.*** In general, a voluntary quit means discontinuing the employment because the employee no longer desires to remain in the relationship of an employee with the employer from whom the employee has separated. The employer has the burden of proving that the claimant is disqualified for benefits pursuant to Iowa Code section 96.5. However, the claimant has the initial burden to produce evidence that the claimant is not disqualified for benefits in cases involving Iowa Code section 96.5, subsection (1), paragraphs “*a*” through “*i*,” and subsection 10. The following reasons for a voluntary quit shall be presumed to be without good cause attributable to the employer:

**24.25(1)** The claimant’s lack of transportation to the work site unless the employer had agreed to furnish transportation.

**24.25(2)** The claimant moved to a different locality.

**24.25(3)** The claimant left to seek other employment but did not secure employment.

**24.25(4)** The claimant was absent for three days without giving notice to employer in violation of company rule.

**24.25(5)** Reserved.

- 24.25(6)** The claimant left as a result of an inability to work with other employees.
- 24.25(7)** The claimant failed to return to work upon the termination of a labor dispute.
- 24.25(8)** The claimant left to enter military service, either voluntarily or by conscription. While in military service such claimant shall be considered to be on leave from employment. It shall only be considered a voluntary quit issue when upon release from military service such claimant does not return to such claimant's employer to apply for employment within 90 days; provided, that such person shall give evidence to the employer of satisfactory completion of such military service and further provided that such person is still qualified to perform the duties of such position.
- 24.25(9)** Reserved.
- 24.25(10)** The claimant left employment to accompany the spouse to a new locality.
- 24.25(11)** The claimant left to get married.
- 24.25(12)** The claimant left without notice during a mutually agreed upon trial period of employment.
- 24.25(13)** The claimant left because of dissatisfaction with the wages but knew the rate of pay when hired.
- 24.25(14)** Reserved.
- 24.25(15)** Reserved.
- 24.25(16)** The claimant is deemed to have left if such claimant becomes incarcerated.
- 24.25(17)** The claimant left because of lack of child care.
- 24.25(18)** The claimant left because of a dislike of the shift worked.
- 24.25(19)** The claimant left to enter self-employment.
- 24.25(20)** The claimant left for compelling personal reasons; however, the period of absence exceeded ten working days.
- 24.25(21)** The claimant left because of dissatisfaction with the work environment.
- 24.25(22)** The claimant left because of a personality conflict with the supervisor.
- 24.25(23)** The claimant left voluntarily due to family responsibilities or serious family needs.
- 24.25(24)** The claimant left employment to accept retirement when such claimant could have continued working.
- 24.25(25)** The claimant left to take a vacation.
- 24.25(26)** The claimant left to go to school.
- 24.25(27)** The claimant left rather than perform the assigned work as instructed.
- 24.25(28)** The claimant left after being reprimanded.
- 24.25(29)** The claimant left in anticipation of a layoff in the near future; however, work was still available at the time claimant left the employment.
- 24.25(30)** The claimant left due to the commuting distance to the job; however, the claimant was aware of the distance when hired.
- 24.25(31)** The claimant left work to keep from earning enough wages during the year to adversely affect claimant's receipt of federal old-age benefits (social security).
- 24.25(32)** The claimant left by refusing a transfer to another location when it was known at the time of hire that it was customary for employees to transfer as required by the job.
- 24.25(33)** The claimant left because such claimant felt that the job performance was not to the satisfaction of the employer; provided, the employer had not requested the claimant to leave and continued work was available.
- 24.25(34)** The claimant left because work was irregular due to weather conditions; however, this working condition was not unusual in claimant's type of employment.
- 24.25(35)** The claimant left because of illness or injury which was not caused or aggravated by the employment or pregnancy and failed to:
- a. Obtain the advice of a licensed and practicing physician;
  - b. Obtain certification of release for work from a licensed and practicing physician;
  - c. Return to the employer and offer services upon recovery and certification for work by a licensed and practicing physician; or
  - d. Fully recover so that the claimant could perform all of the duties of the job.

**24.25(36)** The claimant maintained that the claimant left due to an illness or injury which was caused or aggravated by the employment. The employer met its burden of proof in establishing that the illness or injury did not exist or was not caused or aggravated by the employment.

**24.25(37)** The claimant will be considered to have left employment voluntarily when such claimant gave the employer notice of an intention to resign and the employer accepted such resignation. This rule shall also apply to the claimant who was employed by an educational institution who has declined or refused to accept a new contract or reasonable assurance of work for a successive academic term or year and the offer of work was within the purview of the individual's training and experience.

**24.25(38)** Where the claimant gave the employer an advance notice of resignation which caused the employer to discharge the claimant prior to the proposed date of resignation, no disqualification shall be imposed from the last day of work until the proposed date of resignation; however, benefits will be denied effective the proposed date of resignation.

**24.25(39)** Reserved.

**24.25(40)** Where the claimant voluntarily quit in advance of the announced scheduled layoff, the disqualification period will be from the last day worked to the date of the scheduled layoff. Benefits shall not be denied from the effective date of the scheduled layoff.

This rule is intended to implement Iowa Code sections 96.3(3), 96.4(3), 96.4(5), 96.5(1), 96.5(3), 96.6(1), 96.6(2), 96.16, 96.19(6) "a," and 96.19(38).

**871—24.26(96) Voluntary quit with good cause attributable to the employer and separations not considered to be voluntary quits.** The following are reasons for a claimant leaving employment with good cause attributable to the employer:

**24.26(1)** A change in the contract of hire. An employer's willful breach of contract of hire shall not be a disqualifiable issue. This would include any change that would jeopardize the worker's safety, health or morals. The change of contract of hire must be substantial in nature and could involve changes in working hours, shifts, remuneration, location of employment, drastic modification in type of work, etc. Minor changes in a worker's routine on the job would not constitute a change of contract of hire.

**24.26(2)** The claimant left due to unsafe working conditions.

**24.26(3)** The claimant left due to unlawful working conditions.

**24.26(4)** The claimant left due to intolerable or detrimental working conditions.

**24.26(5)** The claimant was laid off by the employer for being pregnant; however, availability must still be determined.

**24.26(6)** Separation because of illness, injury, or pregnancy.

*a. Nonemployment related separation.* The claimant left because of illness, injury or pregnancy upon the advice of a licensed and practicing physician. Upon recovery, when recovery was certified by a licensed and practicing physician, the claimant returned and offered to perform services to the employer, but no suitable, comparable work was available. Recovery is defined as the ability of the claimant to perform all of the duties of the previous employment.

*b. Employment related separation.* The claimant was compelled to leave employment because of an illness, injury, or allergy condition that was attributable to the employment. Factors and circumstances directly connected with the employment which caused or aggravated the illness, injury, allergy, or disease to the employee which made it impossible for the employee to continue in employment because of serious danger to the employee's health may be held to be an involuntary termination of employment and constitute good cause attributable to the employer. The claimant will be eligible for benefits if compelled to leave employment as a result of an injury suffered on the job.

In order to be eligible under this paragraph "b" an individual must present competent evidence showing adequate health reasons to justify termination; before quitting have informed the employer of the work-related health problem and inform the employer that the individual intends to quit unless the problem is corrected or the individual is reasonably accommodated. Reasonable accommodation includes other comparable work which is not injurious to the claimant's health and for which the claimant must remain available.

**24.26(7)** Reserved.

**24.26(8)** The claimant left for the necessary and sole purpose of taking care of a member of the claimant's immediate family who was ill or injured, and after that member of the claimant's family was sufficiently recovered, the claimant immediately returned and offered to perform services to the employer, but no work was available. Immediate family is defined as a collective body of persons who live under one roof and under one head or management, or a son or daughter, stepson, stepdaughter, father, mother, father-in-law, mother-in-law. Members of the immediate family must be related by blood or by marriage.

**24.26(9)** The claimant left employment upon the advice of a licensed and practicing physician for the sole purpose of taking a family member to a place having a different climate and subsequently returned to the claimant's regular employer and offered to perform services, but the claimant's regular or comparable work was not available. However, during the time the claimant was at a different climate the claimant shall be deemed to be unavailable for work notwithstanding that during the absence the claimant secured temporary employment. (Family is defined as: wife, husband, children, parents, grandparents, grandchildren, foster children, brothers, brothers-in-law, sisters, sisters-in-law, aunts, uncles or corresponding relatives of the classified employee's spouse or other relatives of the classified employee or spouse residing in the classified employee's immediate household.)

**24.26(10)** A claimant who underwent a mandatory retirement as of a certain age because of company policy or in accordance with an agreement between the employer and union.

**24.26(11)** The granting of a written release from employment by the employer at the employee's request is a mutual termination of employment and not a voluntary quit. However, this would constitute a period of voluntary unemployment by the employee and the employee would not meet the availability requirement of Iowa Code section 96.4(3).

**24.26(12)** When an employee gives notice of intent to resign at a future date, it is a quit issue on that future date. Should the employer terminate the employee immediately, such employee shall be eligible for benefits for the period between the actual separation and the future quit date given by the claimant.

**24.26(13)** A claimant who, when told of a scheduled future layoff, leaves employment before the layoff date shall be deemed to be not available for work until the future separation date designated by the employer. After the employer-designated date, the separation shall be considered a layoff.

**24.26(14)** Rescinded IAB 7/28/99, effective 9/1/99.

**24.26(15)** Employee of temporary employment firm.

*a.* The individual is a temporary employee of a temporary employment firm who notifies the temporary employment firm within three days of completion of an employment assignment and seeks reassignment under the contract of hire. The employee must be advised by the employer of the notification requirement in writing and receive a copy.

*b.* The individual shall be eligible for benefits under this subrule if the individual had good cause for not contacting the employer within three days and did notify the employer at the first reasonable opportunity.

*c.* Good cause is a substantial and justifiable reason, excuse or cause such that a reasonable and prudent person, who desired to remain in the ranks of the employed, would find to be adequate justification for not notifying the employer. Good cause would include the employer's going out of business; blinding snow storm; telephone lines down; employer closed for vacation; hospitalization of the claimant; and other substantial reasons.

*d.* Notification may be accomplished by going to the employer's place of business, telephoning the employer, faxing the employer, or any other currently accepted means of communications. Working days means the normal days in which the employer is open for business.

**24.26(16)** The claimant left employment for a period not to exceed ten working days or such additional time as was allowed by the employer, for compelling personal reasons and prior to leaving claimant had informed the employer of such compelling personal reasons, and immediately after such compelling personal reasons ceased to exist or at the end of ten working days, whichever occurred first, the claimant returned to the employer and offered to perform services, but no work was available. However, during the time the claimant was away from work because of the continuance of this compelling personal reason, such claimant shall be deemed to be not available for work.

**24.26(17)** Reserved.

**24.26(18)** Reserved.

**24.26(19)** The claimant was employed on a temporary basis for assignment to spot jobs or casual labor work and fulfilled the contract of hire when each of the jobs was completed. An election not to report for a new assignment to work shall not be construed as a voluntary leaving of employment. The issue of a refusal of an offer of suitable work shall be adjudicated when an offer of work is made by the former employer. The provisions of Iowa Code section 96.5(3) and rule 871—24.24(96) are controlling in the determination of suitability of work. However, this subrule shall not apply to substitute school employees who are subject to the provisions of Iowa Code section 96.4(5) which denies benefits that are based on service in an educational institution when the individual declines or refuses to accept a new contract or reasonable assurance of continued employment status. Under this circumstance, the substitute school employee shall be considered to have voluntarily quit employment.

**24.26(20)** The claimant left work voluntarily rather than accept a transfer to another locality that would have caused a considerable personal hardship.

**24.26(21)** The claimant was compelled to resign when given the choice of resigning or being discharged. This shall not be considered a voluntary leaving.

**24.26(22)** The claimant was hired for a specific period of time and completed the contract of hire by working until this specific period of time had lapsed. However, this subrule shall not apply to substitute school employees who are subject to the provisions of Iowa Code section 96.4(5) which denies benefits that are based on service in an educational institution when the individual declines or refuses to accept a new contract or reasonable assurance of continued employment status. Under this circumstance, the substitute school employees shall be considered to have voluntarily quit employment.

**24.26(23)** The claimant left work because the type of work was misrepresented to such claimant at the time of acceptance of the work assignment.

**24.26(24)** Reserved.

**24.26(25)** Temporary active military duty. A member of the national guard or organized military reserves of the armed forces of the United States ordered to temporary active duty for the purpose of military training or ordered on active state service, shall be entitled to a leave of absence during the period of such duty. The employer shall restore such person to the position held prior to such leave of absence, or employ such person in a similar position; provided, that such person shall give evidence to the employer of satisfactory completion of such training or duty, and further provided that such person is still qualified to perform the duties of such position.

**24.26(26)** Reserved.

**24.26(27)** Refusal to exercise bumping privilege. An individual who has left employment in lieu of exercising the right to bump or oust a fellow employee with less seniority shall be eligible for benefits.

**24.26(28)** The claimant left the transferring employer and accepted work with the acquiring employer at the time the employer acquired a clearly segregable and identifiable part of the transferring employer's business or enterprise. Under this condition, the balancing account shall immediately become chargeable for the benefits paid which are based on the wages paid by the transferring employer, provided the acquiring employer does not receive a partial successorship, and no disqualification shall be imposed if the claimant is otherwise eligible.

This rule is intended to implement Iowa Code sections 96.3(3), 96.4(3), 96.4(5), 96.5(1), 96.5(3), 96.6(1), 96.16, and 96.19(38).

**871—24.27(96) Voluntary quit of part-time employment and requalification.** An individual who voluntarily quits without good cause part-time employment and has not requalified for benefits following the voluntary quit of part-time employment, yet is otherwise monetarily eligible for benefits based on wages paid by the regular or other base period employers, shall not be disqualified for voluntarily quitting the part-time employment. The individual and the part-time employer which was voluntarily quit shall be notified on the Form 65-5323 or 60-0186, Unemployment Insurance Decision, that benefit payments shall not be made which are based on the wages paid by the part-time employer and benefit charges shall not be assessed against the part-time employer's account; however, once the individual has met the

requalification requirements following the voluntary quit without good cause of the part-time employer, the wages paid in the part-time employment shall be available for benefit payment purposes. For benefit charging purposes and as determined by the applicable requalification requirements, the wages paid by the part-time employer shall be transferred to the balancing account.

This rule is intended to implement Iowa Code section 96.5(1) "g."

**871—24.28(96) Voluntary quit requalifications and previously adjudicated voluntary quit issues.**

**24.28(1)** The claimant shall be eligible for benefits even though having voluntarily left employment, if subsequent to leaving such employment, the claimant worked in (except in back pay awards) and was paid wages for insured work equal to ten times the claimant's weekly benefit amount.

**24.28(2)** The claimant shall be eligible for benefits even though having been previously disqualified from benefits due to voluntary quit, if subsequent to the disqualification, the claimant worked in (except in back pay awards) and was paid wages for insured work equal to ten times the claimant's weekly benefit amount.

**24.28(3)** Reserved.

**24.28(4)** Reserved.

**24.28(5)** The claimant shall be eligible for benefits even though the claimant voluntarily quit if the claimant left for the sole purpose of accepting an offer of other or better employment, which the claimant did accept, and from which the claimant is separated, before or after having started the new employment. The employment does not have to be covered employment and does not include self-employment.

**24.28(6)** The claimant voluntarily left employment. However, there shall be no disqualification under Iowa Code section 96.5(1) if a decision on this same separation has been made on a prior claim by a representative of the department and such decision has become final.

**24.28(7)** The claimant voluntarily left employment. However, there shall be no disqualification under Iowa Code section 96.5(1) if a decision on this same separation has been made on a prior claim by the administrative law judge and such decision has become final.

**24.28(8)** The claimant voluntarily left employment. However, there shall be no disqualification under Iowa Code section 96.5(1) if a decision on this same separation has been made on a prior claim by the employment appeal board and such decision has become final.

This rule is intended to implement Iowa Code section 96.5(1) "a."

**871—24.29(96) Business closing.**

**24.29(1)** Whenever an employer at a factory, establishment, or other premises goes out of business at which the individual was last employed and is laid off, the individual's account is credited with one-half, instead of one-third, of the wages for insured work paid to the individual during the individual's base period, which may increase the maximum benefit amount up to 39 times the weekly benefit amount or one-half of the total base period wages, whichever is less. This rule also applies retroactively for monetary redetermination purposes during the current benefit year of the individual who is temporarily laid off with the expectation of returning to work once the temporary or seasonal factors have been eliminated and is prevented from returning to work because of the going out of business of the employer within the same benefit year of the individual. This rule also applies to an individual who works in temporary employment between the layoff from the business closing employer and the Claim for Benefits. For the purposes of this rule, temporary employment means employment of a duration not to exceed four weeks.

**24.29(2)** Going out of business means any factory, establishment, or other premises of an employer which closes its door and ceases to function as a business; however, an employer is not considered to have gone out of business at the factory, establishment, or other premises in any case in which the employer sells or otherwise transfers the business to another employer, and the successor employer continues to operate the business.

**24.29(3)** Verification of going out of business. When the unemployment insurance representative is informed by the individual or has knowledge of an employer going out of business at a factory, establishment, or other premises, the unemployment insurance representative completes a Form 60-0240,

Verification of Business Closing, and refers Form 60-0240 to the field audit section for assignment to a field auditor who verifies the business closing. A Form 62-2056, Review of Business Status for Closing Credits, is completed for each succeeding claimant who requests to be included in a redetermination for business closing credits. This form is added to the Form 60-0240 already in the department file for the appropriate pending investigation. Upon return of the Form 60-0240 from the field audit section, an unemployment insurance representative will issue the appropriate decisions to all claimants who requested that their unemployment insurance claim be redetermined as a business closing based on the results of the investigation.

**871—24.30** Reserved.

**871—24.31(96) Subsequent benefit year condition.**

**24.31(1)** The claimant must have been paid benefits on a previous claim.

**24.31(2)** If the claimant has the qualifying wages for the establishment of a second benefit year as specified in Iowa Code section 96.4(4) which were earned prior to the filing of the previous claim, the claimant must, during or subsequent to that year, have worked in (except in back pay awards) and have been paid wages for insured work totaling at least \$250, to fulfill the condition to be eligible for benefits on a new claim. Vacation pay, severance pay and bonuses are not considered as wages for second benefit year requalification purposes.

**24.31(3)** Insured work means insured work in any state.

**24.31(4)** Employment for a railroad under the Railroad Unemployment Insurance Act is insured work.

**24.31(5)** The amount equal to \$250 in insured work need not be in addition to the qualifying wages for the establishment of a second benefit year.

**24.31(6)** Disqualification for lack of the \$250 in insured work shall be removed upon the verification that the claimant worked in and has been paid wages for insured work totaling \$250 during or subsequent to the previous benefit year.

This rule is intended to implement Iowa Code section 96.4(4).

**871—24.32(96) Discharge for misconduct.**

**24.32(1) Definition.**

*a.* “Misconduct” is defined as a deliberate act or omission by a worker which constitutes a material breach of the duties and obligations arising out of such worker’s contract of employment. Misconduct as the term is used in the disqualification provision as being limited to conduct evincing such willful or wanton disregard of an employer’s interest as is found in deliberate violation or disregard of standards of behavior which the employer has the right to expect of employees, or in carelessness or negligence of such degree of recurrence as to manifest equal culpability, wrongful intent or evil design, or to show an intentional and substantial disregard of the employer’s interests or of the employee’s duties and obligations to the employer. On the other hand mere inefficiency, unsatisfactory conduct, failure in good performance as the result of inability or incapacity, inadvertencies or ordinary negligence in isolated instances, or good faith errors in judgment or discretion are not to be deemed misconduct within the meaning of the statute.

*b.* Any individual who has been discharged or suspended for misconduct connected with work is disqualified for benefits until the individual has worked in (except in back pay awards) and been paid wages for insured work equal to ten times the individual’s weekly benefit amount, provided the individual is otherwise eligible.

**24.32(2)** Reserved.

**24.32(3) Gross misconduct.**

*a.* For the purposes of these rules gross misconduct shall be defined as misconduct involving an indictable offense in connection with the claimant’s employment, provided that such claimant is duly convicted thereof or has signed a statement admitting that such claimant has committed such act.

*b.* An indictable offense means a common law or statutory offense presented on indictment or on county attorney's information, and includes all felonies and all indictable misdemeanors punishable by a fine of more than \$500 or by imprisonment in the county jail for more than 30 days.

**24.32(4) Report required.** The claimant's statement and employer's statement must give detailed facts as to the specific reason for the claimant's discharge. Allegations of misconduct or dishonesty without additional evidence shall not be sufficient to result in disqualification. If the employer is unwilling to furnish available evidence to corroborate the allegation, misconduct cannot be established. In cases where a suspension or disciplinary layoff exists, the claimant is considered as discharged, and the issue of misconduct shall be resolved.

**24.32(5) Trial period.** A dismissal, because of being physically unable to do the work, being not capable of doing the work assigned, not meeting the employer's standards, or having been hired on a trial period of employment and not being able to do the work shall not be issues of misconduct.

**24.32(6) False work application.** When a willfully and deliberately false statement is made on an Application for Work form, and this willful and deliberate falsification does or could result in endangering the health, safety or morals of the applicant or others, or result in exposing the employer to legal liabilities or penalties, or result in placing the employer in jeopardy, such falsification shall be an act of misconduct in connection with the employer.

**24.32(7) Excessive unexcused absenteeism.** Excessive unexcused absenteeism is an intentional disregard of the duty owed by the claimant to the employer and shall be considered misconduct except for illness or other reasonable grounds for which the employee was absent and that were properly reported to the employer.

**24.32(8) Past acts of misconduct.** While past acts and warnings can be used to determine the magnitude of a current act of misconduct, a discharge for misconduct cannot be based on such past act or acts. The termination of employment must be based on a current act.

**24.32(9) Suspension or disciplinary layoff.** Whenever a claim is filed and the reason for the claimant's unemployment is the result of a disciplinary layoff or suspension imposed by the employer, the claimant is considered as discharged, and the issue of misconduct must be resolved. Alleged misconduct or dishonesty without corroboration is not sufficient to result in disqualification.

This rule is intended to implement Iowa Code section 96.5 and Supreme Court of Iowa decision, *Sheryl A. Cospers vs. Iowa Department of Job Service and Blue Cross of Iowa*.

### **871—24.33(96) Labor disputes.**

**24.33(1) Definition.** As used in sections 96.5(3) "b"(1) and 96.5(4), the term labor dispute shall mean any controversy concerning terms, tenure, or conditions of employment, or concerning the association or representation of persons in negotiating, fixing, maintaining, changing, or seeking to arrange terms or conditions of employment regardless of whether the disputants stand in the proximate relation of employer and employee. An individual shall be disqualified for benefits if unemployment is due to a labor dispute.

#### **24.33(2) Initial requirements—workforce development center.**

*a.* As soon as the workforce development center has knowledge of a labor dispute or work stoppage in its administrative area, a report on Form 68-0535, Labor Dispute Report, shall be sent to the administrative office of the department of workforce development, attention: legal counsel, unemployment insurance services division, advising of the labor dispute or work stoppage.

*b.* If the labor dispute or work stoppage is terminated before the report is transmitted to the legal counsel, unemployment insurance services division, the information concerning the termination of the dispute and the date of the worker's return to work must also be entered on Form 68-0535.

*c.* When the labor dispute or work stoppage is terminated subsequent to the filing of the initial Form 68-0535, the legal counsel, unemployment insurance services division, shall be notified of the termination and return to work dates.

*d.* In those instances where an association represents a group of employers, include the names and addresses of the employers who are involved in the labor dispute in your report. Include also the name

and address of the association and the name of the association official who can furnish information about the work stoppage.

*e.* In taking initial claims in which there is a labor dispute, the workforce development center will complete an initial application for unemployment, Form 60-0330, Application for Job Placement Assistance and/or Job Insurance, in the normal manner and will also include the union name and local union number.

*f.* If a claim notice is inadvertently returned by the employer to the workforce development center stating there is a labor dispute, the protest with the postmarked envelope attached shall be transmitted to the unemployment insurance service center.

*g.* If there is a work stoppage at the premises of an employer and it is a known fact that there has not been a union and that at present there is no union representation nor any attempt by a union to organize the workers of the plant, a statement must be taken from each individual claiming benefits.

*h.* Statements from each individual claiming benefits are not required on the labor dispute issue whenever there is union representation even though some of the individuals may not be union members.

*i.* Statements from each individual claiming benefits will be taken whenever the work stoppage is considered as a nonunion stoppage, meaning no union representation at the premises of the employer. In such cases, each individual's statement would become a part of the evidence submitted to the administrative office of the department of workforce development.

*j.* When there is a termination of the work stoppage, or if the issues have not been resolved and all workers returned to work, a report must be made to the legal counsel, unemployment insurance services division. The report will include the:

(1) Date on which an agreement was reached on the issues which caused the work stoppage.

(2) Date on which the workers returned to work, or a schedule as to how the workers will return to work.

*k.* The requirements in subrules 24.33(1) and 24.33(2) will cover the establishment and termination reports of the work stoppage and give the information necessary for the claims section to investigate the work stoppage when claims are filed on which a protest is made that the claimant is involved in a work stoppage.

*l.* During the period of a labor dispute, the claims involved in the labor dispute are processed as though no separation from the employer had occurred. Therefore, if an individual is still unemployed after the termination of the labor dispute, such individual has either been laid off, voluntarily left, or has been discharged from employment, and an additional claim must be taken if the individual continues in claim status.

*m.* When the employer or the union requests advice and information pertaining to what action should be taken in regard to the labor dispute, the workforce development center, at that time, should obtain all the information possible from the caller for inclusion in the labor dispute report to the unemployment insurance services division.

*n.* The employer will receive separate notices of claim filing for each claimant and shall make any protest in the appropriate section on the reverse side of Form 65-5317, Notice of Claim. The employer will receive a copy of the decision which may be appealed.

*o.* Form 65-5317, Notice of Claim Filing, will be used by the employer to report total unemployment due to strike, lockout or other labor dispute.

*p.* Employer shall use Form 60-0154, Notice of Separation or Refusal of Work, or the electronic version of that form, to report separations from work by employees for reasons of voluntary leaving, misconduct and job refusal. Form 60-0154 shall not be used by employers to report labor disputes because the document is not designed for that type of an employment separation or work refusal.

**24.33(3) Initial determination.**

*a.* In any case in which the payment or denial of benefits will be determined by the provisions of Iowa Code section 96.5(4), the representative of the unemployment insurance services division shall promptly review the evidence submitted, and such additional evidence as may be required, and shall make a decision upon the issues involved under that subsection.

*b.* The representative of the unemployment insurance services division shall promptly notify all interested parties to the claim of the decision. Said parties shall have ten days, from the date of mailing the decision to the last known address of record, to appeal the decision.

**871—24.34(96) Labor dispute—policy.**

**24.34(1)** Reserved.

**24.34(2)** Union membership in and of itself is not the determinative factor in whether an individual is participating in, financing or directly interested in the labor dispute.

**24.34(3)** The relationship between employer and employee continues during the period of the labor dispute unless severed by the employer or employee.

*a.* If the relationship is severed by the employer, Iowa Code section 96.5(2) concerning discharge for misconduct shall govern.

*b.* If the relationship is severed by the employee, Iowa Code section 96.5(1) concerning voluntary leaving shall govern.

**24.34(4)** An individual who is unemployed because of a labor dispute and accepts employment elsewhere during the period of the labor dispute, must return to the previous employer when said labor dispute is settled or be subject to a determination on the issue of voluntary leaving.

**24.34(5)** Any individual unemployed because of failure or refusal to cross a picket line during a labor dispute shall be deemed to be involved in such labor dispute.

**24.34(6)** If an initial determination by the representative of the unemployment insurance services division of a labor dispute issue is appealed, the case shall be assigned to an administrative law judge, who shall receive the testimony of any party to the hearing and shall issue a decision on the labor dispute. Such decision may be appealed in conformity with these rules to the employment appeal board of the Iowa department of inspections and appeals.

**24.34(7)** An individual not involved in or participating in a labor dispute who failed to report to work because of a picket line shall be deemed to have voluntarily left employment. However, if the individual was subjected to hostility or violence in an attempt to cross a picket line, then the individual shall be deemed to have involuntarily left employment.

*a.* The division shall presume that any strike or lockout is being conducted in a lawful manner unless evidence to the contrary has been introduced. The division shall presume that any picketing is being conducted in a peaceful manner and that ingress or egress to the employer's facility is not being unlawfully impeded.

*b.* The division shall presume that where an injunction has been sought against actual or threatened violence, unlawful impedance of ingress or egress, or other unlawful conduct and such injunction shall have been denied on the basis that actual or threatened unlawful conduct has not been established that the picket line is peaceful unless evidence is introduced which establishes the violent nature of picket line activity.

*c.* If an injunction is obtained, the division shall presume the picket line is peaceful as of the date the injunction is issued unless evidence is introduced which proves the contrary proposition.

**24.34(8)** A lockout is not a labor dispute if the claimant is willing to continue working under the preexisting terms and conditions of the expired collective bargaining agreement for a reasonable period of time while a new collective bargaining agreement is negotiated. A lockout is a cessation of the furnishing of work to employees or a withholding of work from them in an effort to get more desirable terms for the employer.

*a.* The test for determining whether a stoppage of work is a lockout or labor dispute is to determine the final cause and the party ultimately responsible for the work stoppage. If the employees have offered to continue working for a reasonable period of time under the preexisting terms and conditions of employment so as to avert a work stoppage pending the final settlement of the contract negotiations and the employer refuses to maintain the status quo by extending the expired contract, the resulting work stoppage constitutes a lockout and the claimants shall not be disqualified because of a labor dispute.

*b.* A cessation of employment by the employer is not a lockout if:

(1) The stoppage of work is in the same facility or another facility of the employer and the claimant is directly involved in the labor dispute and the collective bargaining negotiations will directly affect the claimant's condition of employment, or

(2) The claimant or the recognized collective bargaining agent declines an offer from the employer to extend the expired collective bargaining agreement while negotiations continue for a reasonable period of time taking into consideration the nature of the employer's business, or

(3) The employer can demonstrate that its refusal to allow employees to continue working under the terms and conditions of the expired collective bargaining agreement is due to a compelling reason of such degree that the extension of the contract would be unreasonable under the circumstances.

**24.34(9)** To constitute a labor dispute there must be a stoppage of work at the plant or establishment. If there is no stoppage of work, the individual who leaves employment shall be deemed to have voluntarily quit.

**24.34(10)** When individuals, not as a group, union, or under union direction or suggestion but individually, left their work voluntarily in protest against the discharge of a fellow employee by their employer, in an unauthorized strike, it is held to be a voluntary quit.

**24.34(11)** Employment offered by an employer involved in a labor dispute or an employer who becomes involved in a labor dispute prior to acceptance by the claimant is considered:

*a.* Not suitable if the offer is made to a person who would be a new employee or a former employee who was laid off before the labor dispute and the vacancy was created by the strike, lockout, or other labor dispute.

*b.* Suitable if the offer was made to a former employee, who was previously laid off, provided the position offered is not vacant because of the strike, lockout, or other labor dispute and the provisions of section 96.5(4) shall apply.

*c.* Suitable if the offer is made to a new employee, who was not previously laid off by the same employer, and the vacancy was not created by a labor dispute.

**24.34(12)** Other employment accepted during periods of labor disputes does not free the claimant from the labor dispute section of the Iowa employment security law unless the claimant severs relationship with employer and obtains bona fide employment elsewhere.

This rule is intended to implement Iowa Code sections 96.5(3) and 96.5(4).

#### **871—24.35(96) Date of submission and extension of time for payments and notices.**

**24.35(1)** Except as otherwise provided by statute or by division rule, any payment, appeal, application, request, notice, objection, petition, report or other information or document submitted to the division shall be considered received by and filed with the division:

*a.* If transmitted via the United States postal service on the date it is mailed as shown by the postmark, or in the absence of a postmark the postage meter mark of the envelope in which it is received; or if not postmarked or postage meter marked or if the mark is illegible, on the date entered on the document as the date of completion.

*b.* If transmitted by any means other than the United States postal service on the date it is received by the division.

**24.35(2)** The submission of any payment, appeal, application, request, notice, objection, petition, report or other information or document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the division that the delay in submission was due to division error or misinformation or to delay or other action of the United States postal service.

*a.* For submission that is not within the statutory or regulatory period to be considered timely, the interested party must submit a written explanation setting forth the circumstances of the delay.

*b.* The division shall designate personnel who are to decide whether an extension of time shall be granted.

*c.* No submission shall be considered timely if the delay in filing was unreasonable, as determined by the division after considering the circumstances in the case.

*d.* If submission is not considered timely, although the interested party contends that the delay was due to division error or misinformation or delay or other action of the United States postal service, the division shall issue an appealable decision to the interested party.

**24.35(3)** Delivery by mail. Any notice, report form, determination, decision, or other document mailed by the division shall be considered as having been given to the addressee to whom it is directed on the date it is mailed to the addressee's last-known address. The date mailed shall be presumed to be the date of the document, unless otherwise indicated by the facts.

**24.35(4)** Electronic delivery. Any notice, report form, determination, decision, or other document sent by the division via the U.S. Department of Labor state information data exchange system shall be considered as having been given to the party to whom it is directed on the date it is submitted on the system. The date submitted shall be presumed to be the date of the document, unless otherwise indicated by the facts.

[ARC 3116C, IAB 6/7/17, effective 7/12/17]

**871—24.36(96) Interstate benefits.**

**24.36(1)** An interstate claimant is an individual who claims benefits under the unemployment insurance law of one or more liable states. Interstate benefits are payable under the plan approved by the national association of state workforce agencies to unemployed individuals absent from the state(s) in which wage credits were earned.

**24.36(2)** The division shall determine unemployment benefit claims for interstate claimants in accordance with applicable state law and rules and shall be in substantial compliance with those rules promulgated by the United States Department of Labor as published in the Code of Federal Regulations, Chapter 20, Parts 609, 615, 616, 617, and 650.

**871—24.37(96) Payment of benefits to interstate claimants.**

**24.37(1)** Section 96.20 of the employment security law of Iowa authorizes the department to enter into reciprocal arrangements with appropriate and duly authorized agencies of other states or of the federal government, or both. In conformity with this section, the department of workforce development prescribes:

*a. Applicability.* This regulation shall govern the department in its administrative cooperation with other states adopting a similar regulation for the payment of unemployment insurance benefits to interstate claimants.

*b. Definitions.* As used in this rule unless the context clearly requires otherwise:

(1) *"Interstate benefit payment plan."* This is the plan approved by the national association of state workforce agencies under which benefits shall be payable to unemployed individuals absent from the state (or states) in which benefit credits have been accumulated.

(2) *"Interstate claimant."* This is an individual who claims benefits under the unemployment insurance law of one or more liable states. The term interstate claimant shall not include any individual who customarily commutes from a residence in an agent state to work in a liable state unless the department finds that this exclusion would create undue hardship on such a claimant in a specified area.

(3) *"State."* This includes the District of Columbia, Puerto Rico, the Virgin Islands and Canada.

(4) *"Agent state."* This means any state in which an individual files a claim for benefits from another state.

(5) *"Liable state."* A liable state is any state against which an individual files, from another state, a claim for benefits.

(6) *"Benefits."* This is the compensation payable to an individual, with respect to unemployment, under the employment security law of any state.

(7) *"Week of unemployment."* This is any week of unemployment as defined in the law of the liable state from which benefits with respect to such week are claimed.

*c. Registration for work.*

(1) Each interstate claimant shall be registered for work, through any public employment office in the agent state when and as required by the law, rules, regulations, and procedures of the agent state. Such registration shall be accepted as meeting the registration requirements of the liable state.

(2) Each agent state shall duly report to the liable state in question whether each interstate claimant meets the registration requirements of the agent state.

*d. Benefit rights of interstate claimants.*

(1) If a claimant files a claim against any state, and it is determined by such state that the claimant has available benefit credits in such state, then claims shall be filed only against such state as long as benefit credits are available in that state. Thereafter, the claimant may file claims against any other state in which there are available benefit credits.

(2) For the purposes of this regulation, benefit credits shall be deemed to be unavailable whenever benefits have been exhausted, terminated, or postponed for an indefinite period or for the entire period in which benefits would otherwise be payable, or whenever benefits are affected by the application of a seasonal restriction. The department will respect the prior adjudication of a liable state if the department is made aware of the decision and will apply the Iowa requalification criteria, unless the claimant has requalified pursuant to the liable state's requalification criteria.

(3) The benefit rights of interstate claimants established by this regulation shall apply only with respect to new claims filed on or after July 5, 1953.

*e. Claim for benefits.*

(1) Claims for benefits shall be filed by interstate claimants on uniform interstate claim forms or by using the procedures provided by the liable state and in accordance with uniform procedures developed pursuant to the interstate benefit payment plan. Claims shall be filed in accordance with the type of week in use in the agent state. Any adjustments required to fit the type of week used by the liable state shall be made by the liable state on the basis of consecutive claims filed.

(2) Rescinded IAB 8/6/03, effective 9/10/03.

*f. Determination of claims.*

(1) In connection with each claim filed by an interstate claimant, the agent state shall ascertain and report to the liable state in question such facts relating to the claimant's availability for work and eligibility for benefits as are readily determinable in and by the agent state.

(2) The agent state's responsibility and authority in connection with the determination of interstate claims shall be limited to investigation and reporting of relevant facts. The agent state shall not refuse to take an interstate claim unless the liable state has a procedure for taking out-of-state claims.

*g. Appellate procedure.*

(1) The agent state shall afford all reasonable cooperation in the taking of evidence and the holding of hearings in connection with appealed interstate benefit claims.

(2) With respect to the time limits imposed by the law of a liable state upon the filing of an appeal in connection with a disputed benefit claim, an appeal made by an interstate claimant shall be deemed to have been made and communicated to the liable state on the date when it is received by any qualified representative of the agent state.

**24.37(2) Extended benefits interstate claims.** When extended benefits are in effect and a claimant is filing for extended benefits, an eligible individual shall be limited to a maximum of two weeks of the extended benefit entitlement if the individual moves from this state, before or during an extended benefit period triggered by this state's "on" indicator, to another state in which an extended benefit period is not in effect.

This rule is intended to implement Iowa Code sections 96.6(1) and 96.29(3).

**871—24.38(96) Combined wage claim.**

**24.38(1) Purpose of plan.** The combined wage program is to enable an unemployed worker with covered employment or wages in more than one state to combine all such employment and wages in one state in order to qualify for benefits or to receive increased benefits.

*a.* Each state will cooperate with every other state by implementing these uniform combined wage procedures, rules and regulations. This includes the District of Columbia, U.S. Virgin Islands and the Commonwealth of Puerto Rico.

*b.* The benefit year, base period, qualifying wages, benefit rate, and duration of benefits under the unemployment compensation law of the paying state shall be the benefit year, base period, qualifying wages, benefit rate, and duration of benefits applicable to a combined wage claimant.

*c.* The rights of the individual under the combined wage claim plan shall be determined by the paying state after the combining of all wages available from the transferring states; however, in the case in which another state transfers wages to Iowa and Iowa is the paying state, Iowa cannot again adjudicate a separation that has been previously adjudicated by the transferring state. The department shall respect the prior adjudication of the transferring state if the department is aware of the decision and will apply the Iowa requalification criteria, unless the individual has requalified pursuant to the liable state's requalification criteria.

*d.* All other provisions of the unemployment compensation laws and rules of the state agency of the paying state shall be applied to the combined wage claim.

*e.* The state in which the claim is filed will be the paying state except in those cases in which the individual does not qualify after the transfer has been completed or if the claimant meets the definition of a commuter.

**24.38(2)** *Exception to combining wage credits.* Under the following circumstances, wages and employment are not transferable to the paying state:

*a.* Any employment and wages which have been transferred to any other paying state and not returned unused.

*b.* Wages that have been used by the transferring state as the basis of a monetary determination which established a benefit year.

*c.* Any employment and wages that have been canceled or are unavailable as a result of a transferring state determination made prior to the request for transfer.

**24.38(3)** The claimant will be told that if there was a previous election to file a combined wage claim, the claimant may withdraw the combined wage claim any time, up to the date the paying state's monetary determination becomes final. However, if the claimant withdraws a combined wage claim and benefits have been paid, the claimant will be required to repay any such benefits. This repayment may be done by cash or by an authorization to the state(s) from which such claimant next claims benefits to reimburse the combined wage paying state for any benefits which said claimant will be paid.

**871—24.39(96) Department-approved training or retraining program.** The intent of department-approved training is to exempt the individual from the work search requirement for continued eligibility for benefits so individuals may pursue training that will upgrade necessary skills in order to return to the labor forces. In order to be eligible for department-approved training programs and to maintain continuing participation therein, the individual shall meet the following requirements:

**24.39(1)** Any claimant for benefits who desires to receive benefits while attending school for training or retraining purposes shall make a written application to the department setting out the following:

*a.* The educational establishment at which the claimant would receive training.

*b.* The estimated time required for such training.

*c.* The occupation which the training is allowing the claimant to maintain or pursue.

**24.39(2)** A claimant may receive unemployment insurance while attending a training course approved by the department. While attending the approved training course, the claimant need not be available for work or actively seeking work. After completion of department-approved training the claimant must, in order to continue to be eligible for unemployment insurance, place no restriction on employability. The claimant must be able to work, available for work and be actively searching for work. In addition, the claimant may be subject to disqualification for any refusal of work without good cause after the claimant has completed the training.

**24.39(3)** The claimant must show satisfactory attendance and progress in the training course and must demonstrate that such claimant has the necessary finances to complete the training to substantiate the expenditure of unemployment insurance funds.

This rule is intended to implement Iowa Code section 96.4(6).

**871—24.40(96) Training extension benefits.**

**24.40(1)** The purpose of training extension benefits is to provide the individual with continued eligibility for benefits so that the individual may pursue a training program for entry into a high-demand or high-technology occupation. Training extension benefits are available to an individual who was laid off or voluntarily quit with good cause attributable to the individual's employer from full-time employment in a declining occupation or is involuntarily separated from full-time employment as a result of a permanent reduction of operations.

**24.40(2)** The weekly benefit amount shall be pursuant to the same terms and conditions as regular unemployment benefits and the benefits shall be for a maximum of 26 times the weekly benefit amount of the claim which resulted in eligibility. Both contributory and reimbursable employers shall be relieved of charges for training extension benefits.

**24.40(3)** The course or courses must be for a high-demand or high-technology occupation. The department will make available to serve as a guide a list of high-demand, high-technology, and declining occupations. The lists shall be available on the department's Web site and workforce centers.

*a.* High-technology occupations include life sciences, advanced manufacturing, biotechnology, alternative fuels, insurance, environmental technology, and technologically advanced green jobs. A high-technology occupation is one which requires a high degree of training in the sciences, engineering, or other advanced learning area and has work opportunities available in the labor market area or the state of Iowa.

*b.* A high-demand occupation means an occupation in a labor market area or the state of Iowa as a whole in which the department determines that work opportunities are available.

*c.* A declining occupation has a lack of sufficient current demand in the individual's labor market area or the state of Iowa for the occupational skills possessed by the individual, and the lack of employment opportunities is expected to continue for an extended period of time.

*d.* A declining occupation includes an occupation for which there is a seasonal variation in demand in the labor market or the state of Iowa, and the individual has no other skill for which there is a current demand.

*e.* A declining or high-demand occupation will be determined by using Iowa labor market information for each region in the state.

**24.40(4)** The individual must be enrolled in the training no later than the end of the benefit year which included the separation which made the individual eligible for training benefits or the week in which any federal benefit program based upon that benefit year is exhausted. Enrolled before the end of the benefit year means the individual has taken all steps available for entry into the training and has secured a reserved position in the training class. The individual has paid tuition or will pay tuition when the training starts. The training class may begin after the end of the benefit year. The application for training benefits must be received 30 days after the end of the benefit year or 30 days after federal benefits are exhausted. The individual must be enrolled and making satisfactory progress to complete the training program in order to continue to be eligible for training extension benefits.

**24.40(5)** Training benefits shall cease to be available if the training is completed; the individual quits the training course; the individual exhausts the training extension maximum benefit amount; or the individual fails to make satisfactory progress; and benefits shall cease no later than one calendar year following the end of the benefit year in which the individual became eligible for the benefits. Individuals must file and receive benefits under any federal or state unemployment insurance benefit program until the claim has expired or has been exhausted, in order to maintain eligibility for training extension benefits.

This rule is intended to implement 2009 Iowa Code Supplement section 96.3(5).

[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—24.41(96) Unemployed parents program (FIP/UP).** Under Public Law 94-566, an unemployed parent who is eligible for both unemployment insurance and family investment program/unemployed parent (FIP/UP) shall be required to collect any unemployment insurance to which the individual is entitled before receiving any payments under the FIP/UP program.

This rule is intended to implement Iowa Code chapter 91 and Public Law 94-566.

**871—24.42(96) Retention of DHS referral form.** When an unemployed parent presents the DHS referral Form PA-2138-5 to the workforce development center representative, the representative will take the form, sign it and complete an application for job placement assistance and/or employment insurance benefits.

**24.42(1)** The weekly benefit amount and maximum benefit amount of the claimant will be entered in job service comments on Form PA-2138-5. If the person is not monetarily eligible, that notation will be entered and the form mailed to human services.

**24.42(2)** A FIP/UP claimant may have the claim protested which can affect eligibility. Human services may request additional information on a subsequent Form PA-2138-5 concerning nonmonetary allowances or disqualifications on the claim, which will be furnished in the comments section of the form.

This rule is intended to implement Iowa Code chapter 91 and Public Law 94-566.

**871—24.43 and 24.44** Reserved.

**871—24.45(96) Trade Act of 1974.** Unemployment benefits payable to claimants under the Trade Act of 1974 (P.L. 93-618), shall be determined in accordance with the rules of the United States department of labor as published in the Code of Federal Regulations, chapter 29, parts 70 and 91. The Trade Act of 1974 is designed to pay unemployment benefits to workers who become unemployed due to foreign production of goods replacing domestic production.

**871—24.46(96) Extended benefits.**

**24.46(1) Purpose.** Extended benefits are benefits paid to an eligible individual during periods of high unemployment in a state under the Federal-State Extended Unemployment Compensation Act of 1970 and the Extended Benefit Program Regulations under 20 Code of Federal Regulations Part 615. The purpose of extended benefits is to extend the period of time for which an individual may receive benefits to allow the individual additional time to locate employment in recognition of the likelihood that employment is more difficult to find during periods of high unemployment in a state. The cost of extended benefits is shared between the federal and state governments.

**24.46(2) Determination of when extended benefits are paid.**

*a. When paid.* The state “on” indicator determines when extended benefits are paid in this state. A state “on” indicator is in effect during a week for which the rate of insured unemployment is 5 percent or greater and 120 percent or greater than the average of the rates of insured unemployment for the same week in the two immediately preceding calendar years.

*b. When not paid.* The state “off” indicator determines when extended benefits are not paid in this state. A state “off” indicator is in effect during a week for which the rate of insured unemployment is less than 5 percent or less than 120 percent of the average of the rates of insured unemployment for the same week in the two immediately preceding calendar years.

*c. Period of payment.* The extended benefit period is the period of time when extended benefits are paid in this state. An extended benefit period begins with the third week following a week for which there is a state “on” indicator in effect. An extended benefit period ends either with the completion of the thirteenth consecutive week beginning with the third week following a state “on” indicator, or later, with the completion of the third week following the first week for which there is a state “off” indicator. However, another extended benefit period shall not begin until the fourteenth week following the end of a previous extended benefit period.

*d. Rate of insured unemployment.* For the purposes of this subrule, the rate of insured unemployment means the percentage derived by dividing the average weekly number of individuals filing claims for regular benefits (excluding state plant closing benefits and benefits paid to federal civilian employees and ex-servicemembers under 5 U.S.C., chapter 85) in this state for weeks of unemployment with respect to the most recently completed 13-consecutive-week period by the average monthly insured employment for the first four of the six most recently completed calendar quarters immediately preceding the end of the 13-week period.

**24.46(3) Announcement and notice of the beginning and ending of an extended benefit period.**

*a. Announcement by director.* The beginning or ending date, whichever is appropriate, of an extended benefit period is announced by the director of the department of workforce development through appropriate news media in this state. As the case may be, the announcement clearly describes the unemployed individuals who may become eligible or ineligible for extended benefits.

*b. Notice to individuals.* The Form 65-5309, Notice to Individuals, is used by the department to notify individuals of:

(1) The beginning of an extended benefit period. The notice of potential entitlement to extended benefits is sent to each individual who has exhausted all rights to regular benefits either prior to the beginning of, or during, the extended benefit period and who has a benefit year which will not end prior to the beginning of the extended benefit. The notice describes those actions required of the individual to claim the extended benefits.

(2) The ending of an extended benefit period. The notice of termination of entitlement to extended benefits is sent to each individual who is currently filing a claim for extended benefits of the ending of an extended benefit period. The notice describes the effect on the individual's right to extended benefits.

**24.46(4) Amount and duration of extended benefits.**

*a. Weekly extended benefit amount.* An individual's weekly extended benefit amount paid for a week of total unemployment during the individual's eligibility period is equal to the individual's weekly regular benefit amount paid for a week of total unemployment during the individual's applicable benefit year.

*b. Duration of extended benefits.* The total amount of extended benefits which an individual may receive during the individual's applicable benefit year is limited to 50 percent of the total amount of regular benefits, excluding any state plant closing benefits, received by the individual during that benefit year or 13 times the individual's weekly regular benefit amount paid for a week of total unemployment during that benefit year whichever is less; however, an individual is limited to two weeks of extended benefits if the individual files an interstate claim for extended benefits in a state in which an extended benefit period is not in effect.

*c. Eligibility period.* The eligibility period is the period of weeks in and after an individual's benefit year which begin in an extended benefit period when an individual is eligible to receive extended benefits; however, if a benefit year ends within an individual's eligibility period for extended benefits, the remaining extended benefits which the individual is entitled to receive in that portion of the eligibility period which extends beyond the end of the individual's benefit year, is reduced, but not below zero, by an amount arrived at by multiplying the number of weeks of Federal Trade Readjustment Act benefits received by the individual during the benefit year times the individual's weekly extended benefit amount.

*d. Applicable benefit year.* The applicable benefit year includes the period of one year from the date that an individual files a valid claim for benefits and any weeks following this one-year period in which the individual's eligibility period for extended benefits has not expired and the individual is not able to establish a second benefit year for regular benefits.

**24.46(5) Eligibility requirements for extended benefits.** Except where the results are inconsistent with the provisions of the Federal-State Extended Unemployment Compensation Act of 1970 as amended and the Extended Benefit Program Regulations under 20 Code of Federal Regulations Part 615, the provisions of this state's law which apply to claims for, and the payment of, regular benefits apply to claims for, and the payment of, extended benefits. An individual is eligible to receive extended benefits for a week of unemployment during the individual's eligibility period if the department finds that all of the following conditions are met:

*a.* The individual is an exhaustee. An exhaustee is an individual who has exhausted all entitlements to regular benefits under this or any other state law as well as federal civilian employee, railroad unemployment insurance, and ex-servicemember benefits.

An individual is also an exhaustee:

(1) If the individual may be entitled to additional regular benefits as a result of a pending appeal with respect to wages that were not considered in the original monetary determination in the individual's benefit year.

(2) If the individual's benefit year has expired prior to the week, and the individual has no, or insufficient, wages on the basis of which to establish a new benefit year.

(3) If the individual has no right to benefits under other laws of the federal government, as specified in the regulations issued by the United States Secretary of Labor, or a contiguous country with which the United States has an agreement, but if the individual is seeking benefits and the appropriate agency finally determines that the individual is not entitled to the benefits, then the individual is an exhaustee.

*b.* The individual has one and one-half times the high quarter wages. An individual is required to have been paid wages for insured work during the individual's base period in an amount at least one and one-half times the wages paid to the individual during that quarter of the individual's base period in which the individual's wages were highest.

*c.* The individual is required to actively seek, apply for or accept, suitable work. When an individual files an initial claim for extended benefits, the Form 60-0274, Notice for Individuals Claiming Extended Benefits, is used to determine the individual's prospects for obtaining work and to notify the individual that, beginning with the week following the week in which the individual is furnished this notice:

(1) If the individual's prospects for obtaining work within a reasonably short period are "good," the individual is required to actively seek, apply for or accept, suitable work in which, all other considerations being reasonably equal, the gross average weekly wage equals or exceeds 65 percent of the individual's average weekly wage from the highest earnings quarter of the individual's base period.

(2) If the individual's prospects for obtaining work within a reasonably short period are "not good," the individual is required to actively seek, apply for or accept, suitable work which is within the individual's capabilities to perform and which offers a gross average weekly wage which exceeds the individual's weekly extended benefit amount for a week of total unemployment plus any supplemental unemployment benefits; however, the individual is not required to actively seek, apply for or accept, work which offers a gross average weekly wage less than the federal or state minimum wage whichever is higher.

(3) For the purposes of this paragraph, reasonably short period means four weeks. If an individual whose prospects for obtaining work are "good" has not secured work within four weeks following the week in which the individual is furnished the Form 60-0274, Notice to Individuals Claiming Extended Benefits, then the individual is notified on Form 65-5309, Notice to Individuals, that the individual's prospects for obtaining work are now considered as "not good."

(4) For the purposes of this paragraph, actively seeking work means that, for each week following the week in which the individual is furnished the Form 60-0274, Notice to Individuals Claiming Extended Benefits, the individual is required to provide tangible evidence on the weekly claim for benefits that the individual is making a systematic and sustained effort to search for suitable work.

(5) If prospects are determined to be "not good," an individual shall not be disqualified for failing to apply for or accept work which is not offered in writing or is not listed with this state's employment service.

*d.* The individual is required to requalify following a disqualification for failure to actively seek, apply for or accept, suitable work. To become eligible for extended benefits following a disqualification for failure to actively seek, apply for or accept, suitable work, the individual is required to be employed in insured work for four weeks, which need not be consecutive, and earn four times the individual's weekly extended benefit amount.

**871—24.47(96) Disaster benefits.** Benefits under the Disaster Relief Act of 1974. Unemployment benefits payable under Public Law 93-288, the Disaster Relief Act of 1974, will be determined in accordance with the rules of the United States Department of Labor and published in the Code of Federal Regulations, Chapter 20, Parts 625 and 650, and Chapter 32, Part 1710.16. These benefits are payable to claimants who are unemployed due to natural disasters. A claimant who is eligible for regular unemployment benefits shall not be eligible for disaster unemployment assistance.

**871—24.48(96) UCFE claims.** Benefits under the Federal Employer's Compensation Act. Unemployment benefits for civilian federal employees shall be determined in accordance with the applicable state law and rules as well as the rules of the United States Department of Labor and published in the Code of Federal Regulations, Chapter 20, Parts 609, 615, 616, 617, and 650. These benefits are payable under the Federal Employer's Compensation Act, 5 U.S.C. 8101-8150, 8191-8193, and are based on wages earned by civilians in covered federal employment.

**871—24.49(96) UCX claims.** Benefits under the Ex-servicemember's Unemployment Compensation Act.

**24.49(1) Applicable law.** Unemployment benefits for ex-military personnel shall, in addition to being determined in accordance with applicable Iowa law and rules, be determined in substantial compliance with the rules and guidelines of the United States Department of Labor and published in the Code of Federal Regulations, Chapter 20, Parts 614 and 650.

**24.49(2) When payable.** These benefits are payable under the Ex-servicemember's Unemployment Compensation Act of 1958, 5 U.S.C. 8850. They allow unemployment compensation to be based on wages earned while on active military duty.

**871—24.50(96) Temporary extended unemployment compensation.**

**24.50(1) to 24.50(5)** Rescinded IAB 8/6/03, effective 9/10/03.

**24.50(6)** Overpayments will be offset up to and including 50 percent of the temporary extended unemployment compensation benefit payment.

**24.50(7)** Waiver of overpayments.

*a.* Individuals who have received amounts of temporary extended unemployment compensation to which they were not entitled shall be required to repay the amounts of such temporary extended unemployment compensation except that the state repayment may be waived if the workforce development department determines that:

(1) The payment of such temporary extended unemployment compensation was without fault on the part of the individual; and

(2) Such repayment would be contrary to equity and good conscience.

*b.* In determining whether fault exists, the following factors shall be considered:

(1) Whether a material statement or representation was made by the individual in connection with the application for temporary extended unemployment compensation that resulted in the overpayment and whether the individual knew or should have known that the statement or representation was inaccurate.

(2) Whether the individual failed or caused another to fail to disclose a material fact in connection with an application for temporary extended unemployment compensation that resulted in the overpayment and whether the individual knew or should have known that the fact was material.

(3) Whether the individual knew or could have been expected to know that the individual was not entitled to the temporary extended unemployment compensation payment.

(4) Whether, for any other reason, the overpayment resulted directly or indirectly, and partially or totally, from any act or omission of the individual or of which the individual had knowledge and which was erroneous or inaccurate or otherwise wrong.

*c.* In determining whether equity and good conscience exist, the following factors shall be considered:

(1) Whether the overpayment was the result of a decision on appeal;

- (2) Whether the state agency had given notice to the individual that the individual may be required to repay the overpayment in the event of a reversal of the eligibility determination on appeal; and
  - (3) Whether recovery of the overpayment will cause financial hardship to the individual.
- This rule is intended to implement Iowa Code sections 96.11 and 96.29.

**871—24.51(96) School definitions.**

**24.51(1)** Educational institution means public, nonprofit, private and parochial schools in which participants, trainees, or students are offered an organized course of study or training designed to transfer to them knowledge, skills, information, doctrines, attitudes or abilities from, by or under the guidance of an instructor or teacher. It is approved, licensed or issued a permit to operate as a school by the department of education or other government agency that is authorized within the state to approve, license or issue a permit for the operation of a school. The course of study or training which it offers may be academic, technical, trade, or preparation for gainful employment in a recognized occupation.

**24.51(2)** Educational service agency means a governmental agency or governmental entity which is established and operated exclusively for the purpose of providing educational services to one or more educational institutions.

**24.51(3)** Employment definitions.

*a.* Professional employees including educational service agency employees means persons who are employed in an instructional, research or principal administrative capacity as explained below:

(1) Instructional: Services performed for an educational institution which consist of teaching in formal classroom and seminar situations, tutoring, or lecturing in the activity of imparting knowledge; or of services which consist of directing or supervising the instructional activities of others; or services which consist of counseling, advising, or otherwise determining curriculum, courses, and academic pursuits for students.

(2) Research: Services performed for an educational institution which consist of careful and systematic study and investigation in a field of science and knowledge, undertaken to establish facts or principles. The work performed is in a predominantly intellectual field or artistic endeavor which is varied in character and requires the constant exercise of discretion and judgment in performance. The work further requires advanced knowledge in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study.

(3) Principal administrative: Services performed for an educational institution which consist of managing the educational institution or one of its major divisions or departments. Such services include the responsibility for establishing and administering policies, rules, and regulations which have major impact on the overall operations and functions of the educational institutions or one of its major divisions or departments. Work and activities are performed under general direction and broad objectives and missions, with the authority to determine goals and the techniques and methods of operations of the educational institution or one of its major divisions or departments. The duties performed by the individual rather than the title held should determine whether the prohibition applies. Neither providing a title nor withholding it should be controlling in itself.

*b.* Nonprofessional employees including educational service agency employees means persons who perform services in any capacity for an educational institution other than in an instructional, research, or principal administrative capacity.

**24.51(4)** Holiday recess. See vacation period subrule 24.51(8).

**24.51(5)** Institution of higher education means an educational institution which admits as regular students individuals having a certificate of graduation from a high school, or the recognized equivalent of such certificate; is legally authorized in this state primarily to provide a program of education beyond high school; provides an educational program for which it awards a bachelor's or higher degree or provides a program which is acceptable for full credit toward such a degree, a program of postgraduate or postdoctoral studies, or a program of training to prepare students for gainful employment in a recognized occupation; and is a public or other nonprofit institution.

**24.51(6)** Reasonable assurance, as applicable to an employee of an educational institution, means a written, verbal, or implied agreement that the employee will perform services in the same or

similar capacity, which is not substantially less in economic terms and conditions, during the ensuing academic year or term. It need not be a formal written contract. To constitute a reasonable assurance of reemployment for the ensuing academic year or term, an individual must be notified of such reemployment.

**24.51(7) School duration period.**

*a.* Academic year is defined as that period of time that school personnel are obligated by contract to render services to the educational institution during the school year.

*b.* Term is defined as either of the two periods into which the yearly period of instruction is normally divided, commonly referred to as a semester. If the educational institution operates on a quarterly basis, then term shall mean the same as a quarter period. If the educational institution operates on a trimester basis, then term shall mean the same as a trimester period or any other division in a school year during which instruction is regularly given to students.

*c.* Twelve-month employment. School employees that perform services for educational institutions 12 months of a calendar year or years.

**24.51(8) Vacation period or holiday recess.** In Iowa Code section 96.4(5), the term “established and customary” vacation period or holiday recess involved in this provision includes those scheduled at Christmas and in the spring, when those vacation periods or recesses occur within a term.

**24.51(9) Between terms or academic years denial means** any week of unemployment which begins during the period between two successive academic years or during a similar period between two regular terms, whether or not successive, or during a period of paid sabbatical leave provided for in the individual’s contract, if the individual has a contract or reasonable assurance that the individual will perform services in any such capacity for any educational institution for both such terms or academic years.

**871—24.52(96) Determining eligibility of school claims after employer protest.**

**24.52(1) Claim filed.** When a claim has been filed by an employee of an educational institution, the department shall send a Form 65-5317, Notice of Claim, to the educational institution and such educational institution wishing to protest such a claim shall return such notice to the department and shall include on it a statement as to whether or not the individual who filed a claim had been given reasonable assurance for the ensuing academic year or term. The statement should include the date and method of such notification. A copy of the notification may be attached to Form 65-5317, Notice of Claim.

**24.52(2)** If the statement from the school indicates that there is no reasonable assurance of the employee returning to work for the ensuing academic year or term, the claim will be allowed, subject to meeting all other eligibility requirements. However, if an educational institution submits a statement or the claimant furnishes information concerning a reasonable assurance of school employment, the employee is subject to a denial of benefits. If the fact-finding should result in a disqualification, the effective starting date of the disqualification shall be determined as follows:

*a.* No earlier than the effective starting date of the claim as it would serve no useful purpose. If the job offer was prior to the beginning date of the claim and the claimant refuses the offer, the issue shall still be adjudicated since the issue is determined as a voluntary quit rather than a job refusal pursuant to subrules 24.25(37) and 24.26(19).

*b.* The Sunday of the week in which the job was offered under any of the following conditions:

(1) The employer protest was made within ten-day protest period.

(2) The department was notified within ten days of the date of the offer.

(3) The claimant was in a reporting status on a claim for unemployment insurance at the time the offer was made and the claimant failed to notify the department of the offer.

*c.* The Sunday of the week in which the claimant or employer notified this department of the offer unless the offer was prior to the week that the department was notified of the offer and the claimant was in reporting status on a claim for unemployment insurance at that time. In this situation, the effective starting date of disqualification shall be the Sunday of the week in which the job offer was made.

*d.* The Sunday of the week in which the employer notified the department of the offer to the claimant. A refusal to accept the offer of employment shall be adjudicated under the voluntary quit section of the law pursuant to subrules 24.25(37), 24.26(19) and 24.52(11).

**24.52(3)** Professional employee. Unemployment insurance payments which are based on school employment shall not be paid to a professional employee for any week of unemployment which begins between two successive academic years, between regular terms, or during a period of paid sabbatical leave if the individual has a contract or reasonable assurance to perform services in any such capacity for any educational institution for both such academic years or both such terms. However, unemployment insurance payments can be made which are based on non-school-related wage credits pursuant to subrule 24.52(6).

**24.52(4)** Nonprofessional employee.

*a.* Unemployment insurance payments which are based on school employment shall not be paid to a nonprofessional employee for any week of unemployment which begins between two successive academic years or terms if the individual has performed service in the first of such academic years or terms and there is a reasonable assurance that such individual will perform services for the second academic year or term. However, unemployment insurance payments can be made based on non-school-related wage credits pursuant to subrule 24.52(6).

*b.* The nonprofessional employee may qualify for retroactive unemployment insurance payments if the school employment fails to materialize in the following term or year and the individual has filed weekly or biweekly claims on a current basis during the between terms denial period pursuant to subrule 24.2(1), paragraph “*e.*”

**24.52(5)** Twelve-month, year-round employee. An educational institution employee who performs services on a 12-month, year-round basis whose employment is terminated through layoff or reduction in force prior to the completion of the 12-month period, is eligible for benefits and shall not be disqualified under the provisions of Iowa Code section 96.4(5). An offer of reemployment to the 12-month, year-round employee for the succeeding academic year or term shall be adjudicated under Iowa Code section 96.5(3), regarding offers of suitable work and no disqualification may be imposed prior to the week in which the employment is scheduled to commence.

**24.52(6)** Benefits which are denied to an individual that are based on services performed in an educational institution for periods between academic years or terms shall cause the denial of the use of such wage credits. However, if sufficient nonschool wage credits remain on the claim to qualify under Iowa Code section 96.4(4), the remaining wage credits may be used for benefit payments, if the individual is otherwise eligible.

**24.52(7)** Head start programs are considered educational in nature; however, the employing unit as a whole must have as its primary function the education of students. When the employing unit is operated primarily for educational purposes then the between terms denial established by Iowa Code section 96.4(5) will apply between two successive academic years or terms and will apply for holiday and vacation periods to deny benefits to school personnel.

*a.* A nonprofit organization which has as its primary function civic, philanthropic or public assistance purposes does not meet the definition of an educational institution. Community action programs which have a head start school as one component are not an educational institution employer and the between terms denial does not apply.

*b.* A head start program which is an integral part of a public school system conducted by a board of education establishes an employing unit whose primary function is educational; therefore, the between terms denial would apply.

**24.52(8)** Wages earned and payment deferred. Many school employees receive remuneration from their school employers on a 12-month basis for the 9-month period worked. Deductions from unemployment insurance payments are on a “when earned” basis rather than on a “when paid” basis. Deferred wages currently paid which are based on earnings from a prior period are not deductible on a current week claimed pursuant to Iowa Code section 96.19(9) “*b*” and paragraph 24.13(2) “*o.*”

**24.52(9)** Vacation period and holiday recess. With respect to any services performed in any capacity while employed by an educational institution, unemployment insurance payments shall not be paid to

any individual for any week which commences during an established and customary vacation period or holiday recess if such individual performs service in the period immediately before such vacation period or holiday recess and there is a reasonable assurance that such individual will perform service in the period immediately following such vacation period or holiday recess. However, the provision of subrule 24.52(6) could also apply in this situation.

**24.52(10) Substitute teachers.**

*a.* Substitute teachers are professional employees and would therefore be subject to the same limitations as other professional employees in regard to contracts, reasonable assurance provisions and the benefit denials between terms and during vacation periods.

*b.* Substitute teachers who are employed as on-call workers who hold themselves available for one employer and who will not search for or accept other work, are not available for work within the meaning of the law and are not eligible for unemployment insurance payments pursuant to subrule 24.22(2) “i”(1).

*c.* Substitute teachers whose wage credits in the base period consist exclusively of wages earned by performing on-call work are not considered to be unemployed persons pursuant to subrule 24.22(2) “i”(3).

*d.* However, substitute teachers engaged in on-call employment are not automatically disqualified but may be eligible pursuant to subrule 24.22(2) “i”(3) if they are:

- (1) Able and available for work.
- (2) Making an earnest and active search for work each week.
- (3) Placing no restrictions on their employability.
- (4) Show attachment to the labor market. Have wages other than on-call wages with an educational institution in the base period.

*e.* A substitute teacher who elects not to report for further possible assignment to work shall be considered to have voluntarily quit pursuant to subrule 24.26(19).

**24.52(11) Declination of new contract or reasonable assurance.**

*a.* The school employee who is not employed on a 12-month, year-round basis and who fails or refuses to accept a contract or reasonable assurance of employment in the succeeding academic term or year shall have the separation adjudicated under the voluntary quit provision of Iowa Code section 96.5(1) pursuant to subrule 24.25(37).

*b.* This subrule also applies to substitute teachers who fail or refuse to accept a contract or reasonable assurance of employment in the succeeding academic term or year pursuant to subrules 24.26(19) and 24.26(22).

**24.52(12) Delayed offer and acceptance of a contract or reasonable assurance of employment in the succeeding term or year.** School employees who are not offered a contract or reasonable assurance of employment in the succeeding academic term or year are eligible for benefits if all other eligibility conditions are met. However, school employees who subsequently receive a contract or reasonable assurance of employment for the following term or year shall be disqualified under the “between terms denial” provision.

**24.52(13) Continuing supplemental (part-time) school employment after loss of nonschool employment.** All employers, including employers of part-time workers are notified of the filing of a claim. The school employer who continues to furnish part-time employment to the claimant may make a protest on the basis that the individual is still employed at the part-time employment and request removal of any charges to the part-time employer account, whether contributory or reimbursable, pursuant to Iowa Code section 96.7(3) “a”(2).

**871—24.53(96) Noncovered school-related employment.**

**24.53(1)** Pursuant to rule 871—23.20(96), wages earned by a student who performs services in the employ of a school at which the student is enrolled and is regularly attending classes (either on a full-time or part-time basis) cannot be used as wage credits for claim or benefit purposes. However, wages earned by an individual who is a full-time employee for a school whose academic pursuit is incidental to the full-time employment may be used for claim and benefit purposes.

**24.53(2)** Pursuant to rule 871—23.20(96), wages earned by the spouse of such a student in employment with the educational institution attended by the student cannot be used for benefit purposes if the employee-spouse is told prior to commencing the employment that the work is part of a program to provide financial assistance to the student and is not covered by unemployment insurance.

**24.53(3)** Pursuant to rule 871—23.21(96), wages earned by a student who is enrolled at a nonprofit or public educational institution under a program taken for credit at such institution that combines academic instruction with work experience are normally excluded from the definition of employment. Provided, however, that work performed by such individual in excess of the hours called for in the contract between the school and the employer or performed in a period of time during which the institution is on a regularly scheduled vacation and for which such student receives no academic credit shall be considered as insured employment.

**871—24.54(96) Church school coverage.** Schools affiliated with a church are exempt from coverage but may volunteer coverage by request to the department of workforce development. Schools not affiliated with a church are covered employers with covered employment. Church school coverage is defined pursuant to rule 871—23.27(96).

**871—24.55 and 24.56** Reserved.

**871—24.57(96) Athletes—disqualifications.** “Athletes” as used in Iowa Code section 96.5(9), is intended to apply to professional athletes. A professional athlete is an individual whose occupation is participating in athletic or sporting events for wages. A semiprofessional athlete is within the scope of Iowa Code section 96.5(9), if such sports services are compensation in covered wages. Auxiliary personnel, such as coaches, trainers, etc., are not considered professional athletes and are not within the scope of Iowa Code section 96.5(9).

**24.57(1)** As used in Iowa Code section 96.5(9), “any services, substantially all of which consist of participating in sports or athletic events” means all services performed by an individual in any subject employment during the individual’s base year if such individual was engaged in remunerative sports or athletic events for 90 percent or more of the total time spent in subject employment during such base year.

**24.57(2)** As used in Iowa Code section 96.5(9), “participating in sports or athletic events” means any services performed in an athletic activity by an individual as:

- a. A regular player or team member.
- b. An alternate player or team member.
- c. An individual in training to become a regular player or team member.
- d. An individual who, although performing no active services, is retained as a player or team member while recuperating from illness or injury.

**24.57(3)** The beginning and ending dates of any sport season and the beginning and ending dates of the time period between two successive sport seasons shall be determined by the department after taking into consideration factors of custom and practice within a particular sport, published dates for beginning and ending of a season and any other information bearing upon such determination.

**24.57(4)** For the purposes of Iowa Code section 96.5(9), a reasonable assurance that an individual will perform services in sports or athletic events in a subsequent season is presumed to exist if:

- a. The individual has an express or implied multiyear contract which extends into the subsequent sport season, or,
- b. The individual is free to negotiate with other teams or employers for employment as a participant in the subsequent sport season, and
- c. There is reason to believe that one or more employers of participants in athletic events is considering or would be desirous of employing the individual in an athletic capacity in the subsequent sport season, and
- d. The individual has not clearly and affirmatively withdrawn from participating in remunerative and competitive sports or athletic events.

**24.57(5)** Benefits which will be paid with respect to weeks of unemployment during a sports season shall be based on all wage credits of the individual. Wage credits would include those earned in sports as well as in other employment covered by an employment security law. With respect to weeks of unemployment that begin during a period between sports seasons (or similar periods) no benefits are payable on the basis of any athletic or nonathletic wages if substantially all (see subrule 24.57(1)) of the services performed by the individual during the base period were in sports or athletic events.

**24.57(6)** When a professional athlete is denied benefits because there is a reasonable assurance that the individual will again perform services as a professional athlete in the next ensuing season but the assurance fails to materialize, the denial of benefits is effective until the date established that the assurance is ineffective. Following the ineffective date, benefits can be paid if the individual is otherwise eligible. If an assurance given to an individual is found to be not a bona fide assurance, benefits are payable if the individual is otherwise eligible.

**24.57(7)** Benefits will be paid with respect to weeks of unemployment between sports seasons (or similar periods) based on wage credits of the individual, paid in other employment covered by employment security law except those in sports or athletic events or training, or preparing to so participate.

**24.57(8)** Athletes—denial of benefits. An individual (athlete) will be denied benefits between seasons based on services performed by such individual (athlete).

This rule is intended to implement Iowa Code section 96.5(9).

**871—24.58(96) Voluntary shared work.** The voluntary shared work program provides that employers facing a temporary shortfall may reduce the work hours of employees in an affected unit and those employees will receive a portion of their regular unemployment insurance benefits. The program is designed to reduce unemployment and stabilize the workforce by allowing certain employees to collect unemployment insurance benefits if the employees share the work remaining after a reduction in the total number of hours of work and a corresponding reduction in wages. Additional information may be obtained by contacting the voluntary shared work coordinator. The employer may apply to participate in the program by completing a shared work plan application which must be approved by the department. The employer shall submit the plan to the department 30 days prior to the proposed implementation date. The employer will administer the program in cooperation with the department. Participating employees will complete the employee information form and claim for benefits and return them to the employer who will submit them to the department. Administrative penalties in force during the duration of the plan will make an employee ineligible for the program. Child support obligations will be deducted and unemployment insurance overpayments will be offset as they are for regular unemployment insurance benefits.

**24.58(1)** A shared work plan will last no longer than 52 weeks from the date on which the plan is first effective. The minimum length of a plan is four weeks.

**24.58(2)** Employment is considered seasonal if the production or service provided by the employment is curtailed by at least 45 percent or ceases for a four-month or longer period on an annual basis due to climatic conditions.

**24.58(3)** A plan which has been approved may be modified at the discretion of the department. An employer seeking modification of an approved plan must demonstrate good cause as to why the modification is necessary and must demonstrate that the factors necessitating the modification were not foreseeable at the time the plan was submitted.

**24.58(4)** Approval of a plan may be denied or revoked at the discretion of the department if the plan and its actual operation do not meet all the requirements stated in Iowa Code section 96.40 including, but not limited to, the providing of false or misleading information to the department, unequal treatment of any employee in the affected unit, a reduction in fringe benefits resulting from participation in the program, or failure by the employer to monitor and administer the program.

**24.58(5)** The employer may file in writing an appeal of a denial of approval of a plan or revocation of approval by the department within 30 days from the date the decision is issued. The employer's appeal

will be forwarded to the appeals section so that a hearing may be scheduled before an administrative law judge.

**24.58(6)** If the employer provides as part of the plan a training program that will provide a substantive increase in the workplace and employability skills of the employee so as to reduce the potential for future periods of unemployment, the department shall consider the employee to be attending department-approved training and shall relieve the employer of charges for benefits paid to the individual attending training under the plan.

This rule is intended to implement 2009 Iowa Code Supplement section 96.40 as amended by 2010 Iowa Acts, Senate File 2279.

[ARC 8711B, IAB 5/5/10, effective 6/9/10]

**871—24.59(96) Child support intercept.** An individual who owes a child support obligation and who has been determined to be eligible for unemployment insurance benefits under Iowa Code chapter 96, shall have this information furnished to the child support recovery unit. The department of workforce development shall deduct and withhold from benefit payments the amount which is specified by the child support recovery unit. The term “benefits” for child support intercept purposes shall be defined as meaning any compensation payable under Iowa Code chapter 96, including any amounts payable pursuant to any workforce development agreement under any federal law administered by the department.

**24.59(1) Information furnished to child support recovery unit.** The department of workforce development shall furnish information to the child support recovery unit concerning all new claims filed that are monetarily eligible for benefits under any state or federal program administered by the department.

**24.59(2) Action taken by child support recovery unit.** The child support recovery unit shall contact the claimant so that an opportunity is afforded to the claimant for a signed agreement to have a specified amount deducted and withheld from the claimant’s benefits. The child support recovery unit shall submit a copy of the signed agreement to the department of workforce development and the department shall deduct and withhold the amount specified in the agreement.

**24.59(3) Garnishments.** Failure of the child support recovery unit to reach an agreement with the claimant for a specified amount to be deducted may result in the child support recovery unit initiating a garnishment action through legal process under Iowa Code chapter 642. The department of workforce development shall deduct and withhold from the claimant’s benefits the amount specified. Notwithstanding section 96.15, benefits under chapter 96 are not exempt from garnishment, attachment, or execution if garnished by the child support recovery unit as established in Iowa Code section 252B.2, to satisfy the child support obligation of an individual who is eligible under this chapter. Child support obligation is defined as only those obligations which are enforced pursuant to the plan as described in Section 454 of the Social Security Act under Part D of Title IV entitled “State Plan for Child Support.”

**24.59(4) Treatment of amount deducted for child support.** Any amount deducted from unemployment insurance payments for child support obligations shall be treated as if it were paid to the individual as benefits under Iowa Code chapter 96.

**24.59(5) Processing of payments.** The child support recovery unit shall furnish to the department the name and address of the designated public official to whom the amount deducted must be remitted. After the deduction, the remaining balance shall be credited to the claimant.

**24.59(6) Notice to claimant.** The department shall mail a notice to the claimant which explains the beginning date and the amount of the deduction from the claimant’s weekly benefit amount which satisfies the individual’s child support obligation to the child support recovery unit. This notice will be issued when the first deduction is made from the benefit payment. The notice shall explain the authority for the deduction and include the claimant’s right of appeal.

**24.59(7) Appeal rights on the child support deduction.**

*a.* Any appeal on a child support deduction is limited to either the validity of workforce development’s authority to make the deduction or the accuracy of the amount deducted.

*b.* The claimant will be advised to seek remedy either through the child support recovery unit or through the court system whenever the question of reasonableness or fairness of the deducted amount is raised in terms of ability to pay.

*c.* The department does not have the authority under Iowa Code chapter 96 to change the amount of the deduction as specified by garnishment or voluntary agreement or to adjudicate any appeal from garnishment or voluntary agreement.

This rule is intended to implement Iowa Code sections 96.3 and 96.20.

**871—24.60(96) Alien.** Any person who is not a citizen or a national of the United States. A national is defined as a person who lives in mandates or trust territories administered by the United States and owes permanent allegiance to the United States. An alien is a person owing allegiance to another country or government.

**24.60(1)** Section 3304(a)(14) of the Federal Unemployment Tax Act requires that the state law deny benefits which are based on services performed by an alien who has not been legally admitted to the country as a permanent resident. This provision does not deny benefits on the basis of services performed by noncitizens. It applies to services performed by individuals who do not have legal status of permanent residence in this country.

**24.60(2)** It is required that information designed to identify illegal nonresident aliens shall be requested of all claimants for benefits. This shall be accomplished by asking each claimant at the time the individual establishes a benefit year whether or not the individual is a citizen.

*a.* If the response is “yes,” no further proof is necessary and the claimant’s records are to be marked accordingly.

*b.* If the answer is “no,” the claimant shall be requested to present documentary proof of legal residency. Any individual who does not show proof of legal residency at the time it is requested shall be disqualified from receiving benefits until such time as the required proof of the individual’s status is brought to the local office. The principal documents showing legal entry for permanent residency are the Form I-94 “Arrival and Departure Record” and the Forms I-151 and I-551 “Alien Registration Receipt Card.” These forms are issued by the Immigration and Naturalization Service and should be accepted unless the proof is clearly faulty or there are reasons to doubt their authenticity. An individual will be required to provide the individual’s alien registration number at the time of claim filing.

*c.* Any or all documents presented to the department by an alien shall be subject to verification with the immigration and naturalization service. The citizenship question shall be included on the initial claim form so that the response will be subject to the provisions of rule 871—24.56(96), administrative penalties, and rule 871—25.10(96), prosecution on overpayments.

*d.* Rescinded IAB 8/6/03, effective 9/10/03.

**24.60(3)** Disqualification of aliens.

*a.* Aliens shall be disqualified for services performed unless such alien is an individual who:

- (1) Was lawfully admitted for permanent residence at the time such services were performed or;
- (2) Was lawfully present in this country for purpose of performing such service or;
- (3) Was permanently residing in this country under color of law at the time such services were performed.

*b.* Color of law permanent residence is defined as:

(1) An alien admitted as a refugee under Section 207 of the Immigration and Nationality Act, 8 U.S.C. 1157, in effect after March 31, 1980;

(2) An alien granted asylum by the attorney general of the United States under Section 208 of the Immigration and Nationality Act, 8 U.S.C. 1158;

(3) An alien granted a parole into the United States for an indefinite period under Section 212(d)(5)(B) of the Immigration and Nationality Act, 8 U.S.C. 1182(d)(5)(B);

(4) Reserved.

(5) An alien who entered the United States prior to June 30, 1948, and who is eligible for lawful permanent residence pursuant to Section 249 of the Immigration and Nationality Act, 8 U.S.C. 1259; or

(6) An alien who has been formally granted deferred action or nonpriority status by the immigration and naturalization service.

**24.60(4)** Certain nonimmigrants may perform service in this country. All nonimmigrant aliens 18 years and older are required by law to carry alien registration card Form I-94. The immigration and naturalization service places a symbol on the Form I-94 which indicates eligibility to perform service in this country.

a. Nonimmigrant aliens who are allowed to perform certain types of service are:

Class of worker	Symbol on I-94	Employment Permitted
(1) Ambassador, Consular officers and their immediate families	A-1	May accept employment with permission from the Department of State and the Immigration Service. I-94 will be stamped: "Employment Authorized."
(2) Other foreign government officials and their immediate families.	A-2	Same as for A-1.
(3) Treaty trader, spouse and children Treaty investor, spouse and children	E-1 E-2	Admitted to work for a specific employer or as a sole proprietorship or partnership.
(4) Student	F-1 M-1	May accept employment of up to 20 hours per week with permission from the Immigration Service. I-94 will be stamped: "Employment Authorized." Employment should not displace a USC or permanent resident alien.
(5) Representatives of foreign governments to international organization such as the U.N.	G-1 G-2 G-3 G-4 G-5	May accept employment if approved by the Department of State and the Immigration Service. I-94 will be stamped: "Employment Authorized."
(6) Temporary worker of distinguished merit and ability	H-1	Are admitted to work on a petition of an employer. Can only work for that employer unless permission is granted by the Immigration Service to change employers.
(7) Temporary workers performing services unavailable in the U.S.	H-2	Same as for H-1.
(8) Trainee	H-3	Same as for H-1.
(9) Exchange visitor Spouse and children	J-1 J-2	May be admitted to work in a specific program or may be granted permission to work after entry. I-94 will be stamped: "Employment Authorized."
(10) Fiancé or fiancée of USC entering solely to conclude valid marriage Child of a K-1	K-1 K-2	May accept employment upon approval of the Immigration Service. I-94 will be stamped: "Employment Authorized."
(11) Intra company transferee entering to continue employment with same employer. Dependents.	L-1 L-2	Admitted upon petition by an employer. May only work for that employer. May accept employment if approved by the Immigration Service. I-94 will be stamped: "Employment Authorized."
(12) NATO representatives	NATO-1 NATO-2 NATO-3 NATO-4 NATO-5 NATO-6 NATO-7	Dependents may accept employment with approval of the Immigration Service. I-94 will be stamped: "Employment Authorized."

b. Immigrant aliens who are not allowed to perform services are:

Class of worker	Symbol on I-94	Employment Status
(1) Attendant, servant or personal employee of an A-1 or A-2	A-3	May not accept employment.
(2) Temporary visitor for business	B-1	May not accept employment.
(3) Temporary visitor for pleasure	B-2	May not accept employment.
(4) Alien in transit	C-1 C-2 C-3	May not accept employment.
(5) Transit without a visa	TRWOV	May not accept employment.
(6) Seaman	D-1 D-2	May not accept employment.
(7) Dependent of student	F-2 M-2	May not accept employment.
(8) Spouse or child of an H-1, H-2 or H-3	H-4	May not accept employment.
(9) Representative of foreign information media including spouse and children	I	May not accept employment.

This rule is intended to implement Iowa Code section 96.5(10).

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<sup>1</sup> See rule 345—4.50(96)

<sup>2</sup> Effective date of 24.26(14) and 24.26(15) delayed 70 days by the Administrative Rules Review Committee at its meeting held March 8, 1999.