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The Iowa Administrative Code (IAC) Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 17A.6. The Supplement is a compilation of updated Iowa Administrative Code chapters that reflect rule changes which have been adopted by agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17, 17A.4, and 17A.5 and published in the Iowa Administrative Bulletin bearing the same publication date as the one for this Supplement. To determine the specific changes to the rules, refer to the Iowa Administrative Bulletin. To maintain a loose-leaf set of the IAC, insert the chapters according to the instructions included in the Supplement.

In addition to the rule changes adopted by agencies, the chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay or suspension imposed by the ARRC pursuant to section 17A.8(9) or 17A.8(10); rescission of a rule by the Governor pursuant to section 17A.4(8); nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa; other action relating to rules enacted by the General Assembly; updated chapters for the Uniform Rules on Agency Procedure; or an editorial change to a rule by the Administrative Code Editor pursuant to Iowa Code section 2B.13(2).

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to chapters of the Iowa Administrative Code (IAC) with amended content that are included in this Supplement. Such chapters can be replaced. Also included are new chapters published in the IAC for the first time.

Editor's telephone 515.281.3355

Accountancy Examining Board[193A]

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Landscape Architectural Examining Board[193D]

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Real Estate Appraiser Examining Board[193F]

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Transportation Department[761]

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Workers' Compensation Division[876]

Replace Chapter 8

ACCOUNTANCY EXAMINING BOARD[193A]

[Prior to 7/13/88, see Accountancy, Board of[10]]

Pursuant to 2023 Iowa Acts, Senate File 514, rules of Accountancy Examining Board[193A] editorially transferred in IAB 6/10/26;
see 481—Chapters 1021 through 1040 for rules regarding Accountancy Examining Board.

CHAPTER 1
DEFINITIONS

[Prior to 7/13/88, see Accountancy, Board of[10]]

Transferred to 481—Chapter 1021, IAC Supplement 6/10/26

CHAPTER 2
ORGANIZATION AND ADMINISTRATION

[Prior to 7/13/88, see Accountancy, Board of[10]]

Transferred to 481—Chapter 1022, IAC Supplement 6/10/26

CHAPTER 3
CERTIFICATION OF CPAs

[Prior to 7/13/88, see Accountancy, Board of[10]]

Transferred to 481—Chapter 1023, IAC Supplement 6/10/26

CHAPTER 4
LICENSURE OF LPAs

[Prior to 7/13/88, see Accountancy, Board of[10]]

Transferred to 481—Chapter 1024, IAC Supplement 6/10/26

CHAPTER 5
LICENSURE STATUS AND RENEWAL OF CERTIFICATES AND LICENSES

[Prior to 7/13/88, see Accountancy, Board of[10]]

[Prior to 5/1/02, see 193A—Chapter 6]

Transferred to 481—Chapter 1025, IAC Supplement 6/10/26

CHAPTER 6
ATTEST AND COMPILATION SERVICES

Transferred to 481—Chapter 1026, IAC Supplement 6/10/26

CHAPTER 7
CERTIFIED PUBLIC ACCOUNTING FIRMS

[Prior to 5/1/02, see 193A—Chapter 8]

Transferred to 481—Chapter 1027, IAC Supplement 6/10/26

CHAPTER 8
LICENSED PUBLIC ACCOUNTING FIRMS

[Prior to 7/13/88, see Accountancy, Board of[10]]

Transferred to 481—Chapter 1028, IAC Supplement 6/10/26

CHAPTER 9
RECIPROCITY AND SUBSTANTIAL EQUIVALENCY

Transferred to 481—Chapter 1029, IAC Supplement 6/10/26

CHAPTER 10
CONTINUING EDUCATION

[Prior to 7/13/88, see Accountancy, Board of[10]]

Transferred to 481—Chapter 1030, IAC Supplement 6/10/26

CHAPTER 11
PEER REVIEW

[Prior to 5/1/02, see 193A—Chapter 17]

Transferred to 481—Chapter 1031, IAC Supplement 6/10/26

CHAPTER 12

FEES

[Prior to 7/13/88, see Accountancy, Board of[10]]

[Prior to 5/1/02, see 193A—Chapter 14]

Transferred to 481—Chapter 1032, IAC Supplement 6/10/26

CHAPTER 13

RULES OF PROFESSIONAL ETHICS AND CONDUCT

[Prior to 5/1/02, see 193A—Chapter 11]

Transferred to 481—Chapter 1033, IAC Supplement 6/10/26

CHAPTER 14

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Transferred to 481—Chapter 1034, IAC Supplement 6/10/26

CHAPTER 15

DISCIPLINARY INVESTIGATIONS

Transferred to 481—Chapter 1035, IAC Supplement 6/10/26

CHAPTER 16

DISCIPLINARY PROCEEDINGS

Transferred to 481—Chapter 1036, IAC Supplement 6/10/26

CHAPTER 17

ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

Transferred to 481—Chapter 1037, IAC Supplement 6/10/26

CHAPTER 18

LICENSEES' DUTY TO REPORT

[Prior to 5/1/02, see 193A—Chapter 15]

Transferred to 481—Chapter 1038, IAC Supplement 6/10/26

CHAPTER 19

TRANSITION RULES

Rescinded IAB 4/22/09, effective 7/1/09

CHAPTER 20

PRACTICE PRIVILEGE FOR OUT-OF-STATE CERTIFIED PUBLIC ACCOUNTANTS

Transferred to 481—Chapter 1039, IAC Supplement 6/10/26

CHAPTER 21

PRACTICE PRIVILEGE FOR OUT-OF-STATE CERTIFIED PUBLIC ACCOUNTING FIRMS

Transferred to 481—Chapter 1040, IAC Supplement 6/10/26

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”]

Pursuant to 2023 Iowa Acts, Senate File 514, rules of Landscape Architectural Examining Board[193D] editorially transferred in IAB
6/10/26; see 481—Chapters 1081 through 1084 for rules regarding Landscape Architectural Examining Board.

CHAPTER 1

DESCRIPTION OF ORGANIZATION

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

Transferred to 481—Chapter 1081, IAC Supplement 6/10/26

CHAPTER 2

EXAMINATIONS AND LICENSING

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

Transferred to 481—Chapter 1082, IAC Supplement 6/10/26

CHAPTER 3

CONTINUING EDUCATION

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

Transferred to 481—Chapter 1083, IAC Supplement 6/10/26

CHAPTER 4

RULES OF PROFESSIONAL CONDUCT AND DISCIPLINE PROCEDURES

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

Transferred to 481—Chapter 1084, IAC Supplement 6/10/26

CHAPTER 5

PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

Rescinded IAB 8/20/03, effective 9/24/03

CHAPTER 6

SALES OF GOODS AND SERVICES

Rescinded IAB 8/20/03, effective 9/24/03

CHAPTER 7

WAIVERS OR VARIANCES FROM RULES

Rescinded IAB 8/20/03, effective 9/24/03

CHAPTER 8

PETITION FOR RULE MAKING AND FOR DECLARATORY ORDERS

Rescinded IAB 8/20/03, effective 9/24/03

REAL ESTATE COMMISSION[193E]

[Prior to 6/15/88, see Real Estate Commission[700]]

Pursuant to 2023 Iowa Acts, Senate File 514, rules of Real Estate Commission[193E] editorially transferred in IAB 6/10/26; see 481—Chapters 2001 through 2022 for rules regarding Real Estate Commission.

CHAPTER 1
ADMINISTRATION

[Prior to 6/15/88, see Real Estate Commission[700] Ch 1]

[Prior to 9/4/02, see 193E—Chs 2, 5, 7, 8]

Transferred to 481—Chapter 2001, IAC Supplement 6/10/26

CHAPTER 2
DEFINITIONS

[Prior to 6/15/88, see Real Estate Commission[700] Ch 2]

[Prior to 9/4/02, see 193E—1.1(543B) and 193E—2.2(543B)]

Transferred to 481—Chapter 2002, IAC Supplement 6/10/26

CHAPTER 3
BROKER LICENSE

[Prior to 6/15/88, see Real Estate Commission[700] Ch 3]

[Prior to 9/4/02, see 193E—2.10(543B) to 193E—2.12(543B) and 193E—3.3(543B)]

Transferred to 481—Chapter 2003, IAC Supplement 6/10/26

CHAPTER 4
SALESPERSON LICENSE

[Prior to 9/4/02, see 193E—2.10(543B), 193E—2.11(543B), 193E—3.2(543B), and 193E—3.3(543B)]

Transferred to 481—Chapter 2004, IAC Supplement 6/10/26

CHAPTER 5
LICENSEES OF OTHER JURISDICTIONS AND RECIPROCITY

[Prior to 9/4/02, see 193E—2.3(543B)]

Transferred to 481—Chapter 2005, IAC Supplement 6/10/26

CHAPTER 6
TERMINATION AND TRANSFER

Transferred to 481—Chapter 2006, IAC Supplement 6/10/26

CHAPTER 7
OFFICES AND MANAGEMENT

[Prior to 9/4/02, see 193E—Ch 1 and 193E—2.14(543B) to 193E—2.17(543B)]

Transferred to 481—Chapter 2007, IAC Supplement 6/10/26

CHAPTER 8
CLOSING A REAL ESTATE BUSINESS

Transferred to 481—Chapter 2008, IAC Supplement 6/10/26

CHAPTER 9
FEES

[Prior to 9/4/02, see 193E—2.9(543B)]

Transferred to 481—Chapter 2009, IAC Supplement 6/10/26

CHAPTER 10
ADVERTISING

[Prior to 9/4/02, see 193E—Ch 1]

Transferred to 481—Chapter 2010, IAC Supplement 6/10/26

CHAPTER 11
BROKERAGE AGREEMENTS AND LISTINGS

[Prior to 9/4/02, see 193E—Ch 1]

Transferred to 481—Chapter 2011, IAC Supplement 6/10/26

CHAPTER 12
DISCLOSURE OF RELATIONSHIPS

[Prior to 9/4/02, see 193E—Ch 1]

Transferred to 481—Chapter 2012, IAC Supplement 6/10/26

CHAPTER 13
TRUST ACCOUNTS AND CLOSINGS

[Prior to 9/4/02, see 193E—Ch 1]

Transferred to 481—Chapter 2013, IAC Supplement 6/10/26

CHAPTER 14
SELLER PROPERTY CONDITION DISCLOSURE

[Prior to 9/4/02, see 193E—Ch 1]

Transferred to 481—Chapter 2014, IAC Supplement 6/10/26

CHAPTER 15
PROPERTY MANAGEMENT

[Prior to 9/4/02, see 193E—Ch 1]

Transferred to 481—Chapter 2015, IAC Supplement 6/10/26

CHAPTER 16
PRELICENSE EDUCATION AND CONTINUING EDUCATION

[Prior to 9/4/02, see 193E—Ch 3]

Transferred to 481—Chapter 2016, IAC Supplement 6/10/26

CHAPTER 17
APPROVAL OF SCHOOLS, COURSES AND INSTRUCTORS

[Prior to 9/4/02, see 193E—3.5(543B)]

Transferred to 481—Chapter 2017, IAC Supplement 6/10/26

CHAPTER 18
INVESTIGATIONS AND DISCIPLINARY PROCEDURES

[Prior to 9/4/02, see 193E—Ch 4]

Transferred to 481—Chapter 2018, IAC Supplement 6/10/26

CHAPTER 19
REQUIREMENTS FOR MANDATORY ERRORS AND OMISSIONS INSURANCE

[Prior to 9/4/02, see 193E—Ch 6]

Transferred to 481—Chapter 2019, IAC Supplement 6/10/26

CHAPTER 20
TIME-SHARE FILING

[Prior to 9/4/02, see 193E—2.8(557A)]

Transferred to 481—Chapter 2020, IAC Supplement 6/10/26

CHAPTER 21
ENFORCEMENT PROCEEDINGS AGAINST UNLICENSED PERSONS

Transferred to 481—Chapter 2021, IAC Supplement 6/10/26

CHAPTER 22
WHOLESALE OF RESIDENTIAL PROPERTY

Transferred to 481—Chapter 2022, IAC Supplement 6/10/26

CHAPTER 23
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Rescinded **ARC 1436C**, IAB 4/30/14, effective 6/4/14

REAL ESTATE APPRAISER EXAMINING BOARD[193F]

Pursuant to 2023 Iowa Acts, Senate File 514, rules of Real Estate Appraiser Examining Board[193F] editorially transferred in IAB 6/10/26; see 481—Chapters 2031 through 2043 for rules regarding Real Estate Appraiser Examining Board.

CHAPTER 1
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[Prior to 2/20/02, see 193F—Chapters 2, 9 and 11]

Transferred to 481—Chapter 2031, IAC Supplement 6/10/26

CHAPTER 2
DEFINITIONS

[Prior to 2/20/02, see 193F—Chapter 1]

Transferred to 481—Chapter 2032, IAC Supplement 6/10/26

CHAPTER 3
GENERAL PROVISIONS FOR EXAMINATIONS

Transferred to 481—Chapter 2033, IAC Supplement 6/10/26

CHAPTER 4
ASSOCIATE REAL ESTATE APPRAISER

[Prior to 2/20/02, see rule 193F—3.6(543D)]

Transferred to 481—Chapter 2034, IAC Supplement 6/10/26

CHAPTER 5
CERTIFIED REAL ESTATE APPRAISER

[Prior to 4/17/24, see 193F—Chapter 6]

Transferred to 481—Chapter 2035, IAC Supplement 6/10/26

CHAPTER 6
DISCIPLINARY ACTIONS AGAINST CERTIFIED AND
ASSOCIATE APPRAISERS

[Prior to 4/17/24, see 193F—Chapter 7]

Transferred to 481—Chapter 2036, IAC Supplement 6/10/26

CHAPTER 7
INVESTIGATIONS AND DISCIPLINARY PROCEDURES

[Prior to 4/17/24, see 193F—Chapter 8]

Transferred to 481—Chapter 2037, IAC Supplement 6/10/26

CHAPTER 8
RENEWAL, EXPIRATION AND REINSTATEMENT OF
CERTIFICATES AND REGISTRATIONS, RETIRED STATUS, AND INACTIVE STATUS

[Prior to 4/17/24, see 193F—Chapter 9]

Transferred to 481—Chapter 2038, IAC Supplement 6/10/26

CHAPTER 9
RECIPROCITY

[Prior to 4/17/24, see 193F—Chapter 10]

Transferred to 481—Chapter 2039, IAC Supplement 6/10/26

CHAPTER 10
CONTINUING EDUCATION

[Prior to 4/17/24, see 193F—Chapter 11]

Transferred to 481—Chapter 2040, IAC Supplement 6/10/26

CHAPTER 11

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[Prior to 4/17/24, see 193F—Chapter 12]

Transferred to 481—Chapter 2041, IAC Supplement 6/10/26

CHAPTER 12

ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

[Prior to 4/17/24, see 193F—Chapter 16]

Transferred to 481—Chapter 2042, IAC Supplement 6/10/26

CHAPTER 13

LICENSURE OF PERSONS LICENSED IN OTHER JURISDICTIONS

[Prior to 4/17/24, see 193F—Chapter 26]

Transferred to 481—Chapter 2043, IAC Supplement 6/10/26

CHAPTER 14

CERTIFIED GENERAL APPRAISER

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Rescinded IAB 5/20/09, effective 6/24/09

CHAPTER 15

SUPERVISOR RESPONSIBILITIES

Rescinded **ARC 7850C**, IAB 4/17/24, effective 5/22/24

CHAPTER 16

ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

Rescinded **ARC 7855C**, IAB 4/17/24, effective 5/22/24

CHAPTER 17

SUPERINTENDENT SUPERVISION STANDARDS AND PROCEDURES

Rescinded **ARC 7856C**, IAB 4/17/24, effective 5/22/24

CHAPTER 18

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Rescinded **ARC 7857C**, IAB 4/17/24, effective 5/22/24

CHAPTER 19

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Rescinded **ARC 7858C**, IAB 4/17/24, effective 5/22/24

CHAPTER 20

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Rescinded **ARC 7859C**, IAB 4/17/24, effective 5/22/24

CHAPTER 21

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Rescinded **ARC 7860C**, IAB 4/17/24, effective 5/22/24

CHAPTER 22

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Rescinded **ARC 7861C**, IAB 4/17/24, effective 5/22/24

CHAPTER 23

DECLARATORY ORDERS

Rescinded **ARC 7862C**, IAB 4/17/24, effective 5/22/24

CHAPTER 24

SALES AND LEASES OF GOODS AND SERVICES

Rescinded **ARC 7863C**, IAB 4/17/24, effective 5/22/24

CHAPTER 25

PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

Rescinded **ARC 7864C**, IAB 4/17/24, effective 5/22/24

CHAPTER 26

MILITARY SERVICE, VETERAN RECIPROCITY, AND LICENSURE OF PERSONS LICENSED
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Rescinded **ARC 7865C**, IAB 4/17/24, effective 5/22/24

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AND IMPAIRED LICENSEE RECOVERY PROGRAM

Rescinded **ARC 7866C**, IAB 4/17/24, effective 5/22/24

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Rescinded **ARC 7867C**, IAB 4/17/24, effective 5/22/24

CHAPTER 29

VENDOR APPEALS

Rescinded **ARC 7868C**, IAB 4/17/24, effective 5/22/24

CORRECTIONS DEPARTMENT[201]

Rules transferred from Social Services Department[770] to Department of Corrections[291];
see 1983 Iowa Acts, chapter 96. Rules transferred from agency number [291] to [201] to conform with
the 1986 reorganization numbering scheme in general, IAC Supp. 3/20/91.

Note: Iowa Code chapter 246 renumbered as chapter 904 and 247 renumbered as chapter 913 in 1993 Iowa Code.

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Rescinded IAB 4/22/09, effective 5/27/09

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[Prior to 3/20/91, Corrections Department[291]]

Rescinded **ARC 0328D**, IAB 6/10/26, effective 6/30/26

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Rescinded IAB 4/22/09, effective 5/27/09

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AGENCY PROCEDURE FOR RULEMAKING

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2501.2(17A) Exemption from rulemaking.

2501.2(1) The department finds that policies, procedures and statements that relate only to inmates of a penal institution shall be exempted from the rulemaking process as provided in Iowa Code section 17A.2(11) “k.”

2501.2(2) Policies governing activities of incarcerated individuals and clients may be located in the departmental manual, in institutional manuals/handbooks, and on the department’s website.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

This rule is intended to implement Iowa Code section 17A.2(11) “k.”

[Filed Emergency ARC 0328D, IAB 6/10/26, effective 6/30/26]

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CHAPTER 2504
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Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2504.6(904) Public availability. All orders granting or denying a waiver petition shall be indexed, filed, and available for public inspection as provided in Iowa Code section 17A.3. Petitions for a waiver and orders granting or denying a waiver petition are public records under Iowa Code chapter 22. Some petitions or orders may contain information the department is authorized or required to keep confidential. The department may accordingly redact confidential information from petitions or orders prior to public inspection.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

These rules are intended to implement Iowa Code sections 17A.9A and 904.108.

[Filed Emergency ARC 0328D, IAB 6/10/26, effective 6/30/26]

CHAPTER 2505
FAIR INFORMATION PRACTICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2505.3(17A,22) Requests for access to records.

2505.3(1) *Location of record.* A request for access to public records should be directed to the agency's address, the agency's email, or the agency's office where the record is kept. Agency staff will promptly forward public records requests to the lawful custodian when such a request is misdirected.

a. Records of current incarcerated individuals and clients are maintained at the incarcerated individuals' or clients' place of confinement. If the requester does not know the current place of confinement, the request for a record should be directed to the records office at the Iowa medical and classification center.

b. A request for a record of former incarcerated individuals and clients served by the department should be directed to the records office at the Iowa medical and classification center.

2505.3(7) Fees.

b. Fees and costs. The agency may charge for the actual cost of producing public records. These charges may include the actual cost of making photocopies, the actual cost of media necessary to convey electronic copies of public records, and the actual costs of mailing public records. Pricing schedules for these actual costs will be prominently posted on the agency's website. The agency may also charge for the expense associated with supervising and searching for public records. These hourly charges will be based on the actual hourly rate of the person performing the task. The agency will ensure that the employee rate charged is as low as possible based on the circumstances. The agency may impose hourly charges only after the first 30 minutes of labor, which will be provided at no cost to the requester. For any additional review by the agency to address questions of confidentiality, the agency may charge the requester the actual hourly rate of the attorney performing the review, although the first 30 minutes of the attorney's time will be provided at no cost to the requester.

c. Advance payment. When the estimated total fee exceeds \$25, the agency may require an advance payment from the requester to cover all or a part of the estimated fee before proceeding with the work of gathering and reviewing potentially relevant records. If a requester has an unpaid balance from a previous records request, the agency may require the requester to pay both the unpaid balance and the current estimate, regardless of value, before proceeding with the review of public records.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2505.9(904) Confidentiality under Iowa Code chapter 904. Pursuant to Iowa Code sections 904.601, 904.602, and 904.603, certain records maintained by the department are confidential and shall not be disclosed to members of the public, except as otherwise provided by law or court order. The department shall apply the protections of Iowa Code chapter 904 in addition to the protections provided under Iowa Code chapter 22.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2505.10(17A,22) Personally identifiable information.

2505.10(1) This rule describes the nature and extent of personally identifiable information that is collected, maintained, and retrieved by the agency by personal identifier in record systems. As used in this rule, "record system" means any group of records, under the control of the agency, from which a record may be retrieved by a personal identifier, such as the name of an individual, number, symbol, or other unique retriever assigned to an individual. For each record system, this rule

describes the legal authority for the collection of that information, describes the means of storage of that information, and indicates whether a data processing system matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

2505.10(2) Type of record. Disclosures are in accordance with the following code:

CODE	MEANING
O	The records are open for public inspection.
C	The records are confidential and are not open to public inspection.
D	The department has discretion whether to allow public inspection of the record when the record contains information that is partially open or partially confidential.

2505.10(3) The records systems maintained by the department are as follows.

a. Director's office.

Description of Record	Type of Record	Legal Authority	Storage	Comparison
1. Business Correspondence	O, C	22, 904	Paper/ Electronic	Partial
2. General Correspondence	O, C	22, 904	Paper/ Electronic	Partial
3. Incarcerated Individual/Client Correspondence	C, D	904	Paper/ Electronic	Full
4. Investigations and Incident Reports	C	22, 904	Paper/ Electronic	Full

b. Institutions and community-based corrections.

Description of Record	Type of Record	Legal Authority	Storage	Comparison
1. Incarcerated Individual/Client Records				
a. Demographic Data/Action Section	O, C, D	904	Paper/ Electronic	Full
b. Admission Documents	C, D	904	Paper/ Electronic	Full
c. Classification and Release Documents	O, C, D	904	Paper/ Electronic	Full
d. Time Computation	O, C, D	904	Paper/ Electronic	Full
e. Clinical and Medical	C, D	904	Paper/ Electronic	Full
f. Correspondence and Visiting	C, D	904	Paper/ Electronic	Full
g. Legal Documents	O, C	904	Paper/ Electronic	Full
h. Charge/Disposition	O, C, D	904	Paper/ Electronic	Full
i. Status Reports	O, C, D	904	Paper/ Electronic	Full
j. Generic Notes	C, D	904	Paper/ Electronic	Full

Description of Record	Type of Record	Legal Authority	Storage	Comparison
2. Incarcerated Individual/Client Accounts	O, C, D	904	Paper/ Electronic	Full
3. Security and Supervision Records				
a. Disciplinary Records	O, C	904	Paper/ Electronic	Full
b. Segregation and Housing Unit Logs	C	904	Paper/ Electronic	Full
c. Incident Reports	C	904	Paper/ Electronic	Full
d. Violation Reports	C, D	904	Paper/ Electronic	Full
e. Community Supervision Records	C, D	904	Paper/ Electronic	Full
f. Interstate Compact Records	C, D	904	Paper/ Electronic	Full
g. Absconder Tracking and Supervision Violators	O, C, D	904	Paper/ Electronic	Full
h. Grievances and Complaints	C	904	Paper/ Electronic	Full
4. Incarcerated Individual/Client Movement	O	904	Paper/ Electronic	Full
5. Investigations				
a. Presentence Investigations (PSI)	C	901.4, 904	Paper/ Electronic	Full
b. Investigations	C	22, 904	Paper/ Electronic	Full
c. Investigation Requests	O, C, D	904	Paper/ Electronic	Partial
6. Administrative and Programs				
a. Contracts and Agreements	O, D	22, 904	Paper/ Electronic	Partial
b. Staff Training	O, C	904	Paper/ Electronic	Full
c. Jail Inspections	O, C, D	904	Paper/ Electronic	Full
d. Library Records and Publications	O, C, D	22, 904	Paper/ Electronic	Partial
e. Education and Vocation Records	C	904	Paper/ Electronic	Full
f. Lawsuits and Attorney Correspondence	C	22, 904	Paper/ Electronic	Partial
g. Volunteers	D	904	Paper/ Electronic	Partial
h. Miscellaneous	O, C, D	22, 904	Paper/ Electronic	Full

c. Iowa state industries.

Description of Record	Type of Record	Legal Authority	Storage	Comparison
1. Customer Lists	C	22, 904	Paper/ Electronic	Full
2. Formulas, Mixture and Special Designs	C	22, 904	Paper/ Electronic	N/A
3. Unaudited Monthly Balance Sheets and Income Statements	C	22, 904	Paper/ Electronic	Partial
4. Cost Calculations for Sealed Bids	C	22, 904	Paper/ Electronic	Partial
5. Yearly Audits	O	22, 904	Paper/ Electronic	Partial

2505.10(4) Litigation files. These files or records contain information regarding litigation or anticipated litigation, which includes judicial and administrative proceedings. The records include briefs, depositions, docket sheets, documents, correspondence, attorneys' notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. The files contain materials that are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing copies of pleadings and other documents filed in litigation should obtain these from the clerk of the appropriate court that maintains the official copy.

2505.10(5) Personnel files. The agency maintains files containing information about employees, families and dependents, and applicants for positions with the agency. The files include payroll records, biographical information, medical information relating to disability, performance reviews and evaluations, disciplinary information, information required for tax withholding, information concerning employee benefits, affirmative action reports, and other information concerning the employer-employee relationship. Some of this information is confidential under Iowa Code section 22.7(11).

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2505.11(17A,22) Other groups of records. This rule describes agency records not maintained in a record system. These records are routinely available to the public but may contain confidential information as provided in this chapter. Unless otherwise noted, these records are available on the department's website or at the department's central office and are not retrieved by personal identifier.

2505.11(1) *Rulemaking.* Records may contain information about individuals making written or oral comments on proposed rules pursuant to Iowa Code section 17A.4.

2505.11(2) *Board meeting records.* Agendas, minutes, and materials are available. Records of closed sessions are exempt from disclosure under Iowa Code section 21.5(4) or are otherwise confidential by law. Board meeting records contain information about people who participate in meetings pursuant to Iowa Code section 21.3.

2505.11(3) *Publications.* Press releases, annual reports, project reports, newsletters, etc., which describe various agency programs, may contain information about individuals, including department staff or members of department councils or committees.

2505.11(4) *Statistical reports.* Periodic reports of various agency programs are available and do not contain personally identifiable information.

2505.11(5) *Grants.* Records on persons receiving grants for various projects or programs are available. These records may contain information about employees of a grantee. Information is collected under the authority of Iowa Code chapter 904.

2505.11(6) *Published materials.* The agency uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright law.

2505.11(7) *Policies and procedures.* Manuals containing nonconfidential policies and procedures describing the department's regulations and internal practices are available for inspection. Copies may be obtained at the actual cost of production and handling. Policy manuals do not contain information about individuals.

2505.11(8) *Other records.* All other records that are not exempted from disclosure by law are available.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

These rules are intended to implement Iowa Code chapters 17A and 22 and sections 904.601, 904.602, and 904.603.

[Filed Emergency ARC 0328D, IAB 6/10/26, effective 6/30/26]

CHAPTER 2506 CONTESTED CASES

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

The following rules are intended to align the department's statutory inspection duties under Iowa Code sections 356.36 and 356.43 with the statewide uniform contested case procedures by establishing the prehearing process for notices of noncompliance and informal settlements.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2506.32(17A,356) Notice of noncompliance.

2506.32(1) When the director or director's designee of the department of corrections determines that an agency or facility accredited by the department is not in compliance with state standards, or when an order of closure is issued, the appropriate administrator shall be notified of the noncompliance status. The notice shall specify:

- a. The statute(s) and any rules(s) alleged to have been violated.
- b. The deficiencies cited.
- c. The time period allowed for submission of an acceptable plan of compliance if submission of a plan is permitted.

2506.32(2) The administrator of the facility or agency may submit the plan of compliance within the appropriate time limitation or may request a hearing pursuant to rule 201—2506.34(17A,356).

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2506.33(17A,356) Informal settlement. The director or the respondent may request that an informal conference be held to determine whether the noncompliance matter can be resolved in a just manner in furtherance of the public interest. Neither the director nor respondent is required to use this informal procedure. If the director and respondent agree to negotiate a settlement, the various points of the settlement, including a stipulated statement of facts, shall be set forth in writing and shall be binding on both parties.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2506.34(17A,356) The right to request hearing. A hearing will be granted to any agency or facility aggrieved by action of the department when the right to a hearing is granted by the state or federal law or constitution, except as limited herein. A hearing will not be granted when a state or federal law or regulation provides for a different forum for appeals. A prematurely filed appeal may be dismissed.

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

201—2506.35(17A,356) Order for hearing. Upon determination that a plan of compliance is not sufficient to effectuate compliance, or upon request by the agency or facility pursuant to rule 201—2506.34(17A,356), the department shall issue an order fixing the time and place for hearing pursuant to rule 201—2506.5(17A).

[ARC 0328D, IAB 6/10/26, effective 6/30/26]

These rules are intended to implement Iowa Code chapter 17A and sections 356.36 and 356.43.

[Filed Emergency ARC 0328D, IAB 6/10/26, effective 6/30/26]

HISTORICAL DIVISION[223]

[Prior to 5/31/89, see Historical Department[490]
created under the “umbrella” of the Department of Cultural Affairs[221] by Iowa Code section 303.1]

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Rescinded **ARC 0337D**, IAB 6/10/26, effective 7/15/26

ECONOMIC DEVELOPMENT AUTHORITY[261]

[Created by 1986 Iowa Acts, chapter 1245]

[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

[Prior to 9/7/11, see Economic Development, Iowa Department of[261];
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CHAPTER 49
HISTORIC PRESERVATION TAX CREDIT

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/15/31

261—49.1(404A) Definitions. For purposes of this chapter, unless the context otherwise requires:

“Agreement” means an agreement between an eligible taxpayer and the authority entered into pursuant to Iowa Code section 404A.3(3) and rule 261—49.11(404A).

“Applicant” means an eligible taxpayer that has submitted an application pursuant to this chapter.

“Authority” means the economic development authority established pursuant to Iowa Code section 15.105.

“Authority’s website” means the information and related content found at opportunityiowa.gov.

“Barn” means an agricultural building or structure, in whatever shape or design, that was originally used for the storage of farm products or feed or for the housing of farm animals, poultry, or farm equipment.

“Eligible taxpayer” means the same as defined in Iowa Code section 404A.1(2).

“Federal rehabilitation credit” means the tax credit allowed under Section 47 of the Internal Revenue Code.

“Federal standards” means the U.S. Secretary of the Interior’s standards for rehabilitation set forth in 36 CFR §67.7.

“Government funding” includes but is not limited to funding the applicant received from a federal, state, or local government; funding from a third party or a series of third parties where those funds originally came from a government or were derived from a government payment, grant, loan, tax credit or rebate or other government incentive; or funding from a third party or a series of third parties where those funds are derived from, secured by, or otherwise received in anticipation of a government payment, grant, loan, tax credit or rebate or other government incentive.

“Historically significant” means a property that is at least one of the following:

1. Property listed on the National Register of Historic Places or eligible for such listing.
2. Property designated as contributing to a district listed in the National Register of Historic Places or eligible for such designation.
3. Property or district designated a local landmark by a city or county ordinance.
4. A barn constructed prior to 1937.

“Large project” means a qualified rehabilitation project with estimated final qualified rehabilitation expenditures of more than \$750,000.

“National Register of Historic Places” means the same as described in 36 CFR §60.

“Nonprofit organization” means the same as defined in Iowa Code section 404A.1(3).

“Part 1 application” means an application submitted to SHPO to determine whether a property is historically significant.

“Part 2 application” means an application submitted to SHPO to determine whether the proposed rehabilitation work meets the federal standards.

“Part 2B application” means an application submitted to the authority, after a Part 2 application has been approved by SHPO but before a Part 3 application is submitted, to determine whether a project should be registered for a tentative tax credit award.

“Part 3 application” means an application submitted to the authority, after a Part 2B application is approved, to determine whether a project has complied with the terms of an agreement as well as with applicable laws, rules and regulations, including federal standards, and is therefore eligible for issuance of a tax credit certificate.

“Placed in service” means placed in a condition or state of readiness and availability for a specifically assigned function.

“Program” means the historic preservation tax credit program established pursuant to Iowa Code chapter 404A and this chapter.

“Property” means the real property that is the subject of a “qualified rehabilitation project” or that is the subject of an application to become a qualified rehabilitation project.

“Qualified rehabilitation expenditures” or *“QREs”* means expenditures that meet the definition of “qualified rehabilitation expenditures” in Section 47 of the Internal Revenue Code and as described in rule 261—49.3(404A).

“Qualified rehabilitation project” or *“project”* means the same as defined in Iowa Code section 404A.1(6).

“Related entities” means any entity owned or controlled in whole or in part by the applicant; any person or entity that owns or controls in whole or in part the applicant; or any entity owned or controlled in whole or in part by any current or prospective officer, principal, director, or owner of the applicant.

“Related persons” means any current or prospective officer, principal, director, member, shareholder, partner, or owner of the applicant.

“SHPO” means the state historic preservation office established within the authority and subject to the direction of the state historic preservation officer appointed pursuant to Iowa Code section 15.121.

“Small project” means a qualified rehabilitation project with estimated final qualified rehabilitation expenditures of \$750,000 or less.

“Tax credit” means the historic preservation tax credit established in Iowa Code chapter 404A.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.2(404A) Single-family dwelling units.

49.2(1) As part of the evaluation of any application submitted pursuant to this chapter, the authority, including SHPO, shall evaluate whether a property should be classified as a single-family dwelling unit and whether an applicant proposes a qualified rehabilitation project, both as described in Iowa Code section 404A.1(6).

49.2(2) To determine whether a property should be classified as a single-family dwelling unit for the purposes of Iowa Code section 404A.1(6), the authority may consider factors such as:

- a. Whether a dwelling unit is separated from other dwelling units by a ground-to-roof wall;
- b. Whether the dwelling unit has a separate heating system;
- c. Whether the dwelling unit has an individual meter for public utilities;
- d. Whether the dwelling unit has other dwelling units above or below;
- e. The current use of the property;
- f. The intended future use of the property;
- g. The classification of the property by the applicable county assessor; and
- h. The proportion of the property to be used for residential purposes or to be occupied by the owner as a residence.

49.2(3) An applicant shall have the burden to establish that a proposed project including single-family dwelling units will result in two or more new single-family dwelling units that were not available for occupancy as residential housing during the immediately preceding consecutive six months prior to commencement of rehabilitation work on the property and the dwelling units are located in the same neighborhood.

49.2(4) The exclusion of single-family dwelling units as qualified rehabilitation projects in Iowa Code section 404A.1(6) does not apply if a Part 1 application was submitted for a property prior to July 1, 2025.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.3(404A) Qualified rehabilitation expenditures. Qualified rehabilitation expenditures may include:

49.3(1) For projects registered on or after January 1, 2023, expenditures incurred within five years prior to the date an agreement is entered into under Iowa Code section 404A.3(3).

49.3(2) Reasonable developer fees. The authority may establish limits on developer fees and may adjust those limits. Any adjustment made to the established limit will take effect 24 months after the adjustment is published on the authority's website. Developer fees that are qualified rehabilitation expenditures and that meet the limits effective at the time the Part 2B application is submitted shall be deemed reasonable by the authority.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.4(404A) Small projects.

49.4(1) If an applicant anticipates that the final qualified rehabilitation expenditures will exceed \$750,000, the applicant shall not submit its application as a small project. The authority will not permit a small project applicant to submit additional or amended applications that would cause the final qualified rehabilitation expenditures to exceed \$750,000.

49.4(2) For applicants that receive credits from the small project allocation, the cumulative total award for multiple applications for a single property shall not exceed \$750,000 in qualified rehabilitation expenditures plus any allowable cost overruns as described in subrule 49.11(1) regardless of the final qualified rehabilitation expenditures.

49.4(3) Small project Part 2B applications may be accepted on a continuous basis or may be accepted during one or more application periods; however, an application must be submitted no later than 12 months after receipt of approval of a Part 2 application. Small project Part 2B applications may be evaluated on a first-come, first-served basis, subject to the availability of tax credits.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.5(404A) Tax credit eligibility. Only an eligible taxpayer may submit an application pursuant to this chapter. A nonprofit organization may submit an application pursuant to this chapter if the nonprofit organization is the fee simple owner of the property.

49.5(1) In any application submitted pursuant to this chapter, an applicant that is not the fee simple owner of the property must provide the following:

- a.* Documentation that the property owner is aware of the application and has no objection.
- b.* Certification that the applicant understands that the authority will not issue a tax credit pursuant to this chapter if the applicant is not the fee simple owner or not otherwise an eligible taxpayer.

49.5(2) At the time a Part 1 application or Part 2 application is submitted, an applicant will be expected to provide preliminary documentation of the applicant's status as an eligible taxpayer.

a. An applicant that is the fee simple owner shall provide title documentation. If the title is held in the name of an entity, the applicant shall also provide documentation that indicates that the signatory is the authorized representative of the entity.

b. An applicant that is not the fee simple owner but plans to apply for the federal rehabilitation credit shall provide a copy of the approved federal Part 1 application, unless the property is individually listed on the National Register of Historic Places, and certify that the applicant plans to apply and expects to qualify for the federal rehabilitation credit.

49.5(3) At the time an eligible taxpayer enters an agreement with the authority pursuant to rule 261—49.11(404A), the eligible taxpayer must provide documentation that the eligible taxpayer is a fee simple owner or has a binding qualified long-term lease that meets the requirements of the federal rehabilitation credit.

49.5(4) A governmental body as defined in Iowa Code section 362.2 is not eligible to apply for tax credits.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.6(404A) Applications. All applications and other filings related to the program shall be on such forms and in accordance with such instructions as may be established by the authority, including SHPO. Information about the program, including a link to the online applications and instructions, may be obtained by visiting the authority's website. An application shall not be

considered submitted for review until the application is completed and all required supporting documentation and information are provided.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.7(404A) Part 1 application.

49.7(1) *Submission period.* Part 1 applications may be submitted year-round. A Part 1 application must be submitted prior to the project being completed and placed in service.

49.7(2) *Required information.* Applicants must provide a site plan, photographs of the property taken prior to any rehabilitation and any new construction, a copy of the county assessor's statement for the property, applicable documentation of the applicant's status as an eligible taxpayer as described in rule 261—49.5(404A), information about the current and intended future uses of the property, and such other information as SHPO may require to assess whether the property is historically significant.

49.7(3) *Review process.* Generally, the SHPO will review fully completed Part 1 applications within 90 calendar days of receipt; however, this time frame is not mandatory. If the application is incomplete when submitted or if for any other reason SHPO must request additional information, the 90-day review period will restart when the requested information is received by the SHPO. The application may be rejected if any requested information is not provided.

49.7(4) *Response from SHPO.* Upon completion of the review, SHPO shall issue a determination regarding whether the property meets the requirements to be considered historically significant.

49.7(5) *Period of validity.* A determination that the property meets the requirements to be considered historically significant shall be valid for five years from the issuance of the determination, provided that the property is maintained in a manner consistent with federal standards and that the fee simple owner of the property remains the same during such period. Changes to the property that are not approved by SHPO shall automatically invalidate the determination of historical significance and require a new Part 1 application.

49.7(6) *Amendments.* An applicant may amend an approved Part 1 application prior to submission of a Part 2 application.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.8(404A) Preapplication meeting. Once the completed Part 1 application is submitted, the applicant may request a preapplication meeting following the instructions provided by SHPO. The meeting will take place no fewer than 30 days after the submission of the Part 1 application and prior to submission of the Part 2 application. SHPO may instruct applicants on information to be submitted prior to the meeting or to be provided at the meeting.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.9(404A) Part 2 application.

49.9(1) *Submission period.* Part 2 applications may be submitted at any time after the project has received an approved Part 1 application and the applicant has participated in a preapplication meeting.

49.9(2) *Required information.* The applicant must provide any information requested by SHPO, including but not limited to:

- a. A detailed description of the rehabilitation;
- b. An estimate of the total costs related to the rehabilitation and other work to be completed on the property, regardless of whether the costs are qualified rehabilitation costs;
- c. An estimate of the qualified rehabilitation expenditures;
- d. Photographs;
- e. Applicable documentation of the applicant's status as an eligible taxpayer as described in rule 261—49.5(404A);
- f. Information about the current and intended future uses of the property; and
- g. Whether the applicant plans to submit a Part 2B application as a small project or a large project.

49.9(3) *Review process.* Generally, SHPO will review fully completed Part 2 applications within 90 calendar days of receipt; however, this time frame is not mandatory. If the application is incomplete when submitted or if SHPO must request additional information, the 90-day review period will restart when SHPO receives the requested information. The application may be rejected if any requested information is not provided.

49.9(4) *Response from SHPO.* The review of the complete Part 2 application will result in one of three responses:

- a. The project is eligible to submit a Part 2B application because the proposed rehabilitation described in the application meets the federal standards;
- b. The project is eligible to submit a Part 2B application because the proposed rehabilitation described in the application will likely meet the federal standards if stipulated conditions are met; or
- c. The project is ineligible to submit a Part 2B application because the proposed rehabilitation does not meet the federal standards. The project may amend its Part 2 application or submit a new Part 2 application for the property to propose a rehabilitation that meets the federal standards.

49.9(5) *Amendments.* An applicant shall amend an approved Part 2 application to request review of modifications to the previously approved description of rehabilitation, including changes to the ownership of the project. Amendments to the Part 2 application shall not result in the awarding of additional tax credits for the project and may result in a reduction in or rescission of a tax credit award if SHPO determines that the work does not meet the federal standards or does not otherwise comply with the requirements of the program.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.10(404A) Part 2B application. If SHPO has approved Part 1 and Part 2 applications for a project, the applicant may submit a Part 2B application.

49.10(1) *Submission period.* The authority will accept Part 2B applications for small projects as described in subrule 49.4(3). Applications for large projects will be accepted only during application periods established on the authority's website.

49.10(2) *Required information.* The Part 2B application must include the following information as well as any additional information the authority may request: any changes in ownership since submission of the Part 2 application; information about the current and intended future uses of the property; the total project cost; an estimated schedule of qualified rehabilitation expenditures; a schedule of all funding sources, including government funding, that will be used to fund the project in its entirety; and documentation of all project funding sources.

49.10(3) *Certification and release of information.* The applicant must identify and list all related persons and related entities. The applicant must release information requested by the authority regarding the applicant, related persons, and related entities. The applicant must also certify that all representations, warranties, documents, or statements made or furnished in connection with the Part 2B application are true and accurate.

a. The authority may reject an application for registration if:

(1) The applicant fails to answer the questions and provide all requested information and documents in a timely manner.

(2) The applicant provides false or inaccurate information or documents to the authority.

(3) The applicant, a related person, or a related entity is not in good standing with any local, state, or federal taxing authority. This provision shall not apply to an applicant, related person, or related entity that has timely filed an extension to file a local, state or federal tax return.

(4) The applicant, a related person, or a related entity is currently in default, has an uncured breach, or is otherwise not in compliance with any entity or instrumentality of the state of Iowa.

(5) The applicant, a related person, or a related entity has any overdue amounts owed to the state of Iowa, any agency of the state of Iowa, any other entity or instrumentality of the state of Iowa, or any person or entity that is eligible to submit claims to the state offset system.

(6) The authority determines that the applicant will not be able to provide representations, warranties, conditions, or other terms of an agreement that would be acceptable to the authority.

(7) Information is disclosed to the authority that would cause the authority to decline to enter into an agreement with the applicant.

b. The authority may ask the applicant to disclose information and documents about other entities affiliated with the applicant, a related person, or a related entity if the authority determines that the information regarding the applicant, related persons, and related entities does not adequately disclose to the authority the economic, ownership, and management structure and realities related to a project.

c. In determining whether to reject an application in accordance with this subrule, the authority will consider factors including but not limited to the nature of the information disclosed and whether the applicant has a record of violations of law over a period of time that tends to show a consistent pattern.

49.10(4) Scoring process. All completed applications will be reviewed and scored. Scoring of the application will consider readiness criteria, including but not limited to the following:

- a. Rehabilitation planning.
- b. Secured financing.
- c. Ownership.
- d. Local government support.
- e. Rehabilitation timeline.
- f. Code review.

49.10(5) Registration.

a. Upon reviewing and scoring all applications submitted in an application period, the authority may register qualified rehabilitation projects based on the estimated qualified rehabilitation costs identified in the Part 2B applications. Preference will be given to the projects with the highest registration score based on the criteria in subrule 49.10(4).

b. The authority will make its best effort to notify applicants of registration decisions within 60 calendar days after the close of the application period. Registration notices shall include the amount of the applicant's tentative tax credit award determined by the authority along with a notice that the amount is a preliminary, nonbinding determination only. An applicant whose project is not registered may submit future applications for future fiscal year tax credit allocations.

c. The authority shall not register more projects in a given fiscal year for tentative awards than there are tax credits available for that fiscal year under Iowa Code section 404A.4. Tax credits may be reallocated or awarded in future fiscal years to the extent permitted by Iowa Code section 404A.4.

d. If a project registered after July 1, 2025, qualifies for tax credits exceeding \$10 million or more, the authority may award tax credits from the allocation for the following fiscal year, in an amount not to exceed 20 percent of the maximum aggregate tax credit award limit in Iowa Code section 404A.4.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.11(404A) Agreement. Upon successful registration of the project as described in subrule 49.10(5), the eligible taxpayer shall have 90 calendar days or until the end of the fiscal year, whichever is less, to purchase or lease the property, if applicable, and enter into an agreement with the authority. The authority shall not enter an agreement until it receives proof that the eligible taxpayer is the actual fee simple owner or has a binding qualified long-term lease that meets the requirements of the federal rehabilitation credit. An eligible taxpayer shall not be eligible for tax credits unless the eligible taxpayer enters into an agreement with the authority and satisfies the terms and conditions that must be met to receive the tax credit award.

49.11(1) Terms and conditions. The agreement will contain all items required by Iowa Code section 404A.3(3) and other terms, conditions, representations, and warranties as the authority may determine are necessary. The budget of the qualified rehabilitation project required by Iowa Code

section 404A.3(3)“b”(3) shall include all funding sources, including government funding, that will be used to fund the project in its entirety. The agreement may contain allowable cost overruns as described in Iowa Code section 404A.3(3)“b”(3).

49.11(2) Amendments. The authority may for good cause amend an agreement. Any amendment approved by the authority shall be signed by both parties. Agreement amendments must comply with Iowa Code chapter 404A and this chapter.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.12(404A) Part 3 application. The Part 3 application must include the following information:

49.12(1) Certification that the applicant is an eligible taxpayer.

49.12(2) A schedule of total expenditures for the project that identifies the final qualified rehabilitation expenditures and those expenditures that are not qualified, in the form prescribed by the authority.

49.12(3) A schedule of all funding sources, including government funding, used to finance the project in its entirety and documentation of all project funding sources. If the funding sources include those identified in Iowa Code section 404A.1(5)“b,” the authority will identify the impact of the exclusion of such expenditures from qualified rehabilitation expenditures on the approved tax credit amount. Any portion of qualified rehabilitation expenditures that are financed by the redevelopment tax credit administered pursuant to Iowa Code chapter 15, subchapter II, part 9, and the workforce housing tax incentive program administered pursuant to Iowa Code chapter 15, subchapter II, part 17, will also be excluded in determining the amount of expenditures eligible for a tax credit.

49.12(4) CPA examination.

a. An eligible taxpayer shall engage a certified public accountant authorized to practice in this state to conduct an examination of the project in accordance with the American Institute of Certified Public Accountants’ statements on standards for attestation engagements. The attestation applicable to this examination is SSAE No. 10 (as amended by SSAE No. 11, 12, and 14), AT section 101 and AT section 601 or other comparable attestation identified by the authority. Upon completion of the qualified rehabilitation project, the eligible taxpayer shall submit the examination to the authority along with a statement of the amount of final qualified rehabilitation expenditures and any other information deemed necessary by the authority in order to verify that all requirements of the agreement, Iowa Code chapter 404A, and all rules adopted pursuant to Iowa Code chapter 404A have been satisfied.

b. The procedures used by the CPA to conduct the examination should allow the CPA to conclude that, in the CPA’s professional judgment, the qualified rehabilitation expenditures claimed are eligible pursuant to the agreement, Iowa Code chapter 404A, and all rules adopted pursuant to Iowa Code chapter 404A in all material respects. The documents reviewed by the CPA should be made available to the authority upon request. The applicant should generally be able to provide the requested documents within ten business days of a request from the authority.

c. If the examination requirement is waived pursuant to Iowa Code section 404A.3(5)“b,” the authority reserves the right to request any additional information necessary to verify the final qualified rehabilitation expenditures and, if deemed necessary by the authority, to require that an eligible taxpayer for whom the requirement was waived to engage a CPA to conduct an examination of the project pursuant to paragraphs 49.12(4)“a” and “b.”

49.12(5) Photo keys and photos of the property after the rehabilitation is completed.

49.12(6) Any other information deemed necessary by the authority in order to verify that all requirements of the agreement, Iowa Code chapter 404A, and all rules adopted pursuant to Iowa Code chapter 404A have been satisfied or any other information the authority may require for program evaluation.

49.12(7) Election to receive either a refundable or a nonrefundable tax credit.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.13(404A) Fees. Applicants must pay a nonrefundable fee for the processing of Parts 2 and 3 of an application. The review fee for Part 2 will be due with the filing of the Part 2 application and will equal \$500 for projects with estimated qualified rehabilitation costs less than or equal to \$750,000 and will equal \$1,000 for projects with estimated qualified rehabilitation expenditures greater than \$750,000. The fee for review of Part 3 will be due with the filing of the Part 3 application and will be based on the final qualified rehabilitation expenditures. The fee will equal \$500 for projects with final qualified rehabilitation costs less than or equal to \$750,000 and will equal 0.5 percent of final qualified rehabilitation expenditures, not to exceed \$50,000, for projects with final qualified rehabilitation expenditures greater than \$750,000.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.14(404A) Compliance.

49.14(1) Reports. In addition to the annual certification required by Iowa Code section 404A.3(4), the eligible taxpayer shall submit information reasonably required by the authority to make reports to the authority's board, the governor's office, or the general assembly.

49.14(2) Declination. An applicant shall notify the authority in writing of the applicant's decision to irrevocably decline the tax credit. The authority will acknowledge that the tax credit has been irrevocably declined in writing. The tax credit shall be reallocated to the extent permitted by Iowa Code section 404A.4. If the applicant wishes to apply for a tax credit on the same qualified rehabilitation project at a later date, the applicant must complete the application process as though the project is a new project.

49.14(3) Revocation. The authority may revoke a tax credit pursuant to Iowa Code section 404A.3(4) "c."

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.15(404A) Certificate issuance; claiming the tax credit. After determining whether the terms of the agreement, Iowa Code chapter 404A, and the applicable rules have been met, the authority shall issue a tax credit certificate to the eligible taxpayer stating the amount of tax credit under Iowa Code section 404A.2 the eligible taxpayer may claim, or the authority shall issue a notice that the eligible taxpayer is not eligible to receive a tax credit certificate. To receive the tax credit, an eligible taxpayer shall file a claim in accordance with any applicable administrative rules adopted by the department of revenue. Notwithstanding the foregoing, the eligibility of the tax credit remains subject to audit by the department of revenue in accordance with Iowa Code chapters 421 and 422.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.16(404A) Appeals. Appeals of final agency action by the authority will be governed by Iowa Code chapter 17A. Challenges to an action by the department of revenue related to the program must be brought pursuant to any applicable rules adopted by the department of revenue.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

261—49.17(404A) References. All references to the Internal Revenue Code and Code of Federal Regulations in this chapter are to the laws as in effect on July 15, 2026.

[ARC 0336D, IAB 6/10/26, effective 7/15/26]

These rules are intended to implement Iowa Code chapter 404A.

[Filed ARC 2944C (Notice ARC 2774C, IAB 10/12/16), IAB 2/15/17, effective 3/22/17]

[Filed ARC 6728C (Notice ARC 6546C, IAB 9/21/22), IAB 12/14/22, effective 1/18/23]

[Filed ARC 0336D (Notice ARC 0126D, IAB 3/18/26), IAB 6/10/26, effective 7/15/26]

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

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/9/29

441—11.1(217) Definitions.

“*Current*” means that amount which is due and owing within the previous 12 months from the date of submission to the department of administrative services or that amount which is due and owing from the date the repayment agreement or court order is implemented, if less than 12 months, before the date of submission to the department of administrative services.

“*Current repayment*” means that payment of the cumulative sum due and owing in accordance with a repayment agreement or court order for the preceding 12 months or the date of the order or agreement if the order or agreement is more recent.

“*Debtor*” means a current or former recipient of public assistance that has been determined by the department to be responsible for the repayment of a particular debt. For the Supplemental Nutrition Assistance Program (SNAP), “debtor” shall include all adult members of the SNAP household participating at the time the SNAP overpayment or program violation occurred and shall include nonrecipients found guilty of violating SNAP rules by committing an act such as, but not limited to, trafficking. For child care assistance, “debtor” may include the current or former provider or current or former recipient of child care assistance. For Medicaid, “debtor” shall include any current or former Medicaid member, or the parents of a current or former Medicaid member who was under the age of 21 when the parents completed the application and had responsibility for reporting changes, who received services or benefits as a result of client or agency error or administrative overpayment or who owes a debt of unpaid premium payments for medical assistance.

“*Public assistance*” means family investment program, SNAP, Medicaid, state supplementary assistance, PROMISE JOBS, child care assistance, refugee cash assistance, and hawki program.

“*Repayment agreement*” means an agreement entered into voluntarily between the department and the debtor for the repayment of debts and detailed on a form issued by the department.

“*Written notification*” means the notification sent to a debtor by the department on a form issued by the department.

[ARC 8205C, IAB 9/4/24, effective 10/9/24]

441—11.2(217) Establishment of claim.

11.2(1) *Accounts.* The department will maintain an account for each debt that has occurred containing the following information:

- a. A debtor name and account number.
- b. Program in which the debt occurred.
- c. Date the debt was discovered.
- d. Inclusive dates of the debt.
- e. Total dollar amount of each debt.
- f. Primary cause of the debt.
- g. Any transaction applied to this debt.

11.2(2) *Notice of debt.* A claim is established when the first written notice of the debt is issued to the household.

11.2(3) *Change in debt.* An additional written notification of debt will be issued if a change occurs in the amount or period of the debt.

11.2(4) *Collection action.* No collection action will be initiated on:

- a. A debt for which no notice of debt has been issued to the household.
- b. A debt that is in appeal status.
- c. A debt that is in suspended status due to an exception to policy.

[ARC 8205C, IAB 9/4/24, effective 10/9/24]

441—11.3(217) Application of payment. Payment will be applied only to debts subject to collection pursuant to subrule 11.2(4).

11.3(1) *Application of payment to a single program area.*

a. If there is more than one debt in a program, payment will be applied:

- (1) First to all debts that have an agreement in chronological order of discovery, and
- (2) Then to debts that do not have an agreement in chronological order of discovery until all debts have been paid in full or the full payment amount has been exhausted.

b. For SNAP, payment will be applied first to all debts with an agreement and then to debts without an agreement. Within those two groupings, payment will be applied in the following order:

- (1) First to state-only debts in chronological order of discovery,
- (2) Then to intentional program violation (IPV) debts in chronological order of discovery,
- (3) Then to inadvertent household error (IHE) debts in chronological order of discovery, and
- (4) Then to agency error debts in chronological order of discovery.

11.3(2) *Application of payment to multiple program areas.* If there are debts in more than one program area of public assistance, payments received will be applied to those program areas as indicated by the mode of repayment (SNAP benefits, FIP benefits) or as indicated by the client at the time of payment.

11.3(3) *Application of undesignated cash payment.* If an undesignated cash payment is received, it will be applied to each program area proportionally based on the cumulative balance of all debts in all program areas combined.

[ARC 8205C, IAB 9/4/24, effective 10/9/24]

441—11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages.

11.4(1) *Criteria for setoff.*

a. A claim against a debtor may be made by the department for public assistance debts when:

(1) A debtor has failed to negotiate a repayment agreement for that program area of public assistance, or

(2) A repayment agreement is not current, and

(3) The cumulative balance of the applicable debts in 11.4(1) “a”(1) and (2) exceeds \$50.

b. A claim against a debtor will not be made by the department for debts when:

(1) The debt is in suspended status due to an exception to policy or is in an appeal status, or

(2) The debt is being recovered through grant or benefit reduction.

11.4(2) *Frequency of submission.* The department will submit to the department of administrative services twice each month a list of those debtors who have a debt meeting the criteria in subrule 11.4(1).

11.4(3) *Pre-setoff notice.* The department will mail written notification to a debtor to inform the debtor of the amount the department intends to claim and apply to debts in each program when:

a. The department is notified by the department of administrative services that the debtor is entitled to a state income tax refund, rebate, or other state payment;

b. The department makes claim against the debtor.

11.4(4) *Method for division of joint payments.* When either spouse wishes to request a division of a jointly or commonly owned right to payment, a written request shall be submitted to the department within 15 days after the written notification is mailed. When the request is received within the 15-day limit, the spouse’s proportionate share of a jointly or commonly owned right to payment, as determined by the department of administrative services, shall be released by the department of administrative services unless:

a. Other claims are made on that portion of the jointly or commonly owned right to payment, or

b. That spouse was also a member of the same household and the spouse’s income and resources were or should have been considered in the calculation of public assistance.

11.4(5) *Appeal rights.* When a debtor wishes to contest the claim of the department, a written request shall be submitted to the department within 15 days after the written notification is mailed. When the request is received within the 15-day limit, a hearing will be granted pursuant to rules in 441—Chapter 2506.

a. If the department is upheld in the final decision, the setoff process shall continue and the refund, rebate, or other state payment will be applied to the appropriate delinquent debts.

b. If the department is reversed in the final decision, the debtor's refund, rebate, or other state payment will be released to the debtor by the department of administrative services.

11.4(6) *Debt setoff.* If the department has not received a request for an appeal hearing or a request for division of a jointly or commonly owned right to payment within 15 days after the date the written notification is mailed, the department will notify a debtor of the final decision regarding the claim by mail.

11.4(7) *Application of setoff.* The department will apply any setoff received from the department of administrative services as a result of this rule to the debtor's debts as indicated on the written notification mailed to the debtor and in accordance with rule 441—11.3(217).

Any amount remaining after the setoff shall be released back to the individual.

[ARC 8205C, IAB 9/4/24, effective 10/9/24; Editorial change: IAC Supplement 6/10/26]

441—11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages.

11.5(1) *Criteria for setoff.*

a. Debtors not participating in SNAP shall be subject to collection action through the treasury offset program (TOP) which includes, but is not limited to, federal salary offset and federal tax refund offset.

(1) Debtors shall be referred to TOP if they are delinquent in repaying their SNAP debt and there is a claim or combination of claims with an unpaid balance that exceeds \$25.

(2) No claim that is less than three months old or more than ten years old as of January 31 of the offset year shall be referred. EXCEPTION: Claims that have had a final judgment entered are not subject to the ten-year time limit.

(3) Debtors are delinquent in repaying their SNAP debt if:

1. A repayment agreement has not been signed and 120 days have elapsed since the due date of the demand letter as defined in 441—subrule 65.21(4) minus any days the claim was not subject to collection action because of an appeal.

2. A repayment agreement has been signed but the debtor has failed to make the agreed-upon payments and has failed to make up the missed payments. The debtor shall be referred to TOP when 120 days have elapsed since the first of the month following the month that the debtor failed to make the agreed-upon payment and has not subsequently made up the missed payment.

b. A claim against an individual will not be referred to TOP by the department of inspections, appeals, and licensing (DIAL) for debts when:

(1) The debt is in suspended status due to an exception to policy or is in an appeal status, or

(2) The debt is being recovered through benefit reduction.

11.5(2) *Setoff under TOP.* DIAL shall, by December 1 of each year, submit a notification of liability for delinquent claims to the Department of the Treasury.

11.5(3) *Pre-setoff notice.* DIAL shall notify a debtor identifying the amount the department intends to refer to TOP for offset.

11.5(4) *Offset fee.* For each offset that the Department of the Treasury effects against an individual referred to TOP, Treasury will charge the individual a fee.

11.5(5) *Appeal rights.* When an individual wishes to contest the delinquent status of a claim as identified by DIAL, a written request shall be submitted to DIAL within 60 days of the date of the pre-offset notice. When the request is received within the 60-day limit, a review shall be granted.

DIAL shall determine if the claim is past due and legally enforceable and shall notify the individual in writing of the decision.

11.5(6) *Application of setoff.* DIAL shall apply any setoff received as a result of this rule to the individual's SNAP debts.

Any amount remaining after the setoff shall be released back to the individual.

[ARC 8205C, IAB 9/4/24, effective 10/9/24]

These rules are intended to implement Iowa Code sections 217.34, 234.12, 239B.14, and 249A.5.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 38
DEVELOPMENTAL DISABILITIES BASIC STATE GRANT
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/31

441—38.1(217,42USC144) Administering agency. Pursuant to the DD Act, the department has been designated as the administering agency to receive the federal assistance to the state developmental disabilities councils from the federal Administration for Community Living. These funds are used by the Iowa DD council.

[ARC 0347D, IAB 6/10/26, effective 8/1/26]

441—38.2(217,42USC144) Definitions.

“*DD Act*” means the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. Chapter 144 as amended to August 1, 2026. All references to the DD Act herein are as amended to August 1, 2026.

“*Developmental disability*” means a severe, chronic disability of a person that is attributed to a mental or physical impairment or a combination of mental and physical impairments; is manifested before the person attains the age of 22; is likely to continue indefinitely; substantially limits the person’s ability to carry out major life activities in at least three of the areas of self-care, receptive and expressive language, learning, mobility, self-direction, and capacity for independent living and economic self-sufficiency; and reflects an ongoing need for individualized, coordinated services. The term, when applied to infants and children from birth to the age of nine, means a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.

“*Iowa DD council*” means the Iowa developmental disabilities council.

“*Projects*” means activities described in the Iowa DD council’s five-year plan that are designed to address the purpose and priorities established by the DD Act to undertake advocacy, capacity-building, and systemic-change activities that contribute to a coordinated, person- and family-centered, and individual- and family-directed comprehensive system of community services, individualized supports, and other forms of assistance that promote self-determination for individuals with developmental disabilities and their families.

“*State plan*” means the document required under the DD Act that describes goals, objectives and funding priorities.

[ARC 0347D, IAB 6/10/26, effective 8/1/26]

441—38.3(217,42USC144) Program eligibility. For any year in which Congress appropriates funds, the Iowa DD council shall, consistent with the state plan and the priorities established under the DD Act, determine projects to fund under the developmental disabilities basic state grant program. Funding priorities will be established by the Iowa DD council in the state plan and will be consistent with the priorities established in the DD Act. (Applications for capital expenditures or capital renovations are not eligible for funding.) The Iowa DD council may award funding through any of the department-approved processes for competitive, sole source, or unsolicited proposals in accordance with the provisions of 11—Chapter 117 for the procurement of goods and services of general use.

[ARC 0347D, IAB 6/10/26, effective 8/1/26]

441—38.4(217,42USC144) Conflict of interest policy. All Iowa DD council members and those serving in an advisory capacity to the Iowa DD council shall not engage in activities that present a conflict of interest.

38.4(1) Iowa DD council members and those serving in an advisory role to the Iowa DD council are prohibited from applying for any project when they were involved in recommending the project or designing or developing the request for proposal.

38.4(2) All Iowa DD council members and those serving in an advisory capacity to the Iowa DD council who serve or whose family members serve as officers, directors, partners, consultants, or employees of the applicant being evaluated shall be excluded from preliminary review of proposals, discussing with Iowa DD council members who will be voting, and advising or voting on the evaluation of that applicant and all other applicants submitting proposals in that category.

[ARC 0347D, IAB 6/10/26, effective 8/1/26]

These rules are intended to implement Iowa Code section 217.6 and 42 U.S.C. Chapter 144.

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CHAPTER 41
GRANTING ASSISTANCE
[Prior to 7/1/83, Social Services[770] Ch 41]
[Prior to 2/11/87, Human Services[498]]
[Rescinded IAB 2/12/97, effective 3/1/97]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—41.1 to 41.20 Reserved.

441—41.21(239B) Eligibility factors specific to child.

41.21(1) *Age.* The family investment program (FIP) will be available to a needy child under the age of 18 years without regard to school attendance. A child is eligible for the entire month in which the child's eighteenth birthday occurs unless the birthday falls on the first day of the month. The FIP will also be available to a needy child of 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, as defined in paragraph 41.24(2) "e," and who is reasonably expected to complete the program before reaching the age of 19.

41.21(2) Reserved.

41.21(3) *Residing with relative.* The child must be living in the home of one of the relatives specified in subrule 41.22(3). When an unwed mother intends to place her child for adoption shortly after birth, the child will 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.

[ARC 9277C, IAB 5/14/25, effective 7/1/25]

441—41.22(239B) Eligibility factors specific to payee.

41.22(1) and **41.22(2)** Reserved.

41.22(3) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the relatives listed in Iowa Code section 239B.1(13) or with a spouse of the relative even though the marriage is terminated by death or divorce.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

c. The FIP is available to a child of unmarried parents the same as to a child of married parents when all eligibility factors are met.

d. The presence of an able-bodied stepparent in the home will not disqualify a child for assistance, provided that other eligibility factors are met.

41.22(4) *Liability of relatives.* All appropriate steps will be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity.

a. When necessary to establish eligibility, the income maintenance unit will make the initial contact with the absent parent at the time of application. Subsequent contacts will be made by child support services.

b. When contact with the FIP family or other sources of information indicate that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the income maintenance unit will contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

41.22(5) *Referral to child support services.* The income maintenance unit will provide prompt notice to child support services pursuant to Iowa Code section 239B.2(6).

a. A referral to child support services will not be made when a parent's absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. "Prompt notice" means within two working days of the date assistance is approved.

41.22(6) Cooperation in obtaining support. Each applicant for or recipient of the FIP shall cooperate with the department in establishing paternity and securing support for persons whose needs are included in the assistance grant, except when good cause as defined in subrule 41.22(8) for refusal to cooperate is established.

a. The applicant or recipient must cooperate in the following areas:

(1) Identifying and locating the parent of the child for whom aid is claimed.

(2) Establishing the paternity of a child born out of wedlock for whom aid is claimed.

(3) Obtaining support payments for the applicant or recipient and for a child for whom aid is claimed.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the office of the income maintenance unit or child support services to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

(4) Paying to the department any cash support payments for a member of the eligible group, except as described in paragraph 41.27(7) "p," received by a recipient after the date of decision as defined in 441—subrule 40.24(4).

(5) Providing the name of the absent parent and additional necessary information.

c. The applicant or recipient shall cooperate with the income maintenance unit in supplying information with respect to the absent parent, the receipt of support, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to child support services.

d. The applicant or recipient shall cooperate with child support services to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure or enforce a support obligation or establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. In the circumstance as described in paragraph 41.22(6) "b"(4), the income maintenance unit will make the determination of whether or not the applicant or recipient has cooperated. In all other instances, child support services will make the determination of whether the applicant or recipient has cooperated. Child support services delegates the income maintenance unit to make this determination for applicants.

f. Failure to cooperate will result in a sanction to the family. The sanction will be a deduction of 25 percent from the net cash assistance grant amount payable to the family before any deduction for recoupment of a prior overpayment.

(1) When the income maintenance unit determines noncooperation, the sanction will be implemented after the noncooperation has occurred. The sanction will remain in effect until the client has expressed willingness to cooperate. However, any action to remove the sanction will be delayed until cooperation has occurred.

(2) When child support services makes the determination, the sanction will be implemented upon notification from child support services to the income maintenance unit that the client has failed to cooperate. The sanction will remain in effect until the client has expressed to either income maintenance or child support services staff willingness to cooperate. However, any action to remove

the sanction will be delayed until income maintenance is notified by child support services that the client has cooperated.

41.22(7) *Assignment of support payments.*

a. Each applicant for or recipient of assistance shall assign to the department any rights to support pursuant to Iowa Code section 239B.6.

b. An assignment is effective the same date all eligibility information is entered into the department's computer system and is effective for the entire period for which assistance is paid.

41.22(8) *Good cause for refusal to cooperate.* Good cause exists 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 will determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

- (1) Physical harm to the child for whom support is to be sought; or
- (2) Emotional harm to the child for whom support is to be sought; or
- (3) Physical harm to the parent or caretaker relative with whom the child is living that reduces the person's capacity to care for the child adequately; or
- (4) Emotional harm to the parent or caretaker relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The income maintenance unit will determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the income maintenance unit believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

- (1) The child for whom support is sought was conceived as a result of incest or forcible rape.
- (2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.
- (3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm will be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the following will be considered:

- (1) The present emotional state of the individual subject to emotional harm.
- (2) The emotional health history of the individual subject to emotional harm.
- (3) Intensity and probable duration of the emotional impairment.
- (4) The degree of cooperation required.
- (5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

41.22(9) *Claiming good cause.* Each applicant for or recipient of the FIP who is required to cooperate with child support services will have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the income maintenance unit will notify the applicant or recipient using a form prescribed by the department 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 will:

- (1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.
- (2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the FIP.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed; and that if the income maintenance unit determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the income maintenance unit will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit will issue a second notice on a form prescribed by the department. To claim good cause, the applicant or recipient shall sign and date this form and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or recipient must provide corroborative evidence of a good cause circumstance and must, when requested, furnish sufficient information to permit the income maintenance unit to investigate the circumstances.

(2) Informs the applicant or recipient that, upon request, the income maintenance unit will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the department's investigation when necessary, the income maintenance unit will determine whether cooperation would be against the best interest of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that child support services may review the income maintenance unit's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that child support services may attempt to establish paternity and collect support in those cases where the income maintenance unit determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements will constitute a sufficient basis for the income maintenance unit to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

41.22(10) *Determination of good cause.* The income maintenance unit will determine whether good cause exists for each applicant for or recipient of the FIP who claims to have good cause.

a. The applicant or recipient shall be notified by the income maintenance unit of its determination that good cause does or does not exist. The determination will:

(1) Be in writing.

(2) Contain the income maintenance unit's findings and basis for determination.

(3) Be entered in the FIP case record.

b. The determination of whether or not good cause exists will 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 41.22(11).

c. When the income maintenance unit determines that good cause does not exist:

(1) The applicant or recipient will be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The income maintenance unit will make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after the unit has examined the evidence and found that it actually verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the income maintenance unit will:

(1) Afford child support services the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from child support services.

f. Child support services may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance will not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The income maintenance unit will:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

41.22(11) *Proof of good cause.* The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or recipient needs additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit will 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 that indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records that 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 that indicate that the putative father or absent parent might inflict physical or emotional harm on the child or caretaker relative.

(4) Medical records that indicate emotional health history and present emotional health status of the caretaker relative or the child for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the caretaker relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances that provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the income maintenance unit wishes to request additional corroborative evidence that is needed to permit a good cause determination, the income maintenance unit will:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document that is needed.

c. When the applicant or recipient requests assistance in securing corroborative evidence, the income maintenance unit will:

- (1) Advise the applicant or recipient how to obtain the necessary documents, and
- (2) Make a reasonable effort to obtain any specific documents that the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The income maintenance unit will investigate the good cause claim when the unit believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and the investigation that is conducted satisfy the income maintenance unit that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by the worker's immediate supervisor and the findings will be recorded in the case record.

e. The income maintenance unit may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the income maintenance unit determines that it is necessary, the unit may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the income maintenance unit will:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

41.22(12) *Enforcement without caretaker's cooperation.* When the income maintenance unit makes a determination that good cause exists, the unit will also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or caretaker relative when the enforcement or collection activities do not involve the participation of the child or caretaker.

a. Child support services will have an opportunity to review and comment on the findings and basis for the proposed determination, and the income maintenance unit will consider any recommendation from child support services.

b. The determination will:

- (1) Be in writing,
- (2) Contain the income maintenance unit's findings and basis for determination, and
- (3) Be entered into the FIP case record.

c. When the income maintenance unit excuses cooperation but determines that child support services may proceed to establish paternity or enforce support, the income maintenance unit will notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

41.22(13) *Furnishing of social security number.* As a condition of eligibility each applicant for or recipient of and all members of the eligible group must furnish a social security account number or proof of application for a number if it has not been issued or is not known and provide the number upon its receipt. The requirement will not apply to a payee who is not a member of the eligible group.

a. Assistance will not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicant or recipient has complied with the requirements of subrule 41.22(13).

b. When the mother of the newborn child is a current recipient, the mother shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

c. When the applicant is a battered alien, as described in subrule 41.23(4), the applicant shall have until the month following the month the person receives employment authorization from the Immigration and Naturalization Service to apply for a social security account number.

41.22(14) Reserved.

41.22(15) *Requiring minor parents to live with parent or legal guardian.* A minor parent and the dependent child in the minor parent's care must live in the home of a parent or legal guardian of the minor parent in order to receive FIP benefits unless good cause for not living with the parent or legal guardian is established.

a. "Living in the home" includes living in the same apartment, same half of a duplex, same condominium or same row house as the adult parent or legal guardian. It also includes living in an apartment that is located in the home of the adult parent or legal guardian.

b. For applicants, determination of whether the minor parent and child are living with a parent or legal guardian or have good cause must be made as of the date of the first application interview as described in 441—subrule 40.24(2).

(1) If, as of the date of this interview, the minor parent and child are living with a parent or legal guardian or are determined to have good cause, the FIP application for the minor parent and child will be approved as early as seven days from receipt of the application provided they are otherwise eligible.

(2) If, as of the date of this interview, the minor parent and child are not living with a parent or legal guardian and do not have good cause, the FIP application for the minor parent and child will be denied.

c. For recipients, when changes occur, continuing eligibility will be redetermined according to 441—subrules 40.27(4) and 40.27(5).

d. A minor parent determined to have good cause for not living with a parent or legal guardian must attend the family development and self-sufficiency program or other family development as required in 441—subrule 93.4(4).

41.22(16) *Good cause for not living in the home of a parent or legal guardian.* Good cause exists when at least one of the following conditions applies:

a. The parents or legal guardian of the minor parent is deceased, missing or living in another state.

b. The physical or emotional health or safety of the minor parent or child would be jeopardized if the minor parent is required to live with the parent or legal guardian.

(1) Physical or emotional harm shall be of a serious nature in order to justify a finding of good cause.

(2) Physical or emotional harm shall include situations of documented abuse or incest.

(3) When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the minor parent or child, the following will be considered:

1. The present emotional state of the individual subject to emotional harm.

2. The emotional health history of the individual subject to emotional harm.

3. Intensity and probable duration of the emotional impairment.

c. The minor parent is in a foster care supervised apartment living arrangement.

d. The minor parent is participating in the job corps solo parent program.

e. The parents or legal guardian refuses to allow the minor parent and child to return home and the minor parent is living with a specified relative, aged 21 or over, on the day of interview, and the caretaker is the applicant or payee.

f. The minor parent and child live in a maternity home or other licensed adult-supervised supportive living arrangement as defined by the department.

g. Other circumstances exist that indicate that living with the parents or legal guardian will defeat the goals of self-sufficiency and responsible parenting. Situations that appear to meet this good cause reason must be referred to the administrator of the division of community access and eligibility, or the administrator's designee, for determination of good cause.

41.22(17) *Claiming good cause for not living in the home of a parent or legal guardian.* Each applicant or recipient who is not living with a parent or legal guardian will have the opportunity to claim good cause for not living with a parent or legal guardian.

41.22(18) *Determination of good cause for not living in the home of a parent or legal guardian.* The department will determine whether good cause exists for each applicant or recipient who claims good cause.

a. The applicant or recipient will be notified by the department of its determination that good cause does or does not exist. The determination will:

- (1) Be in writing.
- (2) Contain the department's findings and basis for determination.
- (3) Be entered in the FIP case record.

b. When the department determines that good cause does not exist:

- (1) The applicant or recipient will be so notified.
- (2) The application will be denied or FIP assistance canceled.

c. The department will:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements.

41.22(19) *Proof of good cause for not living in the home of a parent or legal guardian.* The applicant or recipient who claims good cause shall provide corroborative evidence to prove the good cause claim within the time frames described in 441—subrule 40.24(1) and 441—paragraph 40.27(4) “c.”

a. A good cause claim may be corroborated by one or more of the following types of evidence:

(1) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the parent or legal guardian might inflict physical or emotional harm on the minor parent or child.

(2) Medical records that indicate the emotional health history and present emotional health status of the minor parent or child; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the minor parent or child.

(3) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances that provide the basis for the good cause claim. Written statements from the client's friends or relatives are not sufficient alone to grant good cause based on physical or emotional harm, but may be used to support other evidence.

(4) Notarized statements from the parents or legal guardian or other reliable evidence to verify that the parents or legal guardian refuse to allow the minor parent and child to return home.

(5) Court, criminal, child protective services, social services or other records that verify that the parents or legal guardian of the minor parent is deceased, missing or living in another state, or that the minor parent is in a foster care supervised apartment living arrangement, the job corps solo parent program, maternity home or other licensed adult-supervised supportive living arrangement.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the department wishes to request additional corroborative evidence that is needed to permit a good cause determination, the department will:

- (1) Promptly notify the applicant or recipient that additional corroborative evidence is needed.
- (2) Specify the type of document that is needed.

c. When the applicant or recipient requests assistance in securing evidence, the department will:

- (1) Advise the applicant or recipient how to obtain the necessary documents.
- (2) Make a reasonable effort to obtain any specific documents that the applicant or recipient is not reasonably able to obtain without assistance.

441—41.23(239B) Home, residence, citizenship, and alienage.**41.23(1) *Iowa residence.***

a. A resident of Iowa is one:

(1) Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence will not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the caretaker is a resident.

b. Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of residence.

41.23(2) *Suitability of home.* The home will be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

41.23(3) *Absence from the home.*

a. An individual who is absent from the home will not be included in the assistance unit, except as described in paragraph 41.23(3) "*b.*"

(1) A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(2) A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

(3) A parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is considered absent from the home, notwithstanding the provisions of subrule 41.22(5). "Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

b. The needs of an individual who is temporarily out of the home are included in the eligible group, if otherwise eligible. A temporary absence exists in the following circumstances:

(1) An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year will result in the individual's needs being removed from the grant.

(2) An individual is out of the home to secure education or training, as described for children in paragraph 41.24(2) "*e*" and for adults in rule 441—93.8(239B), first sentence, as long as the caretaker relative retains supervision of the child.

(3) An individual is out of the home for reasons other than reasons in subparagraphs 41.23(3) "*b*" (1) and "*b*"(2) and the payee intends that the individual will return to the home within three months. Failure to return within three months will result in the individual's needs being removed from the grant.

41.23(4) *Battered aliens.* A person who meets the conditions of eligibility under Iowa Code sections 239B.2 and 239B.2B is eligible for participation in the FIP.

41.23(5) *Citizenship and alienage.*

a. Eligible status. An FIP assistance grant may include the needs of a citizen or national of the United States or a "qualified alien" as defined in rule 441—40.21(239B).

(1) A person who is a "qualified alien" as defined in rule 441—40.21(239B) is not eligible for FIP assistance for a five-year period beginning on the date of the person's entry into the United States with a qualified alien status.

(2) Exceptions: The five-year prohibition from FIP assistance does not apply to:

1. A qualified alien residing in the United States before August 22, 1996.

2. A battered alien as described in subrule 41.23(4).
3. A qualified alien veteran who has an honorable discharge that is not due to alienage.
4. A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.
5. A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in numbered paragraph 41.23(5) “a”(2)“3” or “a”(2)“4,” including a surviving spouse who has not remarried.
6. A refugee admitted under Section 207 of the Immigration and Nationality Act (INA) as amended to December 31, 2024.
7. An alien granted asylum under Section 208 of the INA as amended to December 31, 2024.
8. An alien admitted as an Amerasian as described in 8 U.S.C. Section 1612(a)(2)(A)(ii)(V) as amended to December 31, 2024.
9. A Cuban/Haitian entrant as described in 8 U.S.C. Section 1641(b)(7) as amended to December 31, 2024.
10. An alien whose deportation is withheld under Section 243(h) or Section 241(b)(3) of the INA as amended to December 31, 2024.
11. An alien certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to December 31, 2024.
12. An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to December 20, 2010, or to Section 602(b)(8) of Public Law 111-8 as amended to December 20, 2010.

b. Attestation of status. As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and recipients on an application form, a review form, or another attestation form prescribed by the department. A review form prescribed by the department may be used to attest to the citizenship of dependent children who enter a recipient household. Failure to sign a form attesting to citizenship when required to do so creates ineligibility for the entire eligible group. The attestation may be signed by:

- (1) The applicant;
- (2) Someone acting responsibly on the applicant’s or recipient’s behalf if the applicant or recipient is incompetent or incapacitated; or
- (3) Any adult member of the assistance unit, when eligibility is determined on a family or household basis.

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441—41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program. All persons in an FIP household will be referred to the PROMISE JOBS program, as defined in rule 441—93.1(239B), and shall enter into a family investment agreement (FIA) as a condition of receiving FIP unless exempt from referral, except as described in subrule 41.24(2).

41.24(1) FIA-responsible persons. The following persons are FIA-responsible unless the department determines the person is exempt:

- a.* All persons whose needs are included in a grant under the FIP program.
- b.* Any parent living in the home of a child receiving a grant.
- c.* All FIP applicants unless the department determines that the applicant is exempt or does not meet other FIP eligibility requirements.
- d.* Applicants who have chosen and are in an active limited benefit plan (LBP). FIA-responsible applicants in an active LBP shall complete significant contact with or action in regard to PROMISE JOBS as described in paragraphs 41.24(8) “d” and “e” for FIP eligibility to be considered. For two-parent households, both parents must participate as previously stated except when one parent is exempt. Exceptions:

- (1) The applicant has become exempt from PROMISE JOBS.

(2) The applicant is in a subsequent LBP and it is prior to the last day of the six-month period of ineligibility.

41.24(2) Exemptions. The following persons are exempt from referral:

- a.* and *b.* Reserved.
- c.* A person who is under the age of 16 and is not a parent.
- d.* A person found eligible for supplemental security income (SSI) benefits based on disability or blindness.
- e.* A person who is aged 16 to 19, is not a parent, and attends an elementary, a secondary or an equivalent level of vocational or technical school full-time. For persons who lose exempt status for not attending school, once the person has signed an FIA, the person will remain referred to PROMISE JOBS and subject to the terms of the agreement.

(1) A person will be considered to be attending school full-time when enrolled or accepted in an elementary school, a secondary school, or the equivalent level of vocational or technical school or training leading to a certificate or diploma, and the school certifies the person's attendance as full-time. Enrollment in a correspondence school that gives instruction courses by mail is not an allowable program of study.

(2) A person will also be considered to be in regular attendance in months when the person is not attending because of an official school or training program vacation, an illness, a convalescence, or a family emergency.

(3) A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

f. A person who is not a United States citizen and is not a "qualified alien" as defined in 441—40.21(239B).

41.24(3) Parents aged 19 and under.

a. Unless exempt as described in subrule 41.24(2), parents aged 18 or 19 are referred to PROMISE JOBS as follows:

(1) A parent aged 18 or 19 who has not successfully completed a high school education (or its equivalent) will be required to participate in educational activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent will be required to participate in other PROMISE JOBS options if the person fails to make good progress in completing educational activities or if it is determined that participation in educational activities is inappropriate for the parent.

(3) The parent will be required to participate in parenting skills training in accordance with 441—Chapter 93.

b. Unless exempt as described in subrule 41.24(2), parents aged 17 or younger are referred to PROMISE JOBS as follows:

(1) A parent aged 17 or younger who has not successfully completed a high school education or its equivalent will be required to participate in high school completion activities, directed toward the attainment of a high school diploma or its equivalent.

(2) The parent will be required to participate in parenting skills training in accordance with 441—Chapter 93.

41.24(4) Method of referral. The department will refer each FIA-responsible person as defined in subrule 41.24(1) to PROMISE JOBS to sign an FIA.

a. FIA-responsible applicants. During the application interview, the department will notify the applicant of the requirement to sign an FIA as a condition of FIP eligibility. The department will refer the applicant by scheduling the applicant for an appointment with the PROMISE JOBS provider agency to develop the FIA.

(1) The appointment will be on the earliest available date but no later than ten calendar days from the date of referral unless the applicant requests an appointment on a day that is beyond ten calendar days. The PROMISE JOBS provider agency shall make sufficient appointment times available to allow the applicant to be scheduled within this time frame.

(2) The applicant will be notified verbally and in writing of the scheduled appointment. If the notice of a scheduled appointment is mailed to the applicant, the department will allow at least five working days from the date the notice is mailed for the applicant to appear for the scheduled appointment. The department may allow less than five working days if the applicant is verbally notified and agrees to the appointment.

(3) If a parent fails to appear for an appointment without rescheduling or fails to sign an FIA, the department will deny FIP assistance for the entire family.

(4) If a minor parent fails to appear for an appointment without rescheduling or fails to sign an FIA, the department will deny FIP assistance for the minor parent and any child of the minor parent.

(5) If a referred person who is not a parent fails to appear for an appointment without rescheduling or fails to sign an FIA, the department will deny FIP assistance only for that person.

b. Hardship applicants. While the eligibility decision is pending, unless the applicants are exempt from referral as defined in subrule 41.24(2), the department will refer applicants who must qualify for a hardship exemption before approval of FIP to PROMISE JOBS to sign an FIA as described in paragraph 41.24(4)“a” and will treat applicants in accordance with subrule 41.30(3).

c. Applicants in an LBP. The department will refer FIA-responsible applicants to PROMISE JOBS as described in paragraph 41.24(4)“a” and inform the applicant of the actions needed to reconsider and end the LBP as described in subrule 41.24(8). Failure to appear for the appointment without rescheduling or failure to sign an FIA results in denial of the FIP application.

d. FIP participants who become FIA-responsible. When a person receiving FIP is no longer exempt, the department will send the FIP participant a notice. The notice will contain information about the requirement to sign an FIA and will instruct the FIP participant to contact PROMISE JOBS within ten calendar days to schedule an appointment with PROMISE JOBS to develop an FIA. If the participant fails to schedule or attend the appointment or fails to sign an FIA, PROMISE JOBS will send a clear written reminder. After one written reminder as described in 441—paragraph 93.3(3)“b,” the participant will enter into an LBP as described in paragraph 41.24(8)“c.”

41.24(5) Changes in status and redetermination of exempt status. Any exempt person shall report any change affecting the exempt status to the department within ten days of the change. The department will reevaluate exempt persons when changes in status occur and at the time of six-month or annual review. The participant and the PROMISE JOBS unit will be notified of any change in a participant’s exempt status.

41.24(6) Reserved.

41.24(7) Referral to vocational rehabilitation. The department will make the department of education, division of vocational rehabilitation services, aware of any person who is referred to PROMISE JOBS and who has a medically determined physical or mental disability and a substantial employment limitation resulting from the disability. However, acceptance of vocational rehabilitation services by the client is optional.

41.24(8) LBP. When a participant responsible for signing and meeting the terms of an FIA chooses not to sign or fulfill the terms of the agreement, the FIP assistance unit or the individual participant will enter into an LBP. An LBP is considered imposed as of the date that a “timely” and “adequate notice” is issued to the participant as defined in rules 441—16.1(17A) and 441—16.2(17A). Once the LBP is imposed, FIP eligibility no longer exists as of the first of the month after the month in which timely and adequate notice is given to the participant. Upon the issuance of the notice to impose an LBP, the person who chose the LBP can reconsider and end the LBP, but only as described in paragraphs 41.24(8)“d” and “e.”

a. An LBP shall either be a first LBP or a subsequent LBP. From the effective date of a first LBP, the FIP-eligible group or individual participant shall not be eligible until the participant who chose the LBP completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)“d.” If a subsequent LBP is chosen by the same participant, a six-month period of ineligibility applies to the FIP-eligible group or individual participant and ineligibility continues after the six-month period is over until the participant who chose the LBP

completes significant contact with or action in regard to the PROMISE JOBS program as defined in paragraph 41.24(8)“e.” An LBP imposed in error as described in paragraph 41.24(8)“g” shall not be considered an LBP and shall not count when determining whether a household is subject to a subsequent LBP.

b. The LBP shall be applied to participants responsible for the FIA and other members of the participant’s family as follows:

(1) When the participant responsible for the FIA is a parent, the LBP shall apply to the entire FIP-eligible group as defined in subrule 41.28(1).

(2) When the participant choosing an LBP is a needy specified relative or a dependent child’s stepparent who is in the FIP-eligible group because of incapacity, the LBP shall apply only to the individual participant choosing the plan. Exception: The LBP shall apply to the entire FIP-eligible group as defined in subrule 41.28(1) when a needy specified relative who assumes the role of parent was responsible for the FIA and chose an LBP effective October 1, 2005, or earlier.

(3) When the FIP-eligible group includes a minor parent living with the minor parent’s adult parent or needy specified relative who receives FIP benefits and both the minor parent and the adult parent or needy specified relative are responsible for developing an FIA, each parent or needy specified relative is responsible for a separate FIA, and the LBP shall be applied as follows:

1. When the adult parent chooses the LBP, the requirements of the LBP shall apply to the entire eligible group, even though the minor parent has not chosen the LBP. However, the minor parent may reapply for FIP benefits as a minor parent living with self-supporting parents or as a minor parent living independently and continue in the FIA process.

2. When the minor parent chooses the LBP, the requirements of the LBP shall apply to the minor parent and any child of the minor parent.

3. When the minor parent is the only eligible child in the adult parent’s or needy specified relative’s home and the minor parent chooses the LBP, the adult parent’s or needy specified relative’s FIP eligibility ceases in accordance with subrule 41.28(1). The adult parent or needy specified relative shall become ineligible beginning with the effective date of the minor parent’s LBP.

4. When the needy specified relative chooses the LBP, the requirements of the LBP shall apply as described in subparagraph 41.24(8)“b”(2).

(4) When the FIP-eligible group includes children who are FIA-responsible, the children shall not have a separate FIA but shall be asked to sign the eligible group’s FIA and to carry out the responsibilities of that FIA. An LBP shall be applied as follows:

1. When the parent or needy specified relative responsible for an FIA meets those responsibilities but a child who is FIA-responsible chooses an individual LBP, the LBP shall apply only to the individual child choosing the plan.

2. When the child who chooses an LBP under numbered paragraph 41.24(8)“b”(4)“1” is the only child in the eligible group, the parents’ or needy specified relative’s eligibility ceases in accordance with subrule 41.28(1). The parents or needy specified relative shall become ineligible beginning with the effective date of the child’s LBP.

(5) When the FIP-eligible group includes parents or needy specified relatives who are exempt from PROMISE JOBS participation and children who are FIA-responsible, the children are responsible for completing an FIA. If a child who is FIA-responsible chooses the LBP, the LBP shall be applied in the manner described in subparagraph 41.24(8)“b”(4).

(6) When both parents of an FIP child are in the home, an LBP shall be applied as follows:

1. When only one parent of a child in the eligible group is responsible for an FIA and that parent chooses the LBP, the LBP applies to the entire family and cannot be ended by the voluntary participation in an FIA by the exempt parent.

2. When both parents of a child in the eligible group are responsible for an FIA, both are expected to sign the agreement. If either parent chooses the LBP, the LBP cannot be ended by the participation of the other parent in an FIA.

3. When the parents from a two-parent family in an LBP separate, the LBP shall follow only the parent who chose the LBP and any children in the home of that parent.

4. A subsequent LBP applies when either parent in a two-parent family previously chose an LBP.

c. A participant shall be considered to have chosen an LBP under any of the following circumstances:

(1) A participant who loses exempt status and is referred to PROMISE JOBS as described in paragraph 41.24(4)“d” and who does not schedule or attend an appointment for orientation and development of an FIA with PROMISE JOBS after PROMISE JOBS sends one clear written reminder as described in 441—paragraph 93.3(3)“b” shall enter into the LBP.

(2) A participant who chooses not to sign the FIA shall enter into the LBP. For an applicant, signing an FIA is an FIP eligibility requirement. If an applicant chooses not to sign the agreement, the LBP process is not applicable.

(3) A participant who signs an FIA but does not carry out the FIA responsibilities shall enter into an LBP whether the person signed the agreement as an FIP applicant or as an FIP participant. This includes a participant who fails to respond to the PROMISE JOBS worker’s request to renegotiate the FIA when the participant has not attained self-sufficiency by the date established in the FIA. An LBP shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the FIA.

d. Reconsideration of a first LBP. A person who chooses a first LBP may reconsider at any time from the date timely and adequate notice is issued establishing the LBP. To reconsider and end the LBP, the person must communicate the desire to engage in PROMISE JOBS activities to the department or appropriate PROMISE JOBS office and develop and sign the FIA.

(1) Since a first LBP is considered imposed as of the date that a timely and adequate notice is issued, the person who chose the LBP cannot end it by complying with the issue that resulted in its imposition. To end the LBP, the person must also sign an FIA, even if the person had signed an agreement before choosing the LBP.

(2) FIP benefits shall be effective the date the FIA is signed or the effective date of the grant as described in rule 441—40.26(239B), whichever date is later. FIP benefits may be reinstated in accordance with 441—subrule 40.22(5) when the FIA is signed before the effective date of a first LBP.

e. Reconsideration of a subsequent LBP. A person who chooses a subsequent LBP may reconsider that choice at any time following the required six-month period of ineligibility.

(1) A subsequent LBP is considered imposed as of the date that a timely and adequate notice is issued to establish the LBP. Therefore, once timely and adequate notice is issued, the person who chose the LBP cannot end it by complying with the issue that resulted in its imposition.

(2) FIP eligibility no longer exists as of the effective date of the LBP. Eligibility cannot be reestablished until the six-month period of ineligibility has expired. FIP eligibility does not exist for a person who reapplies for FIP after the notice is issued and before the effective date of the LBP because the person is not eligible to sign an FIA until the six-month period of ineligibility has expired.

(3) To reconsider and end the LBP, the person must:

1. Contact the department or the appropriate PROMISE JOBS office to communicate the desire to engage in PROMISE JOBS activities,

2. Sign a new or updated FIA, and

3. Satisfactorily complete 20 hours of employment or the equivalent in an activity other than work experience or unpaid community service unless problems as described in rule 441—93.14(239B) or barriers as described in 441—subrule 93.4(5) apply. The 20 hours of employment or other activity must be completed within 30 days of the date that the FIA is signed unless problems as described in rule 441—93.14(239B) or barriers as described in 441—subrule 93.4(5) apply.

(4) FIP benefits shall not begin until the person who chose the LBP completes the previously defined significant actions. FIP benefits shall be effective the date the FIA is signed or the effective

date of the grant as described in rule 441—40.26(239B), whichever date is later, but in no case shall the effective date be within the six-month period of ineligibility.

f. Reconsideration by two-parent family. For a two-parent family when both parents are responsible for an FIA as described in subrule 41.24(1), a first or subsequent LBP continues until both parents have completed significant contact or action with the PROMISE JOBS program as described in paragraphs 41.24(8) “*d*” and “*e*.”

g. LBP imposed in error. An LBP imposed in error will not be considered an LBP. This includes any instance when participation in PROMISE JOBS should not have been required as described in the administrative rules. Examples of instances when an error has occurred are:

(1) The person was exempt from PROMISE JOBS participation at the time the person chose the LBP.

(2) It is verified that the person considered to have chosen the LBP moved out of state or requested cancellation of FIP prior to the date that PROMISE JOBS determined the LBP was chosen.

(3) The final appeal decision under 441—Chapter 2506 reverses the decision to impose an LBP.

(4) It is determined that the entire amount of assistance issued for the person who chose the LBP is subject to recoupment for the month when the person chose not to fulfill the terms of the FIA.

(5) The person informs PROMISE JOBS of a newly revealed problem as described in rule 441—93.14(239B) or barrier as described in 441—subrule 93.4(5) after the LBP is imposed, and it is reasonable that the problem or barrier contributed to a failure that resulted in imposition of the LBP. The person may be required to provide documentation of the problem or barrier as described in 441—subrule 93.10(3).

41.24(9) Reserved.

41.24(10) *Notification of services.*

a. The department will inform all applicants for and recipients of FIP of the advantages of employment under FIP.

b. The department will provide a full explanation of the family rights, responsibilities, and obligations under PROMISE JOBS and the FIA, with information on the time-limited nature of the agreement.

c. The department will provide information on the employment, education and training opportunities, and support services to which they are entitled under PROMISE JOBS, as well as the obligations of the department. This information will include explanations of child care assistance and transitional Medicaid.

d. The department will inform applicants for and recipients of FIP benefits of the grounds for exemption from FIA responsibility and from participation in the PROMISE JOBS program.

e. The department will explain the LBP and the process by which FIA-responsible persons can choose the LBP.

f. The department will inform all applicants for and recipients of FIP of their responsibility to cooperate in establishing paternity and enforcing child support obligations.

g. The department will inform applicants for FIP benefits that an FIA must be signed before FIP approval as a condition of eligibility, except as described in subrule 41.24(2).

[ARC 9277C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—41.25(239B) Uncategorized factors of eligibility.

41.25(1) Reserved.

41.25(2) *Duplication of assistance.* A recipient whose needs are included in an FIP grant shall not concurrently receive a grant under any other public assistance program administered by the department, including IV-E foster care, state-funded foster care or kinship caregiver program payments.

a. A recipient shall not concurrently receive the FIP and subsidized adoption unless exclusion of the person from the FIP grant will reduce benefits to the family.

b. When an FIP recipient is approved for foster care or subsidized adoption assistance while remaining in the same home, FIP assistance will be canceled effective the first day of the next calendar month following the date approval of the foster care or subsidized adoption payment is successfully entered into the department's computer system. FIP assistance for the month for which the foster care or subsidized adoption payment is approved or any past months for which foster care or subsidized adoption payments are made retroactively will not be subject to recoupment.

c. A recipient shall not concurrently receive a grant from a public assistance program in another state.

d. When a recipient leaves the home of a specified relative, no payment for a concurrent period will be made for the same recipient in the home of another relative.

41.25(3) *Aid from other funds.* Supplemental aid from any other agency or organization is limited to aid for items of need not covered by the department's standards and to the amount of the percentage reduction used in determining the payment level. Any duplicated assistance will be considered unearned income.

41.25(4) *Contracts for support.* A person entitled to total support under the terms of an enforceable contract is not eligible to receive the FIP when the other party, obligated to provide the support, is able to fulfill that part of the contract.

41.25(5) *Participation in a strike.*

a. The family of any parent with whom the child(ren) is living will be ineligible for the FIP for any month in which the parent is participating in a strike on the last day of the month.

b. Any individual will be ineligible for the FIP for any month in which the individual is participating in a strike on the last day of that month.

c. Definitions:

(1) A strike is a concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees.

(2) An individual is not participating in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The eligibility determination manager will determine whether such a risk to the individual's physical or emotional well-being exists.

41.25(6) *Graduate students.* The entire assistance unit is ineligible for FIP when a member of the assistance unit is enrolled in an educational program leading to a degree beyond a bachelor's degree.

41.25(7) through **41.25(9)** Reserved.

41.25(10) *Fugitive felons, and probation and parole violators.* Assistance will be denied to a person who is (1) convicted of a felony under state or federal law and is fleeing to avoid prosecution, custody or confinement, or (2) violating a condition of probation or parole imposed under state or federal law. The prohibition does not apply to conduct pardoned by the President of the United States, beginning with the month after the pardon is given.

41.25(11) *Access to benefits.* As a condition of eligibility, applicants and recipients must agree in writing to not use an electronic access card at prohibited locations. By signing an application or review form prescribed by the department, the applicant, the applicant's authorized representative or, when the applicant is incompetent or incapacitated, someone acting responsibly on the applicant's behalf agrees to this condition of eligibility. When both parents, or a parent and a stepparent, are in the home and eligibility is determined on a family or household basis, one parent or stepparent may sign the application and agree to this condition for the assistance unit. Failure to sign a form agreeing to not use the electronic access card at prohibited locations creates ineligibility for the entire eligible group.

a. A recipient shall not use the recipient's electronic access card issued pursuant to 441—subrule 45.21(1) to access benefits at any of the following prohibited locations as defined

by federal statute or regulation applicable to this prohibition and as further defined in rule 441—40.21(239B):

- (1) A liquor store,
- (2) A casino, gambling casino, or gaming establishment, or
- (3) A retail establishment that provides adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment.

b. When the department receives a detailed complaint or suspects that a recipient has used the recipient's electronic access card at a prohibited location, the case will be referred to the department of inspections, appeals, and licensing (DIAL) for further investigation.

c. When DIAL finds that a recipient has used the recipient's electronic access card at a prohibited location, the household that includes the recipient is:

- (1) Considered to have committed a fraudulent act;
- (2) Liable for any amounts accessed and any associated fees for accessing the benefits at a prohibited location and required to repay such amount in accordance with 441—Chapter 46;
- (3) Ineligible for FIP for a three-month period after the first report by DIAL that includes a finding of misuse;
- (4) Ineligible for FIP for a six-month period after each subsequent report by DIAL that includes a finding of misuse.

d. When parents from a two-parent family separate during an ineligibility period, if:

- (1) DIAL identifies the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow that recipient.
- (2) DIAL does not identify the recipient who used the electronic access card at a prohibited location, the ineligibility period will follow the recipient who is the case name when the violation occurred.

e. A new period of ineligibility will be established when:

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

Assistance issued pending the final decision of an appeal is not subject to recovery pursuant to rule 441—7.17(17A).

[ARC 9277C, IAB 5/14/25, effective 7/1/25]

441—41.26(239B) Resources.

41.26(1) Limitation. An applicant or recipient may have the following resources and be eligible for the FIP. Any resource not specifically exempted will be counted toward resource limitations.

a. A homestead without regard to its value. A mobile home or similar shelter will be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished will not be considered to have altered the exempt status of the homestead. Except as described in paragraph 41.26(1)“n” or “o” and paragraph 41.26(6)“d,” the net market value of any other real property will 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, that are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance that has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. Motor vehicles.

(1) One motor vehicle without regard to its value.

(2) An equity not to exceed a value of \$4,115 in one motor vehicle for each adult and working teenage child whose resources are considered as described in subrule 41.26(2). The disregard will be allowed when the working teenager is temporarily absent from work. The equity value in excess of \$4,115 of any vehicle will be counted toward the resource limit in paragraph 41.26(1)“e.” When a motor vehicle is modified with special equipment for the handicapped, the special equipment will not increase the value of the motor vehicle.

The department will annually increase the motor vehicle equity value to be disregarded by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed \$2,000 for applicant assistance units and \$5,000 for recipient assistance units. Exception: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the \$5,000 limit. The exception includes those persons who did not receive an assistance grant due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

Resources of the applicant or the recipient will be determined in accordance with subrule 41.26(2).

f. Money that is counted as income in a month, during that same month; and that part of lump sum income defined in subparagraph 41.27(9)“c”(2) reserved for the current or future month’s income.

g. Payments that are exempted for consideration as income and resources under subrule 41.27(6).

h. An equity not to exceed \$1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of \$1,500 will be counted toward resource limitations unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository that 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 that exceeds the exemption will be considered in computing whether the eligible group’s property is within the reserve defined in paragraph 41.26(1)“e.”

o. Nonhomestead property that produces income consistent with the property’s fair market value.

41.26(2) Persons considered.

a. Resources of persons in the eligible group will be considered in establishing property limitations.

b. Resources of the parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group will be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home will not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group will be considered in the same manner as a parent.

d. The resources of supplemental security income recipients will not be counted in establishing property limitations.

e. The resources of a nonparental relative who elects to be included in the eligible group will be considered in the same manner as a parent.

41.26(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it will not exceed ½-acre in area. When outside a city plat, it will 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 will be determined in accordance with subrule 41.26(5).

41.26(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements that are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Property sold under installment contract. Property sold under an installment contract or held as security in exchange for a price consistent with its fair market value is exempt as a resource. If the price is not consistent with the contract's fair market value, the resource value of the installment contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the installment contract.

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 41.27(1) "f" and 41.27(7) "aj." The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

41.26(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

41.26(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant/recipient owns the property in part or in full and has control over it; that is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. Reserved.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all individuals hold equal shares in the property.

d. When the applicant or recipient owns nonhomestead property, the property will be considered exempt for so long as the property is publicly advertised for sale at an asking price that is consistent with its fair market value.

41.26(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource will be considered a resource to the applicant/recipient the month following the month the payment was received. When the applicant/recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds will 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 will be considered a resource in the month following the month in which payment was received.

41.26(8) *Trusts.* The department will determine whether assets from a trust or conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the trust agreement or order establishing a conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance will be considered toward resource or income limitations.

b. When the department questions whether the funds in a trust or conservatorship are available, the trust or conservatorship will be referred to the central office.

(1) When assets in the trust or conservatorship are not clearly available, central office staff may contact the trustee or conservator and request that the funds in the trust or conservatorship be made available for current support and maintenance. When the trustee or conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments.

(2) Funds in a trust or conservatorship that are not clearly available will be considered unavailable until the trustee, conservator or court actually makes the funds available. Payments received from the trust or conservatorship for basic or special needs are considered income.

41.26(9) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) (as amended to December 31, 2024) on behalf of the alien, the resources of the alien will be deemed to include the resources of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the resources of the sponsor and the sponsor's spouse deemed to the alien will be the total countable resources as described in rule 441—41.26(239B) remaining after a \$1,500 deduction is subtracted. The following are exceptions to deeming of a sponsor's resources:

a. Deeming of the sponsor's resources does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act (as amended to December 31, 2024);

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act (as amended to December 31, 2024) or can be credited with 40 qualifying quarters as defined in rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's resources for 12 months after indigence is determined. An alien will be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) (as amended to December 31, 2024) is exempt from the deeming of a sponsor's resources for 12 months.

41.26(10) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment will not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and may include merchandise, grain held in storage, livestock raised for sale, and other unsold inventory. Supplies are items necessary for the operation of the enterprise, such as lumber, paint and seed. Capital assets are those assets that, 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, any inventory or supplies retained by the household will not be considered a resource.

[ARC 9277C, IAB 5/14/25, effective 7/1/25]

441—41.27(239B) *Income.* All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, will be considered in determining initial and continuing eligibility and the amount of the FIP grant.

1. The determination of initial eligibility is a three-step process. Initial eligibility will be granted only when (1) the countable gross nonexempt unearned and earned income, exclusive of the FIP grant, received by the eligible group and available to meet the current month's needs is no more than 185 percent of the standard of need for the eligible group; (2) the countable net unearned and earned income is less than the standard of need for the eligible group; and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the payment standard for the eligible group.

2. The determination of continuing eligibility is a two-step process. Continuing eligibility will be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the standard of need for the eligible group; and (2) countable net unearned and earned income is less than the payment standard for the eligible group.

3. The amount of the FIP grant will be determined by subtracting countable net income from the payment standard for the eligible group. Child support assigned to the department in accordance with subrule 41.22(7) and retained by the department as described in subparagraph 41.27(1)"h"(2) will be considered as exempt income for the purpose of determining continuing eligibility. Deductions and diversions will be allowed when verification is provided.

41.27(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income will be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction will 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. through *e.* Reserved.

f. When the applicant or recipient sells property on contract, proceeds from the sale will be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

g. Every person in the eligible group and any parent living in the home of a child in the eligible group will take all steps necessary to apply for and, if entitled, accept any financial benefit for which that person may be qualified, even though the benefit may be reduced because of the laws governing a particular benefit. When the person claims a physical or mental disability that is expected to last continuously for 12 months from the time of the claim or to result in death and the person is unable to engage in substantial activity due to the disability, or the person otherwise appears eligible, as the person is aged 65 or older or is blind, the person shall apply for social security benefits and supplemental security income benefits.

(1) Except as described in subparagraph 41.27(1)"g"(2), the needs of any person who refuses to take all steps necessary to apply for and, if eligible, to accept other financial benefits will be removed from the eligible group. The person remains eligible for the work incentive disregard described in paragraph 41.27(2)"c."

(2) The entire assistance unit is ineligible for FIP when a person refuses to apply for or, if entitled, to accept social security or supplemental security income. For applicants, this subparagraph applies to those who apply on or after July 1, 2002. For FIP recipients, this subparagraph applies at the time of the next six-month or annual review as described in 441—subrule 40.27(1) or when the recipient reports a change that may qualify a person in the eligible group or a parent living in the home for these benefits, whichever occurs earlier.

h. Support payments in cash will 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, will be treated as unearned income and deducted from the initial

assistance grant(s). Any cash support payment for a member of the eligible group, except as described in paragraph 41.27(7)“p,” received by the recipient after the date of decision as defined in 441—subrule 40.24(4) will be refunded to child support services.

(2) Assigned support collected in a month and retained by child support recovery will be exempt as income for determining prospective or retrospective eligibility. Participants will have the option of withdrawing from FIP at any time and receiving their child support direct.

i. The applicant or recipient shall cooperate in supplying verification of all unearned income as defined in 441—paragraph 40.24(1)“b” and 441—subrule 40.27(4). When the information is available, the department will verify unemployment insurance benefits by using information supplied to the department by the department of workforce development. When the client notifies the department that the amount of unemployment insurance benefits used is incorrect, the client will be allowed to verify the discrepancy. A payment adjustment will be made when indicated. Recoupment will be made for any overpayment. The client must report the discrepancy prior to the payment month or within ten days of the date on the Notice of Decision applicable to the payment month, whichever is later, in order to receive a payment adjustment.

41.27(2) Earned income. Earned income is defined as income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. Income will be considered earned income when it is produced as a result of the performance of services by an individual.

a. *Earned income deduction.* Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, is considered in determining eligibility and the amount of the assistance grant is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include all work-related expenses other than child care. These expenses will include all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Reserved.

c. *Work incentive disregard.* After deducting the allowable work-related expenses as defined in paragraph 41.27(2)“a” and income diversions as defined in subrules 41.27(4) and 41.27(8), the department will disregard 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income will be considered in determining eligibility and the amount of the assistance grant.

(1) The work incentive disregard is not time-limited.

(2) Initial eligibility is determined without the application of the work incentive disregard as described in subparagraphs 41.27(9)“a”(2) and “a”(3).

d. *Self-employment.* A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person’s own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

e. *Self-employment income.* Earned income from self-employment as defined in paragraph 41.27(2)“d” means the net profit from self-employment. “Net profit” means gross self-employment income less:

(1) Forty percent of the gross income to cover the costs of producing the income, or

(2) At the request of the applicant or recipient, actual expenses determined in the manner specified in paragraph 41.27(2)“f.”

f. *Deduction of self-employment expenses.* When the applicant or recipient requests that actual expenses be deducted, the net profit from self-employment income will be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent; the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. *Child care income.* Gross income from providing child care in the applicant's or recipient's own home will include the total payment(s) received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

h. *Income verification.* The applicant or recipient shall cooperate in supplying verification of all earned income and of any change in income, as defined in 441—paragraph 40.24(1)“b” and 441—subrule 40.27(4). A self-employed individual shall keep any records necessary to establish eligibility.

41.27(3) *Shared living arrangements.* When an FIP parent shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the FIP eligible group, exclusively for their needs, are considered income.

41.27(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent will be diverted to meet the unmet needs, including special needs, of the ineligible child(ren) of the parent living in the family group who meets the age and school attendance requirements specified in subrule 41.21(1). Income of the parent will be diverted to meet the unmet needs of the ineligible child(ren) of the parent and a companion in the home only when the income and resources of the companion and the child(ren) are within FIP standards. The maximum income that will be diverted to meet the needs of the ineligible child(ren) will be the difference between the needs of the eligible group if the ineligible child(ren) were included and the needs of the eligible group with the child(ren) excluded, except as specified in subparagraph 41.27(8)“a”(2) and paragraph 41.27(8)“b.”

b. Nonexempt earned and unearned income of the parent will be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

41.27(5) *Income of unmarried specified relatives under age 19.* Treatment of the income of an unmarried specified relative under the age of 19 is determined by whether the specified relative lives with a parent who receives FIP assistance, lives with a nonparental relative, lives in an independent living arrangement, or lives with a self-supporting parent, as follows.

a. Living with a parent on FIP, with a nonparental relative, or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the grant of the specified relative's parent will be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the grant of the specified relative's parent will 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 will be treated in the same manner as though the specified relative had attained majority.

b. Living with a self-supporting parent. The income of an unmarried specified relative under the age of 19 who is living in the same home as one or both of the person's self-supporting parents will be treated in accordance with subparagraphs 41.27(5) "b"(1), "b"(2), and "b"(4) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative will 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 will be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parent(s) will be treated in accordance with paragraph 41.27(8) "c."

(3) Reserved.

(4) When the unmarried specified relative is age 18, the income of the specified relative will be treated in the same manner as though the specified relative had attained majority.

41.27(6) Exempt as income and resources. The following will be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when utilized by the household for its own consumption.

b. The value of the supplemental nutrition 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, both as amended to December 31, 2024.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act, as amended to December 31, 2024.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981, as amended to December 31, 2024.

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, both as amended to December 31, 2024.

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, as amended to December 31, 2024, 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, as amended to December 31, 2024.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act, as amended to December 31, 2024.

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 to December 31, 2024.

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 in subrule 41.22(3), conditional to school attendance, will be exempt. However, any additional amount received for the person's dependents who are in the eligible group will be counted as nonexempt income.

s. Reserved.

t. Any income restricted by law or regulation that is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

u. The first \$50 received and retained by an applicant or recipient that represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case will the total amount exempted exceed \$50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is a borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, kinship caregiver program, 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, as amended to December 31, 2024.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, as amended to December 31, 2024, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians," as amended to December 31, 2024.

aa. Payments received from the Radiation Exposure Compensation Act as amended to December 31, 2024.

ab. Deposits into an IDA when determining eligibility and benefit amount. The amount of the deposit is exempt as income and will not be used in the 185 percent eligibility test. The deposit will be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client will be allowed a deduction only when the deposit is made from the client's money. The earned income deductions in paragraphs 41.27(2) "a" and "c" will be applied to nonexempt earnings from employment or net profit from self-employment that remain after deducting the amount deposited into the account. Allowable deductions will 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 will first be deducted from the client's nonexempt unearned income. Deposits will not be deducted from earned or unearned income that is exempt.

ac. Assigned support collected in a month and retained by child support recovery as described in subparagraph 41.27(1) "h" (2).

41.27(7) Exempt as income. The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for job-related expenses.

c. The following nonrecurring lump sum payments:

- (1) Income tax refund.
- (2) Retroactive supplemental security income benefits.
- (3) Settlements for the payment of medical expenses.
- (4) Refunds of security deposits on rental property or utilities.
- (5) That part of a lump sum received and expended for funeral and burial expenses.
- (6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Foster care or kinship caregiver program payments received by the family that is:

- (1) Providing foster care to a child or children when the family is operating a licensed foster home, or

- (2) Caring for a relative or fictive kin child or children placed in the home by a court order.

e. Reserved.

f. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed \$30 per person per calendar quarter.

When a monetary gift from any one source is in excess of \$30, the total gift is countable as unearned income. When monetary gifts from several sources are each \$30 or less, and the total of all gifts exceeds \$30, only the amount in excess of \$30 is countable as unearned income.

g. Federal or state earned income tax credit.

h. Supplementation from county funds providing:

- (1) The assistance does not duplicate any of the basic needs as recognized by the FIP, or
- (2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

i. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

j. A retroactive corrective payment.

k. The training allowance issued by the division of vocational rehabilitation, department of education.

l. Payments from the PROMISE JOBS program.

m. Reserved.

n. The training allowance issued by the department for the blind.

o. Payment(s) from a passenger(s) in a car pool.

p. Support refunded by child support services for the first month of termination of eligibility and the family does not receive the FIP.

q. and *r.* Reserved.

s. Income of a nonparental relative as defined in subrule 41.22(3) except when the relative is included in the eligible group.

t. and *u.* Reserved.

v. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

w. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

x. Reserved.

y. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined in paragraph 41.24(2)“e.” The exemption applies through the entire month of the person’s twentieth birthday.

Exception: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

z. Income attributed to an unmarried, underage parent in accordance with paragraph 41.27(8) “c” effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns age 18

on the first day of a month, the income of the self-supporting parent(s) becomes exempt as of the first day of that month.

aa. Reserved.

ab. Incentive payments received from participation in the adolescent pregnancy prevention programs.

ac. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

ad. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

ae. Interest and dividend income.

af. and *ag.* Reserved.

ah. Welfare reform and regular household honorarium income. All moneys paid to an FIP household in connection with the welfare reform demonstration longitudinal study or focus groups will be exempted.

ai. Diversion or self-sufficiency grants assistance as described in 441—Chapter 47.

aj. Payments from property sold under an installment contract as specified in paragraphs 41.26(4) “*b*” and 41.27(1) “*f*.”

ak. All census earnings received by temporary workers from the Bureau of the Census.

41.27(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases.

(1) A parent who is living in the home with the eligible child(ren) but whose needs are excluded from the eligible group is eligible for the earned income deduction described in paragraph 41.27(2) “*a*,” the work incentive disregard described in paragraph 41.27(2) “*c*,” and diversions described in subrule 41.27(4).

(2) The excluded parent will be permitted to retain that part of the parent’s income to meet the parent’s needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described in subrule 41.27(11).

(3) All remaining income of the excluded parent will be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but is living with the parent in the home of the eligible child(ren) will be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs 41.27(8) “*b*”(1) and 41.27(8) “*b*”(3) through “*b*”(10).

(1) The stepparent’s monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, will receive a 20 percent earned income deduction.

(2) Reserved.

(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, will be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent will 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 in subrule 41.27(11), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions in subparagraphs 41.27(8) “*b*”(1), “*b*”(3), and “*b*”(4) will 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

will be determined in accordance with the FIP standard of need for a family group of the same composition.

(6) The stepparent will be allowed the work incentive disregard described in paragraph 41.27(2) “c” from monthly earnings. The disregard will be applied to earnings that remain after all other deductions in subparagraphs 41.27(8) “b”(1) and 41.27(8) “b”(3) through “b”(5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described in subparagraphs 41.27(9) “a”(2) and “a”(3).

(7) The deductions described in subparagraphs 41.27(8) “b”(1) and 41.27(8) “b”(3) through “b”(5) will first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs 41.27(8) “b”(3) through “b”(5) will be subtracted from unearned income. Any remaining income will 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 will 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 will be considered as income in the month received. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt will be considered a resource to the stepparent.

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent’s dependents living in the home who are not eligible for FIP, the income of the parent may be diverted to meet the unmet needs of the child(ren) of the current marriage except as described in subrule 41.27(11).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any child(ren) of the parent living in the home who is not eligible for FIP will be considered as one unit, and the stepparent and the stepparent’s dependents, other than the spouse, will be considered a separate unit.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent’s own self-supporting parent(s), the income of each self-supporting parent will be considered available to the eligible group after appropriate deductions. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 41.27(8) “b”(1) and 41.27(8) “b”(3) through “b”(7). Nonrecurring lump sum income received by the self-supporting parent(s) will be treated in accordance with subparagraph 41.27(8) “b”(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse will be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 41.27(8) “b”(1) and 41.27(8) “b”(3) through “b”(7). Nonrecurring lump sum income received by the spouse of the self-supporting parent will be treated in accordance with subparagraph 41.27(8) “b”(8). The self-supporting parent and any ineligible dependents of that person will be considered as one unit; the self-supporting spouse and the spouse’s ineligible dependents, other than the self-supporting parent, will be considered a separate unit.

41.27(9) Budgeting process. Both initial and ongoing eligibility and benefits will be determined using a projection of income based on the best estimate of future income.

a. Initial eligibility.

(1) At time of application, all earned and unearned income received and anticipated to be received by the eligible group during the month the decision is made will be considered to determine eligibility for the FIP, except income that is exempt. All countable earned and unearned income received by the eligible group during the 30 days before the interview will be used to project future income. If the applicant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

When income is prorated in accordance with subparagraph 41.27(9) “c”(1) and paragraph 41.27(9) “i,” the prorated amount is counted as income received in the month of decision. Allowable work expenses during the month of decision will be deducted from earned income, except when determining eligibility under the 185 percent test defined in rule 441—41.27(239B). The determination of eligibility in the month of decision is a three-step process as described in rule 441—41.27(239B).

(2) When countable gross nonexempt earned and unearned income in the month of decision, or in any other month after assistance is approved, exceeds 185 percent of the standard of need for the eligible group, the application will be rejected or the assistance grant canceled. Countable gross income means nonexempt gross income, as defined in 441—41.27(239B), without application of any disregards, deductions, or diversions. When the countable gross nonexempt earned and unearned income in the month of decision equals or is less than 185 percent of the standard of need for the eligible group, initial eligibility under the standard of need will then be determined. Initial eligibility under the standard of need is determined without application of the work incentive disregard as specified in paragraph 41.27(2) “c.” All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the standard of need for the eligible group. When countable net earned and unearned income in the month of decision equals or exceeds the standard of need for the eligible group, the application will be denied.

(3) When the countable net income in the month of decision is less than the standard of need for the eligible group, the work incentive disregard described in paragraph 41.27(2) “c” will be applied when there is eligibility for this disregard. When countable net earned and unearned income in the month of decision, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the payment standard for the eligible group, the application will be denied.

When the countable net income in the month of decision is less than the payment standard for the eligible group, the eligible group meets income requirements. The amount of the FIP grant will be determined by subtracting countable net income in the month of decision from the payment standard for the eligible group, except as specified in subparagraph 41.27(9) “a”(4).

(4) Eligibility for the FIP for any month or partial month before the month of decision will be determined only when there is eligibility in the month of decision. The family composition for any month or partial month before the month of decision will be considered the same as on the date of decision. In determining eligibility and the amount of the assistance payment for any month or partial month preceding the month of decision, income and all circumstances except family composition in that month will be considered in the same manner as in the month of decision. When the applicant is eligible for some, but not all, months of the application period due to the time limit described in subrule 41.30(1), FIP eligibility will be determined for the month of decision first, then the immediately preceding month, and so on until the time limit has been reached.

b. Ongoing eligibility.

(1) The department will prospectively compute eligibility and benefits when review information is submitted as described in 441—subrule 40.27(3). All countable earned and unearned income received by the eligible group during the previous 30 days will be used to project future income. If the participant indicates that the 30-day period is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income.

(2) When a change in eligibility factors occurs, the department will prospectively compute eligibility and benefits based on the change, effective no later than the month following the month the change occurred.

(3) Reserved.

(4) The earned income deduction for each wage earner as defined in paragraph 41.27(2) “a” and the work incentive disregard as defined in paragraph 41.27(2) “c” will be allowed.

c. Lump-sum income.

(1) Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, will be considered as income in the month received. Income received by an individual employed under a contract will be prorated over the period of the contract. Income received at periodic intervals or intermittently will be considered as income in the month received, except periodic or intermittent income from self-employment will be treated as described in paragraph 41.27(9) “i.” When the income that is subject to proration is earned, appropriate disregards, deductions and diversions will be applied to the monthly prorated income. Income that is subject to proration is prorated when a lump sum is received before the month of decision and is anticipated to recur; or a lump sum is received during the month of decision or at any time during the receipt of assistance.

(2) Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 41.26(4) and 41.26(7) and paragraphs 41.27(8) “b” and “c,” will be treated in accordance with this rule. Nonrecurring lump-sum income will be considered as income in the month received and counted in computing eligibility and the amount of the grant unless the income is exempt. Nonrecurring lump-sum unearned income is defined as a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance or workers’ compensation. When countable income, exclusive of the FIP grant but including countable lump-sum income, exceeds the needs of the eligible group, the case will be canceled or the application rejected. In addition, the eligible group will be ineligible for the number of full months derived by dividing the income by the standard of need for the eligible group. Any income remaining after this calculation will be applied as income to the first month following the period of ineligibility and disregarded as income thereafter. The period of ineligibility will begin with the month the lump sum is received.

1. When a nonrecurring lump sum is timely reported as required by 441—paragraph 40.27(4) “f,” recoupment will not be made for the month of receipt. When a nonrecurring lump sum is timely reported, but the timely notice as required by rule 441—16.2(17A) requires that the action be delayed until the second calendar month following the month of change, recoupment will not be made for the first calendar month following the month of change. When a nonrecurring lump sum is not timely reported, recoupment will be made beginning with the month of receipt.

2. The period of ineligibility will be shortened when the schedule of living costs as defined in subrule 41.28(2) increases.

3. The period of ineligibility will be shortened by the amount that is no longer available to the eligible group due to a loss or a theft or because the person controlling the lump sum no longer resides with the eligible group.

4. The period of ineligibility will also be shortened when there is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82 and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over \$25 per incident; cost of replacement of exempt resources as defined in subrule 41.26(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified. A dependent is an individual who is claimed or could be claimed by another individual as a dependent for federal income tax purposes.

5. When countable income, including the lump-sum income, is less than the needs of the eligible group, the lump sum will be counted as income for the month received. For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of ineligibility. During the period of ineligibility, individuals not in the eligible group when the lump-sum income was received may be eligible for the FIP as a separate eligible group. Income of this eligible group plus income, excluding the lump-sum income already considered, of the parent or other legally responsible person in the home will be considered as available in determining eligibility and the amount of the grant.

d. The third digit to the right of the decimal point in any computation of income and hours of employment will be dropped. This includes the calculation of the amount of a child support sanction as defined in paragraph 41.22(6) “*f.*”

e. In any month for which an individual is determined eligible to be added to a currently active FIP case, the individual’s needs will be included subject to the effective date of grant limitations as prescribed in rule 441—40.26(239B).

(1) When adding an individual to an existing eligible group, any income of that individual will be considered prospectively.

(2) The needs of an individual determined to be ineligible to remain a member of the eligible group will be removed prospectively effective the first of the following month.

f. Reserved.

g. When income received weekly or biweekly (once every two weeks) is projected for future months, it will be projected by adding all income received in the period being used and dividing the result by the number of instances of income received in that period. The result will be multiplied by four if the income is received weekly or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis will be budgeted in the same manner as the earnings of an employee. The countable income will 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 will 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 will be handled in accordance with subparagraphs 41.27(9) “*i*”(3) through “*i*”(5).

(1) When a self-employment enterprise that does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income will 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 will establish, with the cooperation of the client, a reasonable estimate that will be considered accurate and projected for three months, after which the income will be averaged and projected for the same period of time. Any changes in self-employment will be considered in accordance with subparagraphs 41.27(9) “*i*”(3) through “*i*”(5).

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, and after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department will recompute the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses will be computed on the basis of the change.

j. Special needs.

(1) A special need as defined in subrule 41.28(3) must be documented before payment will be made.

(2) A one-time special need occurs and is considered in determining need for the calendar month in which the special need is entered on the automated benefit calculation system.

(3) An ongoing special need is considered in determining need for the calendar month following the calendar month in which the special need is entered on the automated benefit calculation system.

(4) When the special need continues, payment will be included, prospectively, in each month's FIP grant. When the special need ends, payment will be removed prospectively. Any overpayment for a special need will be recouped.

k. When a family's assistance for a month is subject to recoupment because the family was not eligible, individuals applying for assistance during the same month may be eligible for the FIP as a separate eligible group. Income of this new eligible group plus income of the parent or other legally responsible person in the home will be considered as available in determining eligibility and the amount of the grant. The income of an ineligible parent or other legally responsible person will be considered prospectively in accordance with subrules 41.27(4) and 41.27(8).

41.27(10) *Aliens sponsored by individuals.* When an alien admitted for lawful permanent residence is sponsored by a person who executed an enforceable affidavit of support as described in 8 U.S.C. Section 1631(a)(1) (as amended to December 31, 2024) on behalf of the alien, the income of the alien will be deemed to include the income of the sponsor (and of the sponsor's spouse if living with the sponsor). The amount of the income of the sponsor and the sponsor's spouse deemed to the alien will be the total gross earned and unearned income remaining after allowing the earned income deduction described in paragraph 41.27(2) "a," the work incentive disregard described in paragraph 41.27(2) "c," and diversions described in subrule 41.27(4). The following are exceptions to deeming of a sponsor's income:

a. Deeming of the sponsor's income does not apply when:

(1) The sponsored alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act (as amended to December 31, 2024);

(2) The sponsored alien has earned 40 qualifying quarters of coverage as defined in Title II of the Social Security Act (as amended to December 31, 2024) or can be credited with 40 "qualifying quarters" as defined in rule 441—40.21(239B); or

(3) The sponsored alien or the sponsor dies.

b. An indigent alien is exempt from the deeming of a sponsor's income for 12 months after indigence is determined. An alien will be considered indigent if:

(1) The alien does not live with the sponsor; and

(2) The alien's gross income, including any income received from or made available by the sponsor, is less than 100 percent of the federal poverty level for the sponsored alien's household size.

c. A battered alien as described in 8 U.S.C. Section 1641(c) (as amended to December 31, 2024) is exempt from the deeming of a sponsor's income for 12 months.

41.27(11) *Restriction on diversion of income.* No income may be diverted to meet the needs of a person living in the home who has been sanctioned under subrule 41.24(8) or 41.25(5), or who has been disqualified under subrule 41.25(10) or rule 441—46.29(239B), or who is required to be included in the eligible group according to paragraph 41.28(1) "a" and has failed to cooperate. This restriction applies to paragraph 41.27(4) "a" and subrule 41.27(8).

[ARC 9277C, IAB 5/14/25, effective 7/1/25]

441—41.28(239B) Need standards.

41.28(1) *Definition of the eligible group.* The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive supplemental security income under Title XVI of the Social Security Act, as amended to December 31, 2024. There will be at least one child in the eligible group except when the only eligible child is receiving supplemental security income. The unborn child is not considered a member of the eligible group for purposes of establishing the number of people in the eligible group.

a. The following persons will be included (except as otherwise provided in these rules), without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

- b.* The following persons may be included:
- (1) The needy specified relative who assumes the role of parent.
 - (2) The needy specified relative who acts as payee when the parent is in the home, but is unable to act as payee.
 - (3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the incapacitated 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 obtained from either an independent physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on a form prescribed by the department. 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 a form prescribed by the department. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity.

41.28(2) *Schedule of needs.* The schedule of living costs represents 100 percent of 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 “standard of need” as defined in rule 441—40.21(239B). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—41.27(239B). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in and are eligible for an FIP grant. 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 assistance grant, when these needs must be determined in accordance with the “payment standard” as defined in rule 441—40.21(239B). 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
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
Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
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	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Supplies										
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communi-cations	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

- (1) Shelter: Rental, taxes, upkeep, insurance, amortization.
- (2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.
- (3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.
- (4) Food: Including school lunches.
- (5) Clothing: Including layette, laundry, dry cleaning.
- (6) Personal care and supplies: Including regular school supplies.
- (7) Medicine chest items.
- (8) Communications: Telephone, newspapers, magazines.
- (9) Transportation: Includes bus fares and other out-of-pocket costs of operating a privately owned vehicle.

b. Special situations in determining eligible group:

- (1) The needs of a child or children in a nonparental home will be considered a separate eligible group when the relative is receiving the FIP assistance for the relative's own children.
- (2) When the unmarried specified relative under age 19 is living in the same home with a parent or parents who receive the FIP, the needs of the specified relative, when eligible, will be included in the same eligible group with the parent(s). When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker will 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 will be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent(s) who receives the FIP but the specified relative is not an eligible child, need of the specified relative will 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 will be determined in the same manner as though the specified relative had attained majority. When the unmarried specified relative is under the age of 18 and living in the same home with a parent(s) who does not receive the FIP, the needs of the specified relative, when eligible, will be included in the assistance grant with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined in subrule 41.22(3), only the needs of the eligible children will be included in the assistance grant. When the unmarried specified relative is aged 18, need will be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group is receiving supplemental security income benefits, the person, income, and resources will not be considered in determining FIP benefits for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of assistance, the assistance grant will be computed on the

basis of their comprising one eligible group. This rule is not intended to mandate that an application for assistance be made for children who are not the natural or adoptive children of the applicant.

41.28(3) *Special needs.* On the basis of demonstrated need the following special needs will be allowed, in addition to the basic needs.

a. School expenses. Any specific charge, excluding tuition, for a child's education made by the school, or in accordance with school requirements in connection with a course in the curriculum, will be allowed provided the allowance will not exceed the reasonable cost required to meet the specifications of the course, and the student is actually participating in the course at the time the expense is claimed. Payment will not be made for ordinary expenses for school supplies.

b. Guardian/conservator fee. An amount not to exceed \$10 per case per month may be allowed for guardian's/conservator's fees when authorized by appropriate court order. No additional payment is permitted for court costs or attorney's fees.

[ARC 9277C, IAB 5/14/25, effective 7/1/25]

441—41.29(239B) Composite FIP/SSI cases. When persons in the FIP household, who would ordinarily be in the eligible group, are receiving supplemental security income benefits, the following subrules will apply:

41.29(1) *Pending SSI approval.* When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the FIP grant pending approval of supplemental security income.

41.29(2) *Ownership of property.* When property is owned by both the supplemental security income beneficiary and the FIP recipient, each will 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.

[ARC 9277C, IAB 5/14/25, effective 7/1/25]

441—41.30(239B) Time limits.

41.30(1) *Sixty-month limit.* Assistance will not be provided to an FIP applicant or recipient family that includes an adult who has received assistance for 60 calendar months under FIP or under any program in another state that is funded by the federal Temporary Assistance for Needy Families (TANF) block grant unless the applicant or recipient family is eligible for a hardship as defined in subrule 41.30(3). The 60-month period need not be consecutive. In two-parent households or households that include a parent and a stepparent, the 60-month limit is determined when either a parent or stepparent has received assistance for 60 months.

a. An "adult" is any person who is a parent of the FIP child in the home, the parent's spouse, or included as an optional member under subparagraph 41.28(1) "b"(1) or "b"(2).

b. "Assistance," for the purpose of this rule, will include any month for which the adult receives an FIP grant or a payment in another state using federal TANF funds that the other state deems countable toward the 60-month federal limit. Assistance received for a partial month will count as a full month.

41.30(2) *Determining number of months.*

a. In determining the number of months an adult received assistance, the department will consider toward the 60-month limit:

(1) Assistance received even when the parent is excluded from the grant unless the parent, or both parents in a two-parent household, are SSI recipients.

(2) Assistance received by an optional member of the eligible group as described in subparagraphs 41.28(1) "b"(1) and "b"(2). However, once the person has received assistance for 60 months, the person is ineligible but assistance may continue for other persons in the eligible group. The entire family is ineligible for assistance when the optional member who has received assistance for 60 months is the incapacitated stepparent on the grant as described in subparagraph 41.28(1) "b"(3).

b. When the parent, or both parents in a two-parent household, have received 60 months of FIP assistance and are subsequently approved for supplemental security income, FIP assistance for the children may be granted, if all other eligibility requirements are met.

c. When a minor parent and child receive FIP on the adult parent's case and the adult parent is no longer eligible due to the 60-month limit on FIP assistance, the minor parent may reapply for FIP as a minor parent living with a self-supporting parent.

d. In determining the number of months an adult received assistance, the department will not consider toward the 60-month limit any month for which FIP assistance was not issued for the family, such as:

(1) A month of suspension.

(2) A month for which no grant is issued due to the limitations described in rules 441—45.26(239B) and 441—45.27(239B).

e. The department will not consider toward the 60-month limit months of assistance a parent or pregnant person received as a minor child and not as the head of a household or married to the head of a household. This includes assistance received for a minor parent for any month in which the minor parent was a child on the adult parent's or the specified relative's FIP case.

f. The department will not consider toward the 60-month limit months of assistance received by an adult while living in Indian country (as defined in 18 U.S.C. Section 1151 as amended to December 31, 2024) or a Native Alaskan village where at least 50 percent of the adults were not employed.

41.30(3) *Exception to the 60-month limit.* A family may receive FIP assistance for more than 60 months as defined in subrule 41.30(1) if the family qualifies for a hardship exemption as described in this subrule. "Hardship" is defined as a circumstance that is preventing the family from being self-supporting. However, the family's safety will take precedence over the goal of self-sufficiency.

a. Reserved.

b. Eligibility determination. Eligibility for the hardship exemption will be determined on an individual family basis. A hardship exemption will not begin until the adult in the family has received at least 60 months of FIP assistance.

c. Hardship exemption criteria. Circumstances that may lead to a hardship exemption may include the following:

(1) Domestic violence. "Domestic violence" means that the family includes someone who has been battered or subjected to extreme cruelty. It includes:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual.
2. Sexual abuse.
3. Sexual activity involving a dependent child.
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities.

5. Threats of, or attempts at, physical or sexual abuse.

6. Mental abuse.

7. Neglect or deprivation of medical care.

(2) Lack of employability.

(3) Lack of suitable child care as defined in 441—subrule 93.4(5).

(4) Chronic or recurring medical conditions or mental health issues, or an accident or disease, when verified by a professional. The applicant or recipient will follow a treatment plan to address the condition or issue.

(5) Housing situations that make it difficult or impossible to work.

(6) Substance use disorder. A family requesting a hardship exemption due to substance use disorder will be required to obtain clinical assessment and follow an intensive treatment plan.

(7) Having a child whose circumstances require the parent to be in the home. This may include but is not limited to a child as defined in rule 441—170.1(237A) or a child receiving child welfare, juvenile court or juvenile justice services. The safety of the child will take precedence over the goal of self-sufficiency.

- (8) Reserved.
- (9) Other circumstances that prevent the family from being self-supporting.
- d. Eligibility for a hardship exemption.

(1) Families may be eligible for a hardship exemption when circumstances prevent the family from being self-supporting. The hardship condition shall be a result of a past or current experience that is affecting the family's current functioning. Current experience may include fear of an event that is likely to occur in the future. The definition of the hardship barrier relies upon the impact of the circumstances upon the family's ability to leave FIP rather than the type of circumstances.

(2) Families with FIA-responsible persons who are not exempt from referral as defined in subrule 41.24(2) determined eligible for more than 60 months of FIP shall make incremental steps toward overcoming the hardship and participate to their maximum potential in activities reasonably expected to result in self-sufficiency.

(3) Barriers to economic self-sufficiency that an FIA-responsible person who is not exempt as defined in subrule 41.24(2) has that were known and existing before the family reached the 60-month limit will not be considered as meeting eligibility criteria for hardship unless the individual complied with PROMISE JOBS activities offered to overcome that specific barrier.

- e. Requesting a hardship exemption.

(1) Families that have or are close to having received 60 months of assistance as defined in subrule 41.30(1) may request a hardship exemption. Requests for the hardship exemption shall be made on a hardship request form prescribed by the department. In addition, families that have received assistance for 60 months and are no longer receiving FIP shall complete an application form prescribed by the department as a condition for regaining FIP eligibility. Failure to provide the required application within ten days from the date of the department's request will result in denial of the hardship request.

(2) In families that request FIP beyond 60 months, all adults as defined in subrule 41.30(1) shall sign the request. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may sign the request.

(3) Requests for a hardship exemption will not be accepted prior to the first day of the family's fifty-ninth month of assistance. The date of the request will be the date an identifiable hardship request form prescribed by the department is received in any department or PROMISE JOBS office. An identifiable form is one that contains a legible name and address and that has been signed.

(4) To receive more than 60 months of FIP assistance, families must be eligible for a hardship exemption and meet all other FIP eligibility requirements.

(5) When an adult as defined in subrule 41.30(1) who has received assistance for 60 months joins a recipient family that has not received 60 months of assistance, eligibility will continue only if the recipient family submits a hardship request form prescribed by the department and is approved for a hardship exemption as described in subrule 41.30(3) and meets all other FIP eligibility requirements.

(6) When an adult as defined in subrule 41.30(1) joins a recipient family that is in an exemption period, the current exemption period will continue, if the recipient family continues to meet all other eligibility requirements, regardless of whether the joining adult has received FIP for 60 months.

(7) When two parents who are in a hardship exemption period separate, the remainder of the exemption period, if there is a need, will follow the parent who retains the current FIP case.

- f. Determination of hardship exemption.

(1) A determination on the request will be made as soon as possible, but no later than 30 days following the date an identifiable hardship request form prescribed by the department is received in any department or PROMISE JOBS office. A written notice of decision will be issued to the family the next working day following a determination of eligibility or ineligibility for a hardship exemption. The 30-day time standard will apply except in unusual circumstances, such as when the department and the family have made every reasonable effort to secure necessary information that has not been supplied by the date the time limit expired; or because of emergency situations, such as fire, flood or other conditions beyond the administrative control of the department.

(2) When a Financial Support Application is required to regain FIP eligibility, the 30-day time frame in rule 441—40.25(239B) will apply.

(3) Income maintenance will determine eligibility for a hardship exemption.

(4) The family shall provide supporting evidence of the hardship barrier and the impact of the barrier upon the family's ability to leave FIP. The department will advise the applicant or recipient about how to obtain necessary documents. Upon request, the department will provide reasonable assistance in obtaining supporting documents when the family is not reasonably able to obtain the documents. The type of supporting evidence is dependent upon the circumstance that creates the hardship barrier.

(5) Examples of types of supporting evidence may include:

1. Court, medical, criminal, child protective services, social services, psychological, or law enforcement records.

2. Statements from professionals or other individuals with knowledge of the hardship barrier.

3. Statements from vocational rehabilitation or other job training professionals.

4. Statements from individuals other than the applicant or recipient with knowledge of the hardship circumstances. Written statements from friends and relatives alone may not be sufficient to grant hardship status, but may be used to support other evidence.

5. Court, criminal, police records or statements from domestic violence counselors may be used to substantiate hardship. Living in a domestic violence shelter will not automatically qualify an individual for a hardship exemption, but would be considered strong evidence.

6. Actively pursuing verification of a disability through the Social Security Administration may not be sufficient to grant hardship status, but may be used to support other evidence.

(6) The department will notify the family in writing of additional information or verification that is required to verify the barrier and its impact upon the family's ability to leave FIP. The family will be allowed ten days to supply the required information or verification. The ten-day period may be extended under the circumstances described in 441—subrule 40.24(1) or 441—paragraph 40.27(4) "c." Failure to supply the required information or verification, or refusal by the family to authorize the department to secure the information or verification from other sources, will result in denial of the family's request for a hardship exemption.

(7) and (8) Reserved.

(9) Recipients whose FIP assistance is canceled at the end of the sixtieth month will be eligible for reinstatement as described in 441—subrule 40.22(5) when a hardship request form prescribed by the department is received before the effective date of cancellation even if eligibility for a hardship exemption is not determined until on or after the effective date of cancellation.

(10) When a hardship request form prescribed by the department is not received before the effective date of the FIP cancellation and a Financial Support Application is required for the family to regain FIP eligibility, the effective date of assistance will be no earlier than seven days from the date of application as described in rule 441—40.26(239B).

(11) Eligibility for a hardship exemption will last for six consecutive calendar months. Exception: The six-month hardship exemption ends when FIP for the family is canceled for any reason and a Financial Support Application is required for the family to regain FIP eligibility. In addition, when FIP eligibility depends on receiving a hardship exemption, the family shall submit a new hardship request form prescribed by the department. A new hardship exemption determination will be required prior to FIP approval.

(12) FIP received for a partial month of the six-month hardship exemption period will count as a full month.

(13) There is no limit on the number of hardship exemptions a family may receive over time.

g. Six-month FIA. Families who request a hardship exemption shall develop and sign a six-month FIA as defined in 441—93.4(239B) to address the circumstances that are creating the barrier. All adults as defined in subrule 41.30(1) shall sign the six-month FIA unless the adult is a stepparent and is not requesting assistance or is exempt as specified at subrule 41.24(2).

(1) The six-month FIA shall contain specific steps to enable the family to make incremental progress toward overcoming the barrier. Each subsequent hardship exemption will require a new six-month FIA. Failure to develop or sign a six-month FIA will result in denial of the family's hardship exemption request.

(2) Families that request a hardship exemption will be notified verbally and will be hand-issued the notice of a scheduled appointment for orientation and FIA development. If the notice of appointment cannot be hand-issued, at least five working days will be allowed from the date the notice is mailed for a participant to appear for the scheduled appointment for orientation and FIA development unless the participant agrees to an appointment that is scheduled to take place in less than five working days.

(3) Failure to attend a scheduled interview when required, except for reasons beyond the adult's control, will result in a denial of the family's hardship exemption request. In two-parent families, both parents will be required to participate in any scheduled interview. When the adult is incompetent or incapacitated, someone acting responsibly on the adult's behalf may participate in the interview.

(4) PROMISE JOBS staff shall provide necessary supportive services as described in 441—Chapter 93 and shall monitor the six-month FIA. Periodic contacts shall be made with the family to monitor progress. These contacts need not be in person. Time and attendance reports shall be required as specified in 441—subrule 93.10(2).

(5) The six-month FIA shall be renegotiated and amended under the circumstances described in 441—subrule 93.4(8).

(6) Any family that is not exempt from referral as defined in subrule 41.24(2), that has been granted a hardship exemption, and that does not follow the terms of the family's six-month FIA will have chosen an LBP in accordance with 441—Chapter 41 and 441—Chapter 93.

h. Any family that is denied a hardship exemption may appeal the decision as described in 441—Chapter 2506.

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CHAPTER 46 OVERPAYMENT RECOVERY

[Prior to 7/1/83, Social Services[770] Ch 46]

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

[Rescinded IAB 2/12/97, effective 3/1/97]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—46.1 to 46.20 Reserved.

441—46.21(239B) Definitions.

“*Agency error*” in overpayments means:

1. The same circumstances as described in 441—subrule 45.24(1) pertaining to underpayments, or

2. Any error that is not a client or procedural error.

“*Client*” means a current or former applicant or recipient of the family investment program.

“*Client error*” means and may result from:

1. False or misleading statements, oral or written, regarding the client’s income, resources, or other circumstances that may affect eligibility or the amount of assistance received;

2. Failure to timely report changes in income, resources, or other circumstances as required by rule 441—40.27(239B);

3. Failure to refund to child support services any nonexempt payment from the absent parent received after the date the decision on eligibility was made; or

4. Access of benefits issued via the electronic access card at a prohibited location pursuant to 441—subrule 41.25(11).

“*Overpayment*” means any assistance payment received in an amount greater than the amount the eligible group is entitled to receive or the amount of any payment accessed and any associated fees for accessing the benefits at a prohibited location pursuant to 441—subrule 41.25(11).

“*Procedural error*” means a technical error that does not in and of itself result in an overpayment. Procedural errors include:

1. Failure to secure a properly signed application at the time of initial application or reapplication.

2. Failure to secure a properly signed form prescribed by the department to request FIP beyond 60 months as described in 441—subrule 41.30(3).

3. Failure of the department to conduct the interviews described in 441—subrules 40.24(2) and 40.27(1).

4. Failure to request a review form prescribed by the department at the time of a semiannual or annual review.

5. Failure of department staff to cancel the family investment program benefits when the client submits a review form prescribed by the department that is not complete as defined in 441—paragraph 40.27(4)“b.” However, overpayments of grants as defined above based on incomplete reports are subject to recoupment.

“*Recoup*” means reimburse, return, or repay an overpayment.

“*Recoupment*” means the repayment of an overpayment, either by a payment from the client or an amount withheld from the assistance grant or both.

[ARC 9260C, IAB 5/14/25, effective 7/1/25]

441—46.22(239B) Monetary standards.

46.22(1) *Amount subject to recoupment.* All family investment program overpayments will be subject to recoupment.

46.22(2) *Grant issued.* When recoupment is made by withholding from the family investment program grant, the grant issued will be for no less than \$10.

[ARC 9260C, IAB 5/14/25, effective 7/1/25]

441—46.23(239B) Notification and appeals. All clients will be notified by the department of inspections, appeals, and licensing, as described in 441—subrule 11.2(2), when it is determined that an overpayment exists. Notification will include the amount, date and reason for the overpayment. The department will provide additional information regarding the computation of the overpayment upon the client's request. The client may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—Chapter 2506.

[ARC 9260C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—46.24(239B) Determination of overpayments. All overpayments due to agency or client error or due to assistance paid pending an appeal decision will be recouped. A procedural error alone does not result in an overpayment.

46.24(1) Agency error. When an overpayment is due to an agency error, recoupment will be made, including those instances when errors by the department prevent the requirements in 441—subrule 41.22(6) or 41.22(7) from being met or when the client receives a duplicate grant.

a. An overpayment of any amount is subject to recoupment with one exception: when the client receives a grant that exceeds the amount on the most recent notice from the department, recoupment will be made only when the amount received exceeds the amount on the notice by \$10 or more.

b. An overpayment due to agency error will be computed as if the information had been acted upon timely.

46.24(2) Assistance paid pending appeal decision. Recoupment of overpayments resulting from assistance paid pending a decision on an appeal hearing will begin no later than the month after the month in which the final decision is issued.

46.24(3) Client error.

a. An overpayment due to client error will be computed as if the information had been reported and acted upon timely.

b. Overpayments due to failure to refund payments received from the absent parent will be the total nonexempt support payment made for members of the eligible group at the time the support payment was received. In addition, assistance payments made to meet the needs of the eligible group may also be subject to recoupment under provisions in 441—subrule 41.22(6).

c. An overpayment due to a recipient's accessing benefits via the electronic access card at a prohibited location will be the total of the transactions and any associated fees for accessing the benefits at the prohibited location pursuant to 441—subrule 41.25(11).

46.24(4) Failure to cooperate. Failure to cooperate in the investigation of alleged overpayments will result in ineligibility for the months in question and the overpayment will be the total amount of assistance received during those months.

[ARC 9260C, IAB 5/14/25, effective 7/1/25]

441—46.25(239B) Source of recoupment. Recoupment will be made from basic needs. The minimum recoupment amount will be the amount prescribed in subrule 46.25(3). Regardless of the source, the client may choose to make a lump sum payment, make periodic installment payments when an agreement to do this is made with the department of inspections, appeals, and licensing, or have repayment withheld from the grant. The client shall sign a form prescribed by the department when requested to do so by the department of inspections, appeals, and licensing. When the client fails to make the agreed upon payment, the agency will reduce the grant.

46.25(1) and 46.25(2) Reserved.

46.25(3) Basic needs.

a. Recoupment by withholding from basic needs for overpayments due to client error or a combination of client and agency errors will be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

b. Recoupment by withholding from basic needs for overpayments due to the continuation of benefits pending a decision on an appeal as provided under 441—Chapter 2506 or a combination

of continued benefits and agency or client errors will be 10 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

c. Recoupment by withholding from basic needs for overpayments due to agency error will be 1 percent of the basic needs standard in accordance with the schedule in 441—subrule 41.28(2).

[ARC 9260C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—46.26 Reserved.

441—46.27(239B) Procedures for recoupment.

46.27(1) Reserved.

46.27(2) *Referral.* When the department determines that an overpayment exists, the case will be referred to the department of inspections, appeals, and licensing for investigation, recoupment, or referral for possible prosecution.

46.27(3) Reserved.

46.27(4) *Change of circumstances.* When financial circumstances change, any agreement to pay a debt is subject to revision.

46.27(5) *Collection.* Recoupment for overpayments will be made from the parent or nonparental relative who was the caretaker relative, as defined in 441—subrule 41.22(3), at the time the overpayment occurred. When both parents were in the home at the time the overpayment occurred, both parents are equally responsible for repayment of the overpayment.

46.27(6) *Suspension and waiver.* Recoupment will be suspended on nonfraud overpayments when the case is canceled and the amount of the overpayment is less than \$35. If the case is reopened within three years, recoupment is initiated again. Recoupment will be waived on nonfraud overpayments of less than \$35 that have been held in suspense for three years.

[ARC 9260C, IAB 5/14/25, effective 7/1/25]

441—46.28 Reserved.

441—46.29(239B) Fraudulent misrepresentation of residence. A person convicted in a state or federal court, or in an administrative hearing, of having made a fraudulent statement or representation of the person's place of residence in order to receive assistance simultaneously from two or more states will be ineligible for assistance for ten years. For the purpose of this rule, the term "assistance" means assistance under Titles IV-A or XIX of the Social Security Act, as amended to December 31, 2024, or the Food Stamp Act of 1977, as amended to December 31, 2024, or benefits in two or more states under the Supplemental Security Income program under Title XVI. The ten-year period begins on the date the person is convicted. The prohibition does not apply to a convicted person who is pardoned by the President of the United States, beginning with the month after the pardon is given.

[ARC 9260C, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 239B.2, 239B.3, 239B.7, and 239B.14.

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 [Editorial change: IAC Supplement 6/10/26]

CHAPTER 47 DIVERSION INITIATIVES

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—47.1 to 47.20 Reserved.

441—47.21(239B) Definitions.

“Appropriate responsible administrator” means the administrator of the department of workforce development’s division of workforce development center administration, or the administrator’s designee.

“Candidate” means anyone expressing an interest in the family self-sufficiency grants program.

“Family” means “assistance unit” as defined in rule 441—40.21(239B).

“Family investment program” or *“FIP”* means the cash grant program provided by 441—Chapters 40 and 41, designed to sustain Iowa families.

“Family self-sufficiency grants” or *“FSSG”* means the payments made to specific PROMISE JOBS participants, to vendors on behalf of specific PROMISE JOBS participants, or for services to specific PROMISE JOBS participants.

“Immediate, short-term assistance” means that assistance provided under this chapter will be authorized upon determination of need and that it will not occur on a regular basis.

“Iowa workforce development” or *“IWD”* means the agency that develops and administers employment, placement and training services in Iowa and is contracted by the department to administer PROMISE JOBS services statewide.

“IWD service delivery area” means the Iowa workforce development service delivery areas designated to provide PROMISE JOBS services.

“Local plan for family self-sufficiency grants” means the written policies and procedures for administering the grants for families as set forth in the plan developed by the PROMISE JOBS IWD service delivery area as described in rule 441—47.26(239B).

“Participant” means anyone receiving assistance under this chapter.

“PROMISE JOBS contract” means the agreement between the department and Iowa workforce development regarding delivery of PROMISE JOBS services.

“PROMISE JOBS participant” means any person receiving services through PROMISE JOBS. A PROMISE JOBS participant must be a member of an eligible FIP household.

“Promoting independence and self-sufficiency through employment, job opportunities, and basic skills (PROMISE JOBS) program” means the department’s work and training program as described in 441—Chapter 93.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

441—47.22(239B) Availability of the family self-sufficiency grants program. The family self-sufficiency grants program will be available statewide.

47.22(1) The program will be available for use by the IWD service delivery areas. Under the PROMISE JOBS contract, IWD shall allocate the funds available for authorization to each of the service delivery areas based on the allocation standards used for PROMISE JOBS service delivery purposes.

47.22(2) The department retains the funds that are released through the PROMISE JOBS expense allowance authorization system.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

441—47.23(239B) General criteria. Family self-sufficiency grants candidates shall be PROMISE JOBS participants. Participation in the family self-sufficiency grants program is voluntary and will be based on an informed decision by the family. Further, candidates must have identifiable barriers to

obtaining or retaining employment that can be substantially addressed through the assistance offered by family self-sufficiency grants.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

441—47.24(239B) Assistance available in family self-sufficiency grants. Family self-sufficiency grants will be authorized for removing an identified barrier to self-sufficiency when it can be reasonably anticipated that the assistance will enable PROMISE JOBS participant families to obtain or retain employment in the two full calendar months following the date of authorization of payment. For example, if a payment is authorized on August 20, it should be anticipated that the participant can find employment in September or October.

47.24(1) *Employment does not occur.* If employment does not occur in the anticipated two-calendar-month period or if the participant loses employment in spite of the self-sufficiency grant, no penalty is incurred and no overpayment has occurred.

47.24(2) *Types of assistance.* The department, in conjunction with IWD, will determine those barriers to self-sufficiency that can be considered for family self-sufficiency grants such as but not limited to auto maintenance or repair, licensing fees, child care, and referral to other resources, including those necessary to address questions of domestic violence. The IWD service delivery areas will have the opportunity to adjust the list of approvable barriers to self-sufficiency based on local resources and circumstances. These adjustments will be approved by the department and the appropriate responsible administrator prior to implementation.

47.24(3) *Limit on assistance.* The total payment limit per FIA-responsible person is \$1,000 per year. A year for a family will be the 12 fiscal months following the date of authorization of the initial payment for the family. A fiscal month begins and ends in different calendar months.

47.24(4) *Frequency of assistance.* Family self-sufficiency grants are intended to provide immediate and short-term assistance and must meet the criteria in this rule. While a family may be a candidate more than once and may receive payments in consecutive months in some circumstances, payments will not be established as regular or ongoing.

47.24(5) *Supplanting.* Family self-sufficiency grants will not be used for services already available through the department, PROMISE JOBS, or other local resources at no cost.

47.24(6) *Relationship to the family investment agreement.* Family self-sufficiency grants are separate from the PROMISE JOBS family investment agreement process. While the family investment agreement must be honored at all times and renegotiated and amended if family circumstances require it, no family will be considered to be choosing the limited benefit plan if the family chooses not to participate in the family self-sufficiency grant program.

47.24(7) *Issuing payments.* Family self-sufficiency grants are PROMISE JOBS benefits and will be authorized through the PROMISE JOBS expense allowance system. Payments may be issued to the participants or to a vendor for support services provided to the family. The department in conjunction with the appropriate responsible administrator will have discretion in determining method of payment. The IWD service delivery area will have the opportunity to adjust these payment options in an individual case based on circumstances and needs of the family with the approval of the department and the appropriate responsible administrator prior to implementation.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

441—47.25(239B) Application, notification, and appeals.

47.25(1) *Application elements.* Each IWD service delivery area shall use the established application form to be completed by the PROMISE JOBS participant and the PROMISE JOBS worker when the participant asks to be a candidate for a family self-sufficiency grant. The application form must contain the following elements:

- a. An explanation of family self-sufficiency grants and the expectations of the program.
- b. Identification of the family and the person representing the family.
- c. A clear description of the barrier to self-sufficiency to be considered.

d. Demonstration of how removing the barrier is related to obtaining or retaining employment, meeting the criteria in rule 441—47.24(239B).

e. Demonstration of why the department, PROMISE JOBS, or community resources cannot deal with the barrier to self-sufficiency.

f. Anticipated cost of removing the barrier to self-sufficiency.

47.25(2) *Notification process.* PROMISE JOBS shall use a form prescribed by the department to notify the candidate of the PROMISE JOBS decision regarding the family self-sufficiency grant. Decisions shall be in accordance with policies of this chapter and the local plan.

a. On approval, the form shall indicate the amount of the benefit that will be issued to the candidate or paid to a vendor, or the service that will be provided to the family.

b. On denial, the form shall indicate the reason for denial.

47.25(3) *Appealable actions.* The PROMISE JOBS decisions on family self-sufficiency grants may be appealed pursuant to 441—Chapter 2506. Copies of the local plan as described in rule 441—47.26(239B) shall be included with the appeal summary.

47.25(4) *Nonappealable actions.* PROMISE JOBS participants will not be entitled to an appeal hearing if the sole basis for denying, terminating or limiting assistance from family self-sufficiency grants is that self-sufficiency grant funds have been reduced, exhausted, eliminated, or otherwise encumbered.

[ARC 9261C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—47.26(239B) *Approved local plans for family self-sufficiency grants.* Each IWD service delivery area shall create and provide to the department the written policies and procedures for administering family self-sufficiency grants. The plan will be reviewed for required elements and quality of service to ensure that it meets the purpose of the program and approved by the department and the appropriate responsible administrator. The written policies and procedures shall be available to the public at county offices and PROMISE JOBS offices. At a minimum, these policies and procedures shall contain or address the following:

47.26(1) *A plan overview.* The plan overview shall contain a general description detailing:

a. Any types of services or assistance that will be excluded from consideration for family self-sufficiency grants by the IWD service delivery area.

b. How determinations will be made that the service or assistance requested meets the program's objective of helping the family obtain or retain employment.

c. How determinations will be made that the proposed family self-sufficiency grant is not supplanting as required in subrule 47.24(5).

d. Services established and any maximum (and minimum, if any) values of payments of the services established by the IWD service delivery area.

e. Verification procedures or standards for documenting barriers, using written notification policies found in rule 441—93.10(239B).

f. Verification procedures or standards for documenting employment attempts if not already tracked by PROMISE JOBS procedures, using policies found in rule 441—93.10(239B).

g. How applications will be processed timely to address barriers to obtaining or retaining employment.

h. Follow-up procedures on participant effort.

i. Procedures for tracking of family self-sufficiency grant authorizations in order to stay within the amount allocated.

j. How staff will be trained to administer the program.

47.26(2) *Intake and eligibility determination.* The policies and procedures shall describe:

a. How families most likely to benefit from self-sufficiency grant assistance are identified.

b. How families can apply for self-sufficiency grant assistance.

c. How families will be informed of the availability of self-sufficiency grant assistance, its voluntary nature, and how the program works.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

441—47.27(239B) Evaluation of family self-sufficiency grants. The department, in conjunction with IWD, will develop an evaluation plan. The evaluation plan will:

1. Describe tracking procedures.
2. Describe the plan for evaluation.
3. Describe how measurable results will be determined.
4. Identify any support needed to conduct an evaluation.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

441—47.28(239B) Recovery of FSSG overpayments. An overpayment exists when an item(s) for which the funds were awarded was not purchased, a duplicate payment was issued or when, according to receipts, the item(s) purchased costs less than the funds received. For purposes of overpayment and recovery, an FSSG payment is considered a PROMISE JOBS expense payment and is subject to rule 441—93.12(239B), recovery of PROMISE JOBS expense payments.

[ARC 9261C, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 234.6 and 239B.11.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 49
FAMILY DEVELOPMENT AND SELF-SUFFICIENCY (FaDSS) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—49.1(216A) Definitions. As used in these rules, unless the context otherwise requires:

“*Applicant*” means a public or private organization that applies for a family development and self-sufficiency grant through the request for proposal process.

“*Council*” means the council on health and human services.

“*Grant*” means an award approved by the council to fund a family development and self-sufficiency project.

“*Grantee*” means an applicant whose proposal is selected by the council and who enters into a grant agreement with the department.

“*Program*” or “*FaDSS program*” means the family development and self-sufficiency (FaDSS) program.

“*Proposal*” or “*grant proposal*” means an application for grant funds to fund specific projects.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.2(216A) Identification of conditions and criteria for families at risk. The council has identified the following conditions and criteria that may place families at risk of instability or of long-term dependency on the family investment program:

49.2(1) *Educational level of head of household.*

- a. Head of household has less than a high school education.
- b. Head of household lacks basic literacy skills.

49.2(2) *Work experience of head of household.*

- a. Head of household has never been employed.
- b. Head of household has multiple episodes of employment lasting less than one year.
- c. Head of household is currently unemployed.

49.2(3) *Household composition.*

- a. Members are homeless or nearly homeless.
- b. Members outside the nuclear family are in residence.
- c. One or more children in the household were born while the parent received public assistance.
- d. One or more children in the household are identified as having special needs.
- e. Household includes a family member with substantiated substance use issues.
- f. Household includes a past or current perpetrator of child abuse or domestic violence.
- g. Household includes a member with a record of incarceration.

49.2(4) *Background of head of household.*

- a. Head of household was a teenager at birth of first child.
- b. Head of household has a disability or chronic illness (mental or physical).
- c. Head of household is a past or current victim of child abuse or domestic violence.
- d. Head of household grew up in a household with substance abuse.

49.2(5) *Public assistance history.*

- a. Head of household grew up in a household that received public assistance.
- b. Household has experienced multiple episodes of receipt of public assistance.
- c. Household has been on public assistance for three or more years.

49.2(6) *Other conditions.* The council has also identified the following conditions that may contribute to instability or long-term dependency:

- a. Lack of employment opportunity.
- b. Lack of available services.
- c. Lack of transportation.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.3(216A) Referral of families. Families who meet one or more of the conditions and criteria identified in rule 441—49.2(216A) may be referred to the program by the department, the department of workforce development, family self-referral, or other sources. Grantees will determine eligibility for the program in accordance with the eligibility criteria determined by the department.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.4(216A) Funding of grants.

49.4(1) Availability of funds. The council will develop requests for proposals for the awarding of grants, subject to availability of funds. Grants will not exceed 60 months; however, the department will approve grantee budgets on an annual basis, based upon and subject to available funds.

49.4(2) Grant application process. The department will distribute applications for grants through a request for proposal. Applications shall be submitted to the department in accordance with the instructions indicated in the request for proposal.

49.4(3) Grant proposals. Grant proposals for the program must include all elements outlined in the application as determined by the council.

49.4(4) Selection of grant proposals. All proposals timely received will be reviewed by the department, which will make recommendations to the council. The council will review the projects recommended by the department and make the final decision with respect to grant awards.

49.4(5) Notification of applicants. Applicants will be notified of grant award decisions within 60 days after the due date for receipt of proposals.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.5(216A) Grants not renewed and grants terminated or reduced. If the council determines that a grantee's project funding will not be renewed or if the council terminates or reduces a grantee's funding, the balance of funds not renewed or terminated or reduced will be awarded by the council to other grantees for which funding is approved, based on criteria approved by the council. In the event no previously approved grantees have been selected, the council will fund new grantees selected by the council as a result of a competitive grant application process.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.6(216A) Appeal.

49.6(1) Applicants dissatisfied with the council's actions regarding grant proposals for funds and grantees dissatisfied with termination of a contract may appeal the council's decision in accordance with 441—Chapter 2506.

49.6(2) In the case of a grant award, no disbursements will be made to a grantee for a period of ten calendar days following issuance of the notice of decision to award. If an appeal is filed within the ten days, all disbursements will be held pending a final decision on the appeal. All applicants will be notified if an appeal is filed.

[ARC 9147C, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—49.7(216A) Contract with grantee. Funds for grants approved by the council will be awarded pursuant to a contract entered into by the department and the grantee.

49.7(1) Negotiation. The department will conduct contract negotiations with the selected applicant, including negotiations regarding possible modifications to a grant proposal.

49.7(2) Withdrawal of contract offer. If the applicant and the department are unable to successfully negotiate a contract, the council may withdraw the award offer and award the grant to the applicant with the next highest-scoring proposal.

49.7(3) Contract revisions. The department and the grantee may negotiate revisions to the contract to allow for nonmaterial expansion or modification of services so long as such revisions do not increase the total amount of the grant. The department has the right to approve an amendment to the contract budget moving grant funds between budget line items if the funds represent more than

10 percent of the budget line item. All contract amendments will be granted at the discretion of the department in accordance with the terms set forth in the contract.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.8(216A) Grantee responsibilities. The grantee will be responsible for providing services in accordance with the policies and procedures set forth in the FaDSS program manual as amended to August 1, 2024; the grant contract; and any other guidance from the department.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

441—49.9(216A) Evaluation. The grantee will be evaluated by the department in accordance with the continuous quality improvement plan developed by the department.

[ARC 9147C, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 216A.107.

[Filed ARC 9147C (Notice ARC 8535C, IAB 12/11/24), IAB 4/30/25, effective 7/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 51 ELIGIBILITY

[Prior to 7/1/83, Social Services[770] Ch 51]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—51.1(249) Definitions.

“Administrative overpayment” means assistance incorrectly paid to or for the client because of continuing assistance during the appeal process.

“Agency error” means 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 local office.
6. Failure to make prompt revisions in payment following changes in policies requiring the changes as of a specific date.

“Client” means a person who has been determined eligible and is a current or former recipient of state supplementary assistance.

“Client error” means 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. It also means assistance incorrectly paid to or for the client because of failure by the client or client’s representative to timely report changes as described in 441—Chapter 76.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.2(249) Application for other benefits. An applicant or any other person whose needs are included in determining the state supplementary assistance payment must have applied for or be receiving all other benefits, including supplemental security income or the family investment program, for which the person may be eligible. The person must cooperate in the eligibility procedures while making application for the other benefits. Failure to cooperate shall result in ineligibility for state supplementary assistance.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.3(249) Supplementation. Any supplemental payment made on behalf of the recipient from any source other than a nonfederal governmental entity will be considered as income, and the payment will be used to reduce the state supplementary assistance payment.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.4(249) Eligibility for residential care.

51.4(1) Licensed facility. Payment for residential care can only be made when the facility in which the applicant or recipient is residing is currently licensed by the department of inspections, appeals, and licensing pursuant to laws governing health care facilities.

51.4(2) Physician’s statement. Payment for residential care must be made only when there is on file an order written by a physician certifying that the applicant or recipient being admitted requires residential care but does not require nursing services. The certification will be updated whenever a change in the recipient’s physical condition warrants reevaluation, but no less than every 12 months.

51.4(3) Income eligibility. The resident is income eligible when the income according to 441—paragraph 52.1(3)“a” is less than 31 times the maximum per diem rate. Partners in a marriage who both enter the same room of the residential care facility in the same month will be income

eligible for the initial month when their combined income according to 441—paragraph 52.1(3) “a” is less than twice the amount of allowed income for one person (31 times the maximum per diem rate).

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.5(249) Dependent relatives.

51.5(1) *Income.* Income of a dependent relative must be less than the amount established by the department based on assistance standards as provided in rule 441—52.1(249). When the dependent’s income is from earnings, an exemption of \$65 will be allowed to cover work expense.

51.5(2) *Resources.* The resource limitation for a recipient and a dependent child or parent is \$2,000. The resource limitation for a recipient and a dependent spouse is \$3,000. The resource limitation for a recipient, spouse, and dependent child or parent is \$3,000.

51.5(3) *Living in the home.* A dependent relative is eligible until the dependent relative is out of the recipient’s home for a full calendar month starting at 12:01 a.m. on the first day of the month until 12 midnight on the last day of the same month.

51.5(4) *Dependency.* A dependent relative may be the recipient’s ineligible spouse, parent, child, or adult child who is financially dependent upon the recipient. A relative will not be considered to be financially dependent upon the recipient when the relative is living with a spouse who is not the recipient.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.6(249) Residence. A recipient of state supplementary assistance must be living in the state of Iowa.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.7(249) Eligibility for supplement for Medicare and Medicaid eligibles. The following eligibility requirements are specific to the supplement for Medicare and Medicaid eligibles:

51.7(1) *Medicaid eligibility.* The recipient must be eligible for and receiving full medical assistance benefits under Iowa Code chapter 249A without regard to eligibility based on receipt of state supplementary assistance under this rule, and without being required to meet a spend down or pay a premium to be eligible for medical assistance benefits.

51.7(2) *SSI eligibility.* The recipient must meet all eligibility requirements for supplemental security income benefits other than limits on substantial gainful activity and income.

51.7(3) *Not otherwise eligible.* The recipient must not be eligible for benefits under another state supplementary assistance group.

51.7(4) *Medicare eligibility.* The recipient must be currently eligible for Medicare Part B.

51.7(5) *Living arrangement.* A recipient may live in one of the following:

- a. The person’s own home.
- b. The home of another person.
- c. A group living arrangement.
- d. A medical facility.

51.7(6) *Income.* Income of a recipient must be within the income limit for the person’s Medicaid eligibility group, but must exceed 120 percent of the federal poverty level.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.8(249) Income from providing room and board. In determining income from furnishing room and board or providing family-life home care, the amount established by the department based on assistance standards as provided in rule 441—52.1(249) will be deducted to cover the cost, and the remaining amount will be treated as earned income.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.9(249) Furnishing of social security number.

51.9(1) As a condition of eligibility, applicants or recipients of state supplementary assistance must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

51.9(2) Assistance will not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

[ARC 9305C, IAB 5/28/25, effective 8/1/25]

441—51.10(249) Recovery.

51.10(1) *Amount subject to recovery.* The department will recover from a client all state supplementary assistance funds incorrectly expended to or on behalf of the client, or when conditional benefits have been granted.

a. The department will seek to recover the state supplementary assistance granted during the period of time that conditional benefits were correctly granted the client under the policies of the supplemental security income program.

b. The incorrect expenditures may result from client or agency error, or administrative overpayment.

51.10(2) *Notification.* All clients will be promptly notified when it is determined that assistance was incorrectly expended. Notification will include for whom assistance was paid; the time period during which assistance was incorrectly paid; the amount of assistance subject to recovery, when known; and the reason for the incorrect expenditure.

51.10(3) *Source of recovery.* Recovery will 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 must come from income, resources, the estate, income tax refunds, and lottery winnings of the client.

51.10(4) *Repayment.* The repayment of incorrectly expended state supplementary assistance funds will be made to the department.

51.10(5) *Appeals.* The client has the right to appeal the amount of funds subject to recovery under the provisions of 441—Chapter 2506.

[ARC 9305C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 249.3 and 249.4.

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CHAPTER 61
REFUGEE SERVICES PROGRAM

[Prior to 9/24/86 IAC Supp., see Refugee Service Center 715—Chapters 1 to 8]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—61.1(217) Definitions.

“*Cash assistance*” means the same as defined in 45 CFR 400 (June 7, 2022).

“*Client*” means refugees or others determined eligible for services funded under the refugee program.

“*Family self-sufficiency plan*” means a plan that addresses the employment-related service needs of the employable members in a family for the purpose of enabling the family to become self-supporting through the employment of one or more family members.

“*Individual employability plan*” means a written plan outlining an individual’s vocational goal and the services to be provided to reach the goal.

“*Iowa state refugee program plan*” means the report that describes the state of Iowa’s refugee program plan to meet the standards, goals, and priorities required under the Immigration and Nationality Act and developed by the department on the basis of a consultative process for the successful resettlement of refugees.

“*Office of refugee resettlement*” means the same as established in 8 U.S.C.A. §1521 (April 30, 1994).

“*Refugee*” means the same as defined in 8 U.S.C. §1101(a) INA 101 (a)(42) (January 5, 2023).

“*Refugee unit*” means either an individual refugee or two or more refugees representing an identifiable group, as determined by the department.

“*Resettlement agency*” means any business, organization or group of related persons having a current contract with the United States Department of State’s Bureau of Population, Refugees, and Migration for the resettlement of refugees within the United States of America.

“*Unaccompanied refugee minor*” means the same as defined in 6 U.S.C.A. §279 (December 23, 2008).

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.2(217) Authority. The department has been given authority to administer the refugee program by Executive Order Number 21, signed by the governor December 24, 1985. United States Department of State and United States Department of Health and Human Services rules govern various program operations.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.3(217) Eligibility.

61.3(1) Eligible immigration status. Refugees eligible for services are those who have a status listed under 45 CFR §400.43 (June 7, 2022) or one of the following statuses:

a. Iraqi and Afghan Special Immigrants pursuant to Section 1244(g) of Div. A of PL 110-181 (August 1, 2024) (8 U.S.C. §1157 note) and Section 602(b)(8) of Div. F of PL 111-8 (August 1, 2024) (8 U.S.C. §1101 note).

b. Victims of a severe form of trafficking in persons per the Victims of Trafficking and Violence Protection Act of 2000, PL 106-386 (August 1, 2024) and 22 U.S.C. §7105(b) (1) (A) and (C) (August 1, 2024).

61.3(2) Unaccompanied minors. In addition to the unaccompanied minors in the categories listed under subrule 61.3(1), the following are eligible for the Office of Refugee Resettlement (ORR) Unaccompanied Refugee Minors Program:

a. Unaccompanied minor with special immigrant juvenile status under 8 U.S.C. §1101(a)(27)(J) (August 1, 2024) who was in the custody of the secretary of health and human services at the time

the dependency order was granted for such child or was receiving services pursuant to Section 501(a) of the Refugee Education Assistance Act of 1980 (8 U.S.C. §1522 note (August 1, 2024)) at the time such dependency order was granted.

b. Unaccompanied minor who has been granted U status pursuant to Section 101(a)(15)(U) of the Immigration and Nationality Act (8 U.S.C. §1101(a)(15)(U) (August 1, 2024)).

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.4(217) Planning and coordinating the placement of refugees. Planning and coordinating the placement of refugees will be established in the bureau of refugee services state plan as required by the United States Department of State and United States Department of Health and Human Services.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.5(217) Services of the department available for refugees. All services provided to the refugee and family have self-sufficiency as the goal. Direct and contracted services may include:

61.5(1) *Job development.* These services involve working with employers in job development, placement, training, retention, and upgrading.

61.5(2) *Social adjustment.* These services include assessment and short-term counseling to persons or families in a perceived crisis, referral to appropriate resources, the making of arrangements for necessary services, home management services, transportation, translation and interpretation services, and case management services.

61.5(3) *Health-related services.* These services include information, referral to appropriate resources, assistance in scheduling appointments and obtaining services, and counseling to individuals or families to help them understand and identify their physical and mental health needs and maintain or improve their physical and mental health.

61.5(4) *Resettlement services.* These services involve securing and training sponsors, arranging for refugees to resettle in Iowa and providing case management, employment services, and social adjustment services.

As required under the resettlement contract with the United States Department of State, the department provides case management, employment services, and social adjustment services to the refugees it resettles during their first 90 days in Iowa.

61.5(5) *Any additional service.* These services, upon submission to and approval of the director of the office of refugee resettlement, include any additional service aimed at strengthening and supporting the ability of a refugee individual, family, or refugee community to achieve and maintain economic self-sufficiency, family stability, or community integration that has been demonstrated as effective and is not available from any other funding source.

61.5(6) *Translation and interpretation services.* These services provide interpreter service from English into the refugee languages or vice versa and assistance in translating written materials.

61.5(7) *Immigration services.* These services provide information and assistance to refugees in securing permanent resident alien status and family reunification.

61.5(8) *Adjustment of status.* These services provide guidance in obtaining permanent alien status and citizenship.

61.5(9) *Employability services.* A family self-sufficiency plan will be developed for anyone who receives employment-related services from the department. These services are specifically designed to assist refugees to obtain employment and to improve the employability of work skills of the individual and include job referral to, and job placement with, private employers. Specific employability services include:

a. Employment services, which include such activities as the development of a family self-sufficiency plan, individual employability plan, world-of-work and job orientation, job clubs, job workshops, job development, referral to job opportunities, job search, and job placement and follow-up.

b. Employability assessment services, which include such activities as aptitude and skills testing.

c. English language instruction, which includes referrals to programs that offer a curriculum that places an emphasis on English as it relates to obtaining and retaining a job and to programs that are provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

d. On-the-job training, which includes referrals to training that is provided at the employment site and is expected to result in full-time, permanent, unsubsidized employment with the employer who is providing the training.

e. Vocational training, which includes referrals to driver education and training when provided as part of an individual employability plan.

f. Skills recertification, which includes referrals to training that meets the criteria for appropriate training. If an individual is a professional in need of professional refresher training and other recertification services in order to qualify to practice the individual's profession in the United States, the training may consist of full-time attendance in a college or professional training program, provided that such training:

- (1) Is approved as part of the individual's employability plan by the state agency, or its designee;
- (2) Does not exceed one year's duration (including any time enrolled in such program in the United States prior to the refugee's application for assistance);
- (3) Is specifically intended to assist the professional in becoming relicensed in the professional's profession; and
- (4) If completed, can realistically be expected to result in such relicensing. This training may only be made available to individuals who are employed.

g. Child care, which includes referrals to child care necessary for participation in an employability service or for the acceptance or retention of employment.

h. Transportation when necessary for participation in an employability service or for the acceptance or retention of employment.

i. Translation and interpretation services when necessary in connection with employment or participation in an employability service.

j. Case management services for refugees who are considered employable and for recipients of public assistance who are considered employable, provided that the services are directed toward a refugee's attainment of employment as soon as possible after arrival in the United States.

k. Assistance in obtaining employment authorization documentations.

l. Referral to Iowa workforce development for provision of any or all of the above services.

61.5(10) Outreach services. These services include activities designed to familiarize refugees with available services, to explain the purpose of these services, and to facilitate access to these services.

61.5(11) Referral. These services enable referral of refugee clients to mainstream service systems.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.6(217) Provision of services.

61.6(1) Priority of services. Services are provided to refugees in the following order of priority, except in certain individual extreme circumstances:

- a. Refugees who are receiving cash assistance.
- b. Unemployed refugees who are not receiving cash assistance.
- c. Employed refugees in need of services to retain employment or to attain economic independence.
- d. All newly arriving refugees in the United States who apply for services during the five-year period from their date of arrival.

61.6(2) *Limitations on eligibility.* Services as described in rule 441—61.5(217) may be provided in the first 60 months of resettlement unless the Office of Refugee Resettlement grants an exception to the 60-month limit. Referral, interpretation, citizenship, and naturalization services may be provided to the extent feasible past 60 months of resettlement for refugees, except that refugees who are receiving employability services, as defined in subrule 61.5(11), as part of an employability plan, as of September 30, 1995, may continue to receive those services through September 30, 1996, or until the services are completed, whichever occurs first, regardless of their length of residence in the United States, pursuant to 45 CFR 400 (June 7, 2022). In any case, services will first be provided for those refugees who are in the first two years of resettlement and who are in need of assistance in securing self-sufficiency.

61.6(3) *Service requirements.*

a. Services provided will be refugee-specific services that are designed specifically to meet refugee needs, except that vocational or job skills training, on-the-job training, or English language training need not be refugee specific.

b. Services will be provided, to the maximum extent feasible, in a manner that is culturally and linguistically compatible with a refugee's language and cultural background.

c. Services will be provided, to the maximum extent feasible, in a manner that includes the use of bilingual or bicultural women on service agency staffs to ensure adequate service access by refugee women.

d. The department will use its social service grants primarily for employability services designed to enable refugees to obtain jobs within one year of becoming enrolled in services in order to achieve economic self-sufficiency as soon as possible.

e. Social services may continue to be provided after a refugee has entered a job to help the refugee retain employment or move to a better job.

f. Social service grant funds may not be used for long-term training programs such as vocational training that last for more than a year or educational programs that are not intended to lead to employment within a year.

g. In planning and providing services, the department will take into account those services that a resettlement agency is required to provide for a refugee whom it sponsors in order to ensure the provision of coordinated services to refugees that are not duplicative.

h. To avoid interference with refugee employment, English language instruction and vocational training must be provided to the fullest extent feasible outside normal working hours.

i. English language instruction must be provided in a concurrent, rather than sequential, time period with employment or with other employment-related services.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.7(217) Application for services. Any person will have an opportunity to apply for services by contacting the department or any of its affiliated offices either in person, by telephone, by fax, in writing, or by contacting any department staff members. The department will determine the eligibility of each person for services. Applicants for refugee cash assistance will automatically be considered as applicants for services. The department will ensure that refugee women have the same opportunities as refugee men to participate in all services, including job placement services.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.8(217) Adverse service actions.

61.8(1) *Denial.* Services will be denied when the department determines any of the following apply:

a. The client is not in need of the service.

b. The client is not legally eligible.

c. The service is not covered in the state refugee program plan.

d. There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.

- e.* The service for which the client is eligible is currently not available.
- f.* Funding is not available to provide the service.
- g.* The client refuses to allow documentation of eligibility.
- h.* The services requested are those for which other resettlement agencies are contractually responsible.
- i.* The person requesting service has been in the United States more than 60 months and the services requested do not include referral, interpretation, citizenship, or naturalization services.

61.8(2) Termination. A service may be terminated when the department determines any of the following apply:

- a.* The need to attain the goals to which the service was directed has been achieved.
- b.* After repeated assessment, it is evident that the family or individual is unable to achieve or maintain goals set forth in the family self-sufficiency or individual employability plan.
- c.* After repeated efforts, it is evident that the client is unwilling to accept further service.
- d.* The service is no longer available in the Iowa state refugee program plan.
- e.* There is another community resource available to provide the services or a similar service free of charge to the client that will meet the client's needs.
- f.* Funding is not available to provide the service.
- g.* The person receiving service has been in the United States more than 60 months and the services the person is receiving do not include referral or interpretation services.

61.8(3) Reduction. A service may be reduced when the department determines any of the following apply:

- a.* Continued provision of service at its current level is not necessary. The department will determine the level to which the service may be reduced without jeopardizing the client's continued progress toward achieving or maintaining the goal.
- b.* Another community resource is available to provide the same or similar service to the client, at no financial cost to the client, that will meet the client's need.
- c.* Funding is not available to continue the service at the current level. The client will be reassessed to determine the level of service to be provided.

61.8(4) Notice of adverse action. In case of an action to terminate, reduce, or deny services, the department will give timely or adequate notice to the person or persons affected pursuant to 441—Chapter 16.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.9(217) Client appeals. Decisions made by the department or its designee adversely affecting its clients may be appealed according to 441—Chapter 2506.

[ARC 9148C, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—61.10(217) Refugee resettlement moneys. Money that is made available to the refugee sponsor for financial assistance in resettling the refugee unit must be spent in accordance with financial requirements and approved expenditures of the department, United States Department of State, and the state of Iowa comptroller and must go toward the benefit of the refugee unit.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.11(217) Unaccompanied refugee minors program. The department administers the unaccompanied refugee minors program under 441—Chapters 156, 112 through 116, and 202 and by federal guidelines provided by the United States Department of Health and Human Services (August 1, 2024). In consultation with other resettlement agencies, the director of the ORR determines the number of unaccompanied minors to be resettled in Iowa pursuant to 45 CFR 400 (June 7, 2022). Resettlement agencies will not bring unaccompanied minors into Iowa without the authorization of the director.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

441—61.12(217) Targeted assistance grants. “Targeted assistance grants” means United States Department of Health and Human Services formula allocation funding granted to the department for assistance to counties where, because of factors such as unusually large refugee populations (including secondary migration), high refugee concentrations, and high use of public assistance by refugees, there exists and can be demonstrated a specific need for supplementation of available resources for services to refugees.

61.12(1) Administration of targeted assistance grants. The department will make 95 percent of the total award available to the designated county except when the designated county has agreed to let the department administer the targeted assistance grant in its stead.

61.12(2) Eligibility for services under targeted assistance grants. Services funded by targeted assistance grants are limited to refugees who reside in the designated county.

61.12(3) Services and limitations for services funded by targeted assistance grants. Rules of 441—Chapter 61 are applicable to services funded by targeted assistance grants, except for subrules 61.5(5) and 61.6(1).

61.12(4) Priority of services. Services funded by targeted assistance grants will be provided in the following order of priority, except in certain individual extreme circumstances:

- (1) Cash assistance recipients, particularly long-term recipients.
- (2) Unemployed refugees who are not receiving cash assistance.
- (3) Employed refugees in need of services to retain employment or to attain economic independence.

[ARC 9148C, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code sections 217.6 and 217.41 and chapter 622A.

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CHAPTER 62 RENT REIMBURSEMENT

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—62.1(425) Eligible claimants. This rule is effective for rent reimbursement claims received by the department on or after January 1, 2023.

62.1(1) The rent reimbursement program is available to claimants who:

- a. Were at least 23 years of age or a head of household on December 31 of the base year,
- b. Were not or will not be claimed as a dependent on another person's federal or state income tax return for the base year in the case of a claimant who is not disabled or at least 65 years of age,
- c. Did not have household income in excess of the indexed amount determined pursuant to Iowa Code section 425.23(4) during the base year,
- d. Are domiciled in Iowa at the time the claim is filed or were at the time of the claimant's death, and occupied and rented the property during any part of the base year.

62.1(2) If a homestead is occupied by two or more eligible claimants, each person may file a claim based upon each person's income and each person's share of the rent paid.

62.1(3) The computed reimbursement shall be determined in accordance with the applicable schedule provided in Iowa Code section 425.23(1) as adjusted by the indexed amount determined in Iowa Code section 425.23(4).

This rule is intended to implement Iowa Code sections 425.16(2) "b," 425.17(2) and 425.23.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.2(425) Dual claims.

62.2(1) A claimant changing homesteads during the base year who will make property tax payments during the fiscal year following the base year and who also made rent payments during the base year is entitled to receive both a property tax credit and rent reimbursement.

62.2(2) Claimants must file separate claim forms for the property tax credit and the rent reimbursement with the county treasurer and the department, respectively.

62.2(3) The claims are to be based on the actual property tax due and rent constituting property tax paid, with a combined maximum of \$1,000 upon which the credit and reimbursement can be calculated.

EXAMPLE: \$800 property tax due

\$400 rent constituting property taxes paid

- a. The claim form for calculating the property tax credit must reflect the entire \$800 amount.
- b. The claim form for calculating the rent reimbursement must reflect only the remaining \$200 of the \$1,000 maximum allowance.
- c. The department will issue refund warrants for rent reimbursement claims. The county treasurer will apply the credit.

This rule is intended to implement Iowa Code section 425.24.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.3(425) Multipurpose building.

62.3(1) A multipurpose building is a building that is used for other purposes in addition to being used for living accommodations. If a portion of a homestead property is utilized for business purposes, the property is considered to be a multipurpose building.

62.3(2) The portion of the property tax due or rent constituting property tax paid attributable to the homestead only is to be used in determining the allowable credit or reimbursement. This portion is to be calculated by determining the percentage of the homestead square footage to the square footage of the entire multipurpose structure. This percentage is then to be applied to the property tax due in the current fiscal year or rent constituting property tax paid for the base year.

This rule is intended to implement Iowa Code section 425.17(8).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.4(425) Income.

62.4(1) Income includes the amount of in-kind assistance received by the claimant for housing expenses, such as federal rent subsidy payments made directly to the landlord on behalf of the claimant and energy assistance benefits received by the claimant from or through a public utility.

62.4(2) In determining income, net operating losses and net capital losses are not to be considered. If the comparison of gains and losses results in a net gain, such amount shall be considered income. If the comparison results in a net loss, the net loss shall be disregarded.

This rule is intended to implement Iowa Code section 425.17(7).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.5(425) Simultaneous homesteads. A person who rents one property and also rents another property for a simultaneous period of time is limited to claiming rent reimbursement on the property that is considered the person's domicile.

This rule is intended to implement Iowa Code section 425.17(4).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.6(425) Mobile, modular, and manufactured homes. Rent paid by an eligible claimant for occupancy of a mobile, modular, or manufactured home subject to the annual tax as provided in Iowa Code chapter 435 is subject to reimbursement regardless of how the home is taxed.

This rule is intended to implement Iowa Code section 425.17(4).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.7(425) Totally disabled.

62.7(1) A claimant is considered totally disabled only if the physical or mental impairment or impairments are of such severity that the claimant is not only unable to do work previously performed but cannot, considering the claimant's age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the claimant lives, or whether a specific job vacancy exists, or whether the claimant would be hired if the claimant applied for work.

62.7(2) For purposes of this rule, a person shall not be considered unable to engage in substantial gainful employment unless the person has attained the age of 18 on or before December 31 of the base year.

This rule is intended to implement Iowa Code section 425.17(11).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.8(425) Household. "Household" includes the claimant and the claimant's spouse if living with the claimant at any time during the base year. "Living with" does not include a temporary visit. Only one claimant per household is entitled to a reimbursement.

This rule is intended to implement Iowa Code sections 425.17(5) and 425.22.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.9(425) Homestead. A person who owns a homestead but is confined to a care facility shall be considered as occupying the owned homestead, provided the person does not lease or otherwise receive profits from others for the use of the homestead. The person shall be eligible for a property tax credit but shall not be eligible for a rent reimbursement.

This rule is intended to implement Iowa Code section 425.17(4).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.10(425) Gross rent/rent constituting property taxes paid. "Gross rent" means the total amount of rent paid for use of the homestead by the claimant.

This rule is intended to implement Iowa Code section 425.17(3).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.11(425) Leased land. An individual who owns a dwelling located on land owned by another may claim a credit of property taxes due on the dwelling and a reimbursement of rental payments made for the use of the land if the land has been assessed for taxation.

This rule is intended to implement Iowa Code section 425.17(4).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.12(425) Property: taxable status. In order for a claimant to be eligible to file a rent reimbursement claim, the property upon which the claimant resided during the base year must have been in a taxable status during the base year. If the property was taxable for only part of the base year, the rent reimbursement must be prorated accordingly (OP.ST. BD. Tax Rev. 187). However, this restriction does not apply to property that became tax exempt on or after July 1, 1986, provided the claimant received a reimbursement of rent constituting property taxes paid on the property when it was in a taxable status and continues to reside in the same property.

This rule is intended to implement Iowa Code section 425.17(4).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.13(425) Income: spouse. The income of a spouse does not have to be reported on the claimant's return unless the spouse lived with the claimant at the property upon which rent reimbursement is claimed. If the spouse lived with the claimant for only a portion of the base year, only that portion of the spouse's income that was received while living with the claimant must be reported as income on the claimant's return. If the spouse is eligible to claim reimbursement, the spouse does not have to include any income that was reported on the other claimant's (spouse's) return.

This rule is intended to implement Iowa Code section 425.17(6).

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.14(425) Common law marriage.

62.14(1) A common law marriage is a social relationship between two persons that meets all the necessary requisites of a marriage except that it was not solemnized, performed, or witnessed by an official authorized by law to perform marriages.

62.14(2) The necessary elements of a common law marriage are:

- a. A present intent of both parties freely given to become married,
- b. A public declaration by the parties or a holding out to the public that they are spouses,
- c. Continuous cohabitation together as spouses (this means consummation of the marriage), and
- d. Capability of both parties to enter into the marriage relationship.

62.14(3) No special time limit is necessary to establish a common law marriage.

This rule is intended to implement Iowa Code section 425.17.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.15(425) Audit of claim.

62.15(1) Authority. The department may investigate the eligibility of a claimant for rent reimbursement.

62.15(2) Recomputed rent reimbursement claim. If the department determines a computed rent reimbursement is in error, the department shall collect any overpayment from the claimant or reimburse the claimant for any underpayment. If a claimant fails to reimburse the department for an overpayment, the amount of overpayment shall be deducted from any future rent reimbursement to which the claimant is entitled.

This rule is intended to implement Iowa Code section 425.27.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.16(425) Extension of time for filing a claim. The granting of an extension of time for filing a claim for reimbursement does not extend the time within which or the dates on or by which eligibility requirements must be satisfied.

This rule is intended to implement Iowa Code section 425.20.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.17(425) Proration of claims. If the director or the director's designee determines that the amount of funding provided pursuant to Iowa Code section 425.39 will be insufficient to pay all rent reimbursement claims filed, the director or the director's designee will estimate the percentage at which the claims will be paid and will prorate the payment of each rent reimbursement claim by the same estimated percentage.

This rule is intended to implement Iowa Code sections 25B.7 and 425.39.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.18(425) Unreasonable hardship. In order to avoid any unreasonable hardship to a claimant, the director or the director's designee may review the facts and circumstances of the claim as set forth by the claimant. The director or the director's designee may investigate all factors related to the specific case as deemed appropriate by the director or the director's designee. If the director or the director's designee is satisfied that the claim qualifies as an undue hardship for the claimant, the claim will be approved by the director or the director's designee.

This rule is intended to implement Iowa Code section 425.37.

[ARC 9309C, IAB 5/28/25, effective 8/1/25]

441—62.19(425) Appeal. Notice of adverse action taken by the department shall be issued in accordance with 441—Chapter 16, and the right to appeal shall be given in accordance with 441—Chapter 2506.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 9309C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

[Filed ARC 6557C (Notice ARC 6382C, IAB 6/29/22), IAB 10/5/22, effective 1/1/23]

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[Editorial change: IAC Supplement 6/10/26]

TITLE VII
FOOD PROGRAMS
CHAPTER 65
SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM ADMINISTRATION
[Prior to 7/1/83, Social Services[770] Ch 65]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—65.1(234) Definitions.

“Notice of expiration” means a message printed on a form prescribed by the department, which is automatically issued to the household.

“Supplemental Nutrition Assistance Program” or *“SNAP”* means benefits provided by the federal program administered through 7 CFR Parts 270 through 283 (May 2, 2022).

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.2(234) Administration of program. SNAP will be administered in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq. (August 1, 2024); 7 CFR Parts 270 through 283 (May 2, 2022); PL 99-603 (August 1, 2024); PL 104-193 (August 1, 2024); PL 107-171 (August 1, 2024); and with 42 U.S.C. Chapter 7 (January 7, 2011). A copy of the federal law and regulations may be obtained at no more than the actual cost of reproduction by contacting the department.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.3(234) State options. The state of Iowa has selected SNAP state options that are tailored to meet the state’s operational considerations and policy preferences. These options can be viewed on the U.S Department of Agriculture website under the State Options Report.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.4(234) Treatment centers and group living arrangements. Substance use treatment or rehabilitation centers and group living arrangements shall provide a list of participating residents to the department on a monthly basis.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.5(234) Appeals. Fair hearings and appeals are provided according to 441—Chapter 2506.

[ARC 9310C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

441—65.6(234) Proration of benefits. Benefits will be prorated using a 30-day month.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.7(234) Notice of expiration issuance. Issuance of the automated Notice of Expiration will occur with the mailing of a form prescribed by the department.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.8(234) Verification. Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a face-to-face interview and additional documentation requirements in accordance with 481—Chapter 72.

Failure to cooperate with the investigations division of the department of inspections, appeals, and licensing in establishing eligibility factors will not result in denial or cancellation of the household’s SNAP benefits. The investigations division will gather as much information as possible without the client’s cooperation. If further information is needed based on those findings, a request for information must be sent to the household.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.9(234) Prospective budgeting.

65.9(1) *Weekly or biweekly income.* The department will convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program (FIP) procedures.

65.9(2) *Income averaging.* The department will average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.10(234) Effective date of change. A SNAP change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.11(234) Work requirements. As a condition of eligibility for SNAP benefits, each nonexempt household member must comply with SNAP work requirements.

65.11(1) *Deregistration.* Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.11(2) *Employment and training (E&T) program.* The department will design and operate an employment and training program with the purpose of providing SNAP participants opportunities to gain skills, training, work, or experience that will increase their ability to obtain regular employment and meet state or local workforce needs in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq. (August 1, 2024).

a. The employment and training program serves individuals who are:

(1) SNAP recipients or SNAP applicants.

(2) Not receiving FIP assistance or other cash assistance under Title IV, such as Tribal Temporary Assistance for Needy Families (TANF) or Refugee Cash Assistance.

(3) Physically and mentally able to work or will be able to work within the next one year.

b. The department or its designee shall serve as the provider of employment and training services for SNAP recipients who wish to volunteer, except for those who are also recipients of FIP benefits. Federal law prohibits FIP recipients from participating in any SNAP E&T program.

c. The program offers a range of services from basic skills to advanced occupational training in order to accommodate persons with various levels of need and abilities. The department or its designee may require a potential E&T participant to engage in aptitude or vocational testing activities when deemed necessary to determine if a component is appropriate for improving employability.

d. The E&T program will be designed in consultation with the state workforce development board or with private employers or employer organizations if the department determines the latter approach is more effective and efficient.

(1) The E&T program will be designed to include case management services and at least one or more or a combination of employment and training components.

(2) An E&T plan will be submitted to the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture annually, in accordance with 7 CFR 273.7(c)(6) (May 2, 2022), and will be amended as necessary within the required time frame prior to implementation.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.12(234) Income. In determining eligibility, the department will exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans' educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. Section 1396 2011 et seq. (August 1, 2024)) for the state's modified adjusted gross income (MAGI)-related medical assistance program, subject to subrule 65.12(4).

65.12(1) Notwithstanding anything to the contrary in these rules or regulations, the department will exclude educational income based on amounts earmarked by the institution, school, program,

or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation, and miscellaneous personal expenses (other than living expenses).

65.12(2) If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students will receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

65.12(3) For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.12(4) Certain types of student income will be treated as follows, regardless of how they are considered for MAGI-related medical assistance.

- a.* Wages are not excluded.
- b.* Federally funded work study is excluded.
- c.* State-funded work study is excluded up to the amount earmarked for educational expenses.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.13(234) Deductions. A household in which all members are homeless may choose the homeless standard deduction in place of the shelter and utility expenses deduction.

65.13(1) Households choosing this option are not required to verify shelter-related expenses.

65.13(2) Households choosing this option are not eligible to receive a shelter or utility deduction.

65.13(3) The amount of the homeless standard deduction is determined by the FNS and adjusted annually.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.14(234) Student resources. Any income excluded by rule 441—65.12(234) will be excluded from resources.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

441—65.15(234) Reinstatement. When assistance has been canceled for failure to provide requested information, assistance will be reinstated without a new application if all information necessary to establish eligibility, including verification of any changes, is provided within 14 days of the effective date of cancellation and eligibility can be reestablished. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. The effective date of assistance will be the date all information required to establish eligibility is provided.

[ARC 9310C, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement Iowa Code sections 234.12 and 234.6.

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◇ Two or more ARCs

¹ Amendments to subrules 65.30(5) and 65.130(7) and rules 65.32(234) and 65.132(234) effective 10/1/96.

² Subrules 65.8(11) and 65.108(11) effective 1/1/97.

CHAPTER 67
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
FOR WOMEN, INFANTS, AND CHILDREN (WIC)

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—67.1(135) Definitions. Definitions can be found in 7 CFR Part 246 (as amended to August 1, 2024) and state-specific definitions can be found in Iowa WIC policies and procedures. Iowa WIC policies and procedures describe the manner in which the department implements and operates all aspects of program administration within its jurisdiction in accordance with 7 CFR Part 246 (as amended to August 1, 2024), United States Department of Agriculture (USDA) policy memorandums, USDA guidance documents, and any other documents issued by USDA to implement the WIC program.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.2(135) Administration of program. The department implements the WIC program by following guidance from 7 CFR Part 246 (as amended to August 1, 2024), USDA policy memos, USDA guidance documents, and any other documents issued by USDA to implement the WIC program.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.3(135) Certification of participants. Eligibility will be determined pursuant to 7 CFR Section 246.7 (as amended to August 1, 2024), any USDA-issued documents used to implement the WIC program, and the WIC Policy and Procedure Manual (as amended to August 1, 2024).

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.4(135) Food delivery.

67.4(1) Responsibilities of department—approving or denying applications. The department will determine if applications meet mandatory specifications and may deny an application pursuant to 7 CFR Part 246 (as amended to August 1, 2024); USDA federal regulations; USDA guidance documents; or the Iowa WIC Program Vendor Guidance (as amended to August 1, 2024), Iowa WIC Program Vendor Application (as amended to August 1, 2024), and Iowa WIC Program Vendor Handbook and Agreement (as amended to August 1, 2024).

67.4(2) Responsibilities of WIC vendors.

a. A potential vendor shall make application to the department's WIC program and shall accept the obligations imposed by the signing of the Iowa WIC Program Vendor Agreement and Handbook (as amended to August 1, 2024) prior to acceptance of any WIC food instrument. To qualify as a WIC vendor, the vendor shall meet all of the criteria outlined in the Iowa WIC Program Vendor Guidance (as amended to August 1, 2024), Iowa WIC Program Vendor Application (as amended to August 1, 2024), and Iowa WIC Program Vendor Agreement and Handbook (as amended to August 1, 2024).

b. The vendor must agree to adhere to all provisions of the Iowa WIC Program Vendor Application (as amended to August 1, 2024), Iowa WIC Program Vendor Agreement and Handbook (as amended to August 1, 2024), and Iowa WIC Program Vendor Guidance (as amended to August 1, 2024).

67.4(3) Criteria for approving products for inclusion in the WIC food package.

a. A product shall meet the federal regulations governing the WIC food package.

b. If a vendor offers specialty eggs for retail sale, the vendor shall maintain an inventory of conventional eggs for retail sale sufficient to meet federal and state requirements for participation in the WIC program.

c. Products will be evaluated for use in the Iowa WIC program based on nutrient content, packaging, container size, labeling, availability to wholesale distributors, cost, and participant preference. The state reserves the right to limit the number of foods, infant formulas, exempt

infant formulas, and WIC-eligible nutritionals for the WIC-approved food list based on accessibility, availability, retail value of product, USDA recommendations, increased number of WIC participants, changes in appropriation of funds and administrative efficiency.

d. The approved food list provides more specifics on what is allowed or not allowed for each of the WIC-approved foods.

e. In addition to the criteria specified above, the department reserves the right to make changes to the criteria or further restrict the number and types of brands of any products in order to contain the cost of the food package through competitive procurement of rebate contracts or other similar means.

f. The department reserves the right to discontinue specific brand names and products if the cost is administratively burdensome for that particular product.

g. The department reserves the right to add or delete products pursuant to federal regulations.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.5(135) Education.

67.5(1) Participants who are high risk, as defined in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024) shall be seen by a licensed dietitian as described in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024) with a care plan developed as described in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).

67.5(2) To the extent that time and resources are available, nutrition education may be provided to applicants who are not eligible to receive other WIC services.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.6(135) Right to appeal—participant. Fair hearings and appeals for participants are provided pursuant to 441—Chapter 2506 and 7 CFR Section 246.9 (as amended to August 1, 2024).

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441—67.7(135) Right to appeal—local agencies. Fair hearings and appeals for local agencies are provided pursuant to 441—Chapter 2506, 7 CFR Section 246.18 (as amended to August 1, 2024), and 7 CFR Section 246.24 (as amended to August 1, 2024).

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441—67.8(135) Right to appeal—vendor. Fair hearings and appeals for vendors are provided pursuant to 441—Chapter 2506, 7 CFR Section 246.12 (as amended to August 1, 2024), and 7 CFR Section 246.18 (as amended to August 1, 2024).

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441—67.9(135) State monitoring of contract agencies. At minimum, one of the persons from the department responsible for reviewing a contract agency shall be a licensed dietitian.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.10(135) Civil rights. The Iowa WIC program shall operate in compliance with state and federal regulations and FNS Instruction 113-1 (as amended to August 1, 2024) to ensure the rights of all individuals under the WIC program.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

441—67.11(135) WIC program violation. Participants or vendors are subject to the sanctions outlined below if determined by contract agency or department staff to be guilty of abusing the WIC program or its regulations.

67.11(1) Participant violation. Violations may be reported by contract agency staff, vendors, the public, FNS staff, or department staff. All suspected cases of fraud will be investigated by the department. All sanctions will be administered by the department. Contract agencies will be notified of any actions taken against WIC participants by the department.

a. Whenever possible, the participant is contacted via telephone concerning the violation. Documentation is maintained according to procedures set forth in the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).

b. Participants who violate WIC program regulations are subject to sanction in accordance with the schedule below:

Violation	Sanction Action
1. Intentional false statement(s) or misrepresentation of income, name, residence, family size (including receiving and using benefits for children no longer in the family), medical data, pregnancy, and/or date of birth to obtain WIC benefits.	One-year disqualification and pay full restitution
2. Return of WIC benefits to vendor for unapproved food items, nonfood items, credit or cash (attempted or actual). Claim amount less than \$100. Buy, trade, exchange, transfer, sell, or offer to buy, trade, exchange, transfer, sell, or allow any other person to buy, trade, exchange, transfer, sell or offer to buy, trade, exchange, transfer or sell eWIC card/benefits for unapproved food items, nonfood items, cash or favors. Claim amount less than \$100.	Two-month disqualification and pay full restitution Subsequent violation of any claim amount: one-year disqualification and pay full restitution
3. Return of WIC benefits to vendor for unapproved food items, nonfood items, credit or cash (attempted or actual). Claim amount greater than \$100. Buy, trade, exchange, transfer, sell, or offer to buy, trade, exchange, transfer, sell or allow any other person to buy, trade, exchange, transfer, sell or offer to buy, trade, exchange, transfer, or sell WIC foods for unapproved food items, nonfood items, cash or favors. Claim amount greater than \$100.	One-year disqualification and pay full restitution
4. Creating a public nuisance or disrupting normal activities through verbal misconduct or physical disruptions at the local WIC agency, farmers market, or vendor location.	First violation: Education/counseling Second subsequent violation: Warning letter Third subsequent violation: Two-month disqualification Fourth subsequent violation: Any subsequent violation(s) will result in a one-year disqualification.
5. Verbal abuse or harassment of WIC staff, vendors, farmers market vendors and/or other WIC participants. This includes verbal abuse or harassment in person, on social media, or over the telephone.	Two-month disqualification Subsequent violation will result in a one-year disqualification.
6. Physical abuse (directly or indirectly carrying out the actual harm or threatening to do harm) of WIC staff, vendors, vendor staff, farmers market vendors, farmers market vendor staff, and/or other WIC participants.	Any violation will result in a one-year disqualification.
7. Destruction of property, theft of eWIC card(s) or theft from a local WIC agency, vendor, vendor staff, farmers market vendor, farmers market vendor staff, and/or another WIC participant.	Any violation will result in a one-year disqualification.

Violation	Sanction Action
8. Collusion with staff to improperly obtain benefits.	One-year disqualification and pay full restitution
9. Dual participation resulting from intentional misrepresentation.	One-year disqualification and pay full restitution
10. Trafficking WIC food benefits, WIC benefits, or WIC items and/or collusion with an authorized vendor.	One-year disqualification and pay full restitution
11. Other violations of this chapter or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).	As appropriate per this chapter or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).

c. Local law enforcement may be notified in appropriate cases.

d. Fifteen days' notice must be given prior to all disqualifications. In all cases, the participant must be informed of the reason for the disqualification, of the right to appeal the decision through the fair hearing process, and of eligibility to receive WIC services at the end of the disqualification period.

e. A disqualification may apply to all members of a family who are on the WIC program.

f. Violations are cumulative. However, a participant will not have sanctions assessed for committing a second violation when the second violation occurs before the participant receives notice of the first violation and the second violation is the same as the first. A participant who commits the same violation a second time following receipt of a notice for the first violation is subject to a one-year disqualification.

g. When a participant improperly received benefits as a result of intentionally making a false or misleading statement(s) or intentionally misrepresenting, concealing, or withholding facts or sells or attempts to sell benefits the participant received from the WIC program and is disqualified from the WIC program, the participant may be required to make restitution of the cash value of the improperly received or used WIC benefits. The department may establish a claim against the participant for the full value of the improperly received benefits.

(1) The department will issue a written notice of restitution and disqualification.

(2) If the participant chooses a repayment plan for claims, the department will assist in developing a payment schedule. If the participant has not paid the department directly within 30 days of the notice of restitution and disqualification, the department will pursue collection of the dollar amount owed and benefits will be discontinued until the claim is paid.

h. The department may decide not to impose a mandatory disqualification pursuant to 7 CFR Section 246.12(u)(2) (as amended to August 1, 2024). All decisions are at the discretion of the department.

i. When a disqualification period has ended, the individual disqualified may be reinstated if the individual's certification period is still current. If the individual's certification period is not current, the individual will need to complete a certification appointment.

j. The department will maintain a master list of all participant violation notices, disqualifications, and statements of restitution. The participant's notice of violation must also indicate when it is a second offense.

67.11(2) Vendor violations. There are five types of sanctions that are applied to vendors for violations of WIC program regulations: nonpayment of food instruments, issuance of violation points, temporary disqualification, permanent disqualification, and civil money penalties (CMPs).

a. Nonpayment of food instruments. If the vendor has been terminated from the WIC program and submits a claim, it will be fully denied.

b. Administrative and procedural violation points. Administrative and procedural violations are offenses to the provisions of the Iowa WIC Vendor Agreement and Handbook (as amended to August 1, 2024) that do not rise to the level of fraud against the WIC program or its participants.

(1) These violations are an indication of a vendor's inattention to or disregard of the requirements of the WIC vendor agreement. It is in the department's interest to record and consider these violations when considering whether to continue its contractual relationship with the vendor.

(2) One or more transactions prior to notification of the vendor constitute only one violation if they contain the same error.

(3) The assignment of violation points does not limit the department's right to effect stronger penalties and sanctions in cases in which there is evidence of an intentional or systematic practice of abusing or defrauding the Iowa WIC program.

Violation	Points Per Event
1. Developing and using promotional materials including stickers, tags, labels, or channel strips with the WIC service mark to identify WIC-approved foods.	5
2. Developing and using vendor-created WIC vendor identification decals to indicate vendor is an authorized vendor.	5
3. Failure to allow WIC participants to leave the vendor with WIC foods that were debited/removed from their eWIC account during a WIC transaction.	5
4. Failure to post eWIC signs in the cash register lane that has a working WIC terminal if the vendor is not integrated.	5
5. Failure to provide vendor ECR system participant receipts to WIC participants during each WIC transaction.	5
6. Failure to reimburse department for potentially overpaid food instrument or provide reasonable explanation for the cost of the food instrument.	10
7. Refusal to accept valid WIC food instruments from participants.	10
8. Discriminatory treatment of WIC participants, such as requiring WIC participants to use special checkout lanes or provide extra identification, or disallowing the use of coupons or other vendor discounts in WIC transactions that are allowed in non-WIC transactions.	10
9. Treating WIC customers differently by offering them incentive items, vendor discounts, coupons, or other promotions that are not offered to non-WIC customers.	10
10. Providing to WIC participants incentive items not prior authorized by the department.	10
11. Failure to carry out corrective action plan developed as a result of monitoring visit.	10
12. Accepting the return of food purchased with WIC food instruments for cash or credit toward other purchases.	10
13. Issuing "rain checks" or credit in exchange for WIC food instruments.	10
14. Stocking out-of-date, stale, or moldy WIC foods.	10
15. Failure to submit vendor price assessment reports as requested.	10
16. Failure to train all employees and ensure their knowledge regarding WIC program procedures set forth in the vendor's current agreement and in the current publication of the Iowa WIC program's vendor instruction booklet.	10
17. Requiring WIC participants to purchase a particular brand when other WIC-approved brands are available.	10
18. Not allowing WIC participants to use discount coupons or promotional specials to reduce the WIC food instrument amount.	10
19. Requiring to enter the PIN for the participant and/or asking for the participant's PIN.	10
20. For vendors that have special WIC prices, failure to post WIC prices on the shelf or on the package.	15
21. Contacting WIC participants in an attempt to recover funds not paid by WIC.	15
22. Providing false information on the price assessment report.	15

Violation	Points Per Event
23. Knowingly entering false information or altering information on the eWIC receipt/benefits.	10
24. Requiring other cash purchases to redeem WIC food instruments.	15
25. Failure to obtain infant and/or special needs formula from an approved source listed by the Iowa WIC program.	15
26. Offering incentive items with a value of more than \$1.99.	15
27. Scanning any UPC code that is not affixed to the actual item being purchased by the WIC participant.	20
28. Failure to allow purchase of up to the full amount of WIC foods authorized on the food instrument if such foods are available and desired by the WIC participant.	20
29. Failure to maintain minimum stocking requirements.	10
30. Other violations of this chapter or the Iowa WIC Program Vendor Agreement and Handbook or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024).	As appropriate per this chapter, the Iowa WIC Program Vendor Agreement and Handout or the Iowa WIC Policy and Procedure Manual (as amended to August 1, 2024)

c. One-year disqualification. With an administrative finding of the following patterns of sanctions, the vendor will be disqualified for one year:

(1) A pattern of allowing purchase of nonapproved food items in exchange for WIC food instruments or for foods provided in excess of those listed on the WIC food instrument (federally mandated sanction).

(2) Accumulation of 45 or more violations points within a single federal fiscal year of the agreement period (department sanction).

(3) Failure to provide access to vendor premises or in any manner to hinder, impede or misinform authorized WIC personnel in the act of conducting an on-site education, monitoring or investigation visit (department sanction).

(4) Loss of department of inspections, appeals, and licensing license (department sanction).

(5) Submitting for payment a WIC food instrument redeemed by another authorized vendor (department sanction).

(6) Threatening or verbally abusing WIC participants or authorized WIC program personnel in the conduct of legitimate WIC program transactions (department sanction).

(7) Submitting for payment WIC food instruments known by the vendor to have been lost or stolen (department sanction).

(8) Participating with other individuals, including but not limited to WIC employees, vendors, and participants, in systematic efforts to submit false claims for reimbursement of improper WIC food instrument (department sanction).

d. A vendor will be disqualified from being a WIC vendor for three years with an administrative finding of any violation detailed in 7 CFR Section 246.12(l)(iii) (as amended to August 1, 2024).

e. A vendor will be disqualified from being a WIC vendor for six years pursuant to 7 CFR Section 246.12(l)(1)(ii) (as amended to August 1, 2024).

f. The department will impose mandatory vendor sanctions pursuant to 7 CFR Section 246.12(l)(1)(i) (as amended to August 1, 2024).

g. The following does not have a point value but shall result in or extend a disqualification period:

For each month in which a vendor accepts WIC food instruments during a disqualification period, the disqualification period shall be extended by 30 days.

h. The above sanctions notwithstanding, the state of Iowa reserves the right to seek civil and criminal prosecution of WIC vendors for any and all instances of dealing in stolen or lost food instruments, trading cash and other inappropriate commodities for food instruments, or cases in which there exists evidence of a clear business practice to improperly obtain WIC funds or other practices meeting the definition of fraud as defined in 7 CFR Part 246 (as amended to August 1, 2024) or the Iowa Code.

i. A vendor shall not be entitled to receive any compensation for revenues lost as a result of any temporary or permanent disqualification.

j. A minimum of 15 days' notice is provided prior to all disqualifications, except for permanent disqualifications assessed under paragraph 73.19(2) "f," which are effective on the date of receipt of the notice of administrative action. When the department determines that an offense has occurred, a disqualification letter with supporting documentation is prepared for the WIC director's signature. The disqualification letter identifies the specific offenses that the vendor is charged with and the procedures for filing an appeal. Voluntary withdrawal from the Iowa WIC Program Vendor Agreement and Handbook to avoid a sanction is not allowed.

k. The department is responsible for issuing all warning and disqualification letters. Contract agencies are informed of all vendor correspondence regarding violations. In situations where participant violations are also involved, the contract agency is responsible for follow-up, as detailed in subrule 73.19(1).

l. Disqualification from the WIC program may result in disqualification as a retailer in SNAP pursuant to 7 CFR Section 246.12(h)(3)(xxvi) (as amended to August 1, 2024), 7 CFR Section 246.18(b)(1) (as amended to August 1, 2024), and 7 CFR Section 246.12(l)(1)(xi) (as amended to August 1, 2024).

m. The department will disqualify a vendor who has been disqualified from SNAP pursuant to 7 CFR Section 246.12(l)(1)(vii) (as amended to August 1, 2024) and 7 CFR Section 246.12(l)(1)(ix) (as amended to August 1, 2024).

n. CMPs.

(1) When the department determines that a CMP shall be imposed in lieu of disqualification for reasons specified under paragraph 73.19(2) "f" or "m," it shall use the civil money penalty formula in accordance with 7 CFR Section 246.12(k)(1)(x) (as amended to August 1, 2024) to determine the CMP.

(2) If a vendor does not pay, only partially pays, or fails to timely pay a CMP, the department will disqualify the vendor for the length of the disqualification corresponding to the violation for which the CMP was assessed. "Failure to timely pay a CMP" includes the failure to pay a CMP in accordance with an installment plan approved by the department.

(3) Money received by the state WIC agency as a result of CMPs or fines assessed against a vendor and any interest charged in the collection of these penalties and fines shall be considered as WIC program income.

[ARC 9149C, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement 42 U.S.C. Section 1786 and Iowa Code section 234.6(1).

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CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
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DIVISION I
DEFINITIONS, COVERAGE GROUPS, AND GENERAL CONDITIONS OF ELIGIBILITY

441—75.1(249A) Definitions. Unless otherwise specified, the definitions in this rule apply to 441—Chapters 74 through 88.

“*Act*” means the federal Social Security Act. All references to the Act herein are as amended to August 1, 2025.

“*Aged*” means a person 65 years of age or older.

“*Applicant*” means a person who is requesting medical assistance on the person’s own behalf or a person for whom medical assistance is requested.

“*AVS*” or “*asset verification system*” means the use of an electronic asset data source to verify assets held in banks and other financial institutions for non-MAGI.

“*Blind*” means 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.

“*Caretaker*” means an individual with whom a child is living and who assumes primary responsibility for the child’s care. For this purpose, two individuals may be considered to have assumed primary responsibility for a child’s care.

“*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.

“*Child*” means a natural or biological child, or an individual legally recognized as the child of a parent based on the conception, gestation, or birth of the child during a legal marriage; an adoptive child; or a child of an individual’s spouse (stepchild) unless parental rights have been legally terminated.

“*Client*” means all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person whose income or assets are considered in determining eligibility for an applicant or member.

“*Code of Federal Regulations*” or “*CFR*” means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

“*Community spouse*” means a noninstitutionalized spouse of an institutionalized spouse.

“*Conditionally eligible*” means that a person has been assigned but not met spenddown as defined in subrule 75.8(1), or has been assigned a monthly premium but has not yet paid the premium for that month pursuant to subparagraph 75.6(6) “b”(4).

“*Coverage group*” means a group of persons who meet certain common eligibility requirements.

“*Dependent child*” or “*dependent children*” means a child or children who meet the nonfinancial eligibility requirements of the applicable family-related coverage group.

“*Electronic data sources*” or “*EDS*” means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include the Internal Revenue Service (IRS), the Social Security Administration (SSA) and the United States Department of Homeland Security. State data sources include Iowa workforce development

(IWD) wage and unemployment compensation, SSA, IRS, and the Public Assistance Reporting Information System (PARIS).

“Family-related Medicaid” includes coverage groups that apply to children, parents and caretakers and pregnant women who are not aged, blind or disabled.

“Federal poverty level” or *“FPL”* means the levels published and updated periodically in the Federal Register by the United States Department of Health and Human Services (DHHS) under the authority of 42 U.S.C. 9902(2) and revised annually on April 1.

“General conditions of eligibility” means the eligibility criteria specified in the following provisions:

1. Rule 441—75.9(249A): furnishing of social security number.
2. Rule 441—75.10(249A): residency requirements.
3. Rule 441—75.11(249A): citizenship or alienage requirements.
4. Rule 441—75.14(249A): establishing liability and obtaining support.
5. Rule 441—75.15(249A): medical resources.
6. Rule 441—75.16(249A): medical assistance lien.
7. Rule 441—75.29(249A): investigation of eligibility.

“Income in-kind” means any gain or benefit that is not in the form of money payable directly to the applicant, member, or person whose income or assets are considered in determining eligibility for an applicant or member, including nonmonetary benefits such as meals, clothing, and vendor payments. Vendor payments are monetary payments to a third party and not to the applicant, member, or person whose income is considered in determining eligibility.

“Institutionalized person” means a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, a person 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 a person who is as described in subrule 75.6(8).

“Institutionalized spouse” means 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.

“Local office” means the county office of the department or a state mental health institute.

“Medical institution,” when used in this chapter, means a facility 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.

“Member” means any person who has been determined eligible and has been enrolled to receive medical assistance pursuant to 441—Chapter 75. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.” For the medically needy program, “member” means a person who has been determined eligible for Medicaid under the medically needy program, has been approved, and has countable income at or below the medically needy income level (MNIL) or has reduced the person’s countable income to the MNIL during the certification period through spenddown. Unless otherwise specified, a person is not a member for any month in which Medicaid for that person is subject to recoupment because the person was ineligible.

“Modified adjusted gross income” or *“MAGI”* means the tax-based methodology used to determine income eligibility and household size for family-related Medicaid and other coverage groups as prescribed by 1902(e)(14) of the Act (42 U.S.C. 1396a(e)(14) and 42 CFR 435.603).

“Non-MAGI-related” means those persons whose eligibility is determined using regulations governing the supplemental security income (SSI) program administered by the SSA, except that

income is considered prospectively. “Non-MAGI-related” also includes persons who would be eligible for SSI except for certain eligibility factors as specified in rule 441—75.6(249A).

“*Nursing facility services*” means the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rules 441—75.23(249A) and 441—75.85(249A).

“*Parent*” means a natural or biological parent, or an individual legally recognized as the parent of a child based on the conception, gestation, or birth of the child during a legal marriage; an adoptive parent; or the spouse of another parent (stepparent) unless parental rights have been legally terminated.

“*Pay and chase*” means that the state pays the total amount allowed under the department’s payment schedule and then seeks reimbursement from a liable third party. The pay and chase provision applies to Medicaid claims for preventive pediatric services and all services provided to a person for whom there is court-ordered medical support.

“*Payee*” refers to an SSI payee as defined in 20 CFR 416.601.

“*Presumptive eligibility*” means that a person is presumed to be eligible for Medicaid on a temporary basis based on statements provided by the person.

“*Presumptive Medicaid*” means immediate and temporary health care coverage based on a presumptive eligibility decision to pay for the cost of care during the presumptive period as described in subrule 75.7(4).

“*Presumptive provider*” means an organization approved by the department to conduct and authorize presumptive eligibility determinations pursuant to 441—subrule 76.7(1).

“*Qualified entity*” means an individual, under the supervision and authority of a presumptive provider, who has been determined by the department to be capable of making presumptive Medicaid eligibility determinations pursuant to 441—subrule 76.7(2).

“*Reasonably compatible*” or “*reasonable compatibility*” means the standard by which the total attested countable income or resources for each person’s household size is compared with the total amount from available EDS or AVS used by the department. Attested income or resources must meet one of the following three criteria to meet the standards for reasonable compatibility:

1. Both the total attested income or resources and the total income or resources from the EDS or AVS are above, at, or below the applicable income or resource limit for Medicaid or hawki; or
2. The total attested income is within 10 percent of the total income from EDS or the total resources are below the resource limit for the applicable program; or
3. The total attested income or resources exceeds the total income or resources from EDS or AVS.

If the attested income or resources meet any of the reasonable compatibility criteria, the income or resources are considered to be verified.

“*Reasonable opportunity period*” means the 90-day period allowed for applicants and members to provide satisfactory documentation of citizenship, nationality, or qualified alien status pursuant to subparagraph 75.11(2)“c”(4).

“*Refugee*” means the same as defined in 8 U.S.C. §1101(a) INA 101 (a)(42).

“*Retroactive period*” means the three calendar months immediately preceding the month in which an application is filed.

“*Sibling*” means an individual who shares at least one common parent with another individual.

“*Spouse*” means a party to a legally recognized marriage, including a common-law marriage.

“*Stepparent*” means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child’s parent. A stepparent is considered a parent under a coverage group that is subject to MAGI methodology pursuant to 42 CFR 435.603.

“*Supply*” or “*supplying*” means the requested information is received by the department by the specified due date.

“*Tax dependent*” means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

“Transfer of assets” means the transfer of resources or income for less than fair market value as provided in rule 441—75.23(249A).

“Unborn child” includes an unborn child during the entire term of pregnancy.

“United States Code” or *“U.S.C.”* means the general and permanent laws of the United States. All references to the U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.2(249A) Categories of persons covered. Persons who meet the criteria of one of the categorical groups below receive Medicaid if they meet the eligibility requirements of a related coverage group described in rules 441—75.3(249A) through 441—75.8(249A) and the general conditions of eligibility described within this chapter.

75.2(1) *Family-related Medicaid.* Medicaid is available to the following categories of persons who meet the eligibility requirements of one of the family-related Medicaid coverage groups described in rule 441—75.3(249A), the general conditions of eligibility specified in Division I of this chapter, and the eligibility factors specific to family-related medical assistance described in Division II of this chapter unless stated otherwise within this chapter:

- a. Children under the age of 19.
- b. Parents and caretakers.
- c. Pregnant women.
- d. Persons in foster care, a subsidized adoption arrangement, or subsidized guardianship.
- e. Former foster care youth.
- f. Persons living in a medical institution.

75.2(2) *Persons who need breast or cervical cancer treatment.* Pursuant to rule 441—75.4(249A), Medicaid is available to persons who have been screened and found to need treatment for breast or cervical cancer.

75.2(3) *Persons aged 19 through 64.* Medicaid is available to persons who are aged 19 or older and under the age of 65 who meet the eligibility requirements of the Iowa health and wellness plan (IHAWP) as described in subrule 75.5(1) and 441—Chapter 74.

75.2(4) *Persons who are refugees.* Medicaid is available to refugees who meet the requirements described in subrules 75.5(3) and 75.5(4) and who do not meet the requirements of another Medicaid coverage group or hawki.

75.2(5) *Aged, blind, or disabled persons.* The following coverage groups are available to persons who are aged, blind, or disabled and who meet the eligibility criteria of a coverage group described in rule 441—75.6(249A) and the general conditions of eligibility specified in this chapter:

- a. Persons receiving SSI or state supplementary assistance or eligible for, but not receiving, SSI.
- b. Aged, blind or disabled persons ineligible for SSI or state supplementary assistance due to income or other requirements.
- c. Certain persons essential to the welfare of an aged, blind, or disabled person.
- d. Persons residing in a medical institution.
- e. Persons participating in Medicare savings programs.
- f. Working persons with disabilities.
- g. Children with disabilities.
- h. Persons who may be eligible for additional services that are not available through regular Medicaid, and a waiver of federal policy has been approved. These are known as waiver services and are defined in 441—Chapter 83.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.3(249A) Family-related Medicaid. Medicaid will be available to children, parents and other caretakers and to pregnant women who meet the eligibility requirements of a coverage group described within this rule and the general conditions of eligibility described in this chapter.

75.3(1) *Family medical assistance program (FMAP)*. Medicaid will be available to low-income children and to the children's parent or other caretaker if the following criteria are met:

a. Children must meet the requirements described in rule 441—75.50(249A), and the parent or other caretaker must meet the requirements described in rule 441—75.51(249A).

b. Countable household income must not exceed the FMAP limits prescribed in rule 441—75.74(249A). Financial eligibility will be determined according to MAGI methodology pursuant to Division III of this chapter.

75.3(2) *Pregnant women, infants, and children (mothers and children (MAC))*. Medicaid will be available to 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) Household income must not exceed the applicable limits for the MAC program as stated in rule 441—75.74(249A).

(2) In establishing eligibility for pregnant women, infants, and children, income and household size will be determined pursuant to rule 441—75.72(249A).

(3) In establishing eligibility for a pregnant woman or any person whose MAGI household size includes a pregnant woman, the unborn child (or children) will be considered when determining the number of persons in the household. Attestation of pregnancy will be accepted in accordance with subrule 75.72(5).

b. Eligibility for pregnant women under this rule will begin no earlier than the first day of the month in which conception occurred and will continue throughout the pregnancy when requirements described in rule 441—75.18(249A) are met.

c. The effect of age on eligibility for an infant or a child will be determined pursuant to rule 441—75.52(249A).

d. When determining eligibility under this coverage group, the requirement to live with a parent or other caretaker as specified at subrule 75.50(2) and the age and school attendance provisions specified in subrule 75.50(1) do not apply.

e. A woman who was both eligible and enrolled in Medicaid on the date her pregnancy ends will be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.3(4).

f. If an infant loses eligibility under this coverage group at the time of the first birthday due to exceeding 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 will continue under this coverage group for the duration of continuous inpatient services.

75.3(3) *Newborn children*. Medicaid will 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 emergency services for labor and delivery for the child's birth. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department will accept any written or verbal statement as verification of the newborn's birth date unless the department determines the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility must be completed.

75.3(4) *Postpartum eligibility following pregnancy*. Medicaid will continue to be available for a period of 12 months beginning the first of the month following the end of pregnancy and continuing for 12 months for a woman who was both eligible and enrolled in Medicaid on the date her pregnancy ends.

a. Except as described in this subrule, the woman is not required to meet any eligibility criteria described in this chapter or the reenrollment requirements in rule 441—76.14(249A) during the 12-month postpartum period.

b. The woman will not be required to file an application.

c. Pregnant women determined eligible only for emergency services pursuant to subrule 75.11(4) are eligible under this provision.

75.3(5) *Healthy and well kids in Iowa (hawki)*. Hawki will be available to children under the age of 19 who are not eligible for Medicaid and who meet the provisions of 441—Chapter 86.

75.3(6) *Transitional Medicaid*.

a. *Eligible persons*. Transitional Medicaid will be available for a period of up to 12 months to the following persons:

(1) A dependent child who becomes ineligible for FMAP due to increased income from employment of the dependent child or the child's parent or other caretaker;

(2) The child's parent or caretaker who becomes ineligible for FMAP due to increased income from employment of the dependent child or the child's parent or other caretaker; and

(3) The following household members of persons described in subparagraph 75.3(6) "a"(1) or "a"(2) who currently meet all FMAP requirements, except for income:

1. Persons who were in the home prior to FMAP discontinuance but did not receive FMAP at the time; and

2. Persons who entered the home prior to FMAP discontinuance or during the transitional Medicaid period.

b. *Increase in income from employment*. Increased income from employment includes but is not limited to the following:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

c. *Transitional Medicaid and continuous eligibility*. Transitional Medicaid eligibility rules supersede continuous eligibility rules for a child as described in rule 441—75.19(249A).

d. *FMAP received in three of six months*. In order to receive transitional Medicaid coverage under the provisions of this subrule, at least one of the individuals described in subparagraph 75.3(6) "a"(1) or "a"(2) must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred. The months the member receives FMAP due to continuous eligibility as described in rule 441—75.19(249A) do not count toward the transitional Medicaid requirement of receiving FMAP for at least three of the last six months. If there is an increase in income from employment when a child's continuous eligibility is ending, the child will not be redetermined to the transitional Medicaid coverage group.

e. *Period of transitional coverage*. The 12 months of transitional Medicaid coverage begin the day following discontinuance of FMAP eligibility and will continue for a consecutive 12-month period without regard to income changes, subject to paragraphs 75.3(6) "g," "h," and "i."

f. Reserved.

g. *Fraud*. Transitional Medicaid will not be allowed under the provisions of this subrule when it has been determined that the member received FMAP in any of the six months immediately preceding the month of discontinuance as the result of fraud. Fraud is defined in accordance with Iowa Code section 239B.14.

h. *Eligible child*. During the transitional Medicaid period, assistance will be discontinued at the end of the first month in which there is no longer an eligible child living in the household who meets the requirements in rule 441—75.50(249A).

i. *Other conditions of eligibility*. Members must meet all applicable general conditions of eligibility described in this chapter except for the income limits described in rule 441—75.74(249A).

j. *Transitional period ends*. Transitional Medicaid will be discontinued beginning with the first month following the month in which the household no longer meets the eligibility criteria. Notice will be provided to the household in accordance with adequate and timely notice provisions as specified in rule 441—16.2(17A).

75.3(7) *Extended Medicaid*.

a. Eligible persons. Extended Medicaid will be available for a period of up to four months to the following individuals:

(1) A dependent child who becomes ineligible for FMAP due to receipt of income from alimony or other spousal support;

(2) The child's parent or caretaker who becomes ineligible for FMAP due to receipt of income from alimony or other spousal support; and

(3) The following household members of persons described in subparagraph 75.3(7) "a"(1) or "a"(2) who currently meet all FMAP requirements, except for income:

1. Persons who were in the home prior to FMAP discontinuance but did not receive FMAP at the time; and

2. Persons who enter the home prior to FMAP discontinuance or during the extended Medicaid period.

b. FMAP received in three of six months. In order to receive extended Medicaid coverage under the provisions of this subrule, at least one member must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. Period of extended coverage. The four months of extended Medicaid coverage begins the day following discontinuance of FMAP eligibility and will continue for four consecutive months, subject to paragraph 75.3(7) "f."

d. Reserved.

e. Other conditions of eligibility. Members must meet all applicable general conditions of eligibility described in this chapter except for the income limits described in rule 441—75.74(249A).

f. Extended period ends. Extended Medicaid will be discontinued beginning with the first month following the month in which the household no longer meets eligibility criteria. Notice will be provided to the household in accordance with adequate and timely notice provisions as specified in rule 441—16.2(17A).

75.3(8) *Children in foster care, subsidized adoption arrangement, or subsidized guardianship arrangement not eligible under Title IV-E or Title XVI of the Act.* Medicaid will be available to persons under the age of 21 if the following criteria are met:

a. For the child medical assistance program (CMAP), the person is in foster care or a subsidized adoption arrangement in accordance with subparagraph 75.3(8) "a"(1), "a"(2), or "a"(3) and the person is not eligible for assistance under Title IV-E or Title XVI of the Act.

(1) The person is placed in licensed foster care for which the state pays foster care maintenance payments pursuant to Iowa Code section 234.35 and rule 441—156.20(234).

(2) The person is a special needs child in an adoption assistance agreement with the department pursuant to rule 441—201.5(600), regardless of whether the adoption assistance agreement provides for adoption subsidy maintenance payments.

(3) The person is a special needs child who resides in Iowa in a private home with the child's adoptive parent(s) and is in an adoption assistance agreement with another state with which Iowa has a reciprocity agreement as follows:

1. The other state is a member of the interstate compact on adoption and medical assistance (ICAMA); and

2. The other state provides medical assistance benefits pursuant to a program funded under Title XIX of the Act under the optional group in Section 1902(a)(10)(A)(ii)(VIII) of the Act to children residing in that state (at least until aged 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 Act.

b. For the subsidized guardianship medically needy program, the person resides in Iowa in a private home pursuant to a court-approved subsidized guardianship arrangement under 441—Chapter 204 and the person is not eligible for assistance under Title IV-E or Title XVI of the Act. As authorized under 42 CFR 435.308, this reasonable classification of individuals is a separate coverage group from the medical assistance available to medically needy persons described in rule 441—75.8(249A).

c. There are no financial eligibility requirements for these coverage groups.
d. The effect of reaching age 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

e. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(9) *Children in foster care, subsidized adoption arrangement, or subsidized guardianship arrangement and eligible under Title IV-E.*

a. Medicaid will be available to a child under the age of 21 who is eligible under Title IV-E of the Act and for whom any of the following is provided:

(1) Foster care maintenance payments for a child placed in licensed foster care pursuant to Iowa Code section 234.35 and rule 441—156.20(234).

(2) Guardianship assistance pursuant to rule 441—204.4(234), regardless of whether the guardianship assistance agreement provides for guardianship subsidy maintenance payments.

(3) Adoption assistance pursuant to rule 441—201.5(600), regardless of whether the adoption assistance agreement provides for adoption subsidy maintenance payments.

b. IV-E assistance from another state. Medicaid will be available to children under the age of 21 who are eligible for federal foster care maintenance payments, adoption assistance, or guardianship assistance under Title IV-E of the Act from another state and live in Iowa, including children with an adoption or guardianship assistance agreement that does not provide for maintenance payments.

c. There are no financial eligibility requirements for these coverage groups.

d. The effect of reaching age 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

e. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(10) *State-only funded medical assistance for children in foster care or a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.*

a. When the department is responsible for foster care maintenance payments for a child placed in licensed foster care pursuant to Iowa Code section 234.35 and rule 441—156.20(234), or has negotiated an adoption assistance agreement pursuant to rule 441—201.5(600) for a child living in a private home regardless of whether the agreement provides for adoption subsidy maintenance payments, state-only funded medical assistance will be available to the child if:

(1) The child is under the age of 21, lives in Iowa, and is not otherwise eligible under a category for which federal financial participation is available; or

(2) The child is under the age of 21, lives in another state, and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the Act, notwithstanding the residency requirements of 441—75.10(249A).

b. There are no financial eligibility requirements for this coverage group.

c. The effect of reaching the age of 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

d. The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(11) *State-only funded medical assistance for children in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.*

a. When the department has negotiated a subsidized guardianship agreement for a child pursuant to 441—Chapter 204, state-only funded medical assistance will be available to the child under this subrule if the child is under the age of 21 and living in a private home pursuant to a court-approved subsidized guardianship agreement if:

(1) The child lives in Iowa and is not eligible for Medicaid 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

(2) Notwithstanding the residency requirements of rule 441—75.10(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 Act, due to reasons other than:

1. Failure to provide information, or
2. Failure to comply with other procedural requirements.
- b.* There are no financial eligibility requirements for this coverage group.
- c.* The effect of reaching the age of 21 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).
- d.* The age requirements and the requirement to live with a parent or other caretaker as provided in rule 441—75.50(249A) do not apply for persons under this coverage group.

75.3(12) *Medicaid for former foster care youth (EMIYA).* Medicaid will 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, as provided in paragraph 75.3(12)“c”) and under 26 years of age. The effect of reaching the age of 26 on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

b. The person is:

(1) Not described in and is not enrolled under any of subclauses (I) through (VII) of Section 1902(a)(10)(A)(i) of Title XIX of the Act; or

(2) 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 Medicaid under such subclause.

c. The person was in foster care as defined in Iowa Code section 232.2(20B):

(1) Under the responsibility of Iowa or a tribe within Iowa on the date of attaining 18 years of age or such higher age as described in Iowa Code section 234.1 on or prior to December 31, 2022; or

(2) Under the responsibility of any state on the date of attaining 18 years of age or such higher age as defined under Section 1902(a)(10)(A)(i) of the Act on or after January 1, 2023.

d. The person was enrolled in the Iowa Medicaid program under Title XIX of the Act on the date of attaining 18 years of age or such higher age as described in Iowa Code section 234.1 on or prior to December 31, 2022; or

e. The person was enrolled in Medicaid in any state on the date of attaining 18 years of age or such higher age as defined under Section 1902(a)(10)(A)(i) of the Act on or after January 1, 2023.

f. There are no financial eligibility requirements for this coverage group.

75.3(13) *Persons under 21 receiving care in a medical facility who would be eligible under a special income standard.* Medicaid will be available to persons under the age of 21 who meet the requirements in paragraph 75.6(4)“b.”

75.3(14) *Presumptive eligibility for family-related medical assistance.* Medicaid will be temporarily available to the following persons who are determined to be presumptively eligible for Medicaid pursuant to rule 441—75.7(249A):

a. Infants (within MAC income limits specified in rule 441—75.74(249A));

b. Children (within hawki income limits specified in 441—subrule 86.2(2));

c. Parents and other caretakers (within FMAP income limits specified in rule 441—75.74(249A));

d. Pregnant women (within MAC income limits specified in rule 441—75.74(249A)); and

e. EMIYA.

75.3(15) *Family-related medically needy.* Pursuant to rule 441—75.8(249A), Medicaid will be available to children under the age of 19 and pregnant women who would be eligible for a family-related coverage group except for excess income. The coverage group is also available to a “parent” and “caretaker” as defined in rule 441—75.1(249A) who meet the requirements described in rule 441—75.8(249A) and who would be eligible for a family-related coverage group or IHAWP except for excess income.

This rule is intended to implement Iowa Code sections 249A.3, 249A.3A and 249A.4.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.4(249A) Persons who have been screened and found to need breast or cervical cancer treatment (BCCT).

75.4(1) Medicaid is available to persons who meet the eligibility requirements described within this rule and the general conditions of eligibility described in this chapter.

a. Medicaid will be available to persons who:

(1) Are under the age of 65;

(2) Have been screened for breast or cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) established under Title XV of the Public Health Service Act as amended to August 1, 2025, and have been found to need BCCT (including a precancerous condition);

(3) 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-3(c)(1)). An individual is not considered to have creditable coverage just because the individual may receive medical services provided by the Indian Health Service, a tribal organization, or an Urban Indian Organization; and

(4) Are not eligible for Medicaid under Iowa Code section 249A.3(1).

b. Eligibility established under this subrule continues until the person is:

(1) No longer receiving BCCT;

(2) Aged 65 or older; or

(3) Covered by creditable coverage or eligible for Medicaid under Iowa Code section 249A.3(1).

c. Persons applying for this coverage group are not subject to MAGI methodologies described in Division III of this chapter. Income eligibility is determined by the NBCCEDP.

75.4(2) Presumptive eligibility. Medicaid is temporarily available to persons who have been screened for breast or cervical cancer and found to need treatment for the cancer and who are determined to be presumptively eligible for Medicaid under BCCT pursuant to rule 441—75.7(249A).

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.5(249A) Persons under age 65; refugees. Medicaid is available to persons who are under age 65 and to persons admitted to the United States as refugees who meet the eligibility requirements of a coverage group described within this rule.

75.5(1) *Iowa health and wellness plan (IHAWP).* This coverage group is available to persons who are aged 19 or older and under the age of 65 who meet the eligibility requirements of the IHAWP as described in 441—Chapter 74 and who are not eligible for Medicaid under a family-related or non-MAGI-related coverage group.

75.5(2) *Presumptive eligibility for IHAWP.* Medicaid will be temporarily available to persons who are aged 19 or older and under the age of 65 who are determined to be presumptively eligible for IHAWP medical assistance pursuant to rule 441—75.7(249A).

75.5(3) *Refugee medical assistance (RMA).* RMA is available to refugees, subject to the time limit set forth in rule 441—60.7(217) and paragraph 75.5(3)“a,” when the requirements of this rule are met and eligibility does not exist under another Medicaid coverage group or hawki.

a. The time limit begins the month of entry, regardless of which day during the month is the refugee’s date of entry. The time limit applies to each person, not to each case or household.

b. The refugee must meet the immigration status and other non-financial requirements described in 441—Chapter 60.

c. Financial eligibility will be determined according to MAGI methodology pursuant to Division III of this chapter. Countable household income must not exceed the FMAP limits prescribed at rule 441—75.74(249A).

d. For purposes of Medicaid, the refugee is not required to meet the work and training requirements specified in rule 441—60.9(217).

75.5(4) *Extended coverage for refugees.* RMA will be available to a refugee for the remainder of the time limit described in subrule 75.5(3) when the refugee, who is a member, becomes ineligible for

RMA or Medicaid under another coverage group solely due to earnings of a household member and eligibility does not exist under another coverage group.

a. A refugee will not be required to meet any minimum program participation time frames to receive RMA coverage under this subrule.

b. A person who returns to the household after the family becomes ineligible for RMA or Medicaid may be included in the extended RMA household if the person was included in the RMA or Medicaid household the month the family became ineligible for RMA or other Medicaid.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.6(249A) Aged, blind or disabled. Medicaid is available to persons who are aged, blind or disabled and who meet the eligibility requirements of a coverage group described within this rule, the general conditions of eligibility, and the eligibility factors specific to non-MAGI-related Medicaid described in Division IV unless stated otherwise within this chapter.

75.6(1) *Persons receiving SSI or state supplementary assistance; persons eligible for but not receiving SSI.*

a. SSI recipients. Medicaid will be available to all persons receiving SSI payments as authorized by the SSA under Title XVI of the Act.

b. State supplementary assistance recipients. Medicaid will be available to all recipients of state supplementary assistance as authorized by Iowa Code chapter 249, 441—Chapters 50 through 54 and 177, and Title XVI of the Act. This applies to mandatory and optional state supplementary assistance payments, whether administered by the department or the SSA.

c. Persons who meet the income and resource requirements of SSI. Medicaid will be available to aged, blind, or disabled persons as described below who meet the income and resource guidelines of SSI but who are not receiving SSI:

- (1) Aged and blind persons, as defined in rule 441—75.1(249A).
- (2) Disabled persons, as determined pursuant to rule 441—75.81(249A).
- (3) In establishing eligibility for children for this coverage group, resources of the child and ineligible parent or stepparent, regardless of age, will be disregarded.
- (4) In establishing eligibility for adults for this coverage group, resources of non-MAGI persons will be treated according to SSI policies.

d. Persons who do not receive an SSI payment but are considered as SSI recipients. Medicaid will be available to a person who is not receiving an SSI payment because the SSA has determined that the person exceeds the income limit when the department still considers the person to be an SSI recipient.

75.6(2) *Persons who are not eligible for SSI or state supplementary assistance.*

a. Persons who are ineligible for SSI because of requirements that do not apply under Title XIX of the Act. Medicaid will be available to persons who would be eligible for SSI except for an eligibility requirement used in that program that is specifically prohibited under Title XIX of the Act.

b. Persons who would be eligible for SSI or state supplementary assistance but for social security cost-of-living increases received. Medicaid will be available to all current social security recipients who meet the following conditions:

- (1) They were entitled to and received concurrently in any month after April 1977 SSI and social security or state supplementary assistance and social security,
- (2) They subsequently lost eligibility for SSI or state supplementary assistance, and
- (3) They would be eligible for SSI or state supplementary assistance if all of the social security cost-of-living increases that they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and SSI (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.

c. Persons who would be eligible for SSI or state supplementary assistance, except that they receive social security benefits from a parent's account based on disability. Medicaid will be available to persons who receive SSI or state supplementary assistance after their eighteenth birthday because of a disability or blindness that began before the age of 22 and who would continue to receive SSI or state supplementary assistance except that they become entitled to or receive an increase in social security benefits from a parent's account.

d. Persons ineligible due to October 1, 1972, social security increase. Medicaid will be available to persons and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these persons and families would be eligible for an assistance grant if the increase were not considered.

e. Persons who would be eligible for SSI 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. Medicaid will be available to all current social security recipients who meet all of the following conditions:

- (1) They were eligible for a social security benefit in December of 1983.
- (2) They were eligible for and received a widow's or widower's disability benefit and SSI or state supplementary assistance for January of 1984.
- (3) They became ineligible for SSI or state supplementary assistance because of an increase in their widow's or widower's benefit that 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.
- (4) They have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.
- (5) They would be eligible for SSI 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.

- (6) They submitted an application prior to July 1, 1988.

f. Widows and widowers who are no longer eligible for SSI or state supplementary assistance because of the receipt of social security benefits. Medicaid will be available to widows and widowers who meet the following conditions:

- (1) They have applied for and received or were considered recipients of SSI or state supplementary assistance.
- (2) 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.
- (3) 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.
- (4) They are no longer eligible for SSI or state supplementary assistance solely because of the receipt of their social security benefits.

g. Continued Medicaid for disabled children from August 22, 1996. Medicaid will 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 (Public Law 104-193) as amended to August 1, 2025, and 42 U.S.C. 1382c(a)(3).

75.6(3) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medicaid will be available to the person living with and essential to the welfare of a Title XVI beneficiary, provided the essential person was eligible for Medicaid as of December 31, 1973. The person will continue to be eligible for Medicaid as long as the person continues to meet the definition of "essential person" in effect for the Old Age Assistance, Aid to the Blind, or Aid to the Permanently and Totally Disabled public assistance programs on December 31, 1973, and as determined by SSA.

75.6(4) *Persons residing in a medical institution.*

a. Persons who would be eligible for SSI or state supplementary assistance except for their institutional status. Medicaid will be available to persons receiving care in a medical institution who would be eligible for SSI or state supplementary assistance if they were not institutionalized.

b. Persons receiving care in a medical facility who would be eligible under a special income standard.

(1) Medicaid will be available to persons who:

1. Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.2(249A), 441—82.6(3) and 441—82.7(249A).

2. Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the intellectually disabled (ICF-ID), or Medicare-certified skilled nursing facility.

3. Have gross countable monthly income that does not exceed 300 percent of the federal SSI benefits for one.

4. Either meets all SSI eligibility requirements except for income or is under age 21 pursuant to subrule 75.3(14).

(2) For all persons in this coverage group, income will be considered as provided for non-MAGI-related coverage groups under rule 441—75.80(249A). In establishing eligibility for persons aged 21 or older for this coverage group, resources will be considered as provided for non-MAGI-related coverage groups.

(3) A person in this group will not be eligible until the person has been institutionalized for a period of 30 consecutive days, and eligibility will be effective no earlier than the first day of the month in which the 30-day period begins. A period of 30 days means beginning 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 will 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.

75.6(5) Medicare savings programs. The purpose of the coverage groups within this subrule is to assist low-income persons with the payments of Medicare premiums, coinsurance, and deductibles. These groups are known as Medicare savings programs.

a. Qualified Medicare beneficiary (QMB) program.

(1) Medicaid will 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:

1. The person's monthly income does not exceed 100 percent of the FPL applicable to the family size.

2. The amount of income will be determined as under the SSI program.

3. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in Section 1905(p)(1)(C) of the Act.

(2) The amount of resources will 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, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility is the first of the month after the month of decision.

(5) Pursuant to 42 CFR 435.909(b), SSI recipients are automatically enrolled in the QMB group.

b. Qualified disabled and working persons. Medicaid will be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

(1) 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 applicable FPL for the family size.

2. The person's resources do not exceed twice the maximum amount allowed under the 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 Act (as added by Section 6012 of the Omnibus Budget Reconciliation Act (OBRA) 1989).

(2) The amount of the person's income and resources will be determined as under the SSI program.

c. Specified low-income Medicare beneficiaries.

(1) Medicaid will 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:

1. The person's monthly income exceeds 100 percent of the FPL but is less than 120 percent of the FPL applicable to a family of the size involved.

2. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in section 1905(p)(1)(C) of the Act.

(2) The amount of income and resources will 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, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility will be as set forth in 441—subrule 76.13(1).

d. Expanded specified low-income Medicare beneficiaries.

(1) Medicaid benefits to cover the cost of the Medicare Part B premium will be available to persons who are entitled to Medicare Part A provided the following conditions are met:

1. The person is not otherwise eligible for Medicaid.

2. The person's monthly income is at least 120 percent of the FPL but is less than 135 percent of the FPL applicable to a family of the size involved.

3. The person's resources do not exceed three times the maximum resource level allowed under the SSI program, annually adjusted by increases in the consumer price index for inflation as defined in Section 1905(p)(1)(C) of the Act.

(2) The amount of the income and resources will 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, in which case the resource determination will be made according to subrules 75.82(3) and 75.82(4).

(3) Income will not include any amount of social security income attributable to the cost-of-living increase beginning January 1 until the annual revision of the FPL on April 1.

(4) The effective date of eligibility will be as set forth in 441—subrule 76.13(1).

75.6(6) *Medicaid for employed people with disabilities (MEPD).*

a. Medicaid will be available to persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.81(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 FPL for the family. Family income will include gross income of all family members, less SSI program disregards, exemptions, and exclusions, including the earned income disregards. The social security cost-of-living increase will be excluded in the current calendar year for January until April.
 - (4) They receive earned income from employment or self-employment or are eligible pursuant to paragraph 75.6(6) "c."
 - (5) They would be eligible for Medicaid under another coverage group set out in this rule (other than the medically needy coverage groups in rule 441—75.8(249A)), disregarding all income, up to \$10,000 of available resources for an individual and \$21,000 for a couple, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account.
 - (6) They have paid any premium assessed pursuant to paragraph 75.6(6) "b."
- b.* Persons whose gross income is greater than 150 percent of the FPL.
- (1) For a person whose gross income exceeds 150 percent of the FPL for an individual, eligibility 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 will be included only in determining premium liability based on a subsequently published FPL. A monthly premium will be assessed at the time of application and at the annual review. The premium amounts and the FPL increments above 150 percent of the FPL used to assess premiums will be adjusted annually on August 1.
 - (2) Beginning with the month of application, the monthly premium amount will be established based on projected average monthly income. The monthly premium established will not be increased for any reason before the next eligibility review. The premium will not be reduced due to a change in the FPL but may be reduced or eliminated prospectively before the next eligibility review if a reduction in projected average monthly income is verified.
 - (3) Eligible persons are required to complete and return forms specified by the department 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.
 - (4) Premiums will be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	\$43
165% of Federal Poverty Level	\$59
180% of Federal Poverty Level	\$70
200% of Federal Poverty Level	\$82
225% of Federal Poverty Level	\$97
250% of Federal Poverty Level	\$113
300% of Federal Poverty Level	\$141
350% of Federal Poverty Level	\$171
400% of Federal Poverty Level	\$202
450% of Federal Poverty Level	\$233
550% of Federal Poverty Level	\$291
650% of Federal Poverty Level	\$351
750% of Federal Poverty Level	\$413
850% of Federal Poverty Level	\$488
1000% of Federal Poverty Level	\$586
1150% of Federal Poverty Level	\$685

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
1300% of Federal Poverty Level	\$790
1480% of Federal Poverty Level	\$913

(5) Eligibility is contingent upon the payment of any assessed premiums. Medicaid eligibility will 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.

(6) 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 will be canceled.

(7) Payments received will 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 will 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 will be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs 75.6(6) “b”(7) “1,” “2,” and “3” above, and then to future months when a premium becomes due.

5. Any excess on an inactive account will be refunded to the client after two calendar months of inactivity, or no longer being assessed a monthly premium, or upon request from the client.

(8) 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.

(9) Premiums may be submitted in the form of money orders or personal checks to the address printed on the coupon attached to the MEPD billing statement.

(10) 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.

(11) 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 be provided in accordance with 441—Chapter 16 and will include reopening provisions that apply if payment is received, as well as appeal rights under 441—Chapter 2506.

(12) A form specified by the department will 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 will 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 a form prescribed by the department 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 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 the age of 18 and unmarried, includes parents living with the individual, unmarried siblings under the age of 18 and 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 the age of 18 and unmarried. No other persons will be considered members of an individual’s family. An individual living alone or with others not listed above will 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.

75.6(7) Medicaid for kids with special needs (MKS). Medicaid will 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—75.81(249A) based on the disability standards for children used for SSI benefits under Title XVI of the 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 FPL applicable to a family of that size.

(1) For this purpose, the child’s household includes 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 unmarried 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 75.6(7) "d"(1) will 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 is not considered to be "receiving Medicaid" for the purposes of subparagraph "d"(1). A child who lives alone or with persons not identified in subparagraph "d"(1) will be considered as having a household of one.

(3) For this purpose, all unearned and earned income of the household, unless specifically exempted, disregarded, deducted for work expenses, or diverted, will be considered in determining initial and continuing eligibility.

75.6(8) *Persons eligible for waiver services.* Medicaid will be available to members eligible for waiver services as defined in 441—Chapter 83.

[ARC 9763C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.7(249A) Presumptive eligibility. Medicaid will be temporarily available to persons who are determined to be presumptively eligible for Medicaid pursuant to this subrule. Presumptive eligibility will be determined by a qualified entity (QE) and will be based solely on the applicant's attested circumstances as provided to the QE and entered by the QE directly online into the Medicaid Presumptive Eligibility Portal (MPEP) system. Verification cannot be requested or required for a presumptive eligibility determination.

75.7(1) *Application process.* Persons and families requesting assistance under this subrule shall apply with a QE using the methods described in 441—subrule 76.7(3). The requirements for filing date of application, effective date of coverage, signature on application, notice and appeal rights, and full Medicaid eligibility determinations described in 441—subrules 76.7(4) through 76.7(7) apply.

75.7(2) *Eligibility requirements applicable to all presumptive eligibility determinations except as stated otherwise within this rule.* The following eligibility requirements are applicable to all presumptive eligibility determinations, except as stated otherwise within this rule.

a. Household size. Household size will be determined using MAGI methodology as described in rule 441—75.72(249A).

b. Countable income. Countable income will be determined using MAGI methodology as described in rule 441—75.73(249A).

c. Citizenship or qualified noncitizen status. The person for whom assistance is requested must be a citizen of the United States or a qualified noncitizen as defined in 441—75.11(249A), except for a pregnant woman described in paragraph 75.7(3) "c."

d. Iowa residency. The person for whom assistance is requested must be a resident of Iowa as described in rule 441—75.10(249A).

e. Prior presumptive eligibility. A person will not be determined presumptively eligible more than once in a 12 calendar month period, except as allowed in paragraph 75.7(3) "g." The first month of the 12 calendar month period begins with the calendar month the application is received by the qualified entity.

75.7(3) *Categories of eligibility and specific requirements.* The following categories of persons are eligible for a presumptive determination. Persons applying for a presumptive determination must meet all specific requirements related to the category of coverage in addition to the requirements in subrule 75.7(2), except as stated otherwise within this subrule. For categories where age is an eligibility factor, the effect of reaching an age limit on the person's eligibility will be determined pursuant to rule 441—75.52(249A).

a. Presumptive eligibility for children. Presumptive eligibility is available to children who meet the following requirements:

- (1) Age—the child must be under the age of 19 as described in rule 441—75.52(249A).
- (2) Income limits—household income must not exceed:

1. The MAC program limit for infants and the applicable household size as specified in rule 441—75.74(249A) when the child is under the age of one; or

2. The hawki program limit for a household of the same size as specified in 441—subrule 86.2(2) when the child is aged 0 through 18.

b. Presumptive eligibility for parents and other caretakers. Presumptive eligibility will be available to a parent or other caretaker who meets the following requirements:

(1) Household income must not exceed the family medical assistance program income limits specified in rule 441—75.74(249A).

(2) The parent or caretaker lives with a dependent child as described in subrule 75.50(2) and has primary responsibility for the child's care as described in subrule 75.51(2).

c. Presumptive eligibility for pregnant women. Presumptive eligibility for ambulatory prenatal care is available to a woman who is pregnant and who also meets the following requirements:

(1) Household income must not exceed the MAC program limit for pregnant women specified at rule 441—75.74(249A) for the applicable household size.

(2) A pregnant woman will not be required to meet the citizen or noncitizen requirements of rule 441—75.11(249A).

d. Presumptive eligibility for IHAWP. Presumptive eligibility for IHAWP is available to a person who meets the following requirements:

(1) The non-financial eligibility requirements described in rule 441—74.2(249A,249N).

(2) Household income not exceeding 133 percent of the FPL based on the size of the household pursuant to rule 441—74.4(249A,249N).

e. Presumptive eligibility for former foster care youth. Presumptive eligibility will be available to a person who is under the age of 26, was formerly in foster care, and meets the requirements described in subrule 75.3(12).

f. Presumptive eligibility for persons who have been screened and found to need treatment for breast or cervical cancer. Presumptive eligibility is available to a person who has been screened and found to need treatment for either breast or cervical cancer, subject to the following:

(1) The person must be determined to meet the eligibility requirements described in subrule 75.4(1).

(2) The person will not be required to meet the eligibility requirements described in paragraph 75.7(2) "a," "b," or "c."

g. Presumptive eligibility more than once in a 12 calendar month period. A person will be determined presumptively eligible only once in a 12 calendar month period beginning with the calendar month the application is received by the qualified entity, except as follows:

(1) A new period of presumptive eligibility will begin each time a person is screened as described in subparagraph 75.4(1) "a" and determined to need treatment for a new occurrence of breast or cervical cancer.

(2) A pregnant woman may be determined presumptively eligible for Medicaid once per pregnancy but no more than once per pregnancy.

75.7(4) Presumptive eligibility period. Presumptive eligibility is effective on the date that a qualified entity completes the presumptive eligibility determination pursuant to 441—subrule 76.7(5) and ends as described in the paragraphs below.

a. For persons determined presumptively eligible under paragraphs 75.7(3) "b" through "f," presumptive eligibility will continue until:

(1) In the case of a person on whose behalf a Medicaid application has not been filed, the last day of the calendar month following the month of the presumptive eligibility determination; or

(2) In the case of a person on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application. Withdrawal of a Medicaid application before a decision is made will not affect the person's eligibility during the presumptive period.

b. For children determined presumptively eligible under paragraph 75.7(3) "a," presumptive eligibility will continue until:

(1) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the calendar month following the month of the presumptive eligibility determination; or

(2) In the case of a child on whose behalf a Medicaid (including hawki) application has been filed, the day the child is determined eligible for Medicaid, the last day of the month before the child is determined eligible for hawki, or the day the child is determined ineligible for both Medicaid and hawki. Withdrawal of a Medicaid (including hawki) application before a decision is made will not affect the child's eligibility during the presumptive period.

75.7(5) Services covered.

a. Persons determined presumptively eligible under paragraphs 75.7(3) "a," "b," "e," and "f" will be entitled to all Medicaid-covered services, including early and periodic screening, diagnosis, and treatment (EPSDT) services for children. Payment of claims for Medicaid services provided during the presumptive period is not dependent upon the department's determination of Medicaid or hawki eligibility.

b. Covered services for pregnant women determined presumptively eligible under paragraph 75.7(3) "c" will be limited to ambulatory prenatal care services during the presumptive period. Payment of claims for ambulatory prenatal care services is not dependent upon a determination of Medicaid eligibility by the department. "Ambulatory prenatal care" means all Medicaid-covered services, except inpatient hospital or institutional care and charges associated with delivery of the baby (including miscarriage or termination of a pregnancy).

c. Persons determined presumptively eligible under paragraph 75.7(3) "d" will be limited to all services offered under IHAWP pursuant to 441—Chapter 74. Payment of claims for services offered under IHAWP and provided during the presumptive eligibility period is not dependent upon the department's determination of IHAWP eligibility.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.8(249A) Medically needy persons.

75.8(1) Medically needy definitions. For purposes of this rule, the following definitions apply:

"Break in assistance" for medically needy means 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.

"Certification period" for medically needy means the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" for medically needy means all of the following:

1. A medically needy applicant;
2. A medically needy member;
3. A person who is conditionally eligible for Medicaid under the medically needy coverage group; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"Conditionally eligible" means 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.

"Family-related medically needy" means those persons who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income.

"FMAP-related medically needy" means those persons who would be eligible for FMAP pursuant to subrule 75.3(1) except for excess income.

"Incurred medical expenses" for the medically needy program means:

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.

“Member” for the medically needy program means 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.

“Necessary medical and remedial services” for the medically needy program means medical services recognized by law that are currently covered under the Medicaid program.

“Needy specified relative” means a nonparental specified relative, as defined for the family investment program (FIP) in rule 441—40.21(239B), who meets all of the eligibility requirements of the FMAP coverage group pursuant to subrule 75.3(1).

“Noncovered Medicaid services” for the medically needy program means medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones that are otherwise not covered under Medicaid, the bill is for a responsible relative who is not included in the Medically needy eligibility determination pursuant to subrule 75.8(3) or the bill is for services delivered before the start of a certification period.

“Obligated medical expense” for the medically needy program means a medical expense for which the client or responsible relative continues to be legally liable.

“Ongoing eligibility” for the medically needy program means that eligibility continues for an SSI-related, family-related, or FMAP-related medically needy person with a zero spenddown.

“Recertification” in the medically needy coverage group means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“Responsible relative” for medically needy means a spouse, parent, or stepparent of the applicant or member who lives with the applicant or member.

“Retroactive certification period” for the medically needy program means one, two, or three calendar months prior to the date of application. When applicable pursuant to 441—subrule 76.13(3), the retroactive certification period begins with the first day of the first month within the three-month period that Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“Retroactive period” means the three calendar months immediately preceding the month in which an application is filed and applies when applicable pursuant to 441—subrule 76.13(3).

“Spenddown” means the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“SSI-related medically needy” means those persons whose eligibility is determined using regulations governing the supplemental security income (SSI) program except for income or resources.

75.8(2) Coverage groups. Medically needy will be available to the following persons who meet the general conditions of eligibility described in this chapter:

a. *Pregnant women.* Pregnant women who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income. For family-related programs, pregnant women will have the unborn child or children counted in the household size as if the child or children were born and living with them pursuant to subrule 75.72(5).

b. *FMAP-related persons under 19.* Persons under the age of 19 who would be eligible for a family-related coverage group pursuant to rule 441—75.3(249A) except for excess income.

c. *SSI-related persons.* Persons who would be eligible for SSI except for excess income or resources.

d. *FMAP-related parents and caretakers.* Parents and caretakers who:

(1) Meet the requirements of rule 441—75.51(249A) and whose income exceeds the limits for FMAP; and

(2) Live with a dependent child who meets the requirements of rule 441—75.50(249A).

75.8(3) Family-related eligible group.

a. The eligible group consists of all eligible people specified below and living together, except when one or more of these people receive SSI under Title XVI of the Act. There will be at least one eligible parent or needy specified relative and at least one dependent child in the eligible group, except

when the only eligible child is receiving SSI. The parent or needy specified relative may be the only FMAP-related eligible group member receiving Medicaid if:

- (1) The only dependent child receives SSI, or
- (2) The dependent child is ineligible for Medicaid, or
- (3) The parent or needy specific relative voluntarily chooses to exclude the dependent child or children in order to receive coverage for the parent or needy relative.

b. The following persons will 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.

c. The following persons may be included:

- (1) The needy specified relative who assumes the role of parent.
- (2) The needy specified relative who acts as payee when the parent is in the home but is unable to act as payee.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent and the incapacitated 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 obtained from either an independent licensed physician or psychologist or the state rehabilitation agency. The evidence may be submitted either by letter from the physician or on a form specified by the department. When an examination is required and other resources are not available to meet the expense of the examination, the physician will be authorized to make the examination and submit the claim for payment on a form specified by the department. A finding of eligibility for social security benefits or SSI benefits based on disability or blindness is acceptable proof of incapacity.

75.8(4) *Resources and income of all persons considered.*

a. Resources of all parents and other caretakers and of all potentially eligible individuals living together, except as specified at paragraph 75.8(4)“*b*” or those excluded in accordance with the provisions of paragraph 75.8(4)“*d*,” will be considered in determining eligibility of adults. Resources of all parents and other caretakers and of all potentially eligible individuals living together will be disregarded in determining eligibility of children. Income of all parents and other caretakers and of all potentially eligible individuals living together, except as specified in paragraph 75.8(4)“*b*” or those excluded in accordance with the provisions of paragraph 75.8(4)“*d*,” will be considered in determining eligibility.

b. The amount of income of the responsible relative that has been counted as available to a family-related household other than the medically needy applicant or member household or SSI individual will not be considered in determining the countable income for the medically needy applicant or member household.

c. The resource determination will be according to subrules 75.82(3) and 75.82(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

d. Certain persons may be voluntarily excluded from the family-related medically needy eligibility determination as follows:

(1) Exclusions from the eligibility determination. In determining eligibility under the family-related medically needy coverage groups described in paragraphs 75.8(2)“*a*,” “*b*,” and “*d*,” the following persons may be excluded from consideration when determining medically needy eligibility of other household members:

1. Siblings (of whole or half blood, or adoptive) of eligible children.

2. Self-supporting parents of minor unmarried parents.
3. Stepparents of eligible children.
4. Children living with a parent or caretaker.

(2) Needs, income, and resource exclusions. The needs, income, and resources of persons who are voluntarily excluded will also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent will 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 will be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the legally recognized natural or adoptive parent will 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 will be used in determining eligibility for the natural or adoptive parent's children.

(3) Medicaid entitlement. Persons whose needs are voluntarily excluded from the eligibility determination will not be entitled to Medicaid under this or any other coverage group.

(4) Situations where a 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 will be allowed the earned income deduction, child care expenses, and work incentive disregard as provided at paragraph 75.8(6) "a."

(5) Situations where a 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 subparagraph 75.8(4) "d"(2), and the child's income is not sufficient to meet the child's needs, the parent will be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted will be the difference between the schedule of basic needs of all potentially eligible individuals living together with the child included and the schedule of basic needs with the child excluded, in accordance with the FIP provisions in 441—subrule 41.28(2), minus any countable income of the child.

75.8(5) Resources.

- a. The resource limit for adults in SSI-related households will be \$10,000 per household.
- b. Disposal of resources for less than fair market value by SSI-related applicants or members is governed by rule 441—75.23(249A).
- c. The resource limit for family-related adults will be \$10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the medically needy household, regardless of age, will be disregarded. In establishing eligibility for adults for this coverage group, resources will be considered according to rule 441—41.26(239B).
- d. The resources of SSI-related persons will be treated according to SSI policies.
- e. When a resource is jointly owned by SSI-related persons and family-related persons, the resource will be treated according to SSI policies for the SSI-related person and according to the policies described in paragraph 75.8(5) "c" for the family-related persons.

75.8(6) Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted, will be considered in determining initial and continuing eligibility.

a. Income policies for family-related medically needy coverage groups. MAGI income and household size policies do not apply to the family-related medically needy coverage groups described in subrule 75.8(2). When determining eligibility for a family-related medically needy coverage group described in subrule 75.8(2), the department will determine countable income as described in the following subparagraphs.

(1) Earned income. "Earned income" means 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.

(2) Earned income deductions. Deductions from earned income will be made as follows:

1. Each person in the household whose gross nonexempt earned income is considered in determining eligibility is entitled to one 20 percent earned income deduction from the monthly gross earnings. The deduction is intended to include work-related expenses other than child care such as taxes, transportation, meals, and uniforms.

2. Each person in the household is entitled to a deduction for child or incapacitated adult care expenses for employment-related hours subject to the following limitations:

- The going rate in the community up to \$175 per month for each child aged two or older or each incapacitated adult.

- The going rate in the community up to \$200 per month for each child under the age of two.

- No deduction is allowed for any portion of the cost of care that is paid for by a third party such as but not limited to the child care assistance program.

- Stepparents and self-supporting parents on minor parent cases will be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

- No deduction is allowed when both parents are in the home and one parent is not employed during the hours that care is needed if the parent at home during those hours is physically and mentally able to provide the care.

- A deduction is allowable only when the care covers the actual employment hours plus a reasonable period of time for commuting, or the period of time when the person who would normally care for the child or incapacitated adult is employed at such hours that the person is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

- Any special needs of a physically or mentally handicapped child or adult will be taken into consideration in determining the deduction allowed.

- If the amount claimed is questionable, the expense shall be verified by a receipt or a statement from the provider of care. The expense will be allowed when paid to any person except a parent or legal guardian of the child or another member of the household.

(3) With respect to self-employment, a person is considered to be self-employed if the requirements of FIP in 441—subrule 41.27(2) are met. Income will be considered earned income when it is produced as a result of the performance of services by an individual.

1. Earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income as allowed for FIP pursuant to 441—subrule 41.27(2) for a non-home based enterprise.

2. In determining net profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the costs allowed for FIP pursuant to 441—subrule 41.27(2) will be allowed except deductions are limited to 10 percent of the total gross income to cover the costs of upkeep for the home.

(4) When the client is renting out apartments in the client's home, the following will 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 for FIP in 441—subrule 41.28(2).

2. That portion of expense for utilities furnished to tenants that exceeds the amount set forth on the chart of basic needs components for FIP in 441—subrule 41.28(2).

3. Ten percent of gross rentals to cover the cost of upkeep.

(5) In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts will be deducted from the payments received:

1. \$41 plus an amount equivalent to the monthly maximum Supplemental Nutrition 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.

(6) Gross income from providing child care in the applicant's or member's own home will include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 as amended to August 1, 2025, 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 will 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 will be determined in the same manner as specified at numbered paragraph 75.8(6) "a"(3)"2."

(7) 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 Contributions Act as amended to August 1, 2025, state and federal income taxes). Net unearned income will be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction will be considered gross income available to meet the needs of the eligible group.

1. Social security income is the amount of the entitlement before withholding of a Medicare premium.

2. When the client sells property on contract, proceeds from the sale will be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined for FIP in 441—subrule 41.26(4). The interest portion of the payment is considered a resource the month following the month of receipt.

3. Support payments in cash will be considered as unearned income in determining initial and continuing eligibility.

- Any nonexempt cash support payment for a member of the eligible group made while the application is pending will be treated as unearned income.

- Support payments will be considered as unearned income in the month in which the IV-A agency (the department's income maintenance area) is notified of the payment by the IV-D agency (child support services). The amount of income to consider will be the actual amount paid or the monthly entitlement, whichever is less.

- Support payments reported by child support services during a past month for which eligibility is being determined will be used to determine eligibility for the month. Support payments anticipated to be received in future months will be used to determine eligibility for future months. When support payments terminate in the month of decision of a family-related application, both support payments already received and support payments anticipated to be received in the month of decision will be used to determine eligibility for that month.

(8) Income will be diverted to meet the unmet needs of ineligible children and to permit payment of court-ordered support to children not living with the parent as allowed for FIP pursuant to 441—subrule 41.27(4).

(9) The following FIP policies also apply to determining income eligibility for family-related medically needy: 441—subrules 41.27(3), 41.27(5), 41.27(6), 41.27(7), and 41.27(8) and 441—paragraphs 41.27(9) "c," "g," "h," and "i."

b. 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.

c. The monthly income will be determined prospectively unless actual income is available.

d. The income for the certification period will be determined by adding both months' net income together to arrive at a total.

e. The income for the retroactive certification period when applicable pursuant to 441—subrule 76.13(3) will be determined by adding each month of the retroactive period to arrive at a total.

75.8(7) *Medically needy income level (MNIL).*

a. The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided for FIP in 441—subrule 41.28(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

b. When determining household size for the MNIL, all potentially eligibles and all individuals whose income is considered as specified in subrule 75.8(4) shall be included unless the person has been excluded according to the provisions of paragraph 75.8(4) “*d.*”

c. The MNIL for the certification period will be determined by adding both months’ MNIL to arrive at a total. The MNIL for the retroactive certification period when applicable pursuant to 441—subrule 76.13(3) will be determined by adding each month of the retroactive period to arrive at a total.

d. The total net countable income for the certification period will be compared to the total MNIL for the certification period based on family size as specified in paragraph 75.8(7) “*b.*” If the total countable net income is equal to or less than the total MNIL, the medically needy individuals will be eligible for Medicaid. If the total countable net income exceeds the total MNIL, the medically needy individuals will not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

e. Effective date of approval. Eligibility during the certification period, or the retroactive certification period when applicable pursuant to 441—subrule 76.13(3), will be effective as of the first day of the first month of the certification period or the retroactive certification period when the MNIL is met.

75.8(8) *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.

a. 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 Iowa Medicaid 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. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the worker will obtain the claim form from the provider.

b. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) will be on forms specified by the department. Applicants who have not established that they met spenddown in the current certification period will 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.

75.8(9) *Spenddown calculation.*

a. Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period will 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:

(1) The expenses remain unpaid as of the first day of the certification period.

(2) The expenses are not Medicaid-payable in a previous certification period or the retroactive certification period when applicable pursuant to 441—subrule 76.13(3).

(3) The expenses are not incurred during any prior certification period with the exception of the retroactive period, when applicable pursuant to 441—subrule 76.13(3), in which the person was conditionally eligible but did not meet spenddown.

(4) Notwithstanding subparagraphs 75.8(9)“a”(1) through “a”(3), paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

b. Spenddown will be adjusted under the following circumstances:

(1) 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.

(2) When a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service.

(3) 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.

c. Order of deduction. 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, will 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 will not be allowed as a deduction to meet the spenddown obligation of household members 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 will 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 will be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed by multiplying the previous year's average per day rate by the inflation factor increase during the preceding calendar year ending December 31 of the consumer price index for all urban Consumers as published by the United States Bureau of Labor Statistics.

(3) Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

(4) Medical expenses for acupuncture, chronologically by date of submission.

(5) Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

d. When spenddown has been met and a bill is received with a service date after spenddown has been met, the bill will not be deducted to meet spenddown.

e. When incurred medical expenses have reduced income to the applicable MNIL, the individuals will be eligible for Medicaid.

f. Medical expenses reimbursed by a public program other than Medicaid prior to the certification period will not be considered a medical deduction.

75.8(10) Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

a. Care in a nursing facility or an ICF-ID.

b. Care in an institution for mental disease.

c. Care in a Medicare-certified skilled nursing facility.

75.8(11) *Reviews.* Reviews of eligibility will be made for SSI-related and family-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance will the period of time between reviews exceed 12 months. Family-related medically needy persons and SSI-related needy persons shall complete forms specified by the department as part of the review process when requested to do so by the department.

75.8(12) *Redetermination.* When an SSI-related or family-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility will be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination will be effective the month the income exceeds the MNIL or the first month following timely notice.

a. The department will 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.

b. All eligibility factors will be reviewed on redeterminations of eligibility.

75.8(13) *Recertifications.* A new application must be submitted when the certification period has expired and there has been a break in assistance as defined at subrule 75.8(1). When the certification period has expired and there has not been a break in assistance, the family-related members and SSI-related members shall use forms specified by the department to be recertified.

75.8(14) *Disability determinations.* An applicant receiving social security disability benefits under Title II of the Act or railroad retirement benefits based on the Act's definition of disability by the Railroad Retirement Board will be deemed disabled without any further determination. In other cases under the medically needy program, the department will conduct an independent determination of disability unless the applicant has been denied SSI benefits based on lack of disability and the applicant does not allege either (1) a disabling condition different from or in addition to that considered by the SSA or (2) that the applicant's condition has changed or deteriorated since the most recent SSA determination.

a. In conducting an independent determination of disability, the department will use the same criteria required by federal law to be used by the SSA in determining disability for purposes of SSI under Title XVI of the Act. The disability determination services division of Iowa workforce development will make the initial disability determination on behalf of the department.

b. For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign, and submit forms as specified by the department.

c. In connection with any independent determination of disability, the department will 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 specified by the department as required in paragraph 75.8(14) "b."

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.9(249A) Furnishing of social security number.

75.9(1) *Requirement.* As a condition of eligibility, except as provided by subrule 75.9(2), a Medicaid client must provide to the department all social security numbers issued to each individual (including children) for whom Medicaid is sought.

75.9(2) *Exceptions to requirement.* The requirement of subrule 75.9(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.

75.9(3) Cooperation in obtaining social security number. 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 SSA or in requesting the SSA to furnish the number.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) Definitions. The following definitions apply for the purposes of this subrule:

a. Institution. “Institution” means an “institution” or a “medical institution” as those terms are defined in 42 CFR §435.1010. For purposes of state placement, “institution” also includes foster care homes licensed as set forth in 45 CFR §1355.20 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.

c. Iowa resident. An Iowa resident is one:

(1) Who is living in Iowa voluntarily with the intention of making that person’s home there and not for a temporary purpose. A person is a resident of Iowa when living there on other than a temporary basis. Residence will not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

(2) Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed.

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. Individuals receiving Title IV-E payments. Individuals who are receiving federal foster care maintenance payments or have a guardianship assistance agreement or have an adoption assistance agreement under Title IV-E of the Act are considered to be residents of the state where the child lives.

b. 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.

c. 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.

d. 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 providing 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.

e. 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 441—Chapters 50 through 54 and Chapter 177) are considered to be residents of the state paying the supplementary assistance.

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 capable 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 capable 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 capable 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.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) Definitions. For purposes of this rule, the following definitions apply.

"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 will be limited to medical services that are required and directly related to the treatment of the emergency medical condition.

"Citizen" and *"citizenship"* includes both citizens of the United States and nationals of the United States as defined in 8 U.S.C. §1101(a)(22).

"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 as amended to August 1, 2025.

4. Assistance or benefits under the Child Nutrition Act of 1966 as amended to August 1, 2025.

5. Public health assistance (not including any assistance under Title XIX of the 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 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 of the Act.

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 as amended to August 1, 2025, and Titles III, VII, and VIII of the Public Health Services Act as amended to August 1, 2025.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965 as amended to August 1, 2025.

10. Benefits under the Head Start Act, as amended to August 1, 2025.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

“*INA*” means the Immigration and Naturalization Act as amended to August 1, 2025, unless another effective date is specified.

“*Noncitizen*” means the same as “alien” as defined in 8 U.S.C. §1101(a)(3).

“*Qualified noncitizen*” means the same as “qualified alien” as defined in 8 U.S.C. §1641(b) and (c). A qualified noncitizen is:

1. Lawfully admitted for permanent residence in the United States under the INA;
2. Granted asylum in the United States under Section 208 of the INA;
3. A refugee admitted to the United States under Section 207 of the INA;
4. Paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
5. An individual 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;
6. Granted conditional entry to the United States pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980;
7. An Amerasian admitted to the United States as described in 8 U.S.C. Section 1612(b)(2)(A)(i) (V);
8. A Cuban/Haitian entrant to the United States as described in Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422) as amended to August 1, 2025;
9. A battered noncitizen as described in 8 U.S.C. Section 1641(c);
10. Certified as a victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to August 1, 2025;
11. 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) as amended to August 1, 2025;
12. 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); or
13. Lawfully residing in the United States in accordance with a Compact of Free Association with the Government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of Public Law 116-260 and as amended to August 1, 2025.

“*Qualifying quarters*” includes all of the qualifying quarters of coverage as defined under Title II of the Act worked by a parent of a noncitizen while the noncitizen was under the age of 18 and all of the qualifying quarters worked by a spouse of the noncitizen during their marriage if the noncitizen remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Act for any period beginning after December 31, 1996, may be credited to a noncitizen if the parent or spouse of the noncitizen 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. Eligibility. 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 noncitizen continuously present (as described in Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility under Title IV of the Personal Responsibility and

Work Opportunity Reconciliation Act (PRWORA) at 62 FR 61415 dated November 11, 1997, and as amended to August 1, 2025) in the United States since before August 22, 1996.

- (3) A qualified noncitizen under the age of 21.
- (4) A refugee admitted to the United States under Section 207 of the INA.
- (5) A noncitizen who has been granted asylum under Section 208 of the INA.
- (6) A noncitizen whose deportation is withheld under Section 243(h) or 241(b)(3) of the INA.
- (7) A qualified noncitizen veteran who has an honorable discharge that is not due to alienage.
- (8) A qualified noncitizen who is on active duty in the Armed Forces of the United States other than active duty for training.
- (9) A qualified noncitizen who is the spouse or unmarried dependent child of a qualified noncitizen described in subparagraph 75.11(2)“a”(7) or “a”(8), including a surviving spouse who has not remarried.
- (10) A qualified noncitizen who has resided in the United States for a period of at least five years beginning on the date of the qualified noncitizen’s entry into the United States with a status within the meaning of numbered paragraph “1,” “4,” or “9” under the definition of “qualified noncitizen” in subrule 75.11(1).
- (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 Section 501(e) of the Refugee Education Assistance Act of 1980 (Public Law 96-422) as amended to August 1, 2025.
- (13) A certified victim of trafficking as described in Section 107(b)(1)(A) of Public Law 106-386 as amended to August 1, 2025.
- (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) as amended to August 1, 2025.
- (15) An Iraqi or Afghan immigrant treated as a refugee pursuant to Section 1244(g) of Public Law 110-181 as amended to August 1, 2025, or to Section 602(b)(8) of Public Law 111-8 as amended to August 1, 2025.
- (16) An Afghan paroled into the United States treated as a refugee pursuant to Section 2502 of Public Law 117-43 as amended to August 1, 2025.
- (17) A qualified noncitizen lawfully residing in the United States in accordance with a Compact of Free Association with the Government of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau as described in 8 U.S.C. Section 1612(b)(2)(G) as amended by Section 208 of Division CC of Public Law 116-260 and as amended to August 1, 2025.
- (18) A conditional entrant pursuant to Section 203(a)(7) of the INA as in effect before April 1, 1980.

b. Attestation of citizenship or qualified noncitizen status. As a condition of eligibility, each applicant and member shall attest in writing to the applicant’s or member’s citizenship or qualified noncitizen status by signing the applicable form identified in subparagraph 75.11(2)“b”(1), “b”(2), “b”(3), or “b”(4). The attestation may be provided, in writing and under penalty of perjury, by an adult member of the individual’s household, an authorized representative as defined in rule 441—76.1(249A), or, if the individual is a minor or incapacitated, by someone acting responsibly for the individual provided the person acting responsibly attests to having knowledge of the individual’s status.

- (1) All applicants for Medicaid shall attest to their citizenship or qualified noncitizen status by signing forms prescribed by the department that contain the declaration of their citizenship or qualified noncitizen status.
- (2) Family-related Medicaid members and members subject to MAGI methodology shall attest to their citizenship or qualified noncitizen status by completing and signing forms prescribed by the department that contain the declaration of their citizenship or qualified noncitizen status.

(3) Non-MAGI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship or qualified noncitizen status by signing the application form described in subparagraph 75.11(2) “b”(1) at time of review.

(4) The department will prescribe forms for an attestation of citizenship or qualified noncitizen status that will meet the requirements of subrule 75.11(2) for children under the age of 19 who are otherwise eligible pursuant to rule 441—76.4(249A).

c. Verification of citizenship and identity or qualified noncitizen status. An applicant or member attestation of citizenship or qualified noncitizen status must be verified as a condition of eligibility for Medicaid. An applicant or member who attests to citizenship must also verify their identity. The verification of citizenship status is acceptable as identity verification, except as stated otherwise within this subrule.

(1) Verification by electronic data sources. The department will accept applicant or member attestation of citizenship or qualified noncitizen status as verified when the attestation is consistent with available EDS.

(2) Satisfactory documentation of citizenship and identity is required. Except for the persons identified in paragraph 75.11(2) “i,” applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph 75.11(2) “b” shall present satisfactory documentation of the attested status and their identity when the attestation is not verified by available electronic data sources. Satisfactory documentation is identified in paragraphs 75.11(2) “d,” “e,” “f,” “g,” and “h.” The provisions of the reasonable opportunity period described in subparagraphs 75.11(2) “c”(4) and “c”(5) apply.

(3) Satisfactory documentation of qualified noncitizen status is required. Except for persons receiving SSI benefits under Title XVI of the Act, applicants or members for whom an attestation of a qualified noncitizen status has been made pursuant to paragraph 75.11(2) “b” shall present satisfactory documentation of the attested status when the attestation is not verified by available EDS. Satisfactory documentation of qualified noncitizen status is identified in paragraph 75.11(2) “j.” The department will request documentation in writing from the applicant or member. The provisions of the reasonable opportunity period described in subparagraphs 75.11(2) “c”(4) and “c”(5) applies.

(4) Reasonable opportunity period for providing satisfactory documentation. Applicants and members will be allowed a reasonable opportunity period of 90 days to provide satisfactory documentation of citizenship and identity or qualified noncitizen status. The reasonable opportunity period begins on the date a written request for documentation or a notice pursuant to subparagraph 75.11(2) “c”(3) or “c”(7) above is issued to an applicant or member, whichever is later, and continues for 90 days.

(5) Medicaid approval pending reasonable opportunity period. Medicaid will be approved for new applicants and continue for members not previously required to provide documentation of citizenship and identity or qualified noncitizen status until the end of the reasonable opportunity period, subject to 441—subrule 76.16(1).

(6) No retroactive eligibility until citizenship and identity or qualified noncitizen status is verified. Retroactive eligibility pursuant to 441—subrule 76.13(3) is available only after citizenship and identity or qualified noncitizen status has been verified with EDS or documentation has been provided pursuant to paragraph 75.11(2) “d,” “e,” “f,” “g,” “h,” or “j.” When applicable, the retroactive months are outside the reasonable opportunity period during which Medicaid coverage may be provided without required documentation of citizenship and identity or qualified noncitizen status.

(7) Verification of citizenship and identity or qualified noncitizen status not required. Applicants who reapply following a break in coverage and members who are subject to an eligibility review are not required to reverify citizenship and identity or qualified noncitizen status unless:

1. The individual reports a change in citizenship or qualified noncitizen status;
2. The individual’s qualified noncitizen status is a type the department has determined is subject to change; or

3. The department receives information indicating a potential change in the individual's citizenship or qualified noncitizen status.

d. Standalone evidence of citizenship and identity. Any one of the documents described in 42 CFR 435.407(a) will be accepted as sufficient evidence of citizenship and identity. In addition, provision of an individual's name, social security number, and date of birth to the department will constitute satisfactory documentation of citizenship and identity if submission of the name, social security number, and date of birth to the SSA produces a data match response that substantiates the individual's citizenship and identity. If submission of the name, social security number, and date of birth to the SSA does not produce a data match response that substantiates the individual's citizenship and identity, the department will issue a written request for documentation or a notice to the applicant or member pursuant to subparagraph 75.11(2)"c"(4) 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 SSA's records; or to provide other documentation of citizenship and identity pursuant to paragraphs 75.11(2)"d" through "h."

e. Combination evidence of citizenship.

(1) If an applicant does not provide documentary evidence of citizenship and identity from the list in paragraph 75.11(2)"d," information or documentation as described in 42 CFR 435.407(b) will be accepted as satisfactory evidence to establish citizenship if accompanied by an identity document listed in paragraph 75.11(2)"f":

(2) If the applicant does not have one of the documents listed in paragraph 75.11(2)"d" or "e," they may submit an affidavit provided by the department, signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

f. Evidence of identity. Any of the following documents described in 42 CFR 435.407(c) or (d) will be accepted as proof of identify, provided the document has a photograph or other identifying information sufficient to establish identity, including but not limited to name, age, sex, race, height, weight, eye color, or address.

g. Reserved.

h. Documentary evidence. The department will accept documents in accordance with 42 CFR 435.407(f) and provide assistance in a timely manner to individuals who need assistance in securing satisfactory documentary evidence of citizenship or identity in accordance with 42 CFR 435.407(e).

i. Persons not required to verify citizenship and identity status. A person for whom an attestation of United States citizenship has been made pursuant to paragraph 75.11(2)"b" is not required to present documentation of citizenship and identity 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 Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving SSI benefits under Title XVI of the Act.

(4) The person is or was exempted while assisted by child welfare services funded under Part B of Title IV of the Act on the basis of being a child in foster care as defined in Iowa Code section 232.2. This exemption does not apply and the person is subject to the citizenship and identity documentation requirements described in paragraph 75.11(2)"c" when services under Part B of Title IV were terminated due to failure to meet citizenship requirements.

(5) The person is or was exempted while assisted by foster care as defined in Iowa Code section 232.2 or adoption assistance funded under Part E of Title IV of the Act. This exemption does not apply and the person is subject to the citizenship and identity documentation requirements described in paragraph 75.11(2)"c" when services under Part E of Title IV were terminated due to failure to meet citizenship requirements.

(6) The person has previously presented satisfactory documentary evidence of citizenship and identity as specified by the United States Secretary of Health and Human Services.

(7) The person is or was deemed eligible for medical assistance pursuant to 42 U.S.C. Section 1396a(e)(4) on or after July 1, 2006, 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 Act.

j. Satisfactory documentation of qualified noncitizen status. For the purpose of subparagraph 75.11(2)“c”(3), satisfactory documentation of qualified noncitizen status is documentation issued by the U.S. Citizenship and Immigration Services (USCIS) of the Department of Homeland Security (formerly Immigration and Naturalization Service (INS)) that identifies the person's qualified noncitizen status.

75.11(3) Deeming of sponsor's income and resources. When a qualified noncitizen admitted for lawful permanent residence (including those who applied for an immigrant visa or for adjustment of status, other than those whose status was adjusted from refugee or asylee status under 8 U.S.C. §1159 on or after December 19, 1997) 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 qualified noncitizen, the income and resources of each sponsor will be deemed to determine eligibility only for the sponsored qualified noncitizen and not for any nonsponsored members of the sponsored qualified noncitizen's household as follows:

a. Income. For the family-related and non-MAGI-related coverage groups described in rules 441—75.3(249A) through 441—75.9(249A) applicable to the sponsored qualified noncitizen, the amount deemed to the sponsored qualified noncitizen will be the total gross countable income of each sponsor less the following deductions that will be applied to both family-related and non-MAGI-related applicants or members:

(1) The deductions described at 20 CFR §416.1166a, except that the amount to be deemed from each sponsor will be divided by the number of noncitizens sponsored by that sponsor.

(2) Diversion from countable earned and unearned income of the sponsor for the following:

1. Alimony or child support payments to persons not living with the sponsor.

2. Payments made to persons not living with the sponsor but who are claimed (or could be claimed) by the sponsor for federal income tax purposes.

b. Resources for non-MAGI-related coverage groups. When the sponsored qualified noncitizen's coverage group is non-MAGI-related, the total gross countable resources of each sponsor will be deemed to determine eligibility of the sponsored qualified noncitizen pursuant to 20 CFR §416.1204 less the applicable following deduction: \$2,000 if the sponsor does not live with a spouse, \$3,000 if the sponsor lives with a spouse who is not a sponsor, or \$4,000 if the sponsor lives with a spouse who is also the qualified noncitizen's sponsor. Resources are not considered for family-related coverage groups and therefore not deemed to a sponsored qualified noncitizen applying for or receiving under a family-related coverage group.

c. An indigent qualified noncitizen is exempt from the deeming of a sponsor's income and resources for 12 months after indigence is determined. A qualified noncitizen will be considered indigent if the following are true:

(1) The qualified noncitizen does not live with the sponsor; and

(2) The qualified noncitizen's gross income, including any income actually received from or made available by the sponsor, is less than 100 percent of the FPL for the sponsored qualified noncitizen's household size.

d. A battered qualified noncitizen 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.

e. Deeming of the sponsor's income and resources does not apply when:

(1) The sponsored qualified noncitizen attains citizenship through naturalization pursuant to Chapter 2 of Title II of the INA as amended to August 1, 2025.

(2) The sponsored qualified noncitizen has earned 40 qualifying quarters of coverage as defined in Title II of the Act or can be credited with 40 qualifying quarters as defined in subrule 75.11(1).

(3) The sponsored qualified noncitizen or the sponsor dies.

(4) The sponsored qualified noncitizen is a lawfully residing child under the age of 21 as allowed by 42 U.S.C. Section 1396b(v)(4)(A)(ii).

(5) For non-MAGI-related Medicaid, the sponsored qualified noncitizen becomes blind or disabled as defined under Title XVI of the Act after admission to the United States as a lawful permanent resident.

(6) For non-MAGI-related Medicaid, three years after the date the sponsored qualified noncitizen was admitted to the United States as a lawful permanent resident.

75.11(4) *Eligibility for payment of emergency medical services.* Noncitizens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their noncitizen 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, the noncitizen must meet all other eligibility criteria, including state residence requirements in rule 441—75.10(249A), with the exception of rule 441—75.9(249A) and subrules 75.11(2) and 75.11(3).

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

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” mean the same as defined in 42 CFR Section 435.1010.

75.12(1) *Suspension.* Medical assistance will be suspended rather than canceled while 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 daily report that is provided to the department by the public institution and includes the person’s first name and last name 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 limited to inpatient hospital claims only.

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 daily report provided to the department by the public institution that includes the person’s first name and last name 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 9763C, IAB 11/26/25, effective 1/1/26]

441—75.13 Reserved.

441—75.14(249A) Establishing liability and obtaining support.

75.14(1) As a condition of eligibility, adult Medicaid applicants and members shall cooperate in obtaining medical support for themselves and for any other person in the household for whom

Medicaid is requested or received and for whom the applicant or member can legally assign rights for medical support, except when the member has good cause for refusal to cooperate as defined in subrule 75.14(7).

a. The adult applicant shall agree to cooperate in obtaining medical support at the time of application.

b. The adult member shall cooperate in the following:

(1) Identifying and locating parties liable for the support of household members receiving Medicaid.

(2) Establishing liability for the support of household members receiving Medicaid, including establishment of paternity if paternity has not previously been established.

(3) Obtaining medical support and payments for medical care for household members receiving Medicaid.

c. Cooperation is defined as including the following actions by the adult member upon request:

(1) Appearing at the child support services as defined in 441—Chapter 95 to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the 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.

d. Upon request, the adult member shall cooperate with the department in supplying information with respect to potentially liable parties, the receipt of medical support or payments for medical care, and the establishment of liability for support to the extent necessary to establish eligibility for assistance.

e. Upon request, the adult member shall cooperate with child support services by supplying all known information and documents pertaining to the location of potentially liable parties and taking action as may be necessary to secure medical support and payments for medical care or to establish liability. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

f. Child support services will make the determination of whether or not the adult member has cooperated for the purposes of this rule.

75.14(2) Failure of an adult applicant to agree to cooperate or an adult member to cooperate will result in denial or cancellation of the noncooperating adult's Medicaid benefits. In family-related Medicaid cases, all exclusions, expenses and deductions described in rule 441—75.73(249A) will be allowed when otherwise applicable.

75.14(3) Each Medicaid member who is required to cooperate with child support services shall have the opportunity to claim good cause for refusing to cooperate in establishing liability or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(7) through 75.14(11) will be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid 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 member's own behalf or on behalf of any other person in the household who receives Medicaid.

An assignment is effective the same date the notice of eligibility is issued and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support will not be assigned to the department.

75.14(5) Pregnant women establishing eligibility under the MAC coverage group as provided in subrule 75.3(2) will 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 75.3(4) will not be subject to the provisions in this rule until after the end of the month in which the postpartum period expires.

Pregnant women establishing eligibility under any other coverage groups, except those set forth in subrule 75.3(2) or 75.3(4), will 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 will lose eligibility under her current coverage group and her eligibility for Medicaid will be automatically redetermined under subrule 75.3(2).

75.14(6) Notwithstanding subrule 75.14(5), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.3(2) or 75.3(4) will not be exempt from the provisions of 75.14(4) that require an adult member to assign any rights to medical support and payments for medical care.

75.14(7) Good cause exists when it is determined that cooperation in establishing liability and securing support is against the best interests of the child.

a. The department will determine that cooperation is against the child's best interest when the member's cooperation in establishing liability or securing support is reasonably anticipated to result in:

- (1) Physical or emotional harm to the child for whom support is to be sought;
- (2) Physical or emotional harm to the parent or other caretaker with whom the child is living that reduces the person's capacity to care for the child adequately.

b. The department will determine that cooperation is against the child's best interest when at least one of the following circumstances exists and the department believes that because of the existence of that circumstance, in the particular case, proceeding to establish liability 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 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 will 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 other caretaker, 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 liability establishment or support enforcement activity to be undertaken.

75.14(8) Each Medicaid member who is required to cooperate with child support services will have the opportunity to claim good cause for refusing to cooperate in establishing liability or securing support payments.

a. Before requiring cooperation, the department will notify the member 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 will:

(1) Advise the member of the potential benefits the child may derive from the establishment of liability and securing support.

(2) Advise the member that by law cooperation in establishing liability and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the member of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the member that good cause for refusal to cooperate may be claimed and that if the department determines, in accordance with these rules, that there is good cause, the member will be excused from the cooperation requirement.

(5) Advise the member that upon request, or following a claim of good cause, the department will provide further notice with additional details concerning good cause.

c. When the member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the department will issue a second notice. To claim good cause, the member shall sign and date a form prescribed by the department and return it. This form:

(1) Indicates that the 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 member that, upon request, the department will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the member that on the basis of the corroborative evidence supplied and the department's investigation, when necessary, the department will 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 member that child support recovery services may review the findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the member that child support recovery services may attempt to establish liability and collect support in those cases where it is determined that this can be done without risk to the member if done without the member's participation.

d. The 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 department to determine that good cause does not exist. The member shall:

(1) Specify the circumstances that the 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(9) The department will determine whether good cause exists for each Medicaid member who claims to have good cause.

a. The department will notify the member of its determination that good cause does or does not exist. The determination will:

(1) Be in writing.

(2) Contain the findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether good cause exists will be made within 45 days from the day the good cause claim is made. The department may exceed this time standard only when:

(1) The case record documents that the department 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(10).

c. When the department determines that good cause does not exist:

(1) The member will 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 department will make a good cause determination based on the corroborative evidence supplied by the member only after it has examined the evidence and found that it verifies the good cause claim.

e. Before making a final determination of good cause for refusing to cooperate, the department will:

(1) Afford child support services the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from child support services.

f. Child support services may participate in any appeal hearing that results from a member's appeal of a department action with respect to a decision on a claim of good cause.

g. Assistance will not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the 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 department will:

(1) Periodically, but not less frequently than every six months, review those cases in which the department 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 liability and securing support.

75.14(10) The member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the department determines that the member requires additional time because of the difficulty in obtaining the corroborative evidence, the department will 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 that indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records that 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 that indicate that the potentially liable person might inflict physical or emotional harm on the child.

(4) Medical records that indicate emotional health history and present emotional health status of the parent or other caretaker or the children for whom support would be sought; also, written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the parent or other caretaker or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the 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 member with knowledge of the circumstances that provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the member, the department wishes to request additional corroborative evidence needed to permit a good cause determination, the department will:

(1) Promptly notify the member that additional corroborative evidence is needed, and

(2) Specify the type of corroborative evidence needed.

c. When the member requests assistance in securing evidence, the department will:

(1) Advise the member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents that the member is not reasonably able to obtain without assistance.

d. When a claim is based on the member's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The department will investigate the good cause claim when it believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause will be found when the claimant's statement and investigation satisfies the department that the member has good cause for refusing to cooperate.

(3) A determination that good cause exists will be reviewed and approved or disapproved by a supervisor and the findings will be recorded in the case record.

e. The department may further verify the good cause claim when the member's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the department determines that it is necessary, the department may conduct an investigation of good cause claims to determine whether good cause exists.

f. When it conducts an investigation of a good cause claim, the department will:

(1) Contact the potentially liable person 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 member so the member may present additional corroborative evidence or information so that contact with the potentially liable person becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(11) Enforcement without parent or other caretaker's cooperation. When the department makes a determination that good cause exists, the department will also make a determination of whether child support services can proceed without risk of harm to the child, parent, or other caretaker when the enforcement or collection activities do not involve their participation.

a. Child support services will have an opportunity to review and comment on the findings and basis for the proposed determination and the department will consider any recommendations from child support services.

b. The determination will be in writing, contain the department's findings and basis for the determination, and be entered into the case record.

c. When the department excuses cooperation but determines that child support services may proceed to establish liability or enforce support, the department will notify the member to enable the individual to have the case closed.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.15(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, services received through Title XVIII of the Act (Medicare), and other resources for meeting the cost of medical care that may be available to the member. These resources must be used when reasonably available.

75.15(1) The department will 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—75.1(249A) are applicable.

75.15(2) As a condition of eligibility for Medicaid, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department all rights to payments of medical care from any third party to the extent that payment has been made under the Medicaid program. The applicant's signature on the application form listed in 441—paragraph 76.2(1) "c" shall constitute agreement to the assignment. The assignment shall be effective for the entire period during which Medicaid makes payment for medical care.

b. Cooperate with the department in obtaining third-party payments. The member or someone 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 Medicaid program.

75.15(3) Good cause for failure to cooperate in the filing or processing of a claim or application will be considered to exist when the member, or someone acting on behalf of a minor or legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause will 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 legally incompetent adult member, for whom medical resources are being sought.

75.15(4) Failure to cooperate as required in subrule 75.15(2) without good cause as defined in subrule 75.15(3) will result in the termination of Medicaid benefits. The department will make the determination of good cause based on information and evidence provided by the member or by someone acting on the member's behalf.

a. The Medicaid benefits of a minor or legally incompetent adult member will 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 Medicaid benefits of the parent or payee will be terminated.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.54.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.16(249A) Medical assistance lien.

75.16(1) When the Medicaid program pays for a member's medical care or expenses, the department will have a lien upon all monetary claims that the member may have against third parties for those expenses. Monetary claims will include medical malpractice claims for injuries sustained on or after July 1, 2011. The lien will be to the extent of the Medicaid 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 Medicaid is established. The notice of lien will 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 that 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 required by law shall be directed to the department. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.16(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 rule, upon the receipt of the judgment or settlement of the total claim, of which the lien for Medicaid payments is a part, the court costs and reasonable attorney fees will first be deducted from this total judgment or settlement. One-third of the remaining balance will then be deducted and paid to the member. From the remaining balance, the lien of the department will be

paid. Any amount remaining will 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 that is in excess of the amount 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.

75.16(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 someone acting on the member's behalf, Medicaid benefits will be terminated. The Medicaid benefits of a minor child or a legally incompetent adult member will not be terminated under this subrule. Subsequent eligibility for Medicaid benefits will 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 will not be paid by the Medicaid program.

a. The member, or someone acting on the member's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. The member or person acting on the member's behalf shall complete a form prescribed by the department, 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 will 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 Act (Medicare) and other resources.

(3) The date the member, or someone acting on the member'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 someone 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 someone 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 forms prescribed by the department when annual reviews are completed and when the client requests a form.

c. The member, or someone acting on the member's behalf, shall complete a form prescribed by the department 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 will result in the termination of Medicaid benefits.

d. 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 will be terminated. When a parent or payee fails to cooperate in completing or returning any form required by the department, or fails to give complete and accurate information concerning the accident-related injuries of a minor legally incompetent adult member, the department will terminate the Medicaid benefits of the parent or payee.

e. The member, or someone 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 will 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 will be terminated.

75.16(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on 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 Medicaid 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 75.16(1). The mailing and deposit in a U.S. 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.

75.16(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 Medicaid 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 will 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 that indicates Medicaid involvement will be construed as showing involvement by the department under Iowa Code section 249A.54. 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 will issue notice to that attorney of the department's lien rights.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department will issue notice to the insurer of the department's lien rights.

d. The mailing and deposit in a U.S. 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.

75.16(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency that 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 Medicaid or a past or present Medicaid member.

75.16(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 and 249A.54.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.17 Reserved.

441—75.18(249A) Continuous eligibility for pregnant women.

75.18(1) A pregnant woman who was eligible and enrolled in Medicaid under the provisions of this chapter prior to the end of her pregnancy shall remain continuously eligible throughout the pregnancy and the 12-month postpartum period as provided in subrule 75.3(4), regardless of changes in circumstances, except if any of the following occur:

- a.* The woman requests voluntary termination of eligibility.
- b.* The woman ceases to be a resident of the state of Iowa.

c. Iowa Medicaid finds that the woman's eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury.

d. The woman dies.

75.18(2) Except as described in subrule 75.3(4), the woman is not required to meet any eligibility criteria described in this chapter or the reenrollment requirements at 441—paragraph 76.14(1) “a” during the pregnancy and 12-month postpartum period.

75.18(3) At the end of the 12-month postpartum period, the woman will be subject to the reenrollment requirements at 441—paragraph 76.14(1) “b.”

75.18(4) Pregnant women determined eligible only for emergency services pursuant to subrule 75.11(4) are eligible under this provision.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid will 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:

a. Children whose eligibility was determined under the newborn coverage group described in subrule 75.3(3).

b. Children whose eligibility was determined under the medically needy coverage group described in rule 441—75.8(249A).

c. Children whose Medicaid is state-funded only.

d. Children eligible only in a retroactive month pursuant to 441—subrule 76.13(3).

e. Children whose U.S. citizenship and identity, or noncitizenship status, is not verified within the reasonable opportunity period described in paragraph 75.11(2) “c.”

f. Children whose eligibility was determined under express lane procedures described in rule 441—76.4(249A).

g. Children whose initial eligibility was established incorrectly.

75.19(2) Duration of coverage. Coverage under this rule will extend through the earliest of the following:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19, except as stated in rule 441—75.52(249A);

c. The month when the child ceases to be a resident of Iowa or fails to provide the department with adequate information to determine whether the child meets residency requirements pursuant to rule 441—75.10(249A);

d. The month that voluntary termination of eligibility is requested; or

e. The month the child is determined to be deceased.

75.19(3) Assignment of review date. Children entering an existing Medicaid household will be assigned the same annual eligibility review date as that established for the household.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.20(249A) Medical assistance corrective payments. If a decision by the department or SSA following an appeal on a denied application for any of the coverage groups set forth in 441—75.3(249A) through 441—75.8(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 Medicaid 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:

75.20(1) These bills must be for services covered by the Medicaid program as set forth in 441—Chapter 78.

75.20(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.20(3) If a county relief agency has paid medical bills on the member'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 member.

75.20(4) Members and county relief agencies may file claims for payment under this subrule on forms prescribed by the department. These forms are available from the county office. All requests for reimbursement will be acted upon within 60 days of receipt of the forms in the county office.

75.20(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 2506.

[ARC 9763C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the HIPP program, the department will pay for the cost of premiums, coinsurance, copayments, and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid, including managed care capitation fees. Payment will include only the cost to the Medicaid-eligible individual or household.

75.21(1) Definitions. For purposes of this rule, the following definitions apply:

"Absent parent" means a noncustodial parent or a parent who is not living with the member.

"Authorized representative" means an individual or organization authorized by a competent applicant or member; authorized by a responsible person acting for an incompetent applicant or member pursuant to 441—subrule 76.9(2); or with other legal authority to represent the applicant or member in the application process, renewal of eligibility and other ongoing communications with the department.

"Capitation payment" means a monthly payment to the managed care contractor on behalf of each member for the provision of health services under the managed care organization contract. Payment is made by the department regardless of whether the member receives services during the month. The managed care capitation payment varies based on the eligible member's sex, age, and eligibility aid type.

"Cost-effective" means a determination has been made that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost.

"Cost sharing" means the member's portions of in-network health care costs not covered by an insurance plan. "Cost sharing" includes copayments, coinsurance and deductibles, which vary among health care plans.

"Custodian" means the person recognized as representing the interests of the member for Medicaid assistance. When the member reaches the age of 18 and the custodian is not used in determining Medicaid eligibility, there shall be legal documentation in place that the custodian is now the responsible person or authorized representative.

"Employer-sponsored insurance" or *"ESI"* means any health insurance plan paid for by a business on behalf of its employees.

"High-deductible health plan" or *"HDHP"* means a health insurance plan that meets the definition found in Section 223(c)(2) of the United States Internal Revenue Code as amended to August 1, 2025.

"HIPP-eligible member" or *"HIPP enrollee"* means a person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP.

"Household" means the group of people who are used in the budgeting and size when determining Medicaid eligibility.

"Individual plan" means an insurance plan purchased through a government-run health insurance marketplace or through a local broker or agent.

"Insurance plan" means major medical comprehensive health coverage provided through an employer, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended to

August 1, 2025, a government-run health insurance marketplace, or a local broker or agent. Dental and vision plans are not considered to be insurance plans for purposes of this definition.

“Member” means an individual who has been determined eligible for Medicaid assistance and is enrolled to receive assistance.

“Policyholder” means the person in whose name an insurance policy is registered.

“Responsible person” means an individual recognized by the department pursuant to 441—subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“Wrap benefits” means the services covered under the Medicaid state plans that are not paid for by insurance plans (i.e., waiver services, transportation).

75.21(2) Insurance plans. Participation in an insurance plan is not a condition of Medicaid eligibility. The department will pay for the cost of the insurance plan premiums, coinsurance, copayment, and deductibles of an insurance plan for a member if:

- a. A member is enrolled in or can be added to the insurance plan; and
- b. The insurance plan is cost-effective as described in subrule 75.21(3).

75.21(3) Cost-effectiveness. An insurance plan shall be considered cost-effective when the amount the department would pay for the member’s insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid, including managed care capitation fees. When determining the cost-effectiveness of an insurance plan, the following data will be considered:

- a. The cost to the member or household for the insurance premium, coinsurance, copayments and deductibles. Costs paid by an employer or other plan sponsor will not be considered in the cost-effectiveness determination.
- b. The cost of care through Medicaid, including managed care capitation fees, the department would pay for the member.
- c. The estimated cost of wrap benefits per member based on the member’s sex, age, and eligibility aid type.
- d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire will be used to obtain this information. When the information indicates any health conditions that could be expected to result prospectively in higher-than-average bills for any Medicaid member:

(1) If the member is currently covered by the insurance plan, the department will request from the policyholder, or from the responsible person for the member, an insurance summary of the member’s paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the insurance plan. The cost of the insurance plan premium, member’s cost sharing, and administrative cost are compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, fee-for-service paid Medicaid claims may be used to project the cost-effectiveness of the plan.

- e. Annual administrative expenditures of \$150 per HIPP member covered under the health plan.
- f. Whether the estimated savings to the department for members covered under the health insurance plan is at least \$5 per month per household.

75.21(4) Coverage of non-Medicaid-eligible family members. When an insurance plan is determined to be cost-effective, the department will pay for insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the insurance plan in order to obtain coverage for the Medicaid-eligible family members. However:

- a. The needs of the non-Medicaid-eligible family members will not be taken into consideration when determining cost-effectiveness; and

b. Payments for deductibles, coinsurances or other cost-sharing obligations will not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) *Insurance plans ineligible for reimbursement.* Premiums will not be paid for insurance plans under any of the following circumstances:

- a. The insurance plan is that of an absent parent.
- b. The insurance plan is an indemnity policy that supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., \$50 per day for hospital services instead of 80 percent of the charge).
- c. The insurance plan is a school plan offered on the basis of attendance or enrollment at the school.
- d. The insurance premium is used to meet a spenddown obligation under the medically needy program, as provided in rule 441—75.8(249A), 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 will be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the insurance premium will not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.
- e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).
- f. The persons covered under the insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments will be made if the case is not Medicaid-eligible on the date of decision.
- g. The person is eligible only for a coverage group that does not provide full Medicaid services.
- h. Insurance coverage is provided through the Iowa Comprehensive Health Insurance Association in accordance with Iowa Code chapter 514E.
- i. Insurance on the member(s) is maintained by someone who does not live with the member(s), is not the legal guardian of the member(s), is not a responsible person, or does not have legal permission to access the Medicaid information of the member(s) (e.g., self-supporting adult children).
- j. The member has Medicare. If other members in the household are covered by the insurance plan, cost-effectiveness is determined without including the Medicare-covered member.
- k. The insurance plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).
- l. The health plan pays secondary to another plan.
- m. The only Medicaid member is in foster care.
- n. The member is active for Medicaid under Medicaid for children with disabilities (i.e., MKSN) pursuant to subrule 75.6(7). Any other Medicaid members in the household who are covered by the health plan will be determined for cost-effectiveness.
- o. The insurance plan is limited due to preexisting conditions.
- p. The insurance plan is a subsidized insurance plan purchased through a government-run health insurance exchange.
- q. On the date the decision regarding eligibility for the HIPP program is made, the insurance is no longer available.
- r. The insurance plan is an HDHP.

75.21(6) *Department evaluation of ESI plans.* When evaluating ESI plans available through an employer, if there is more than one cost-effective insurance plan available, the department will pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan will be determined as follows:

- a. Premium payments shall begin the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, HIPP Program Application, or the automated HIPP referral is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the insurance plan when eligibility for participation in the HIPP program is established, premium payments will 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 will not be made for any period of time before the current effective date of coverage.

d. In no case will payments be made for premiums that were used as a deduction to income for determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage will be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage of an insurance plan not obtained through an employer will 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 will reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department will 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 will be made directly to the insurance carrier, the COBRA administrator, or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment; or

(2) The department pays for only part of the total premium.

75.21(9) *Payment of claims.* Claims from medical providers for persons participating in this program will 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 will be completed annually and may be conducted more frequently at the discretion of the department.

a. Annual review of ESI cost-effectiveness and eligibility will be completed using the HIPP Program Review form.

b. Annual review of individual health plan cost-effectiveness and eligibility will be the HIPP Private Policy Review form.

c. Failure of the household to cooperate in the annual review process will result in cancellation of premium payment.

d. Redeterminations will be completed whenever:

(1) A premium rate, copayment, deductible, or coinsurance changes;

(2) A person covered under the policy loses full Medicaid eligibility;

(3) Changes in employment or hours of employment affect the availability of an insurance plan;

(4) The insurance carrier changes;

(5) The policyholder leaves the Medicaid home;

- (6) There is a decrease in the services covered under the policy; or
- (7) The Medicaid category of coverage changes.

e. The policyholder shall report changes that may affect the availability of the insurance plan reimbursed by the HIPPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(15)“a,” will be considered if they are 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 will verify whether coverage may be continued under the provisions of COBRA.

(1) The Employer Verification of COBRA Eligibility form may be used for this purpose.

(2) If it is cost-effective to do so, the department will pay premiums to maintain insurance coverage for members after the occurrence of the event that would otherwise result in termination of coverage.

75.21(11) Time frames for determining cost-effectiveness. The department will determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule 75.21(7)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(12) Notices.

a. Adequate notice will be provided to the household under the following circumstances:

- (1) To inform the household of the initial decision on cost-effectiveness and premium payment.
- (2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.
- (3) The insurance plan is no longer available to the family (e.g., the employer no longer provides health insurance coverage or the policy is terminated by the insurance company).

b. The department will provide timely and adequate notice as defined in rule 441—16.2(17A) to inform the household of a decision to discontinue payment of the health insurance premium because:

- (1) The department has determined the insurance plan is no longer cost-effective; or
- (2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the HIPPP program.

75.21(13) Rate refund. The department is entitled to any rate refund made when the insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(14) Reinstatement of HIPPP eligibility.

a. When eligibility for the HIPPP program is canceled because the persons covered under the insurance plan lose Medicaid eligibility, HIPPP eligibility will be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPPP eligibility is canceled because of the policyholder's failure to cooperate in providing information necessary to establish continued eligibility for the HIPPP program, benefits will be reinstated the first day of the first month in which cooperation occurs if all other eligibility factors are met.

75.21(15) Amount of insurance premium paid.

a. For ESI plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) The HIPPP program will pay only for the option that provides coverage to the cost-effective members of the household.

(2) The HIPPP program will not pay the portion of the premium cost that is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program will pay the cost of covering the cost-effective members covered by the plan.

c. For insurance plans, if another household member must be covered to obtain coverage for the members, the HIPP program will pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(16) *Reporting changes.* Failure to report and verify changes may result in cancellation of HIPP benefits.

a. The policyholder shall verify changes by providing a pay stub, a summary of benefits and coverage, a rate sheet, or a letter from the insurance carrier reflecting the change.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

d. Any underpayment that results from an unreported change will be paid effective the first day of the month in which the change is reported.

75.21(17) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments will be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department will complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the insurance plan is no longer cost-effective, premium payment will be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility for the HIPP program, the department will discontinue premium payment after timely and adequate notice. The department will 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 will be discontinued pending timely and adequate notice.

e. If the insurance plan is no longer available or the policy has lapsed, premium payments will be discontinued as of the effective date of the termination of the coverage.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, “AIDS” and “HIV” mean the same as defined in Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department will pay for the cost of continuing health insurance coverage to persons with AIDS or an HIV-related illness when the following criteria are met:

a. The person with AIDS or an 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 rule 441—75.8(249A), 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 an HIV-related illness. The Physician's Verification of Diagnosis form shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the FPL for a family of the same size. The gross income of all family members will be counted using the definition of gross income under the 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, and certificates of deposit, excluding IRS-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 HIPP Application. The applicant shall be required to provide documentation of income and assets. The application will be available from and may be filed at any county office or the department.

An application will be considered as filed on the date an AIDS/HIV HIPP Application containing the applicant's name, address and signature is received and date-stamped in any county office or the department.

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, the department will deny pending applications. The department will mail a notice of decision within ten calendar days following the determination that funds have been obligated. The notice will 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 will 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 will 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 will be granted when all of the following occur:

- a. The application is accompanied by a completed Physician's Verification of Diagnosis form.
- 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 will 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 will be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The department will review circumstances of persons participating in the program quarterly to ensure eligibility criteria continue to be met. The AIDS/HIV HIPPA Program Review form 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 rule 441—16.1(17A) will be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in rule 441—16.2(17A) will 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 will 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 shall be signed by the recipient authorizing the department to make the contact.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

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 subrule 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 subrule 75.23(3). The department will determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When assets were transferred before February 8, 2006, the period of ineligibility begins on the first day of the first month during which the assets were transferred, except as provided in subparagraph 75.23(1)“a”(3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph 75.23(1)“a”(3), when the assets were transferred on or after February 8, 2006, the period of ineligibility begins 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 will 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 subrule 75.23(3). The department will determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the assets were transferred before February 8, 2006, the period of ineligibility begins on the first day of the first month during which the assets were transferred, except as provided in subparagraph 75.23(1)“b”(3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph 75.23(1)“b”(3), when the assets were transferred on or after February 8, 2006, the period of ineligibility begins 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 will 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 will not be deducted as medical expenses in determining client participation pursuant to subrule 75.83(2).

75.23(2) Look-back date.

a. Transfer before February 8, 2006. When assets were transferred 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. When assets were transferred 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 will 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 will determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. Current average statewide costs will be published on the department's website.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset will be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual will 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 child 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 that 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 exists only when all of the following conditions are met:

(1) Applying 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, will 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 that results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility will 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 will 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 will be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* For the purposes of this rule the following definitions apply:

"Assets" includes all income and resources of the individual and the individual's spouse, including any income or resources that 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" means the same as defined in 42 U.S.C. Section 1382a.

"Institutionalized individual" means 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" means the same as defined in 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 (subparagraph 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 633E.5 on or after July 1, 2000 (Iowa Code section 249A.3(11) "c");

75.23(9) *Purchase of annuities.* Funds used to purchase an annuity for more than its fair market value will 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 will 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 as amended to August 1, 2025 (U.S. IRC).

(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 U.S. IRC;
2. A simplified employee pension (within the meaning of Section 408(k) of the U.S. IRC); or
3. A Roth IRA described in Section 408A of the U.S. IRC.

(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 SSA); 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 will 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, will 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 subrule 75.23(1) unless the note, loan, or mortgage meets all of the following conditions:

(1) Has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the SSA).

(2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) 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 will be treated as assets transferred for less than fair market value regardless of whether the note, loan, or mortgage was:

(1) Purchased before February 8, 2006; or

(2) Purchased on or after February 8, 2006, and the conditions described in paragraph 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, will 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 will be treated as assets transferred for less than fair market value regardless of whether the life estate was:

- (1) Purchased before February 8, 2006; or
- (2) Purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

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 (except for trusts specified in subrule 75.24(3)) established after August 10, 1993, will be treated in accordance with subrule 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual is 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:

- (1) The individual,
 - (2) The individual's spouse, or
 - (3) A person, including a court or administrative body:
 1. With legal authority to act in place of or on behalf of the individual or the individual's spouse,
- or
2. 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 that the individual or the individual's spouse is entitled to but does not receive because of action by:

- (1) The individual,
 - (2) The individual's spouse, or
 - (3) A person, including a court or administrative body:
 1. With legal authority to act in place of or on behalf of the individual or the individual's spouse,
- or
2. 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 apply to the portion of the trust attributable to the individual.

d. This rule applies 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 will be considered an available resource.
- (2) Payments from the trust to or for the benefit of the individual will be considered income of the individual.
- (3) Any other payments from the trust will be considered assets disposed of by the individual subject to the penalties described in 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 or income on the principal from which payment to the

individual could be made will be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual will be considered income to the individual. Payments for any other purpose will be considered a transfer of assets by the individual subject to the penalties described in 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 will 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 in subrule 75.23(3) and 441—Chapter 89. The value of the trust will 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 does not apply to any of the following:

a. A trust that contains the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Act) and that is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or 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); 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 chapter 633C, the average statewide charges and Medicaid rates are updated annually and will be published on the department's website.

c. A trust containing the assets of an individual who is disabled (as defined in Section 1614(a)(3) of the 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 Section 1614(a)(3) of the 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.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.25(249A) Treatment of Medicaid qualifying trusts.

75.25(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 an intellectually disabled person who resides in an ICF-ID are exempt.

75.25(2) The amount of income and principal from a Medicaid qualifying trust that will be considered available will be the maximum amount 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 will be counted as income.

b. Trust principal (including accumulated income) considered available will 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 will be counted as income for that period of time.

c. To the extent that the trust principal and income are available only for medical care, the principal or income will not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it will be used as a third-party resource.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.26(249A) Conservatorships.

75.26(1) *Conservatorships established prior to February 9, 1994.* The department will determine whether assets from a conservatorship established prior to February 9, 1994, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

a. Funds clearly conserved and available for care, support, or maintenance will be considered toward income limitations and resource limitations when applicable for the coverage group.

b. When assets in the conservatorship are not clearly available, the department 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.

c. Funds in a conservatorship that are not clearly available will be considered unavailable until the conservator or court actually makes the funds available.

d. Payments received from the conservatorship for basic or special needs are considered income.

75.26(2) *Conservatorships established on or after February 9, 1994.* Conservatorships established on or after February 9, 1994, will be treated according to the provisions of paragraphs 75.24(1)“e” and 75.24(2)“b.”

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

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.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.28(249A) Recovery.

75.28(1) *Definitions.* For the purposes of this rule, the following definitions apply:

“*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).

“Premiums paid for medical assistance” means monthly premiums assessed to a member or household for Medicaid or IHAWP coverage.

75.28(2) *Amount subject to recovery.* The department will 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 will be promptly notified when it is determined that assistance was incorrectly expended or when assessed premiums are unpaid.

a. Notification of incorrect expenditures will include:

- (1) The person 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 will include:

- (1) The amount of the premium; and
- (2) The month covered by the medical assistance premium.

75.28(4) *Source of recovery.* Recovery will 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 ICF-ID, or a mental health institute enrolled as an inpatient psychiatric facility may be made by the client to the facility. The department will 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 2506.

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, of the member’s surviving spouse, or 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 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 in Iowa Code section 633.425(7).

a. *Definitions.* In addition to the definitions in subrule 75.28(1), the following definitions apply:

“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” 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.

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;
2. Is a resident of a nursing facility, an ICF-ID, 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 will presume that the member cannot or could not reasonably be expected to be discharged and return home and a debt due will be established. The department will 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 will 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 will 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 a determination, the department will determine if the member can or could have returned home.

(1) The department 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 department 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, Iowa Medicaid will 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 department will notify the member or the member’s representative 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 2506. 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 department upon the death of a member residing in the facility by submitting a form prescribed by the department.

(2) Upon receipt of the form or a report of a member's death through other means, the department will request a statement of the member's assets from the member's personal representative. The representative shall sign and return a form prescribed by the department 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 those procedures provide for an inventory, an accounting, and a final report of the estate.

g. Waiving the collection of debt.

(1) The department will 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 FPL 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" will be defined as being under FIP.

(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 will 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 2506.

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 will 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 Medicaid under subrule 75.82(5) will not be subject to a claim for Medicaid paid on the member's behalf up to the amount of the assets disregarded by asset disregard. Medicaid paid on behalf of the member before these conditions will be recovered from the estate, regardless of the member's having purchased precertified or approved insurance.

j. Interest on debt. Interest will accrue on a debt due under this subrule in accordance with Iowa Code section 249A.53(2)"e."

k. Reimbursement to a 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 will reimburse the county on a proportionate basis.

[ARC 9763C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.29(249A) Investigation of eligibility. An applicant or member shall cooperate when the applicant's or member's case is selected by the department or the department of inspections, appeals, and licensing for verification of eligibility unless the investigation revolves solely around the circumstances of a person whose income and resources do not affect Medicaid eligibility. (More information is contained in 481—Chapter 72.) Failure to cooperate will serve as a basis for denial of an application or discontinuance of Medicaid unless the Medicaid eligibility is determined by SSA. Once a person's eligibility is denied or discontinued for failure to cooperate, the person may reapply but will not be determined eligible until cooperation occurs.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.30 to 75.49 Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO FAMILY-RELATED COVERAGE GROUPS

441—75.50(249A) Eligibility factors specific to child. A child must meet the requirements of this rule to be eligible for FMAP or the coverage groups specified in subrules 75.3(6), 75.3(7), and 75.3(14).

75.50(1) Age and school attendance. Medicaid will be available to a child under the age of 18 without regard to school attendance.

a. The effect of age on the child's eligibility will be determined pursuant to rule 441—75.52(249A).

b. Medicaid will also be available to a 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 will 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 will 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 will be continued for a reasonable period of time to complete the adjustment.

75.50(2) Residing with a parent or other caretaker. The child shall be living in the home of a parent or other caretaker as defined in rule 441—75.1(249A). The parent or other caretaker must meet the requirements of rule 441—75.51(249A).

a. When the mother intends to place her child for adoption shortly after birth, the child will be considered as living with the mother until the time custody is actually relinquished.

b. Living with a parent or other caretaker implies the existence of a relationship involving an accepted responsibility on the part of the caretaker for the primary care of the child. A non-parental caretaker must attest to having primary responsibility for the child's care pursuant to paragraph 75.51(2) "b."

c. A child can receive Medicaid in one household only. In a joint custody situation, when a child lives in the home of one parent or other caretaker some of the time and also lives in the separate home of the other parent or another caretaker, who the child will be considered to be living with is determined as follows:

(1) As specified in a court order or binding separation, divorce or custody agreement, or,

(2) If there is no such order, the parent or other caretaker with whom the child spends most nights will be considered the custodial parent or other caretaker. When a child spends equal amounts of time in the home of each parent and both parents apply for Medicaid for the child, the parents must decide which parent will continue with the application. Likewise, when a child spends equal amounts of time in the home of a parent and the home of another caretaker, the parent or other caretaker must decide which caretaker will continue with the application. If the parents, or the parent and other caretaker, cannot reach a decision, the department will make the determination based on the totality of the available information.

d. Upon the determination that a child is living with a parent or other caretaker, the Medicaid household size for each applicant or member is determined according to rule 441—75.72(249A) for the purpose of determining eligibility.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.51(249A) Eligibility factors specific to parents and caretakers.

75.51(1) *FMAP and other requirements.* To be eligible for FMAP or the coverage groups specified in subrules 75.3(6), 75.3(7), and 75.3(14), a parent or other caretaker must:

- a.* Meet the definition of “parent” or “caretaker” in rule 441—75.1(249A);
- b.* Live with an eligible child as defined in rule 441—75.50(249A); and
- c.* Satisfy the FMAP requirements specified in subrule 75.3(1) and the general conditions of eligibility specified in this chapter.

75.51(2) *Assumes primary responsibility for care of child.* To be eligible for FMAP, the parent or other caretaker living in the home with the child must assume primary responsibility for the care of the child.

a. A parent who is living with their child is presumed to have primary responsibility for the child’s care.

b. For a child and a non-parental caretaker to meet the requirements of this subrule, the non-parental caretaker who is living with the child must attest to having primary responsibility for the child’s care on an application or other document submitted to the department.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.52(249A) The effect of age on eligibility. When age is an eligibility factor and a person has reached the age limit, the birth date impacts eligibility for the birth month.

75.52(1) A person is eligible for the entire month in which the person’s birth date occurs, unless the birthday falls on the first day of the month. Ineligibility based on age will be effective the first of the month following the birth month.

75.52(2) A person whose birth date is on the first day of the month is not eligible for the age-limited coverage group for the birth month. Ineligibility based on age will be effective on the person’s birth date.

75.52(3) This rule applies to the following coverage groups:

- a.* FMAP;
- b.* MAC;
- c.* Child medical assistance program (CMAP);
- d.* Subsidized guardianship medically needy program;
- e.* Children eligible under Title IV-E;
- f.* State-only funded medical assistance for children in foster care or subsidized adoption;
- g.* State-only funded medical assistance for children in subsidized guardianship; and
- h.* Medicaid for former foster care youth (EMIYA).

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.53(249A) Absence from the home.

75.53(1) A person who is absent from the home will not be included in the household, except when temporarily absent as described in subrule 75.53(2).

a. A parent who 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.

b. A parent whose absence from the home is due solely to a pattern of employment is not considered to be absent.

c. 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.

75.53(2) The needs of a person who is temporarily absent from the home are included in a household if otherwise eligible. A temporary absence exists in any of the following circumstances:

a. A person is anticipated to be in a 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 person no longer being included in the household;

b. A child is out of the home to secure education or training as defined in paragraph 75.50(1) “*b*” as long as the child remains a dependent;

c. A parent or other caretaker is temporarily out of the home to secure education or training and was in the household 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; or

d. A person is out of the home for reasons other than reasons in paragraphs 75.53(2) “*a*” through “*c*” and intends to return to the home within three months. Failure to return within three months from the date the person left the home will result in the person no longer being included in the household.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.54(249A) Pending SSI approval. When a person who would ordinarily be in the family-related Medicaid household has applied for SSI benefits, the person’s needs will be included in the family-related Medicaid household pending approval of SSI.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.55(249A) Resources not considered. There is no resource test to determine eligibility for family-related Medicaid coverage groups.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.56(249A) Income eligibility. Unless otherwise stated within this chapter, income eligibility under family-related coverage groups will be determined using MAGI methodologies pursuant to Division III of this chapter.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.57 to 75.69 Reserved.

DIVISION III FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

441—75.70(249A) Financial eligibility based on MAGI. Notwithstanding any other provision of this chapter, financial eligibility for Medicaid is determined using 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 Act. For this purpose, financial eligibility for Medicaid includes any applicable purpose for which a determination of income is required for a coverage group that is subject to MAGI methodology as specified in rule 441—75.71(249A) and defined in rule 441—75.1(249A), including the imposition of any premiums or cost sharing.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.71(249A) Coverage groups subject to MAGI methodology. Financial eligibility will be determined under MAGI methodology for the following coverage groups:

1. FMAP as described in subrule 75.3(1).
2. MAC program as described in subrule 75.3(2).
3. Hawki as described in 441—Chapter 86.
4. IHAWP as described in 441—Chapter 74.
5. RMA as described in subrule 75.5(3).

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.72(249A) MAGI household composition. For the purpose of determining financial eligibility, each applicant's or member's household is determined based on federal tax policy and with regard to the applicant's or member's federal tax status as described below.

75.72(1) *Applicant or member is a tax-filer.* An applicant or member who expects to file a federal tax return for the year in which the applicant or member requests Medicaid and does not expect to be claimed as a tax dependent by another taxpayer is considered a tax-filer. A tax-filer's Medicaid household includes:

- a. The tax-filer,
- b. The tax-filer's spouse, under either of the following circumstances:
 - (1) The tax-filer and spouse are living together, or
 - (2) The expected tax status is married filing jointly, regardless of whether the spouse is present in the home, and
- c. Each dependent that the tax-filer expects to claim.

75.72(2) *Applicant or member is a tax dependent.* An applicant or member who expects to be claimed as a tax dependent on a federal tax return for the year in which the applicant or member requests Medicaid is a tax dependent. A tax dependent's Medicaid household is the same as the tax-filer who claims the dependent, except the dependent's household is determined pursuant to subrule 75.72(3) when the dependent:

- a. Expects to be claimed by someone other than a spouse or parent.
- b. Is a child under the age of 19 who expects to be claimed by one parent while living with two parents who do not expect to file a joint return.
- c. Is a child under the age of 19 who expects to be claimed by a noncustodial parent in accordance with a court order or binding separation, divorce, or custody agreement establishing physical custody controls. If there is no such order or agreement, the custodial parent is the parent with whom the child spends most nights pursuant to subparagraph 75.50(2) "c"(2).

75.72(3) *Applicant or member is a non-filer (does not file taxes) and is not claimed as a tax dependent.*

- a. This subrule applies to an applicant or member who:
 - (1) Does not expect to file a federal tax return for the year in which Medicaid is requested,
 - (2) Does not expect to be claimed as a tax dependent for the year in which Medicaid is requested,
 or
 - (3) Meets an exception described in paragraph 75.72(2) "a," "b," or "c."
- b. The household consists of the applicant or member and each of the following who is living with and in relation to the applicant:
 - (1) Parent, when the applicant or member is a child under the age of 19.
 - (2) Spouse.
 - (3) Child under the age of 19.
 - (4) Sibling under the age of 19, when the applicant or member is a child under the age of 19.
- c. For the purpose of paragraph 75.72(3) "b," "living with" must be in accordance with subrule 75.50(2).

75.72(4) *Married couples.* In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of federal tax status.

75.72(5) Pregnancy.

a. Household size. In establishing eligibility for a pregnant woman or any person whose household includes a pregnant woman, the unborn child (or children if more than one fetus exists) will be considered when determining the number of persons in the household.

b. Verification of pregnancy. The applicant's or member's attestation of the pregnancy, date of conception, due date, and number of children expected to deliver will serve as verification unless questionable as determined by the department.

75.72(6) Applicant or member attestation of federal tax status. The department will accept the applicant's or member's statement of the applicant's or member's federal tax status and claimed dependents or such statement from an adult who is living with and in the Medicaid household of an applicant or member who is a child.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.73(249A) Income under MAGI methodology. The total countable earned and unearned income of the applicant or member included in the household as defined in rule 441—75.72(249A) will be considered when determining initial and ongoing Medicaid eligibility for coverage groups that are subject to MAGI methodology as specified in rule 441—75.71(249A). For eligibility to exist, the total countable monthly income of the applicant's or member's household must be at or below the income limit for the applicable coverage group pursuant to rule 441—75.74(249A).

75.73(1) Household member income exclusions under MAGI. The income of a household member that meets the requirements of paragraph 75.73(1)“a” or “b” is excluded from the household's total countable income.

a. Income of children under age 19.

(1) The income of a child under the age of 19 who is:

1. Included in the household of the child's parent, and

2. Not expected to be required to file a federal tax return under 26 U.S.C. Section 6012(a)(1) for the taxable year in which Medicaid is being determined, regardless of whether a tax return is filed by the child for the tax year.

(2) A child with income of less than the threshold determined annually by the IRS is considered not expected to be required to file a tax return for the taxable year in which Medicaid is being determined.

b. Income of tax dependent other than spouse or child.

(1) The income of a tax dependent other than a spouse or a child who is not expected to be required to file a federal tax return under 26 U.S.C. Section 6012(a)(1) for the taxable year in which Medicaid is being determined is not included, regardless of whether a tax return is filed by the tax dependent for the tax year.

(2) A dependent with income of less than the threshold determined annually by the IRS is considered not expected to be required to file a tax return for the taxable year in which Medicaid is being determined.

(3) Any cash support provided to the claimed dependent by the tax-filer.

75.73(2) Countable income under MAGI. For the purpose of determining initial and ongoing MAGI Medicaid eligibility, countable income is the amount that remains after allowable expenses and deductions have been subtracted from gross countable income as defined in paragraph 75.73(2)“a.” Income described in paragraph 75.73(2)“b” is excluded as countable income. Allowable expenses and deductions are limited to those allowed in accordance with paragraphs 75.73(2)“c” and “d.”

a. Gross countable income. Gross countable income under MAGI includes income types that are considered as gross income for federal tax purposes pursuant to 26 U.S.C. Sections 61 and 71 through 91 and calculated pursuant to 26 U.S.C. Section 36B(d)(2)(B), except as specified in paragraph 75.73(2)“b.” Gross countable income for the purpose of Medicaid eligibility under MAGI includes but is not limited to the following income types:

(1) Earned income, including salaries, wages, tips and other compensation for services that include fees, commissions, fringe benefits such as sick pay, vacation pay, severance pay, and similar items, and including foreign earned income and housing expenses of a U.S. citizen or resident who lives abroad even though these types of income may not be taxable.

(2) Gross profit derived from a self-employment trade or business as defined in paragraph 75.73(2) “e” and 26 U.S.C. Section 1402;

(3) Capital gains derived from dealings in assets or property;

(4) Interest (taxable and non-taxable);

(5) Rental income, including room and board;

(6) Royalties;

(7) Taxable dividends;

(8) Alimony and separate maintenance payments;

(9) Taxable annuities;

(10) Income from life insurance and endowment contracts;

(11) Pensions;

(12) Income from discharge of indebtedness;

(13) Distributive share of partnership or S-corporation gross income;

(14) Income in respect of a deceased person;

(15) Income from an interest in an estate or trust;

(16) Deemed sponsor income;

(17) Social security benefits (taxable and nontaxable);

(18) Disability payments, including government, private, temporary and permanent payments;

(19) Unemployment Insurance Benefits (UIB);

(20) Gambling winnings;

(21) Survivor’s benefits; and

(22) Strike pay.

b. Income types excluded from gross income. Income that meets the following criteria is not considered when determining countable gross income under MAGI despite the fact that the income may be considered for federal tax purposes. The exclusion of these income types is in accordance with 42 CFR Section 435.603(e).

(1) An amount received as a nonrecurring lump sum from a source that is considered in determining adjusted gross income for federal tax purposes pursuant to paragraph 75.73(2) “a” is counted only in the month received for determining Medicaid eligibility under MAGI. A nonrecurring lump sum received from a source that is not considered in determining adjusted gross income for federal tax purposes is entirely excluded.

(2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.

(3) Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights, and student financial assistance pursuant to 42 CFR Section 435.603(e)(3) is excluded from income.

(4) Student financial assistance provided under the Bureau of Indian Affairs education programs is excluded from income.

(5) Any other type of income that is not identified as countable in paragraph 75.73(2) “a” and is not otherwise included in “adjusted gross income” for federal tax purposes pursuant to 26 U.S.C. Section 62 is excluded from income.

c. Allowable expenses. Expenses that are allowed as deductions from gross income when determining a person’s adjusted gross income for federal tax purposes pursuant to 26 U.S.C. Section 62 are subtracted from gross income as defined in paragraphs 75.73(2) “a” and “b” when determining countable income under MAGI. Allowable expenses include:

(1) Educator expenses.

- (2) Certain business expenses of reservists, performing artists, and fee-based government officials.
- (3) Health savings account contributions.
- (4) Moving expenses for members of the Armed Forces.
- (5) Deductible part of self-employment tax.
- (6) Contributions to self-employed Simplified Employee Pension (SEP), Savings Incentive Match Plan for Employees of Small Employers (SIMPLE) and Qualified Plans.
- (7) Self-employed health insurance contributions.
- (8) Amount of penalty for early withdrawal of savings.
- (9) Alimony payments made under a divorce or separation agreement executed before January 1, 2019.
- (10) Certain individual retirement account (IRA) contributions.
- (11) Student loan interest expense.
- (12) Expenses directly related with the conduct of a self-employment trade or business, including but not limited to depreciation and capital losses.

d. MAGI Income Deduction. An amount equal to 5 percent of the FPL for the applicable household size will be subtracted from the total monthly countable MAGI income amount when:

- (1) An applicant's monthly MAGI income exceeds the highest income limit of all of the coverage groups for which the applicant meets the categorical requirements, and
- (2) Deducting 5 percent results in the applicant's income being within the income limit of the coverage group with the highest income limit for which the applicant meets categorical requirements.

e. Self-employment defined for MAGI purposes. A person is considered self-employed if the person:

- (1) Carries on a trade or business with the goal of making a profit and is the sole proprietor of the trade or business, or
- (2) Is an independent contractor and the person paying for the work has the right to control or to direct only the result of the work and not how the work will be done.

75.73(3) *Income verification.* The department will accept an applicant's or member's attestation of income and use the attested income to determine eligibility when the attested amount is reasonably compatible with electronic data sources as defined in rule 441—75.1(249A).

a. Verification not required. The department will not require the applicant or member to provide verification when attested income is reasonably compatible with EDS or verification is available to the department from other sources.

b. Verification required. When attested income is not reasonably compatible with EDS or verification is not available to the department from other sources, the applicant or member must provide verification of the income in accordance with 441—subrule 76.8(2) or provide a statement that reasonably explains the discrepancy between the attested income and electronic data sources.

75.73(4) *Budgeting procedures for determining financial eligibility under MAGI.* Initial and ongoing financial eligibility under MAGI is based on current monthly household composition and income with consideration given to any anticipated changes or fluctuation in income or expenses pursuant to 42 CFR Section 435.603(h). Total countable earned and unearned income of all persons in the applicant or member household after applicable expenses and deductions is considered in determining financial eligibility under MAGI in accordance with subrules 75.73(1) and 75.73(2).

a. Current monthly household income. Both initial and ongoing eligibility will be based on current monthly income when current income and any applicable expenses are a good indicator of future income except when the income is unemployment insurance benefits as described in paragraph 75.73(4)“c.”

b. Change in current month's income. If the household indicates that current countable income is not indicative of future income due to a change that is reasonably expected to occur in the current or next month, the amount of monthly income used for initial and ongoing eligibility will be calculated

based on the change. When the anticipated change is with unemployment insurance benefits, income will be budgeted as described in paragraph 75.73(4) "c."

c. Unemployment insurance benefits (UIB). When current income includes UIB, the monthly amount of UIB income used for initial and ongoing eligibility will be determined by annualizing the remaining balance according to the applicable item below:

(1) For applicants, the monthly amount is determined by using the remaining balance as of the first day of the month in which the application was filed and dividing the balance by 12. If the UIB will end in the application month, the annualized amount will be used for the application month only and no UIB income will be used for months thereafter.

(2) For members in the review process described in rule 441—76.14(249A), the monthly amount is determined by using the remaining balance as of the first day of the month of the new certification period and dividing the balance by 12. If the UIB will end in the first month of the new certification period, the annualized amount will be used for the first month and no UIB income will be used for months thereafter.

(3) For members reporting a change and not due for review as described in rule 441—76.14(249A), the monthly amount is determined by using the remaining balance as of the first day of the month in which the change can be acted upon in accordance with rule 441—76.16(249A).

d. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, will 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 will be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently will 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 will be treated as described in paragraph 75.73(4) "h."

(3) Applicable expenses and deductions will be applied to the monthly prorated income.

e. Conversion of weekly or biweekly income to a monthly amount. When income received weekly or biweekly (once every two weeks) is projected for future months, it will 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 will 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.

f. Self-employment income. Countable income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis will be annualized (annual income averaged over a 12-month period of time) to arrive at the monthly amount to be used to determine eligibility, even if the income is received within a short period of time during that 12-month period. Countable self-employment income is gross countable income as defined in paragraph 75.73(2) "a" less allowable expenses pursuant to subrule 75.73(2) "c." Any change in self-employment will be handled in accordance with subparagraph 75.73(4) "f"(3).

(1) When a self-employment enterprise that does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income will be averaged over the period of time the enterprise has been in existence to arrive at a projected monthly amount to be used to determine eligibility. If the enterprise has been in existence for such a short time that there is very little income information or income in the period of time is not a good indicator of future income, the department will establish, with the cooperation of the applicant or member, a reasonable estimate of the projected monthly income to be used for eligibility.

(2) The policies outlined in this paragraph apply when 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 that will result in a significant change in the person's annual net income. Change in self-employment income is defined as a change that will result in a significant change in the person's annual income.

1. When an applicant or member reports that change in operating expenses has occurred and the person's self-employment income has been annualized, the department will recalculate the expenses on the basis of the change.

2. When a change in self-employment income occurs and the person's self-employment income has been annualized, the department will recalculate income and expenses on the basis of the change.

3. A change in the cost of producing self-employment income or income received from self-employment that occurs as a result of seasonal business fluctuations is not considered a change for the purpose of this subparagraph.

g. Rounding procedures. The following rounding procedures apply when determining countable MAGI income.

(1) The third digit to the right of the decimal point in any calculation of income will be dropped.

(2) When the monthly countable income is converted to a percentage of the FPL and the resulting percentage is not a whole number, the FPL percentage is rounded up to the next whole percentage.

75.73(5) 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, except as described at 75.73(1) "b"(3).

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.74(249A) Income limits. The following income limits apply to the MAGI-related coverage groups specified below, as identified by the legal references provided:

Coverage Group	Legal Reference	Household Size (persons)	Income Limit (per month)
FMAP	441—subrule 75.3(1); 42 CFR Part 435.110 and 435.118; Title XIX of the 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	\$1,950 plus \$178 for each additional person
Mothers and Children, for pregnant women	441—subrule 75.3(2); 42 CFR Part 435.116 and 435.118; Title XIX of the Act, Section 1902	215% of the FPL for the household	
Mothers and Children, for infants under one year of age		300% of the FPL for the household	
Mothers and Children, for children aged 1 through 18 years	441—subrule 75.3(2); 42 CFR Part 435.118; Title XIX of the Act, Section 1902	167% of the FPL for the household	

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.75 to 75.79 Reserved.

DIVISION IV

ELIGIBILITY FACTORS SPECIFIC TO NON-MAGI-RELATED COVERAGE GROUPS, PERSONS IN MEDICAL INSTITUTIONS AND PERSONS RECEIVING LONG-TERM CARE SERVICES

441—75.80(249A) Categorical relatedness to supplemental security income (SSI). 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 SSI program administered by the SSA.

75.80(1) SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI (collectively, “SSI policies”) are found in Title XVI of the Act (42 U.S.C. Sections 1381 through 1383f), in the federal regulations promulgated pursuant to Title XVI of the Act (20 CFR 416.101 to 416.2227), and in Part 5 of the program operations manual system published by the SSA. The program operations manual system is available online; at SSA offices in Ames, Burlington, Carroll, Cedar Rapids, Coralville, Council Bluffs, Creston, Davenport, Des Moines, Dubuque, Fort Dodge, Marshalltown, Mason City, Ottumwa, Sioux City, Spencer, and Waterloo; and through the department.

75.80(2) Income considered. For non-MAGI-related Medicaid eligibility purposes, income will be considered prospectively.

75.80(3) Trust contributions. Income that a person contributes to a trust as specified in paragraph 75.24(3)“b” will not be considered for purposes of determining eligibility for non-MAGI-related Medicaid.

75.80(4) Conditional eligibility. For purposes of determining eligibility for non-MAGI-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 Sections 416.1240 through 416.1245, is not considered an eligibility methodology.

75.80(5) Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property will 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 member disputes the value determined using the following table, the applicant or member may submit other evidence and the value of the life estate or remainder interest will 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

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
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			

75.80(6) *Resource eligibility for non-MAGI-related Medicaid for children.* Resources of all household members will be disregarded when determining eligibility for children under any non-MAGI-related coverage group except for those groups in paragraphs 75.6(1) “a” and “b”; 75.6(2) “a,” “b,” “c,” “d,” “e,” and “g”; 75.6(4) “a”; and 75.6(5) “a,” “b,” “c,” and “d.”

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.81(249A) Disability requirements for non-MAGI-related Medicaid.

75.81(1) *Applicants receiving federal benefits.* An applicant receiving SSI on the basis of disability, social security disability benefits under Title II of the Act, or railroad retirement benefits based on the Social Security Act’s definition of disability by the Railroad Retirement Board, will be deemed disabled without further determination of disability.

75.81(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 SSA, the department will determine eligibility for non-MAGI-related Medicaid based on disability as follows:

a. An SSA disability determination under either a social security disability (Title II) application or an SSI 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 that 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 that 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 non-MAGI-related Medicaid based on disability, initial determinations will be made by the department of workforce development's disability determination services division. The applicant or the applicant's authorized representative shall complete and submit forms as prescribed by the department.

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 will stay a decision on disability pending the SSA decision on disability.

75.81(3) *Time frames for decisions.* Determination of eligibility based on disability will 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.

75.81(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 forms as prescribed by the department.

75.81(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 will 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 will be canceled with timely notice in accordance with 441—Chapter 16. If there is an appeal to SSA within 65 days, the member will continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

75.81(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 will redetermine the member's disability after the member attains the age of 18 years. The member's disability will 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.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.82(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rules 441—75.3(249A) through 441—75.8(249A), certain factors must be considered differently for persons who reside in a medical institution, as follows.

75.82(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 will 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 will 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 will be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income will be considered available as provided in the trust. In the absence of specific provisions in the trust, the income will be considered as stated above for nontrust property.

75.82(2) *Division of income between married people for non-MAGI coverage groups.*

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized spouse's income will 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 will 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 Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid 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 75.6(4). 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 75.6(4).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, will be treated as individuals effective the month after the month the partners cease living together. Their income will 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 Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid 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 75.6(4).

75.82(3) *Attribution of resources to institutionalized spouse and community spouse.* The department will 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 will 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 a form prescribed by the department 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 a form prescribed by the department and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process will include a match of the IRS 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 by the department.

(6) For natives of Alaska, shares of stock held in a regional or village corporation, during the period of 20 years in which the stock is inalienable, as provided in Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act as amended to August 1, 2025.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act as amended to August 1, 2025, 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 benefits due either spouse for one or more months prior to the month of receipt. This exclusion is limited to the first six months following receipt.

(9) A life insurance policy (or policies) whose total face value is \$1,500 or less per spouse.

(10) An amount, not more than \$1,500 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 \$1,500 will be reduced by an amount equal to the total face value of all insurance policies that 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 as amended to August 1, 2025, which is subject to the treatment required by Section 216 of that 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 the minimum set by the federal spousal impoverishment provisions, then the greater of \$24,000 or the federally established minimum will 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 under the federal spousal impoverishment provisions, the amount over the maximum will be attributed to the institutionalized spouse. (The minimum and maximum limits are indexed annually according to the consumer price index.) The federal spousal impoverishment provisions are defined in Section 1924(f)(2)(A)(i) of the Act (42 U.S.C. §1396r-5(f)(2)(A)(i)). 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 will be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department will provide each spouse a notice of the attribution results. The notice will 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 are governed by procedures in 441—Chapter 2506. 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 will 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 paragraph 75.83(2)“d” will 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 will 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 will be based on the maintenance needs allowance as provided by these rules at the time the appeal is filed.

(4) To receive the substituted allowance, the applicant will be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity will 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 will be no substitution for the cost of the annuity and the attribution will remain as previously determined.

(6) The applicant will 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 will be determined using the following calculation: the difference between the community spouse’s gross monthly income not generated by countable resources (multiplied by 12) and the minimum monthly maintenance needs allowance (multiplied by 12) will be multiplied by the annuity factor for the age of the community spouse. This amount will be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.82(3)“f”(5).

75.82(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 will 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 75.82(3) will 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 will be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources that are owned wholly or in part by the institutionalized spouse and that are not transferred to the community spouse will be counted in determining ongoing eligibility. The resources of the institutionalized spouse will 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 will 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 will 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 will 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 Medicaid effective with the seventh month if one partner would be ineligible for Medicaid 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, will 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 Medicaid effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for Medicaid 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 will be combined and will be subject to the resource limit for a married couple.

75.82(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 191—Chapter 39 or 72.*

a. Eligibility. A person may be eligible for Medicaid 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 Medicaid under subrule 75.3(14), 75.3(15), 75.6(4), or 75.6(8), 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" means 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 Medicaid 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 9763C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—75.83(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.

75.83(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income. Income is determined pursuant to the SSI program under Title XVI of the Act (42 U.S.C. §1396r-5(f)(2)(A)(i)), with the following exceptions.

a. MAGI-related clients. The income of a client and family whose eligibility is MAGI-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. Non-MAGI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by SSA, 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. Non-MAGI-related clients returning home within three months. If SSA 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 will 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 will be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage will 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 will be determined individually from each person's income.

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 will 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.

75.83(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 \$55 of their monthly income for a personal needs allowance. Iowa Code section 249A.30A contains information regarding potential state-funded personal needs supplements.

(1) If the client has a trust described in Section 1917(d)(4) of the Act (including Medicaid 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 will 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.

b. Personal needs in the month of entry.

(1) Single person. A single person will 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 will 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 will 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 will be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses will 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 will 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 will be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction will 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 will 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 will also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents will be considered in determining maintenance needs. The gross income of the spouse and dependent will include all monthly earned and unearned income and assistance from FIP, SSI, and state supplementary assistance. It will also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income will be considered as the SSI program considers income.

(3) Needs of spouse. The maintenance needs of the spouse will 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 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 will 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 will not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents will be established by subtracting each person's gross income from 150 percent of the monthly FPL for a family of two and dividing the result by three.

e. Maintenance needs of children (without spouse). When the client has children under the age of 21 at home, an ongoing allowance will 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 will be their gross income less the disregards allowed in FIP.

The children's maintenance needs will 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 will 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.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.84(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 will 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:

75.84(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;

75.84(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

75.84(3) The entrance fee does not confer an ownership interest in the community.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

441—75.85(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 the limit set annually according to subrule 75.85(1), the individual will not be eligible for Medicaid with respect to nursing facility services or other long-term care services, except as provided in subrule 75.85(2).

75.85(1) Equity interest limit. The limit on the equity interest in the individual's home for purposes of this rule will be increased from year to year 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.

75.85(2) Exception to disqualification. Disqualification based on equity interest in the individual's home will 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 the age of 21 or is blind or disabled as defined in Section 1614 of the Act.

[ARC 9763C, IAB 11/26/25, effective 1/1/26]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

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◇ Two or more ARCs

¹ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

CHAPTER 76 ENROLLMENT AND REENROLLMENT

[Ch 76, 1973 IDR, renumbered as Ch 911]
[Prior to 7/1/83, Social Services[770] Ch 76]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/31

441—76.1(249A) Definitions. The following definitions apply to this chapter in addition to the definitions in rule 441—75.1(249A).

“Act” or *“the Act”* means the federal Social Security Act, and all references herein are as amended to August 1, 2025.

“Authorized representative” means an individual or organization authorized by a competent applicant or member, authorized by a responsible person acting for an incompetent applicant or member pursuant to subrule 76.9(2), or with other legal authority to represent the applicant or member in the application process, the review of eligibility and other ongoing communications with the department.

“Business hours” or *“HHS business hours”* means the hours between 8 a.m. and 4:30 p.m. Central Time during a weekday (Monday through Friday), excluding public holidays.

“Code of Federal Regulations” or *“CFR”* means the United States Code of Federal Regulations. All references to the CFR herein are as amended to August 1, 2025, unless another effective date is specified.

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

“Electronic case record” means an electronic file that includes all information collected and generated by the department regarding each individual’s Medicaid eligibility and enrollment.

“Electronic data sources” or *“EDS”* means federal and state data sources with which the department conducts data matches for the purpose of determining eligibility. Federal data sources include the Internal Revenue Service (IRS), the Social Security Administration (SSA) and the United States Department of Homeland Security. State data sources include Iowa workforce development (IWD) wage and unemployment compensation, SSA, IRS, and the Public Assistance Reporting Information System (PARIS).

“Federally Facilitated Marketplace” or *“FFM”* means the health insurance marketplace established by the United States Secretary of Health and Human Services for states that choose not to set up their own marketplace or that do not get approval for one pursuant to 42 U.S.C. §18041.

“Federally Facilitated Marketplace referral” or *“FFM referral”* means an application submitted at [healthcare.gov](https://www.healthcare.gov) that requests help paying for health insurance. These applications are screened by the FFM and, if found to be potentially eligible for Iowa Medicaid or hawki, are transmitted via an electronic data file to the department for a final Medicaid/hawki determination.

“Health insurance marketplace” means a health insurance marketplace established pursuant to 42 U.S.C. §18031.

“Medicare savings program” refers to the limited Medicaid coverage groups that provide payment of Medicare premiums, coinsurance, and deductibles for low-income elderly or disabled individuals. Those groups are:

1. Qualified disabled and working people (QDWP) pursuant to 42 U.S.C. §1396a(a)(10)(E)(ii);
2. Qualified Medicare beneficiaries (QMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(i);
3. Specified low-income Medicare beneficiaries (SLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iii); and
4. Expanded specified low-income Medicare beneficiaries (ESLMB) pursuant to 42 U.S.C. §1396a(a)(10)(E)(iv).

“Presumptive provider” means an organization approved by the department to conduct and authorize presumptive eligibility determinations as described in subrule 76.7(1).

“Qualified entity” means an individual, under the supervision and authority of a presumptive provider, approved by the department to conduct and authorize presumptive eligibility determinations.

“Responsible person” means an individual recognized by the department pursuant to subrule 76.9(1) as acting for an applicant or member who is unable to act on the applicant’s or member’s own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased.

“SSA” means the federal Social Security Administration.

“Supplemental Security Income” or *“SSI”* is a federally administered program established by Title XVI of the Social Security Act to provide supplemental income to individuals who have attained the age of 65 or are blind or disabled.

“United States Code” or *“U.S.C.”* means the general and permanent laws of the United States. All references to U.S.C. herein are as amended to August 1, 2025, unless another effective date is specified.

“WIC” is the Special Supplemental Nutrition Program for Women, Infants, and Children established pursuant to 42 U.S.C. §1786.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.2(249A) Application for medical assistance. This rule describes the process of applying for medical assistance from the department. Applications for Medicaid must be made as provided in this rule.

76.2(1) *Application with the department or qualified entity.*

a. Who can file. An application may be filed by:

- (1) The applicant;
- (2) An adult in the applicant’s household, as described in 42 CFR §435.603(f), or family, as described in 26 CFR §1.36B-1(d), including:
 1. A spouse as defined in rule 441—75.1(249A);
 2. A parent of an applicant child, as defined in rule 441—75.1(249A), including either parent of an unborn child;
 3. A caretaker of an applicant child, when the caretaker meets the requirements of rules 441—75.1(249A) and 441—75.51(249A); or
 4. A tax-filer who claims the applicant as a dependent;
- (3) An authorized representative described in subrule 76.9(2); or
- (4) A responsible person described in subrule 76.9(1).

b. How and where to file.

(1) An application may be filed online on the department’s website or www.healthcare.gov; at any local HHS office; or at any HHS outstation at a disproportionate share hospital, federally qualified health center in Iowa, or other facility in Iowa where outstationing activities are provided. Applications may be submitted in person, by mail, by telephone at 1.855.889.7985, or by email or fax to a local HHS office. Addresses, email addresses, and fax numbers of local HHS offices are available on the department’s website.

(2) An application may also be filed at the office of a qualified entity pursuant to subrule 76.7(2), a WIC office, a maternal health clinic, or a well-child clinic.

c. Form. Applications for Medicaid, including Medicaid applications for foster care and subsidized adoption, may be submitted on forms prescribed by the department.

d. Minimum application requirements. Initial applications must contain a legible name and address and must be signed under penalty of perjury, pursuant to 42 CFR §435.907(f). At least one person listed in paragraph 76.2(1) “a” must sign the application. Electronic (including telephonically recorded) signatures and handwritten signatures (transmitted via any electronic means) are acceptable. An application that does not include a legible name, address, and signature under penalty of perjury will not be considered a valid application and will be rejected without a determination of eligibility.

76.2(2) *Date of filing.*

a. An application is considered filed on the date a valid application is received in any place of filing specified in paragraph 76.2(1) “*b.*”

b. Reserved.

c. The date of filing and effective date for applications received by a qualified entity for purposes of a presumptive Medicaid eligibility determination are further described in subrule 76.7(5).

d. The department will honor the application date of any application filed at the FFM that is subsequently transmitted to the department for an eligibility determination as described in rule 441—76.3(249A).

76.2(3) *Decision.* The department will notify the applicant of the eligibility decision pursuant to 441—Chapter 16.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.3(249A) Referrals from the FFM. Upon receipt of an FFM referral indicating that an application has been screened and that the applicant has been found to be potentially eligible for Medicaid or hawki, the department will treat the application as if it had been received directly by the department pursuant to rule 441—76.2(249A).

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.4(249A) Express lane eligibility. For purposes of the initial enrollment of a child in medical assistance, the department will use express lane procedures as allowed by 42 U.S.C. §1396a(e)(13) and as described in this rule.

76.4(1) For purposes of initial enrollment, the department will rely on a determination of the child’s eligibility for the Supplemental Nutrition Assistance Program (SNAP) pursuant to 441—Chapter 65 as establishing that a child under the age of 19 meets all eligibility requirements established in 441—subrule 75.3(2) except for citizenship or alienage requirements unless:

a. The child’s household already includes other persons receiving Medicaid based on the use of the modified adjusted gross income (MAGI) methodology, or

b. The child was previously granted express lane eligibility and the household has not had at least a two-month break in SNAP eligibility since that time.

76.4(2) To obtain express lane enrollment for a child, the child’s household must request medical assistance for the child on forms prescribed by the department. The department will send forms to the household when a child eligible for express lane enrollment is approved for SNAP pursuant to 441—Chapter 65. An adult member of the child’s household or a child receiving SNAP benefits as head of household must sign the form and return it to the department within 30 calendar days of issuance.

76.4(3) As a condition of express lane enrollment, the child must meet the citizenship or alienage requirements of rule 441—75.11(249A).

76.4(4) The month of application for express lane enrollment is the month of the child’s SNAP effective date. Express lane eligibility begins on the first day of the month of the child’s SNAP effective date.

76.4(5) After the initial express lane enrollment, all redeterminations of medical assistance eligibility will be made without reliance on any SNAP eligibility determination.

76.4(6) Retroactive enrollment is available pursuant to subrule 76.13(3) for any of the three months before the month of the child’s SNAP effective date. The retroactive eligibility determination must be made without regard to SNAP eligibility.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.5(249A) Enrollment through SSI. Upon receipt of a referral from the SSA indicating that an individual has been approved for SSI, the department will treat the referral as an application for medical assistance and will process the application as if received directly by the department. The SSI recipient may be required to provide additional information when necessary to determine Medicaid eligibility. The SSI recipient may be required to attend an interview to clarify information.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.6(249A) Referral for Medicare savings program. Referrals received from the SSA pursuant to 42 U.S.C. §1320b-14(c)(3) when the individual has indicated that the individual wants to apply for the Medicare savings program will be treated by the department as an application for the Medicare savings program and will be processed as if the application were received directly by the department. The date of the individual's application with SSA will be the application date for benefits under the Medicare savings program. When requested to do so, the applicant must complete a Medicare Savings Programs Additional Information Request form to provide additional information needed to determine Medicare savings program eligibility.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.7(249A) Presumptive eligibility. Persons may be temporarily and immediately enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity at a presumptive provider pursuant to this rule.

76.7(1) Presumptive provider. A presumptive provider is an organization approved by the department to conduct and authorize presumptive eligibility determinations. A provider organization that seeks to be authorized to make presumptive Medicaid eligibility determinations shall do all of the following:

- a. Complete the required self-directed policy and system training.
- b. Apply to the department using the Application for Initial/Recertification to Be a Presumptive Provider form.
- c. Read the Memorandum of Understanding with a Presumptive Provider for Presumptive Medicaid Eligibility Determinations form and agree in writing to its terms.
- d. Comply with the requirements outlined in Iowa's Medicaid state plan.
- e. Meet the definition of "qualified provider" pursuant to 42 U.S.C. §1396r-1.
- f. Meet the definition of "qualified entity" in the following federal regulations for the category of persons covered:

(1) For children under the age of 19, as described in 42 CFR §435.118, the provider must meet the requirements of paragraphs (1) through (10) of the definition of "qualified entity" in 42 CFR §435.1101;

(2) For pregnant women, as described in 42 CFR §435.116, the provider must meet the requirements of 42 U.S.C. §1396r-1(b)(2);

(3) For parents and caretakers, as described in 42 CFR §435.110, the provider must meet the requirements in 42 CFR §435.1103(b);

(4) For persons aged 19 through 64, as described in 42 CFR § 435.119, the provider must meet the requirements in 42 CFR §435.1103(b);

(5) For former foster care children, as described in 42 CFR §435.150, the provider must meet the requirements in 42 CFR §435.1103(b);

(6) For persons needing breast or cervical cancer treatment (BCCT), as described in 42 U.S.C. §1396r-1b(b)(2); and

(7) For all of the categories of persons covered in subparagraphs 76.7(1) "f"(1) through "f"(6), a qualifying hospital must meet the requirements in 42 CFR §435.1110(b).

g. Be recertified annually by doing the following:

- (1) Complete the required self-directed policy and system training;
- (2) Complete the Application for Initial/Recertification to Be a Presumptive Provider form; and
- (3) Re-attest to the terms of the Provider Memorandum of Understanding by signing in writing.

76.7(2) Qualified entity.

a. An individual that seeks to be authorized to make presumptive Medicaid eligibility determinations under the supervision and authority of a presumptive provider shall do all of the following:

- (1) Complete the required self-directed policy and system training.

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal (MPEP) Access Request.

(3) Read the Provider Memorandum of Understanding and agree in writing to its terms.

(4) Obtain confirmation of acceptance by the department that the individual is determined by the department to be capable of making presumptive Medicaid eligibility determinations.

b. In addition to the requirements in paragraph 76.7(2)“*a*,” a qualified entity for BCCT must also have either:

(1) Been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department; or

(2) A cooperative agreement with the department under the Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act as amended to August 1, 2025, 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.

c. Only employees of the presumptive provider may be given the authority to make presumptive eligibility determinations.

d. Qualified entities are required to be recertified annually by doing the following:

(1) Complete the required self-directed policy and system training;

(2) Complete the Qualified Entity Medicaid Presumptive Eligibility Portal Recertification form; and

(3) Re-attest to the terms of the Provider Memorandum of Understanding in writing.

76.7(3) *How and where to file.* An applicant for presumptive Medicaid shall complete an application with a qualified entity in one of two ways:

a. Provide information in person to the qualified entity that enters the applicant’s information into the MPEP system; or

b. Complete a paper application provided by the qualified entity that enters the applicant’s information into the MPEP system.

76.7(4) *Signature.* An individual listed in paragraph 76.2(1)“*a*” must sign the completed paper application or a printed version of the completed MPEP application. A copy of the signed application must be maintained by the qualified entity.

76.7(5) *Date of filing and effective date of coverage.*

a. For purposes of determining the application date of filing for an ongoing eligibility determination, a paper application is valid only if it contains the applicant’s legible name, address, and signature under penalty of perjury and must be date-stamped on the date it is received by the qualified entity. The date of filing as described in paragraph 76.2(2)“*a*” is used for purposes of determining the effective date of coverage for ongoing eligibility but does not determine the effective date of coverage for presumptive Medicaid.

b. The effective date of coverage for presumptive Medicaid is the date on which a qualified entity completes the presumptive eligibility determination within the MPEP system.

c. The applicant must provide to the qualified entity all information necessary to make a presumptive eligibility determination in the MPEP system.

76.7(6) *Notice and appeal rights.* The qualified entity shall inform the applicant of the eligibility decision as soon as possible but no later than two working days after the date the determination is made by the qualified entity. Timely and adequate notice requirements and appeal rights of the Medicaid program, including those outlined in 42 CFR Part 431, subpart E; Iowa Code chapter 17A; 441—Chapter 2506; and 441—Chapter 16, do not apply to determinations of presumptive eligibility under this rule.

76.7(7) *Full medical assistance eligibility determination.* All presumptive eligibility applications will be given the option within the MPEP system to also receive a full determination of eligibility for Medicaid or hawki.

441—76.8(249A) Applicant and member responsibilities.

76.8(1) *Accurate information.* Clients, and those individuals acting on behalf of clients, are responsible for giving complete and accurate information needed to establish eligibility.

76.8(2) *Additional information or verification needed to determine eligibility.* An applicant or member will not be required to provide additional verifications if attested income meets the department's standards for reasonable compatibility and if the department can verify all other required information through an EDS. If attested income does not meet the department's standards for reasonable compatibility or if the department is not able to verify other required information through an EDS, the department will send the applicant or member a written request for the additional information or verification. The applicant or member must provide the additional information or verification by the requested due date or such application may be denied or Medicaid or hawki benefits may be discontinued.

76.8(3) *Time frames for providing information or verification.* Clients have ten calendar days from the date on the written request by the department to provide additional information or verification requested. If the tenth calendar day falls on a weekend or state holiday, the individual will have until the end of business hours on the next business day to provide the information or verification. The information or verification is considered provided on the date it is received by the department.

76.8(4) *Extensions.* The applicant or member may request an extension for a reasonable period of time when the applicant or member is making every effort but is unable to secure the required information or verification.

76.8(5) *Interviews.* Applicants and members who are being evaluated on the basis of the MAGI methodology will not be required to attend an interview. Applicants and members who are being evaluated on a basis other than the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the application process. If applicable, the department will notify the applicant, authorized representative, or responsible person of the date, time, and method of the interview. Notification will be provided personally by telephone, email, mail, or fax.

76.8(6) *Failure to comply.* An application will be denied or assistance will be discontinued if:

- a.* The applicant or member does not attend a required interview, pursuant to subrule 76.8(5), or
- b.* The department does not receive one of the following by the due date indicated on the written request for additional information in accordance with subrules 76.8(2) through 76.8(4):
 - (1) The information, verification, or a statement that reasonably explains the discrepancy;
 - (2) An authorization for the department to obtain the information or verification; or
 - (3) A request for an extension of the due date.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.9(249A) Responsible persons and authorized representatives.

76.9(1) *Responsible person.* If an applicant or member is unable to act on the applicant's or member's own behalf because the applicant or member is a minor or is incompetent, incapacitated, or deceased, a responsible person may act for the applicant or member.

a. Except as provided in paragraph 76.9(1) "d," when the applicant or member is incompetent, incapacitated, or deceased, the responsible person shall be a family member, friend or other person who has knowledge of the applicant's or member's financial affairs and circumstances and has a personal interest in the applicant's or member's welfare.

b. Except as provided in paragraph 76.9(1) "d," when the applicant or member is unable to act on the applicant's or member's own behalf solely because the applicant or member is a minor, the responsible person shall be an adult in the child's household or family as described in paragraph 76.2(1) "a."

c. The responsible person shall assume the applicant's or member's position and responsibilities during the application process or for ongoing eligibility. The responsible person may designate an

authorized representative pursuant to subrule 76.9(2) to represent the applicant or member. However, the designation of an authorized representative does not relieve the responsible person from assuming the applicant's or member's position and responsibilities during the application process or for ongoing eligibility.

d. When there is no person as described in paragraphs 79.6(1)“a” through “c” to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member, any individual or organization may be allowed to act as the responsible person if the individual or organization conducts a diligent search and completes the required form, attesting to the individual's or organization's inability to find a responsible person to act on behalf of the minor, incompetent, incapacitated, or deceased applicant or member.

e. The department may require verification of the applicant's or member's incompetence or death and of the responsible person's relationship to the applicant or member.

f. Copies of all correspondence the department would otherwise provide to the applicant or member will be provided to the recognized responsible person.

76.9(2) *Authorized representative.*

a. An individual or organization designated by a competent applicant or member, or by a responsible person recognized pursuant to subrule 76.9(1), or with other legal authority to do so may act on behalf of the applicant or member in the application process, in the review process, or for ongoing eligibility.

b. The designation of an authorized representative by an applicant, member, or responsible person must be in writing and must be signed and dated by the applicant, member, or responsible person. The applicant, member, or responsible person may authorize the representative to complete and sign an application on the applicant's or member's behalf, complete and submit a review form, receive copies of the applicant's or member's notices and other communications from the department, and act on behalf of the applicant or member in all other matters with the department.

c. Legal documentation of authority to act on behalf of the applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of a written authorization by the applicant or member.

d. Designations of authorized representatives, legal documentation of authority to act on behalf of the applicant or member, and modifications or terminations of designations or legal authority may be submitted via the department's website, mail, email, or fax or in person.

e. For purposes of this rule, the department will accept electronic, including telephonically recorded, signatures and handwritten signatures (including when transmitted by fax or other electronic means).

f. If the authorization:

(1) Indicates the time period or dates the authorization is to cover, the stated period or dates will be honored until or unless a rescission is submitted to the department as described in subparagraph 76.9(2)“f”(2) and may include subsequent applications, if necessary, that relate to the time period or dates indicated on the authorization.

(2) Does not indicate the time period or dates it is to cover, the authorization will be valid until the applicant, member, or responsible person modifies the authorization and notifies the department that the representative is no longer authorized to act on behalf of the applicant or member or until the authorized representative informs the department that the representative no longer is acting in such capacity. Such notice must be in writing and should include the signature of the applicant, member, responsible person, or authorized representative, as appropriate.

g. Copies of all correspondence will be provided to the applicant or member and the authorized representative.

76.9(3) *Additional requirements applicable to all authorized representatives and responsible persons.*

a. An authorized representative or responsible person must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding an applicant or member provided by the department.

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

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

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.10(249A) Right to withdraw the application. The applicant may withdraw the application at any time before the eligibility determination has been made. The applicant may request that the application be withdrawn entirely or request withdrawal for any month covered by the application process except as provided in the medically needy program in accordance with the provisions of rule 441—75.8(249A).

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.11(249A) Choice of electronic notifications. The applicant is responsible to indicate whether notices and other communications are to be provided by the department in an electronic format through the individual's electronic account rather than by regular mail. The applicant may change the selection at any time. Notices and other communications provided through the individual's electronic account are deemed to be received upon the sending of an email to the individual notifying the individual of the notice or other communication.

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441—76.12(249A) Application not required.

76.12(1) Adding a new person.

a. Adding an eligible person. For members whose eligibility is based on the MAGI methodology, a new application is not required when an eligible person is added to an existing Medicaid household. Such a person is considered to be included in the application that established eligibility for the existing household. However, in these instances, the date of application to add a person is the date the change is reported. When it is reported that a person is anticipated to enter the home, the date of application to add the person shall be no earlier than the date the person begins to live in the household or the date of report, whichever is later.

b. Adding a person previously ineligible due to a failure to cooperate. In those instances where a person previously ineligible for Medicaid for failure to cooperate in obtaining medical support or establishing liability for support as described in 441—subrule 75.14(2) is to be granted Medicaid benefits, the earliest month for which that person may be eligible for coverage is the month that the person takes action(s) to meet the cooperation requirements described in 441—subrule 75.14(1) and as determined by child support services.

c. Adding a person previously ineligible due to failure to provide a social security number. In those instances where a person previously ineligible for Medicaid for failure to provide a social security number or proof of application for a social security number as described in rule 441—75.9(249A) is to be granted Medicaid benefits, the person will be granted Medicaid benefits effective the first of the month in which the person becomes eligible by providing a social security number.

76.12(2) *Loss of hawki eligibility.* In those instances where a child loses hawki eligibility and has been determined eligible for Medicaid, with no break in coverage, an application for Medicaid is not required.

76.12(3) *Grace period.*

a. At application. If benefits are denied for failure to provide requested information or verification and the information or verification is provided within 14 calendar days of the effective date of the denial, the department will complete the eligibility determination as though the information were timely received. If the fourteenth calendar day falls on a weekend or state holiday, the applicant shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

b. At reinstatement after cancellation (including cancellation at the time of reenrollment). Eligibility for Medicaid may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the information. The grace period does not apply to late payment of premiums or noncooperation actions.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.13(249A) Initial enrollment.

76.13(1) *Enrollment date.* The department will enroll applicants who have been determined to be eligible in the Medicaid program.

a. First day of the month. The effective date of enrollment is the first day of the month that the application was filed or the first day of the first month for which eligibility has been determined, whichever is later, with the following exceptions:

(1) Presumptive eligibility is effective on the date that presumptive eligibility was determined by a qualified entity for presumptive Medicaid eligibility determinations pursuant to subrule 76.7(5).

(2) Eligibility under the qualified Medicare beneficiary coverage group described in 441—paragraph 75.6(5) “a” begins on the first day of the month after the month of decision.

(3) For individuals who are approved for Medicaid and who are eligible for SSI, programs related to SSI, or state supplementary assistance, Medicaid benefits will be effective on the first day of the month for which the individual meets all eligibility requirements, including resource eligibility, as of the first moment of the first day of the month.

(4) The enrollment date for retroactive Medicaid eligibility is determined pursuant to subrule 76.13(3).

b. Care or services prior to enrollment. No payment will be made for medical care or services received prior to the effective date of enrollment.

76.13(2) *Certification for services.* The department will issue a medical assistance eligibility card to persons who have been determined to be eligible for the benefits provided under the Medicaid program, with the following exceptions.

a. Presumptive eligibility. A person who has been determined only presumptively eligible will be issued a Presumptive Medicaid Eligibility Notice of Action form that will include certification information.

b. Emergency Medicaid for noncitizens. An individual who is eligible only for limited emergency Medicaid for noncitizens pursuant to 441—subrule 75.11(4) will be issued a Notice of Action that will include certification information.

76.13(3) *Retroactive enrollment.* Medical assistance will be available for all or any of the three months preceding the month in which an application is filed to persons who meet the requirements described within this subrule.

a. Except as provided in paragraph 76.13(3) “e,” retroactive medical assistance will be available for the months a person was pregnant, an infant (under the age of 1), a child under 19 years of age, or

a resident of a nursing facility licensed under Iowa Code chapter 135C during any of the three months preceding the month in which an application is filed and who also meets the following conditions:

(1) Has medical bills for covered care or services received during the three-month retroactive period; and

(2) Would have been eligible for medical assistance in the month services were received if the application for medical assistance had been made in that month.

b. The applicant need not be eligible in the month of application to be eligible in any of the three months prior to the month of application.

c. Retroactive medical assistance will be made available when an application has been made on behalf of a deceased person if the conditions in paragraph 76.13(3) "a" are met.

d. Persons enrolled in Medicaid based on receipt of SSI benefits who wish to apply for Medicaid benefits for the three months preceding the month of application shall complete a form provided by the department.

e. Exceptions to retroactive enrollment. This subrule does not apply to the following persons who are otherwise eligible for retroactive enrollment:

(1) Persons whose citizenship status has not been verified even if they are eligible during a 90-day reasonable opportunity period.

(2) Persons determined eligible only under presumptive Medicaid benefits.

(3) Persons eligible for Medicaid only under the qualified Medicare beneficiary program.

(4) Persons eligible only under the home- and community-based waiver services program.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.14(249A) Reenrollment. The department will review all conditions of eligibility for the purpose of determining continued enrollment in Medicaid pursuant to 441—Chapter 75.

76.14(1) *Reenrollment frequency.*

a. The department will conduct eligibility reviews for members whose eligibility is based on the MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided by rule 441—76.15(249A) and paragraph 76.14(1) "b."

b. The department will conduct eligibility reviews for the following coverage groups as circumstances indicate but no more frequently than once every 12 months:

(1) Transitional Medicaid as described in 441—subrule 75.3(6).

(2) Medicaid for former foster care youth (EMIYA) as described in 441—subrule 75.3(12).

(3) Postpartum Medicaid as described in 441—subrule 75.3(4).

c. The department will conduct eligibility reviews for members whose eligibility is based on non-MAGI methodology once every 12 months and no more frequently than once every 12 months, except as provided in rule 441—76.15(249A) and paragraph 76.14(1) "b."

76.14(2) *Reenrollment process.*

a. *Reenrollment procedure.* Reenrollment will be based on reliable information contained in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS. If the department is able to renew eligibility based on such information, the department must notify the individual of the eligibility determination and the basis of that determination. If any information in that notification form is inaccurate, the member must inform the department through any of the modes permitted for submission of an application under paragraph 76.2(1) "b" within 30 days.

b. *Members whose eligibility for Medicaid is based on the MAGI methodology.* If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

c. Members whose eligibility for Medicaid is in non-MAGI related coverage groups. If eligibility cannot be determined based on information in the member's electronic case record or other more current information available to the department, including but not limited to information through EDS, the member will be provided with a prepopulated review form and will have at least 30 days from the date the review form is mailed to complete necessary information, sign, and return the completed review form.

d. Failure to reenroll. Enrollment will end when information or documentation necessary to complete the determination of continued eligibility pursuant to subrules 76.8(2) through 76.8(4) is not returned before the end of the enrollment period. The department will notify the member of the disenrollment pursuant to 441—Chapter 16. Individuals whose eligibility ends must reapply unless the individual satisfies the requirements of subrule 76.12(3) or paragraph 76.14(2)“e.”

e. Reconsideration period.

(1) For all coverage groups, except those specified in subparagraph 76.14(2)“e”(2), the department will reconsider the eligibility of an individual who is terminated for failure to submit the applicable review form as described in paragraph 76.14(2)“b” or “c” or for failure to provide necessary information in a timely manner and without requiring an application if the individual subsequently submits a review form within 90 days after the effective date of termination. The department will also reconsider eligibility as described in this subparagraph if the member provides an application form. If the ninetieth calendar day falls on a weekend or state holiday, the member shall have until the end of business hours on the next business day to provide the review form. The eligibility effective date will go back to the first day of the first month of ineligibility only if all other eligibility criteria are met for that month. Eligibility for subsequent months within the reconsideration period can still be determined even if the applicant remains ineligible for the initial reconsideration month(s), but eligibility will not be granted any earlier than the month in which all eligibility criteria are met.

(2) For qualified Medicare beneficiaries (QMB), the provisions in subparagraph 76.14(2)“e”(1) apply, except that the review form as described at lettered paragraph 76.14(2)“b” or “c” will be acted upon and treated like an application and the eligibility effective date will be determined pursuant to subparagraph 76.13(1)“a”(2).

f. Interview required. An individual whose eligibility is not based on the MAGI methodology may be required to attend an interview to clarify information or to resolve conflicting information. The department will not require an in-person interview as part of the process.

[ARC 9702C, IAB 11/12/25, effective 1/1/26]

441—76.15(249A) Report of changes. As a continuing condition of enrollment for Medicaid, applicants and current members shall report changes in circumstances as required in this rule.

76.15(1) A change in circumstance that may affect the eligibility of applicants and members must be reported within ten days of the date the change occurred. Changes required to be reported are described in this subrule.

a. In coverage groups for which Medicaid eligibility is determined using the MAGI methodology, any change in the following must be reported:

- (1) Income from all sources.
- (2) Members of the household.
- (3) School attendance.
- (4) Mailing or living address.
- (5) Receipt of a social security number.
- (6) Health insurance premiums or coverage.
- (7) Alien or citizenship status.
- (8) Federal income tax filing status or claimed dependents for federal tax purposes.

b. In coverage groups for which Medicaid eligibility is not determined using the MAGI methodology, any change in the following must be reported.

EXCEPTION: Persons actually receiving SSI benefits are exempted from these reporting requirements unless the persons have a trust or are applying for or are receiving home- and community-based waiver services.

- (1) Income from all sources.
- (2) Resources.
- (3) Members of the household.
- (4) Recovery from disability.
- (5) Mailing or living address.
- (6) Health insurance premiums or coverage.
- (7) Medicare premiums or coverage.
- (8) Receipt of social security number.
- (9) Gross income of the community spouse or of the dependent children, parents, or siblings of the institutionalized or community spouse who are living with a community spouse when a diversion is made to the community spouse or family, as those terms are defined in rule 441—75.1(249A).
- (10) Income and resources of parents and spouses when income and resources are used in determining Medicaid eligibility, client participation, or spenddown.
- (11) Residence in a medical institution for other than respite care for more than 15 days for home- and community-based waiver services recipients.

c. Individuals in the breast and cervical cancer coverage group are required to report changes in their health insurance coverage and changes in their living or mailing address.

d. Individuals receiving Medicaid based on the receipt of Title IV-E-funded foster care, based on an adoption assistance agreement, or based on a guardianship assistance agreement are required to report changes in health insurance coverage, when their living or mailing address changes, upon receipt of a social security number, and upon termination of the adoption assistance agreement.

e. Individuals receiving state-only funded Medicaid are required to report any change in the following:

- (1) Income from all sources.
- (2) Mailing or living address.
- (3) Receipt of a social security number.
- (4) Health insurance coverage.
- (5) Alien or citizenship status.

76.15(2) Failure to report. When a change is not reported as required by this rule, any Medicaid expenditures for care or services provided when the member was not eligible will be considered overpayments and subject to recovery from the member.

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441—76.16(249A) Action on information received. When a change in circumstance is reported, or when a change in a member's circumstances otherwise comes to the attention of the department, its effect on eligibility will be evaluated and eligibility will be redetermined regardless of whether the report of change was required by rule 441—76.15(249A). When the department has information about an anticipated change in a member's circumstances that may affect eligibility, eligibility will be redetermined at the appropriate time based on such change.

76.16(1) After assistance has been approved, except as provided in subrules 76.16(2) and 76.16(3) or as otherwise stated in 441—Chapter 75 or this chapter, action based on a change reported during a month will be effective the first day of the next calendar month unless timely notice of adverse action is required as specified in rule 441—16.2(17A).

76.16(2) When a request is made to add a new person to the Medicaid household and that person meets the eligibility requirements, assistance will be acted upon pursuant to rule 441—76.12(249A).

76.16(3) When the reported change causes a change in coverage from a Medicare Savings Program coverage group described in 441—subrule 75.6(5) to coverage under Medicaid for employed

people with disabilities (MEPD) as described in 441—subrule 75.6(6), the reported change will be effective the first day of the calendar month that the change was reported.

76.16(4) When the change creates ineligibility, eligibility under the current coverage group will be canceled and an automatic redetermination of eligibility will be completed in accordance with rule 441—76.17(249A).

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441—76.17(249A) Timeliness requirements for conducting automatic redeterminations of eligibility. Whenever a Medicaid member no longer meets the eligibility requirements of the current coverage group, the department will automatically redetermine eligibility for other Medicaid coverage groups unless the reason for ineligibility is due to not meeting the requirements in rule 441—76.8(249A). If the reason for ineligibility under the initial coverage group pertained to a condition of eligibility that applies to all coverage groups, no further redetermination will be required. When the redetermination is completed, the member will be notified of the decision in writing. The redetermination process will be completed as follows:

76.17(1) *Information received by the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department by the tenth of the month, the redetermination process will be completed by the end of that month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be the first day of the month following the month in which the information is received, pursuant to rule 441—76.16(249A).

76.17(2) *Information received after the tenth of the month.* If information that creates ineligibility under the current coverage group is received by the department after the tenth of the month, the redetermination process will be completed by the end of the following month unless the provisions of rule 441—76.14(249A) apply. The effective date of cancellation for the current coverage group will be no earlier than the first day of the first month following the month in which the information is received, pursuant to rule 441—76.16(249A), but no later than the second month following the month in which the information is received.

76.17(3) *Change in federal law.* If a change in federal law affects the eligibility of large numbers of Medicaid members and the United States Secretary of Health and Human Services has extended the redetermination time limits, in accordance with 42 CFR §435.1003, the redetermination process will be completed within the extended time limit and the effective date of cancellation for the current coverage group will be no later than the first day of the month following the month in which the extended time limit expires.

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CHAPTER 81 NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—81.1(249A) Definitions.

“Abuse” means any of the following that occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury that is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.

2. The commission of a sexual offense under Iowa Code chapter 709 or section 726.2 or 728.12(1), or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.

3. Exploitation of a resident, which means the act or process of taking unfair advantage of a resident or the resident’s physical or financial resources for one’s own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident’s life or health.

“Advance directive” means the same as defined in 42 CFR 489.100 (as amended to August 1, 2024).

“Allowable costs” means the price a prudent, cost-conscious buyer would pay a willing seller for goods or services in an arm’s-length transaction, not to exceed the limitations set out in rules.

“Beginning eligibility date” means date of an individual’s admission to the facility or date of eligibility for medical assistance, whichever is the later date.

“Case mix” means a measure of the intensity of care and services used by similar residents in a facility.

“Case-mix index” means a numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

“Civil penalty” means a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

“Clinical experience” means application or learned skills for direct resident care in a nursing facility.

“Clock hour” means 60 minutes.

“CMS” means the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services.

“Complete replacement” means completed construction on a new nursing facility to replace an existing licensed and certified nursing facility. The replacement facility shall have no more licensed beds than the facility being replaced and shall be located either in the same county as the facility being replaced or within 30 miles from the facility being replaced.

“Cost normalization” refers to the process of removing cost variations associated with different levels of resident case mix. Normalized cost is determined by dividing a facility’s per diem direct care component costs by the facility cost report period case-mix index.

“Denial of critical care” is a pattern of care in which the resident’s basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident’s serious social maladjustment, or is a gross failure of the facility employee to meet

the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

“Direct care component” means the portion of the Medicaid reimbursement rates that is attributable to the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses, and contracted nursing services.

“Discharged resident” means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility.

“Facility” means a licensed nursing facility certified in accordance with the provisions of 42 CFR 483.5 (as amended to August 1, 2024) to provide health services and includes hospital-based nursing facilities that are Medicare-certified and provide only skilled level of care and swing-bed hospitals unless stated otherwise.

“Facility-based nurse aide training program” means a nurse aide training program that is offered by a nursing facility and taught by facility employees or under the control of the licensee.

“Facility cost report period case-mix index” is the average of quarterly facilitywide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/2000-12/31/2000 financial and statistical reporting period would use the facilitywide average case-mix indices for quarters ending 03/31/00, 06/30/00, 09/30/00 and 12/31/00.

“Facilitywide average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter.

“Informed consent” means a resident’s agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

“Laboratory experience” means practicing care-giving skills prior to contact in the clinical setting.

“Level I review” means screening to identify persons suspected of having mental illness or intellectual disability as defined in 42 CFR 483.102 (as amended to August 1, 2024).

“Level II review” means the evaluation of a person identified in a Level I review to determine whether nursing facility services and specialized services are needed.

“Major renovations” means new construction or facility improvements to an existing licensed and certified nursing facility in which the total depreciable asset value of the new construction or facility improvements exceeds \$750,000. The \$750,000 threshold shall be calculated based on the total depreciable asset value of new construction or facility improvements placed into service during a two-year period ending on the date the last asset was placed into service. When the property costs of an asset have been included in a facility’s financial and statistical report that has already been used in a biennial rebasing, the costs of that asset shall not be considered in determining whether the facility meets the \$750,000 threshold.

“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.

“Medicaid average case-mix index” is the simple average, carried to four decimal places, of all resident case-mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

“Minimum data set” or *“MDS”* refers to a federally required resident assessment tool. Information from the MDS is used by the department to determine the facility’s case-mix index for purposes of normalizing per diem allowable direct care costs as provided by paragraph 81.5(16) “b,” for determining the Medicaid average case-mix index to adjust the direct care component pursuant to paragraphs 81.5(16) “c” and “e,” the excess payment allowance pursuant to paragraph 81.5(16) “d,” and the limits on reimbursement components pursuant to paragraph 81.5(16) “f.” MDS is described in subrule 81.12(9).

“Minimum food, shelter, clothing, supervision, physical or mental health care, or other care” means that food, shelter, clothing, supervision, physical or mental health care, or other care that, if not provided, would constitute denial of critical care.

“Mistreatment” means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact that is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

“New construction” means the construction of a new nursing facility that does not replace an existing licensed and certified facility and that requires the provider to obtain a certificate of need pursuant to Iowa Code chapter 135, division VI.

“Non-direct care component” means the portion of Medicaid reimbursement rates attributable to administrative, environmental, property, and support care costs reported on the financial and statistical report. Support care costs will include costs related to therapy services provided to residents during inpatient stays and not billed as an outpatient service.

“Non-facility-based nurse aide training program” means a nurse aide training program that is offered by an organization that is not licensed to provide nursing facility services.

“Non-state government owned nursing facility” or *“NSGO nursing facility”* is a nursing facility owned by a governmental entity that is not the state.

“Nurse aide” means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

“Nurse aide registry” means the nurse aide registry within the department of inspections appeals, and licensing.

“Nurse aide training and competency evaluation programs” or *“NATCEP”* means educational programs approved by the department of inspections, appeals, and licensing for nurse aide training as designated in subrule 81.13(3).

“Nursing facility level of care” means that the following conditions are met:

1. The presence of a physical or mental impairment that restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“PASRR” means a Level I screening or a Level II evaluation for mental illness or intellectual disability for all persons who live in or seek entry to a Medicaid-certified nursing facility, as required by 42 CFR Part 483, Subpart C (as amended to August 1, 2024).

“Patient-day-weighted median cost” means the per diem cost of the nursing facility that is at the median per diem cost of all nursing facilities based on patient days provided when per diem allowable costs are ranked from low to high. A separate patient-day-weighted median cost amount shall be determined for the direct care and non-direct care components.

“Physical abuse” means any nonaccidental physical injury, or injury that is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue that results in the death of the person who has sustained the damage.

“Poor performing facility” or *“PPF”* is a facility designated by the department of inspections, appeals, and licensing as a PPF based on surveys conducted by the department of inspections, appeals, and licensing pursuant to subrule 81.12(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.12(19)“o.”

“*Primary instructor*” means a registered nurse responsible for teaching a state-approved nurse aide training course.

“*Program coordinator*” means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

“*Rate determination letter*” means the letter that is distributed quarterly by the department to each nursing facility notifying the facility of the facility’s Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34 (as amended to August 1, 2024).

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

- A physician order for all skilled services.
- Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
- An individualized care plan that identifies support needs.
- Confirmation that skilled services are provided to the member.
- Skilled services that are provided by, or under the supervision of, medical personnel as described above.
- Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

“*Skills performance record*” means a record of major duties and skills taught that consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

“*Special population nursing facility*” refers to a nursing facility that serves the following populations:

1. One hundred percent of the residents served are aged 30 and under and require the skilled level of care.
2. Seventy percent of the residents served require the skilled level of care for neurological disorders.
3. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness.
4. One hundred percent of the residents require care from a facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with medical complexity.

“*Surgical or other invasive procedure*” means an operative procedure in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Surgical or other invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multiorgan transplantation. Surgical or other invasive procedures include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) published by the American Medical Association, as amended to August 1, 2024, and other invasive procedures

such as percutaneous transluminal angioplasty and cardiac catheterization. Surgical or other invasive procedures include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. "Surgical or other invasive procedure" does not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

"*Terminated from the Medicare or Medicaid program*" means a facility has lost the final appeal to which it is entitled.

"*Testing entity*" means a person, agency, institution, or facility approved by the department of inspections, appeals, and licensing to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) "a," and 249A.4.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.2(249A) Initial approval for nursing facility care.

81.2(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department.

a. Decisions on level of care, subject to paragraph 81.2(1) "b," will be made by the department within two working days of receipt of medical information. The department determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

b. For residents subject to a Level II PASRR review pursuant to subrule 81.2(3), the level of care determination will be made as part of the Level II PASRR review, based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

c. Adverse level of care decisions may be appealed to the department pursuant to 441—Chapter 2506.

81.2(2) *Preadmission review.* The department's contractor for PASRR screening and evaluation shall complete a Level I review for all persons seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the person's care. When a Level I review identifies evidence for the presence of mental illness or intellectual disability, the department's contractor for PASRR evaluations shall complete a Level II review before the person is admitted to the facility.

a. Exceptions to Level II review. Persons in the following circumstances may be exempted from Level II review based on a categorical determination that, in that circumstance, admission to or residence in a nursing facility is normally needed and the provision of specialized services for mental illness or intellectual disability is normally not needed.

(1) The person's attending physician certifies that the person is terminally ill with death expected within six months, the person requires nursing care or supervision due to the person's physical condition, and the person is not a danger to self or others. If the person's nursing facility stay exceeds six months, a Level II review must be completed.

(2) The severity of the person's illness results in impairment so severe that the person could not be expected to benefit from specialized services, and the person does not present a danger to self or others. This category includes persons who are comatose, who function at brain-stem level, who are ventilator-dependent, or who have diagnoses such as Parkinson's disease, Huntington's chorea, amyotrophic lateral sclerosis, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF).

(3) The person is suffering from delirium. Exemptions made on a basis of delirium are valid until the delirium clears or for seven days, whichever is sooner.

(4) The person is in an emergency situation that requires protective services with placement in the nursing facility. A Level II review must be completed if the admission lasts more than seven days.

(5) The admission is for the purpose of providing respite to the person's caregiver. If the nursing facility stay exceeds 30 days, a Level II review must be completed.

(6) The person has dementia in combination with an intellectual disability.

(7) The person has been approved for specialized services in another facility based on a previous Level II evaluation, the specialized services still meet the person's needs, and the receiving facility agrees to provide the specialized services.

(8) The person is transferring directly from receiving acute hospital inpatient care and requires nursing facility services for the same acute physical illness for which hospital care was received, and the person's attending physician certifies before the admission that the person is likely to require less than 30 days of nursing facility services. If the person is later found to require more than 30 days of nursing facility care, a Level II review must be completed within 40 calendar days of the person's admission date.

(9) The person:

1. Is transferring to a nursing facility directly from receiving acute hospital inpatient care, and
2. Requires nursing facility services for convalescence from the same acute physical illness for which the person received hospital care, and

3. Is clearly sufficiently psychiatrically and behaviorally stable enough for nursing facility admission, and

4. Before entering the facility, has been certified by the attending physician as likely to require less than 60 days of nursing facility services.

b. Outcome of Level II review. The Level II review shall determine:

- (1) Whether nursing facility care or skilled nursing care is medically necessary and appropriate under 441—subrules 79.9(1) and 79.9(2) for the person seeking admission;

- (2) Whether the person seeking admission needs specialized services for mental illness as defined in paragraph 81.12(14)“*b*,” using the procedures set forth in 42 CFR 483.134 (as amended to August 1, 2024); and

- (3) Whether the person seeking admission needs specialized services for intellectual disability as defined in paragraph 81.12(14)“*c*,” using the procedures set forth in 42 CFR 483.136 (as amended to August 1, 2024).

c. The department or its designee will review each Level II evaluation and plan for obtaining needed specialized services before the person's admission to a nursing facility to determine whether nursing facility care or skilled nursing care is medically necessary and whether the nursing facility is an appropriate placement.

d. Nursing facility payment under the Iowa Medicaid program will be made for Medicaid members residing in the nursing facility:

- (1) Only if a Level I review was completed prior to admission;

- (2) For persons with mental illness or intellectual disability, only if a Level II review has been completed, or an exception under paragraph 81.2(3)“*a*” has been approved, and it is determined by the department that nursing facility care or skilled nursing care is medically necessary and appropriate and that the person's treatment needs related to a mental illness or intellectual disability will be or are being met.

e. Adverse PASRR decisions may be appealed to the department pursuant to 441—Chapter 2506.

f. A nursing facility requesting an administrative hearing regarding a PASRR determination must have the prior, express, signed, written consent of the resident or the resident's lawfully appointed guardian to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 2506, no hearing will be granted unless the nursing facility submits a document providing such resident's consent to the request for a state fair hearing. The document must specifically inform the resident that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the resident's knowledge of

the potential for PHI to become public and that the resident knowingly, voluntarily, and intelligently consents to the nursing facility's bringing the state fair hearing on the resident's behalf.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2) "a," and 249A.4.

[ARC 9279C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—81.3(249A) Arrangements with residents.

81.3(1) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

81.3(2) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. (See paragraph 81.12(5) "c.") The funds shall be deposited in a bank within the state of Iowa insured by FDIC. Expense for bank service charges for this account is an allowable expense under rule 441—81.5(249A) if the service cannot be obtained free of charge. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, dated receipt shall be required to be deposited in the resident's files.

d. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

e. Upon a patient's death, a receipt shall be obtained from the next of kin, the resident's guardian, or the representative handling the funeral before releasing the balance of the personal needs funds. In the event there is no next of kin or guardian available and there are no outstanding funeral expenses, any funds shall revert to the department. In the event that an estate is opened, the department will turn the funds over to the estate.

81.3(3) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that all mail is delivered unopened to the resident to whom it is addressed, except in those cases where the resident is too confused, as documented in the person's permanent medical record, to receive it, in which case the mail is held unopened for the resident's conservator or relatives.

Mail may be opened by the facility in cases where the resident or relatives or guardian have given permission in writing for mail to be opened and read to the resident.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a,” and 249A.4.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.4(249A) Discharge and transfer. (See paragraph 81.12(6) “c.”)

81.4(1) Notice. When a Medicaid member requests transfer or discharge, or another person requests this for the member, the administrator shall promptly notify the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

81.4(2) Case activity report. A Case Activity Report shall be submitted to the department whenever a Medicaid applicant or recipient enters the facility, changes level of care, or is discharged from the facility.

81.4(3) Plan. The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

81.4(4) Transfer records. When a resident is transferred to another facility, transfer information shall be summarized from the facility’s records in a copy to accompany the resident. This information shall include:

- a. A transfer form of diagnosis.
- b. Aid to daily living information.
- c. Transfer orders.
- d. Nursing care plan.
- e. Physician’s orders for care.
- f. The resident’s personal records.
- g. When applicable, the personal needs fund record.
- h. Resident care review team assessment.

81.4(5) Unused client participation. When a resident leaves the facility during the month, any unused portion of the resident’s client participation shall be refunded.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) “a,” and 249A.4.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.5(249A) Financial and statistical report and determination of payment rate. With the exception of hospital-based nursing facilities that are Medicare-certified and provide only the skilled level of care, herein referred to as Medicare-certified hospital-based nursing facilities, all facilities in Iowa wishing to participate in the program shall submit a Financial and Statistical Report to the department. All Medicare-certified hospital-based nursing facilities must submit a copy of their Medicare cost report. These reports shall be based on the following rules.

81.5(1) Failure to maintain records. Failure to adequately maintain fiscal records, including census records, medical charts, ledgers, journals, tax returns, canceled checks, source documents, invoices, and audit reports by or for a facility, may result in the penalties specified in subrule 81.14(1).

81.5(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statements of the facility. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases.

a. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. A schedule shall be required when necessary for a fair presentation of expense attributable to nursing facility patients.

b. Costs for patient care services shall be divided into the subcategories of “direct patient care costs” and “support care costs.” Costs associated with food and dietary wages shall be included in the “support care costs” subcategory.

81.5(3) *Submission of reports.* All nursing facilities, except the Iowa Veterans Home, shall submit reports electronically, in a format approved by the department, to the department not later than the last day of the fifth calendar month after the close of the provider’s reporting year. The Iowa Veterans Home shall submit the report electronically, in a format approved by the department, no later than three months after the close of each six-month period of the facility’s established fiscal year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within 60 days after the initial certification of a provider. The option to change the reporting period may be exercised only one time by a provider, and the reporting period shall coincide with the fiscal year end for Medicare cost-reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider’s records and the annual financial report.

a. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a copy of their Medicare cost report that covers their most recently completed historical reporting period as submitted to the Medicare fiscal intermediary.

b. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the nursing facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 81.5(3) “e.”

c. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report as set forth in subrule 81.5(2).

d. For nursing facilities, except the Iowa Veterans Home, an extension of the five-month filing period shall not be granted unless one is granted for the filing of the Medicare cost report. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, the Medicaid cost report and all required forms shall be submitted on the date Medicare requires submission of its report. Notice of the extension shall be presented to the department within ten days of a decision by Medicare.

e. A complete submission shall include all of the items identified in this subrule. Failure to submit a complete report that meets the requirements of this rule within the stated time shall reduce payment to 75 percent of the current rate.

(1) The reduced rate will be effective the first day of the sixth month following the provider’s fiscal year end and will remain in effect until the first day of the month after the delinquent report is received by the department.

(2) The reduced rate will be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the department.

f. When a nursing facility continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility’s fiscal year end. If the adjustment has been contested and is still in the appeals process, the provider may include the cost, but must include sufficient detail so that the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

g. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

h. A facility may change its fiscal year one time in any two-year period. If the facility changes its fiscal year, the facility shall notify the department 60 days prior to the first date of the change.

81.5(4) *Payment at new rate.*

a. Except for state-operated nursing facilities and special population nursing facilities, payment rates will be updated July 1, 2001, and every second year thereafter with new cost report data, and adjusted quarterly to account for changes in the Medicaid average case-mix index. For nursing facilities receiving both an ICF and SNF Medicaid rate effective June 30, 2001, the June 30, 2001, Medicaid rate referenced in subparagraphs (1) and (2) below will be the patient-day-weighted average of the ICF and SNF Medicaid rates effective June 30, 2001, excluding the case-mix transition add-on amount.

(1) The Medicaid payment rates for services rendered from July 1, 2001, through June 30, 2002, will be 66.67 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, not to exceed \$94, and 33.33 percent of the July 1, 2001, modified price-based rate pursuant to subrule 81.5(16). In no case will the July 1, 2001, Medicaid rate be less than the Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, and increased by a 6.21 percent inflation allowance.

(2) Payment rates for services rendered from July 1, 2002, through June 30, 2003, shall be 33.33 percent of the facility's Medicaid rate effective June 30, 2001, excluding the case-mix transition add-on amount, plus an inflation allowance of 6.21 percent, and an additional inflation factor based on the CMS/SNF Total Market Basket Index. However, the current system rate to be used effective July 1, 2002, shall not exceed \$94, times an inflation factor pursuant to subrule 81.5(18), and 66.67 percent of the July 1, 2002, modified price-based rate. In no case will the July 1, 2002, Medicaid rate be less than the Medicaid rate effective June 30, 2002, plus an inflation factor pursuant to subrule 81.5(18) projected for the following 12 months.

(3) Payment rates for services rendered from July 1, 2003, and thereafter will be 100 percent of the modified price-based rate.

b. The Medicaid payment rate for special population nursing facilities will be updated annually without a quarterly adjustment.

c. The Medicaid payment rate for state-operated nursing facilities will be updated annually without a quarterly adjustment.

81.5(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

81.5(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

81.5(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

81.5(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

81.5(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient's status at midnight at the end of each day.

b. When a recipient is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance

patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

81.5(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services include room, board, nursing services, therapies, and such services as supervision, feeding, pharmaceutical consulting, over-the-counter drugs, incontinence, and similar services, for which the associated costs are in nursing service. Routine daily services shall not include:

(1) Laboratory or diagnostic radiology services, unless the service is provided by facility staff using facility equipment, and

(2) Prescription (legend) drugs.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

81.5(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following:

a. Federal and state income taxes are not allowed as reimbursable costs.

b. Fees paid directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Bad debts are not an allowable expense.

d. Charity allowances and courtesy allowances are not an allowable expense.

e. Personal travel and entertainment are not allowable as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal costs shall be prorated. Amounts that appear to be excessive may be limited after consideration of the specific circumstances. Records shall be maintained to substantiate the indicated charges.

(1) Commuter travel by the owner(s), owner-administrator(s), administrator, nursing director or any other employee is not an allowable cost (from private residence to facility and return to residence).

(2) The expense of one car or one van or both designated for use in transporting patients shall be an allowable cost. All expenses shall be documented by a sales slip, invoice or other document setting forth the designated vehicle as well as the charges incurred for the expenses to be allowable.

(3) At the time of annual contract renewal with the Iowa department of transportation, each facility that supplies transportation services as defined in Iowa Code section 324A.1 shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code section 324A.5 and 761—Chapter 910 of the Iowa department of transportation's rules. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation shall result in disallowance of vehicle costs and other costs associated with transporting residents.

(4) Expenses related to association business meetings, limited to individual members of the association who are members of a national affiliate, and expenses associated with workshops, symposiums, and meetings that provide administrators or department heads with hourly credits required to comply with continuing education requirements for licensing, are allowable expenses.

(5) Travel of an emergency nature required for supplies, repairs of machinery or equipment, or building is an allowable expense.

(6) Travel for which a patient must pay is not an allowable expense.

(7) Allowable expenses in subparagraphs (2) through (5) above are limited to 6 percent of total administrative expense.

f. Entertainment provided by the facility for participation of all residents who are physically and mentally able to participate is an allowable expense except that entertainment for which the patient is required to pay is not an allowable expense.

g. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

h. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation includes all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits shall include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation shall be considered unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, shall be required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report will be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 81.5(3) "e."

(2) Reasonableness requires that the compensation allowance be the same amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$3,296 per month plus \$35.16 per month per licensed bed capacity for each bed over 60, not to exceed \$4,884 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by an annual inflation factor as specified by subrule 81.5(18).

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having

a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership or a relative as are maintained for any other employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for anyone working for another entity (e.g., home office) that allocates cost to the nursing facility and is involved in ownership of the facility or allocating entity or who is an immediate relative of an owner of the facility or allocating entity is 60 percent of the amount allowed for the administrator. An employee working for another entity that allocates cost to the nursing facility is considered to be involved in ownership of a facility when that individual has ownership interest of 5 percent or more of the home office or the nursing facility.

(8) The maximum allowed compensation for employees as set forth in subparagraphs 81.5(11)“h”(4) through 81.5(11)“h”(7) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the nursing facility for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. In the case that an owner’s or immediate relative’s time is allocated to the facility from another entity (e.g., home office), the compensation limit shall be adjusted by the percentage of total costs of the entity allocated to the nursing facility. In no case shall the amount of salary for one employee allocated to multiple nursing facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

i. Management fees paid to a related party shall be limited on the same basis as the owner administrator’s salary, but shall have the amount paid the resident administrator deducted. When the parent company can separately identify accounting costs, the costs are allowed.

j. For financial and statistical reports received after March 18, 2020, the depreciation, as limited in this rule, may be included as an allowable patient cost.

(1) Limitation on calculation. Depreciation shall be calculated based on the tax cost using only the straight-line method of computation and recognizing the estimated useful life of the asset as defined in the most recent edition of the American Hospital Association’s Estimated Useful Lives of Depreciable Hospital Assets (2023 edition).

(2) Limitation—full depreciation. Once an asset is fully depreciated, no further depreciation shall be claimed on that asset.

(3) Change of ownership. Depreciation is further limited by the limitations in subrule 81.5(12).

k. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

l. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those that commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for the services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

m. For financial and statistical reports received after March 18, 2020, the following definitions, calculations, and limitations shall be used to determine allowable rent expense on a cost report.

(1) Landlord's other expenses. Landlord's other expenses are limited to amortization, mortgage interest, property taxes unless claimed as a lessee expense, utilities paid by the landlord unless claimed as a lessee expense, property insurance, and building maintenance and repairs.

(2) Reasonable rate of return. Reasonable rate of return means the historical cost of the facility in the hands of the owner when the facility first entered the Medicaid program multiplied by the 30-year Treasury bond rate as reported by the Federal Reserve Board at the date of lease inception.

(3) Nonrelated party leases. When the operator of a participating facility rents from a party that is not a related party, as defined in paragraph 81.5(11)"*l*," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11)"*j*" plus the landlord's other expenses, plus a reasonable rate of return; or

2. Actual rent payments.

(4) Related party leases. When the operator of a participating facility rents from a related party, as defined in paragraph 81.5(11)"*l*," the allowable cost report rental expense shall be the lesser of:

1. Lessor's annual depreciation as identified in paragraph 81.5(11)"*j*" plus the landlord's other expenses; or

2. Actual rent payments.

n. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are unallowable:

- (1) Any fees or portion of fees used or designated for lobbying.
- (2) Nonrefundable and unused retainers.
- (3) Fees paid by the facility for the benefit of employees.
- (4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the conditions below are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,
2. The costs are reasonable expenditures for the services obtained,
3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and
4. The facility prevails on the disputed issue.

o. The nursing facility quality assurance assessment paid pursuant to 441—Chapter 36 shall not be an allowable cost for cost reporting and audit purposes but shall be reimbursed pursuant to paragraph 81.5(21)“*a.*”

p. Prescription (legend) drug costs are excluded from services covered as part of the nursing facility per diem rate as set forth in paragraph 81.10(5)“*d.*” The department will provide direct payment for drugs covered pursuant to 441—subrule 78.1(2) to relieve the facility of payment responsibility. As Medicaid reimburses pharmacy providers only for the cost and dispensation of legend drugs included on the Medicaid preferred drug list, no drug costs will be recognized for other payor sources.

q. Inpatient therapy services provided by nursing facilities are included in the established rate as a direct care cost and subject to the normalization process and quarterly case-mix index adjustments.

(1) Under no circumstances shall therapies for Medicaid members residing in a nursing facility be billed to Medicaid through any provider other than the nursing facility. Therapy services for nursing facility residents that are reimbursed by other payment sources shall not be reimbursed by Medicaid.

(2) For purposes of determining allowable therapy costs, the department will adjust each provider’s reported cost of therapy services, including any employee benefits prorated based on total salaries and wages, to account for nonfacility patients including patients with costs paid by Medicare. Such adjustments will be applied to each cost report in order to remove reported costs attributable to outpatient therapy services reimbursed for non-inpatient services. When the costs of the services are not determinable, an adjustment shall be calculated based on an allocation of reported therapy revenues and shall be subject to field audit verification.

r. Penalties or fines imposed by federal, state or local agencies are not allowable expenses.

s. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

t. Laboratory costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

u. Diagnostic radiology costs are excluded from services covered as part of the nursing facility per diem rate unless the service is provided by facility staff using facility equipment.

81.5(12) Termination or change of owner:

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days’ prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. The new owner shall be responsible for all Medicaid debts incurred by the previous owner, including those incurred due to changes in rates, fines, penalties and quality assurance fees, from the first day of the quarter until the date the change occurs. No

payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing facility is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

81.5(13) *Amended reports.* The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem summary and adjustments following a review of a financial and statistical report. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

81.5(14) *Payment to new facility.* The payment to a new facility will be the sum of the patient-day-weighted median cost for the direct care and non-direct care components pursuant to paragraph 81.5(16)“c.” After the first full calendar quarter of operation, the patient-day-weighted median cost for the direct care component will be adjusted by the facility’s average Medicaid case-mix index pursuant to subrule 81.5(19). A financial and statistical report shall be submitted from the beginning day of operation to the end of the fiscal year. Following the completion of the new facility’s first fiscal

year, rates will be established in accordance with subrule 81.5(16). Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year.

81.5(15) *Payment to new owner.* An existing facility with a new owner will continue to be reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average case-mix index. The facility shall submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent financial and statistical reports shall be submitted annually for a 12-month period ending with the facility's fiscal year. The facility shall notify the department of the date the facility's fiscal year will end.

81.5(16) *Establishment of the direct care and non-direct care patient-day-weighted medians and modified price-based reimbursement rate.* This subrule provides for the establishment of the modified price-based reimbursement rate.

a. Calculation of per diem cost. For purposes of calculating the non-state government owned nursing facility Medicaid reimbursement rate and the Medicare-certified hospital-based nursing facility Medicaid reimbursement rate, the costs will be divided into two components, the direct care component and non-direct care component as defined in rule 441—81.1(249A). Each nursing facility's per diem allowable direct care and non-direct care cost shall be established. Effective July 1, 2001, and every second year thereafter, the per diem allowable cost will be determined by dividing total reported allowable costs by total inpatient days during the reporting period. On July 1, 2001; July 1, 2003; July 1, 2004; July 1, 2005; and every second year thereafter, total reported allowable costs will be adjusted using the inflation factor specified in subrule 81.5(18) from the midpoint of the cost report period to the beginning of the state fiscal year rate period.

(1) Non-state government owned nursing facilities. Effective December 1, 2009, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7) or 85 percent of the licensed capacity of the facility, whichever is greater. For the reimbursement period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days as determined in subrule 81.5(7) or 70 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses will be inpatient days as determined in subrule 81.5(7).

(2) Medicare-certified hospital-based nursing facilities. Patient days for purposes of the computation of all expenses shall be inpatient days as determined by subrule 81.5(7).

b. Cost normalization. The per diem allowable direct care costs are normalized by dividing a facility's per diem direct care costs by the facility's cost report period case-mix index as defined in rule 441—81.1(249A) and subrule 81.5(19).

c. Calculation of patient-day-weighted medians. For each of the rate components, a patient-day-weighted median will be established for both the non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities, hereinafter referred to as the non-state government owned nursing facility patient-day-weighted medians and the Medicare-certified hospital-based nursing facility patient-day-weighted medians.

The per diem normalized direct care cost for each facility is arrayed from low to high to determine the direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. The per diem non-direct care cost for each facility is also arrayed from low to high to determine the non-direct care component patient-day-weighted median cost based on the number of patient days provided by facilities. An array and patient-day-weighted median for each cost component is determined separately for both non-state government owned nursing facilities and the Medicare-certified hospital-based nursing facilities.

(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-

weighted medians will be calculated using the latest financial and statistical report with a fiscal year end of December 31, 2000, or earlier, inflated from the midpoint of the cost report period to July 1, 2001, using the inflation factor specified in subrule 81.5(18).

(2) Effective July 1, 2003, and each second year thereafter, the patient-day-weighted medians used in rate setting will be recalculated. The non-state government owned nursing facility direct care and non-direct care patient-day-weighted medians and the Medicare-certified hospital-based nursing facility direct care and non-direct care patient-day-weighted medians will be calculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient-day-weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period using the inflation factor specified in subrule 81.5(18).

(3) For the fiscal period beginning July 1, 2004, and ending June 30, 2005, the non-state-owned and Medicare-certified hospital-based nursing facility direct care and the non-direct care patient-day-weighted medians calculated July 1, 2003, will be inflated to July 1, 2004, using the inflation factor specified in subrule 81.5(18).

d. Excess payment allowance.

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area as defined by CMS, not including Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day direct care costs pursuant to 81.5(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)“a.” In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area as defined by CMS (not including Medicare-certified hospital-based nursing facilities), the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the wage index factor specified below times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's allowable normalized per patient day direct care costs pursuant to paragraph 81.5(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care non-state government owned nursing facility patient-day-weighted median.

The wage index factor will be determined annually by calculating the average difference between the Iowa hospital-based rural wage index and all Iowa hospital-based Metropolitan Statistical Area wage indices as published by CMS each July. The geographic wage index adjustment will not exceed \$8 per patient day.

A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, locations, and total cost. The nursing facility shall request the exception within 30 days of receipt of notification to the nursing facility of the new reimbursement rate using the department's procedures for requesting exceptions at rule 441—1.8(17A,217).

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care non-state government owned nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)“a.” In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care non-state government owned nursing facility patient-day-weighted median.

(3) For Medicare-certified hospital-based nursing facilities, the excess payment allowance is calculated as follows:

1. For the direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19), minus a provider's normalized allowable per patient day direct care costs pursuant to paragraph 81.5(16)“b” times the Medicaid average case-mix index pursuant to subrule 81.5(19). In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

2. For the non-direct care component, subject to the limit provided below, the excess payment allowance is equal to the percentage specified in 441—subrule 79.1(2) times the difference (if greater than zero) of the following: the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage specified in 441—subrule 79.1(2), minus a provider's allowable per patient day non-direct care cost pursuant to paragraph 81.5(16)“a.” In no case will the excess payment allowance exceed the percentage specified in 441—subrule 79.1(2) times the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median.

e. Reimbursement rate. The Medicaid reimbursement rate is based on allowable costs, updated July 1, 2001, and every second year thereafter, as specified in subparagraphs (1) and (2) below, plus a potential excess payment allowance determined by the methodology in paragraph “d,” not to exceed the rate component limits determined by the methodology in paragraph “f.”

(1) For non-state government owned nursing facilities and Medicare-certified hospital-based nursing facilities, direct care and non-direct care rate components are calculated as follows:

1. The direct care component is equal to the provider's normalized allowable per patient day costs times the Medicaid average case-mix index pursuant to subrule 81.5(19), plus the allowed excess payment allowance as determined by the methodology in paragraph “d.”

2. The non-direct care component is equal to the provider's allowable per patient day costs, plus the allowed excess payment allowance as determined by the methodology in paragraph “d” and the allowable capital cost per diem instant relief add-on as determined by the methodology in paragraph “h.”

(2) The reimbursement rate for state-operated nursing facilities and special population nursing facilities will be the facility's average allowable per diem costs, adjusted for inflation pursuant to subrule 81.5(18), based on the most current financial and statistical report.

f. Notwithstanding paragraphs “d” and “e,” in no instance will a rate component exceed the rate component limit defined as follows:

(1) For non-state government owned nursing facilities not located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(2) For non-state government owned nursing facilities located in a Metropolitan Statistical Area (not including Medicare-certified hospital-based nursing facilities), the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care non-state government owned nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the wage factor specified in paragraph “d” times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care non-state government owned nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(3) For Medicare-certified hospital-based nursing facilities, the direct care and non-direct care rate component limits are calculated as follows:

1. The direct care rate component limit is the direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2) times the Medicaid average case-mix index pursuant to subrule 81.5(19).

2. The non-direct care rate component limit is the non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or is 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

(4) For special population nursing facilities enrolled on or after June 1, 1993, the upper limit on their rate is equal to the sum of the following:

1. The direct care Medicare-certified hospital-based nursing facility patient-day-weighted median times the percentage of the median specified in 441—subrule 79.1(2).

2. The non-direct care Medicare-certified hospital-based nursing facility patient-day-weighted median multiplied by the percentage of the median specified in 441—subrule 79.1(2) or 120 percent of the median if the facility qualifies for the enhanced non-direct care rate component limit pursuant to paragraph “h.”

g. Pay-for-performance program. Additional reimbursement based on the nursing facility pay-for-performance program is available for non-state government owned nursing facilities as provided in this paragraph in state fiscal years for which funding is appropriated by the legislature. The pay-for-performance program provides additional reimbursement based upon a nursing facility’s achievement of multiple favorable outcomes as determined by established benchmarks. The reimbursement is issued as an add-on payment after the end of any state fiscal year (which is referred to in this paragraph as the “payment period”) for which there is funding appropriated by the legislature.

(1) Scope. Additional reimbursement for the nursing facility pay-for-performance program is not available to Medicare-certified hospital-based nursing facilities, state-operated nursing facilities, or special population nursing facilities. Therefore, data from these facility types will not be used when determining eligibility for or the amount of additional reimbursement based on the nursing facility pay-for-performance program.

(2) Benchmarks. The pay-for-performance benchmarks include characteristics in four domains: quality of life, quality of care, access, and efficiency. These characteristics are objective and measurable and when considered in combination with each other are deemed to have a correlation to a resident’s quality of life and care. While any single measure does not ensure the delivery of

quality care, a nursing facility's achievement of multiple measures suggests that quality is an essential element in the facility's delivery of resident care.

(3) Definition of direct care. For the purposes of the nursing facility pay-for-performance program, "direct care staff" is defined to include registered nurses (RNs), licensed practical nurses (LPNs), certified nurse assistants (CNAs), rehabilitation nursing, and other contracted nursing services. "Direct care staff" does not include the director of nursing (DON) or minimum data set (MDS) coordinator.

(4) Qualifying for additional reimbursement. The department will annually award points based on the measures achieved in each of the four domains, as described in subparagraphs (5) through (8). The maximum available points are 100. To qualify for additional Medicaid reimbursement under the nursing facility pay-for-performance program, a facility must achieve a minimum score of 51 points. The relationship of the score achieved to additional payments is described in subparagraph (10). Payments are subject to reduction or forfeiture as described in subparagraphs (12) and (13).

(5) Domain 1: Quality of life.

Standard	Measurement Period	Value	Source
Subcategory: Person-Directed Care			
Enhanced Dining A: The facility makes available menu options and alternative selections for all meals.	Payment period	1 point	Self-certification
Enhanced Dining B: The facility provides residents with access to food and beverages 24 hours per day and 7 days per week and empowers staff to honor resident choices.	Payment period	1 point	Self-certification
Enhanced Dining C: The facility offers at least one meal per day for an extended period to give residents the choice of what time to eat.	Payment period	2 points	Self-certification
Resident Activities A: The facility employs a certified activity coordinator for at least 38 minutes per week per licensed bed.	Payment period	1 point	Self-certification
Resident Activities B: The facility either has activity staff that exceed the required minimum set by law or has direct care staff who are trained to plan and conduct activities and carry out both planned and spontaneous activities on a daily basis.	Payment period	1 point	Self-certification
Resident Activities C: The facility's residents report that activities meet their social, emotional and spiritual needs.	July through March of payment period	2 points	Self-certification
Resident Choice A: The facility allows residents to set their own schedules, including what time to get up and what time to go to bed.	Payment period	1 point	Self-certification
Resident Choice B: The facility allows residents to have a choice of whether to take a bath or shower and on which days and at what time the bath or shower will be taken.	Payment period	1 point	Self-certification
Consistent Staffing: The facility has all direct care staff members caring for the same residents at least 70% of their shifts.	Payment period	3 points	Self-certification
National Accreditation:	Payment period	13 points NOTE: A facility that receives points	Self-certification

Standard	Measurement Period	Value	Source
The facility has CARF or another nationally recognized accreditation for the provision of person-directed care.		for this measure does not receive points for any other measures in this subcategory.	
Subcategory: Resident Satisfaction			
Resident/Family Satisfaction Survey: The facility administers an anonymous resident/family satisfaction survey annually. The survey tool must be developed, recognized, and standardized by an entity external to the facility. Results must be tabulated by an entity external to the facility. To qualify for the measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Long-Term Care Ombudsman: The facility has resolved 70% or more of complaints received and investigated by the local or state ombudsman.	Calendar year ending December 31 of the payment period	5 points if resolution 70% to 74% 7 points if resolution 75% or greater	LTC ombudsman's list of facilities meeting the standard

(6) Domain 2: Quality of care.

Standard	Measurement Period	Value	Source
Subcategory: Survey			
Deficiency-Free Survey: The facility is deficiency-free on the latest annual state and federal licensing and certification survey and any subsequent surveys, complaint investigations, or revisit investigations. If a facility's only scope and severity deficiencies are an A level pursuant to 42 CFR Part 483, Subparts B and C, as amended to August 1, 2024, the facility is deemed to have a deficiency-free survey for purposes of this measure. Surveys are considered complete when all appeal rights have been exhausted.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisit, or complaint investigations	10 points	DIAL list of facilities meeting the standard
Regulatory Compliance with Survey: No on-site revisit to the facility is required for recertification surveys or for any substantiated complaint investigations during the measurement period.	Calendar year ending December 31 of the payment period, including any subsequent surveys, revisits, or complaint investigations	5 points. A facility that receives points for a deficiency-free survey does not receive points for this measure.	DIAL list of facilities meeting the standard
Subcategory: Staffing			
Nursing Hours Provided: The facility's per-resident-day nursing hours are at or above one-half standard deviation above the mean of per-resident-day nursing hours for all facilities. Nursing hours include those of RNs, LPNs, CNAs, rehabilitation nurses, and other contracted nursing services. Nursing hours will be normalized to remove variations in	Facility fiscal year ending on or before December 31 of the payment period	5 points if case-mix adjusted nursing hours are above mean plus one-half standard deviation 10 points if case-mix adjusted nursing hours are greater than mean plus one standard deviation	Financial and Statistical Report, as analyzed by the department. The facility cost report period case-mix index shall be used to normalize nursing hours.

Standard	Measurement Period	Value	Source
staff hours associated with different levels of resident case mix.			
Employee Turnover: The facility has overall employee turnover of 50% or less and CNA turnover of 55% or less.	Facility fiscal year ending on or before December 31 of the payment period	5 points if overall turnover is between 40% and 50% and CNA turnover is between 45% and 55% 10 points if overall turnover is less than or equal to 40% and CNA turnover is less than or equal to 45%	Financial and Statistical Report, as analyzed by the department
Staff Education, Training and Development: The facility provides staff education, training, and development at 25% above the basic requirements for each position that requires continuing education. The number of hours for these programs must apply to at least 75% of all staff of the facility, based upon administrator or officer certification.	Calendar year ending December 31 of the payment period	5 points	Self-certification
Staff Satisfaction Survey: The facility annually administers an anonymous staff satisfaction survey. The survey tool must be developed, recognized, and standardized by an entity external to the facility and must identify worker job classification. Results must be tabulated by an entity external to the facility. To qualify for this measure, the facility must have a response rate of at least 35%. A summary report of the aggregate results and point scale must be made publicly available and be posted prominently along with the facility's state survey results until the next satisfaction survey is completed.	Survey completed between October 1 and March 31 of the payment period	5 points	Nursing Facility Opinion Survey Transmittal, submitted by independent entity that compiled results
Subcategory: Nationally Reported Quality Measures			
High-Risk Pressure Ulcer: The facility has occurrences of high-risk pressure ulcers at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean percentage of occurrences 5 points if one standard deviation or more below the mean percentage of occurrences	Department report based on MDS data as reported by CMS
Physical Restraints: The facility has a physical restraint rate of 0% based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	5 points	Department report based on MDS data as reported by CMS
Chronic Care Pain: The facility has occurrences of chronic care pain at rates one-half standard deviation or more below the mean rate of occurrences for all facilities based on MDS data as applied to the nationally reported quality measures.	12-month period ending September 30 of the payment period	3 points if one-half to one standard deviation below the mean rate of occurrences 5 points if one standard deviation	Department report based on MDS data as reported by CMS

Standard	Measurement Period	Value	Source
		or more below the mean rate of occurrences	
High Achievement of Nationally Reported Quality Measures: The facility received at least 9 points from a combination of the measures listed in this subcategory.	12-month period ending September 30 of the payment period	2 points if the facility receives 9 to 12 points in the subcategory of nationally reported quality measures 4 points if the facility receives 13 to 15 points in this subcategory	Department report based on MDS data as reported by CMS

(7) Domain 3: Access.

Standard	Measurement Period	Value	Source
Special Licensure Classification: The facility has a unit licensed for the care of residents with chronic confusion or a dementing illness (CCDI unit).	Status on December 31 of the payment period	4 points	DIAL list of facilities meeting the standard
High Medicaid Utilization: The facility has Medicaid utilization at or above the statewide median plus 10%. Medicaid utilization is determined by dividing total nursing facility Medicaid days by total nursing facility patient days.	Facility fiscal year ending on or before December 31 of the payment period	3 points if Medicaid utilization is more than the median plus 10% 4 points if Medicaid utilization is more than the median plus 20%	Financial and Statistical Report, as analyzed by the department

(8) Domain 4: Efficiency.

Standard	Measurement Period	Value	Source
High Occupancy Rate: The facility has an occupancy rate at or above 95%. "Occupancy rate" is defined as the percentage derived when dividing total patient days based on census logs by total bed days available based on the number of authorized licensed beds within the facility.	Facility fiscal year ending on or before December 31 of the payment period	4 points	Financial and Statistical Report, as analyzed by the department
Low Administrative Costs: The facility's percentage of administrative costs to total allowable costs is one-half standard deviation or more below the mean percentage of administrative costs for all Iowa facilities.	Facility fiscal year ending on or before December 31 of the payment period	3 points if administrative costs percentage is less than the mean less one-half standard deviation 4 points if administrative costs percentage is less than the mean less one standard deviation	Financial and Statistical Report, as analyzed by the department

(9) Source of measurements. Source reports are due to the department by May 1 of each year. For those measures whose source is self-certification, the data will be drawn from a report submitted by the facility to the department. The independent party that collects and compiles the results of the resident/family survey shall communicate the results to the department on the Nursing Facility Opinion Survey Transmittal. The department will request required source reports from the long-term care ombudsman and the department of inspections, appeals, and licensing.

(10) Calculation of potential add-on payment. The number of points awarded will be determined annually, for each state fiscal year for which funding is appropriated by the legislature. A determination is made on whether a facility qualifies for an add-on payment at the end of the payment period. Based upon the number of points awarded, a retroactive add-on payment is made effective beginning the first day of the payment period as follows, contingent upon legislative funding for the state fiscal year, and subject to subparagraph (11):

<u>Score</u>	<u>Amount of Add-on Payment</u>
0-50 points	No additional reimbursement
51-60 points	1 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
61-70 points	2 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
71-80 points	3 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
81-90 points	4 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)
91-100 points	5 percent of the direct care plus nondirect care cost component patient-day-weighted medians, subject to reduction as provided in subparagraph (13)

(11) Monitoring for reduction or forfeiture of reimbursement. The department will request the department of inspections, appeals, and licensing to furnish by September 1, December 1, March 1, and August 1 of each year a list of nursing facilities subject to a reduction or forfeiture of the additional reimbursement pursuant to the criteria in subparagraph (12) or (13).

(12) Forfeiture of additional reimbursement. A nursing facility shall not be eligible for any additional reimbursement under this program if during the payment period the nursing facility is cited for a deficiency resulting in actual harm or immediate jeopardy pursuant to the federal certification guidelines at a scope and severity level of H or higher, regardless of the amount of fines assessed.

(13) Reduction of additional reimbursement. The additional reimbursement for the nursing facility pay-for-performance program calculated according to subparagraph (10) shall be subject to reduction based on survey compliance as follows:

1. The add-on payment shall be suspended for any month in which the nursing facility has received denial of payment for new admission status that was enforced by CMS.
2. A facility's add-on payment shall be reduced by 25 percent for each citation received during the year for a deficiency resulting in actual harm at a scope and severity level of G pursuant to the federal certification guidelines.
3. If the facility fails to cure a cited level G deficiency within the time allowed by the department of inspections, appeals, and licensing, the add-on payment shall be forfeited, and the facility shall not receive any nursing facility pay-for-performance program payment for the payment period.

(14) Application of additional payments. The additional reimbursement for the nursing facility pay-for-performance program will be paid to qualifying facilities at the end of the state fiscal year. At the end of each state fiscal year, the department will:

1. Retroactively adjust each qualifying facility's quarterly rates from the first day of the state fiscal year to include the amount of additional reimbursement for the nursing facility pay-for-performance program calculated according to paragraph 81.5(16) "g"; and

2. Reprice all facility claims with dates of service during the period in which an additional reimbursement for the nursing facility pay-for-performance program is effective to reflect the adjusted reimbursement rate.

(15) Use of additional payments. As a condition of eligibility for such payments, any additional payments received by a nursing facility for the pay-for-performance program must be:

1. Used to support direct care staff through increased wages, enhanced benefits, and expanded training opportunities; and
2. Used in a manner that improves and enhances quality of care for residents.

(16) Monitoring facility compliance on the use of payments. Each nursing facility shall complete the Nursing Facility Medicaid Enhanced Payment Report to report the use of any additional payments received for the nursing facility pay-for-performance program. The report is due to the department each year by May 1. Failure to submit the report by the due date shall result in disqualification for add-on payment for the next pay-for-performance payment period.

(17) Reporting results of the program. The department will publish the results of the nursing facility pay-for-performance program annually.

h. Capital cost per diem instant relief add-on and enhanced non-direct care rate component limit. Contingent upon approval from the CMS and to the extent that funding is appropriated by the Iowa general assembly, additional reimbursement is available for nursing facilities that have completed a complete replacement, new construction, or major renovations. Additional reimbursement under this paragraph is available for services rendered beginning on October 1, 2007, or beginning on the effective date of CMS approval if CMS approval is effective on a later date.

(1) Types of additional reimbursement. Two types of additional reimbursement are available:

1. The capital cost per diem instant relief add-on is an amount per patient day to be added to the non-direct care component of the reimbursement rate and is subject to the non-direct care rate component limit as determined in paragraph *"f."*
2. The enhanced non-direct care rate component limit provides an increase in the percentage of the median that is applied when calculating the non-direct care rate component limit as defined in paragraph *"f."* The percentage of the median is increased to 120 percent when the enhanced non-direct care rate component limit is granted.

(2) Eligible projects. To qualify for either the capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit, a facility must have undertaken a complete replacement, new construction, or major renovations for the purpose of:

1. Rectification of a violation of Life Safety Code requirements; or
2. Development of home- and community-based waiver program services; or
3. Improving infection control by replacing or enhancing an HVAC system, as defined in Iowa Code section 105.2.

(3) Additional requirements for all requests. To qualify for additional reimbursement, a facility with an eligible project must also meet the following requirements:

1. The facility has Medicaid utilization at or above 40 percent. Medicaid patient day utilization for this purpose is calculated as total nursing facility Medicaid patient days divided by total patient days as reported on the facility's most current financial and statistical report. Medicaid hospice patient days will be counted toward the total nursing facility Medicaid patient days.
2. The facility meets the accountability measure criteria set forth in paragraph *"g,"* subparagraph (1), deficiency-free survey, or subparagraph (2), regulatory compliance with survey, based on the most current information available when the request for additional reimbursement is submitted.
3. The facility has documented active participation in a quality of care program.
4. The facility has documented plans to facilitate person-directed care, dementia units, or specialty post-acute services.

(4) Additional requirements for waiver services. To qualify for additional reimbursement for the development of home- and community-based waiver services, the facility shall also meet the following requirements:

1. Services shall be provided in an underserved area, which may include a rural area.
2. Services shall be provided on the direct site of the facility but not as a nursing facility service.
3. Services shall meet all federal and state requirements for Medicaid reimbursement.
4. Services shall include one or more of the following: adult day care as defined by 441—subrule 78.37(1), consumer-directed attendant care as defined by 441—subrule 78.37(15) provided in an assisted living setting, day habilitation as defined by 441—subrule 78.41(14), home-delivered meals as defined by 441—subrule 78.37(8), emergency response system as defined by 441—subrule 78.37(2), and respite care as defined by 441—subrule 78.37(6).

(5) Submission of request. A facility shall submit a written request for the capital cost per diem instant relief add-on, the enhanced non-direct care rate component limit, or a preliminary evaluation of whether a project may qualify for additional reimbursement to the department. A qualifying facility may request one or both types of additional reimbursement.

1. A request for the capital cost per diem instant relief add-on may be submitted no earlier than 30 days before the complete replacement, new construction, or major renovations are placed in service.

2. A request for the enhanced non-direct care rate component limit may be submitted with a request for a capital cost per diem instant relief add-on or within 60 days after the release of a rate determination letter reflecting a change in the non-direct care rate component limit.

3. A request for a preliminary evaluation may be submitted when a facility is preparing a feasibility projection for a construction or renovation project. A preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

(6) Content of request for add-on. A facility's request for the capital cost per diem instant relief add-on shall include:

1. A description of the project for which the add-on is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. The period during which the add-on is requested (no more than two years).

4. Whether the facility is also requesting the enhanced non-direct care rate component limit. (See subparagraph (7) for requirements.)

5. A copy of the facility's most current depreciation schedule that clearly identifies the cost of the project for which the add-on is requested if assets placed in service by that project are included on the schedule. Any removal of assets shall be clearly identifiable either on the depreciation schedule or on a separate detailed schedule, and that schedule shall include the amount of depreciation expense for removed assets that is included in the current reimbursement rate.

6. If the cost of the project is not reported on the submitted depreciation schedule, a detailed schedule of the assets to be placed in service by the project, including:

- The estimated date the assets will be placed into service;
- The total estimated depreciable value of the assets;
- The estimated useful life of the assets based upon existing Medicaid and Medicare provisions;

and

- The estimated annual depreciation expense of the assets using the straight-line method in accordance with generally accepted accounting principles.

7. The facility's estimated annual licensed bed capacity and estimated annual total patient days. If this information is not provided, estimated annual total patient days will be determined using the most current submitted financial and statistical report.

8. If interest expense has been or will be incurred and is related to the project for which the add-on is requested, a copy of the general terms of the debt service and the estimated annual amount of interest expense shall be submitted.

9. If any debt service has been retired, a copy of the general terms of the debt service and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

(7) Content of request for enhanced limit. A facility's request for the enhanced non-direct care rate component limit shall include:

1. A description of the project for which the enhanced non-direct care rate component limit is requested, including a list of goals for the project and a time line of the project that spans the life of the project.

2. Documentation that the facility meets the qualifications in subparagraphs (2) and (3) and, if applicable, in subparagraph (4).

3. Identification of any period in which the capital cost per diem instant relief add-on was previously granted and the number of times the capital cost per diem instant relief add-on and the enhanced non-direct care rate component limit have previously been granted.

(8) Content of request for preliminary evaluation. A facility's request for a preliminary evaluation of a proposed project shall include:

1. The estimated completion date of the project.

2. The estimated date when a formal request for an add-on or enhanced limit will be submitted.

3. For a preliminary evaluation for a capital cost per diem instant relief add-on, all information required in subparagraph (6).

4. For a preliminary evaluation for the enhanced non-direct care rate component limit, all information required in subparagraph (7).

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Effective December 1, 2009, total patient days will be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days will be the greater of the estimated annual total patient days or 85 percent of the facility's estimated licensed capacity. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government-owned facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The annual estimated property costs for the project are calculated as the estimated annual depreciation expense for the cost of the project, plus estimated annual interest expense for the cost of the project, less the amount of depreciation expense for assets removed that is included in the current reimbursement rate and the amount of interest expense for debt service retired that is included in the current reimbursement rate.

3. Estimated amounts and actual amounts will be reconciled as described in subparagraph (12).

(10) Effective date of capital cost per diem instant relief add-on. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, a capital cost per diem instant relief add-on will be effective the first day of the calendar quarter following the placement in service of the assets associated with the add-on and receipt of all required information. The capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate, not to exceed the non-direct care rate component limit as determined in paragraph "f."

(11) Term of capital cost per diem instant relief add-on. The period for which a facility may be granted the capital cost per diem instant relief add-on shall not exceed two years. The capital cost per diem instant relief add-on shall terminate at the time of the subsequent biennial rebasing. If the

facility's submitted annual financial and statistical report used in the subsequent biennial rebasing does not include 12 months of property costs for the assets with which the capital cost per diem instant relief add-on is associated, including interest expense, if applicable, the facility may submit a new request for the capital cost per diem instant relief add-on.

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the department will recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation will be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days will be based on the greater of the number of actual patient days during the period in which the add-on was paid or 85 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid. For the period beginning July 1, 2023, and ending June 30, 2025, patient days for purposes of the computation of administrative, environmental, and property expenses for non-state government owned nursing facilities will be inpatient days or the minimum occupancy of 70 percent of the licensed capacity of the facility, whichever is greater.

2. The recalculated capital cost per diem instant relief add-on will be added to the non-direct care component of the reimbursement rate for the relevant period, not to exceed the non-direct care rate component limit as determined in paragraph "f." The facility's quarterly rates for the relevant period will be retroactively adjusted to reflect the recalculated non-direct care component of the reimbursement rate. All claims with dates of service during the period the capital cost per diem instant relief add-on is paid will be repriced to reflect the recalculated capital cost per diem instant relief add-on.

(13) Effective date of enhanced non-direct care rate component limit. Subject to available funding and previously approved requests for capital cost per diem instant relief add-ons and enhanced non-direct care rate component limits, an enhanced non-direct care rate component limit will be effective:

1. With a capital cost per diem instant relief add-on (if requested at the same time); or
2. Retroactive to the first day of the quarter in which the revised non-direct care rate component limit amount is effective. All claims with dates of service from the effective date will be repriced.

(14) Term of enhanced non-direct care rate component limit. The period for which a facility may be granted an enhanced non-direct care rate component limit without reapplication shall not exceed two years. The total period for which a facility may be granted enhanced non-direct care rate component limits shall not exceed ten years. If the amount of the non-direct care rate component limit is revised during the period for which a facility is granted the enhanced limit, the approval will be terminated effective the first day of the quarter in which the revised non-direct care rate component limit is effective. The facility may submit a new request for the enhanced non-direct care rate component limit.

(15) Ongoing conditions. Any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit granted by the department is temporary. Additional reimbursement shall be immediately terminated if:

1. The facility does not continue to meet all of the initial qualifications for additional reimbursement; or
2. The facility does not make reasonable progress on any plans required for initial qualification; or
3. The facility's medical assistance program or Medicare certification is revoked. A facility whose certification is revoked is not eligible to submit a subsequent request for a capital cost per diem instant relief add-on or the enhanced non-direct care rate component limit.

(16) Change of ownership. Following a change in nursing facility ownership, any capital cost per diem instant relief add-on or enhanced non-direct care rate component limit that was granted before the change in ownership will continue under the new owner. Future reimbursement rates will be determined pursuant to subrules 81.5(15) and 81.5(16).

i. Quality incentive payment program (QIPP). The QIPP add-on rate will be made to a qualified non-state government-owned nursing facility (NSGO nursing facility) to promote, maintain, and improve resident quality of care and health outcomes.

(1) An NSGO nursing facility qualifies for participation in the QIPP if all the following conditions are met:

1. The NSGO nursing facility has executed a participation agreement with the department.
2. The NSGO nursing facility has provided proof that the entity holds the NSGO nursing facility's license and has complete operational responsibility for the NSGO nursing facility.
3. The NSGO nursing facility has filed a certification of eligibility application for the QIPP add-on rate program with the department and has received approval from the department for participation in the program.
4. The NSGO nursing facility is in compliance with all care criteria requirements.
5. The non-state government entity (NSGE) has executed a nursing facility provider contract with an NSGO nursing facility.
6. The NSGE has provided and identified the source of state share dollars for the intergovernmental transfer (IGT).
7. The NSGO nursing facility has provided proof of ownership, if applicable, as the licensed operator of the NSGO nursing facility.
8. The NSGO nursing facility has provided to the department an executed management agreement between the NSGE and the NSGO nursing facility manager if applicable.

(2) If at any time a provider is determined not eligible due to not meeting survey standards, the provider will be disqualified for the remainder of the year.

(3) An NSGO nursing facility will qualify for participation in the QIPP if all the following quality measures are met:

Quality Measures	Metrics	Tracking/Scoring	Data Resource
Staffing	Metric 1: Nursing facility maintains an additional four or more hours of registered nurse (RN) coverage per day beyond the CMS minimum standard (8 hrs/day). Does not include managerial hours. Metric 2: Nursing facility's per-resident day certified nursing assistants (CNAs), rehabilitation aid, and other contracted aid services are at or above one-half standard deviation above the statewide mean of per-resident-day CNA hours. CNA hours include those of CNAs, rehabilitation aid, and other contracted aide services. CNA hours will be normalized to remove variations in staff hours associated with different levels of resident case mix. Metric 3: Nursing facility's per-resident day total nursing hours are at or above one-half standard deviation above the statewide mean of per-resident-day total nursing hours. Nursing hours include those of RNs and licensed practical nurses (LPNs) including restorative nurses. Nursing hours will be normalized to remove variations in staff hours associated with different levels of resident case mix.	Staffing metrics 1, 2, and 3 must be met for facility to be eligible for per diem rate add-on payment.	Payroll-based journal (PBJ) or cost reports
Infection Control	Metric 1: Nursing facility has an infection control program that includes antibiotic stewardship. The program incorporates policies	Infection control metrics 1, 2, and 3 must be met for facility	Nursing facility will be required to provide its infection control

	and training as well as monitoring, documenting, and providing staff with feedback.	to be eligible for per diem rate add-on payment.	policy and procedure. In addition, facilities will need to provide information regarding training, monitoring, documentation and monitoring of required elements to meet this metric on a periodic basis
	Metric 2: Percentage of residents with urinary tract infections (UTIs) at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on minimum data set (MDS) data as applied to the nationally reported quality measures.		CASPER Report MDS Assessment Care Compare
	Metric 3: Percentage of residents with up-to-date pneumonia vaccine measured against a fixed benchmark that is set as the most recently published national average for the related MDS quality metric.		
Quality Measures	Metric 1: Percentage of high-risk residents with pressure ulcers (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. Metric 2: Percentage of residents who had a fall with major injury (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. Metric 3: Percentage of residents who received antipsychotic medications are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures. Metric 4: Percentage of residents who required increased activities of daily living (ADL) assistance (for longer-term stay residents) are at rates one-half standard deviation or more below the mean percentage of occurrences for all facilities, based on MDS data as applied to the nationally reported quality measures.	Quality measures metrics 1, 2, 3, and 4 must be met for the facility to be eligible for per diem rate add-on payment.	CASPER Report MDS Assessment Care Compare
State Survey Results	Number of deficiencies is at or below the state of Iowa average number of nursing facility deficiencies <u>AND</u> the facility has no deficiencies with a scope of F, H, I, J, K, or L.	State survey results must be met for the facility to be eligible for per diem rate add-on payment.	Department of inspections, appeals, and licensing (DIAL) surveys
Quality Assurance Performance Improvement (QAPI) Report	Nursing facility must submit QAPI reports on quarterly basis.	QAPI results must be submitted for the facility to be eligible for per diem rate add-on payment.	QAPI reports

(4) A provider must submit the Intent to Participate Agreement on or before September 30 each year and include all necessary documentation related to the quality measures.

1. Upon receipt of the participation agreement, the department will complete a determination of eligibility based on the care criteria defined above.

2. Providers will be notified of their eligibility annually within 60 days of the agreement due date.

(5) The nursing facility QIPP add-on rate provided to a participating NSGO nursing facility under the QIPP will not exceed Medicare payment principles pursuant to 42 CFR 447.272 (as amended to August 1, 2024) and will be calculated pursuant to 42 CFR 438.6 (as amended to August 1, 2024). The QIPP add-on rate will be calculated and paid as follows:

1. The methodology utilized to calculate the upper payment limit will be based on the data available during the calculation period.

2. The eligible amount used in determining the QIPP add-on rate will be the difference between the state Medicaid payment and the Medicare upper payment limit as determined, on an annual basis, using all Medicaid claims, including fee-for-service (FFS) and Medicaid managed care claims.

3. The difference calculated under numbered paragraph “2” will be divided by total patient days pursuant to subrule 81.5(7).

4. The QIPP add-on rate will be paid prospectively.

(6) A participating NSGO nursing facility shall notify the department of any change of ownership that may affect the participating NSGO nursing facility’s continued eligibility for the QIPP a minimum of 30 days prior to such change.

1. If a participating NSGO nursing facility changes ownership to a privately owned entity, on or after the first day of the QIPP add-on rate calculation period, the privately owned provider is no longer eligible for the QIPP add-on rate.

2. A participating facility must meet the CMS and department requirements to be classified as an NSGO nursing facility. All changes of ownership must be a fair market value transaction.

3. If it is determined that a provider is not a qualified NSGO nursing facility per CMS and the department, the provider shall repay all QIPP add-on payments to the department.

(7) Providers that do not meet eligibility requirements above will be notified of the metrics that were not met.

(8) A participating NSGO nursing facility shall secure allowable intergovernmental transfer funds from a participating NSGE to provide the state share amount. The process for the intergovernmental transfer shall comply with the following:

1. The department, or the department’s designee, will notify the participating NSGO nursing facility of the state share amount to be transferred in the form of an intergovernmental transfer for purposes of seeking federal financial participation for the QIPP add-on rate, within 15 business days after the end of each month. The participating NSGO shall have until the end of the month to remit payment of the state share amount in the form of an intergovernmental transfer to the department or the department’s designee.

2. If there is any outstanding intergovernmental transfer amount at the end of the payment period, the provider will not be able to participate in the QIPP the following year.

81.5(17) *Cost report documentation.* All nursing facilities, except the Iowa Veterans Home, shall submit an annual cost report based on the closing date of the facility’s fiscal year that incorporates documentation as set forth below. The Iowa Veterans Home shall submit semiannual cost reports based on the closing date of the facility’s fiscal year and the midpoint of the facility’s fiscal year that incorporate documentation as set forth below. The documentation incorporated in all cost reports shall include all of the following information:

a. Information on staffing costs, including the number of hours of the following provided per resident per day by all the following: nursing services provided by registered nurses, licensed practical nurses, certified nurse aides, restorative aides, certified medication aides, and contracted nursing services; other care services; administrative functions; housekeeping and maintenance; and dietary services.

b. The starting and average hourly wage for each class of employees for the period of the report.

c. An itemization of expenses attributable to the home or principal office or headquarters of the nursing facility included in the administrative cost line item.

81.5(18) *Inflation factor.* The department will consider an inflation factor in determining the reimbursement rate. The inflation factor will be based on the CMS Total Skilled Nursing Facility (CMS/SNF) Market Basket Index published by Data Resources, Inc. The CMS/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting will be used to determine the inflation factor.

81.5(19) *Case-mix index calculation.*

a. The RUG-III Version 5.12b, 34 group, index maximizer model will be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS)

submitted by each facility pursuant to subrule 81.12(9). Standard Version 5.12b case-mix indices developed by CMS will be the basis for calculating the average case-mix index and will be used to adjust the direct care costs in the determination of the direct care patient-day-weighted median and the reimbursement rate pursuant to subrule 81.5(16).

b. Each resident in the facility on the last day of each calendar quarter with a completed and submitted assessment will be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the last day of each calendar quarter. This RUG-III group will be translated to the appropriate case-mix index referenced in paragraph "*a.*" From the individual resident case-mix indices, two average case-mix indices for each Medicaid nursing facility will be determined four times per year based on the last day of each calendar quarter.

The facilitywide average case-mix index is the simple average, carried to four decimal places, of all resident case-mix indices. The Medicaid average case-mix index is the simple average, carried to four decimal places, of all indices for residents where Medicaid is known to be the per diem payor source on the last day of the calendar quarter. Assessments that cannot be classified to a RUG-III group due to errors will be excluded from both average case-mix index calculations.

81.5(20) *Medicare crossover claims for nursing facility services.*

a. Definitions. For purposes of this subrule:

"*Crossover claim*" means a claim for Medicaid payment for Medicare-covered nursing facility services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including but not limited to qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"*Medicaid-allowed amount*" means the Medicaid reimbursement rate for the services rendered (including any portion to be paid by the Medicaid beneficiary as client participation) multiplied by the number of Medicaid units of service included in a crossover claim, as determined under state and federal law and policies.

"*Medicaid reimbursement*" includes any amount to be paid by the Medicaid beneficiary as Medicaid client participation and any amount to be paid by the department after application of any applicable Medicaid client participation.

"*Medicare payment amount*" means the Medicare reimbursement rate for the services rendered multiplied by the number of Medicare units of service included in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Crossover claims. Crossover claims for services covered under Medicare Part A and under Medicaid are reimbursed as set out in this paragraph.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim will be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim is the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

81.5(21) *Nursing facility quality assurance payments.*

a. Quality assurance assessment pass-through. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance assessment pass-through will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through will equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

b. Quality assurance assessment rate add-on. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, a quality assurance add-on of \$37 per patient day will be added to the Medicaid per diem reimbursement rate as otherwise calculated pursuant to this rule.

c. Use of the pass-through and add-on. As a condition for receipt of the pass-through and add-on, each nursing facility shall submit information to the department on the Nursing Facility Medicaid Enhanced Payment Report demonstrating compliance by the nursing facility with the requirements for use of the pass-through and add-on. If the sum of the quality assurance assessment pass-through and the quality assurance assessment rate add-on is greater than the total cost incurred by a nursing facility in payment of the quality assurance assessment:

(1) No less than 35 percent of the difference will be used to increase compensation and costs of employment for direct care workers determined pursuant to Iowa Code section 249L.4.

(2) No less than 60 percent of the difference will be used to increase compensation and costs of employment for all nursing facility staff, with increases in compensation and costs of employment determined pursuant to Iowa Code section 249L.4.

d. Effective date. Until federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 has been approved by CMS, none of the nursing facility rate-setting methodologies of this subrule will become effective.

e. End date. If CMS determines that federal financial participation to match money collected from the quality assurance assessment pursuant to 441—Chapter 36 is unavailable for any period, or if the department no longer has the authority to collect the assessment, then beginning on the effective date that such federal financial participation is not available or authority to collect the assessment is rescinded, none of the nursing facility rate-setting methodologies of this subrule will be effective. If the period for which federal match money is unavailable or the authority to collect the assessment is rescinded includes a retroactive period, the department will:

(1) Recalculate Medicaid rates in effect during that period without the rate-setting methodologies of this subrule;

(2) Recompute Medicaid payments due based on the recalculated Medicaid rates;

(3) Recoup any previous overpayments; and

(4) Determine for each nursing facility the amount of quality assurance assessment collected during that period and refund that amount to the facility.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.16 and chapters 249K and 249L.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.6(249A) Continued review.

81.6(1) Level of care. The department will review Medicaid members' need for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.2(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member's need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the member's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

81.6(2) PASRR. As a condition of payment for nursing facility care under the Medicaid program when there is a significant change in a resident's condition, the nursing facility shall, within 24 hours, initiate a PASRR review by the department's contractor for PASRR evaluations. For purposes of this subrule, "significant change in a resident's condition" means any admission or readmission to the facility immediately following an inpatient psychiatric hospitalization or any change that is likely to impact the resident's treatment needs related to a mental illness or intellectual disability. The evaluation shall determine:

a. Whether nursing facility care or skilled nursing care is medically necessary and appropriate for the resident under 441—subrules 79.9(1) and 79.9(2);

b. Whether nursing facility services continue to be appropriate for the resident, as opposed to care in a more specialized facility or in a community-based setting; and

c. Whether the resident needs specialized services for mental illness or intellectual disability, as described in paragraph 81.2(3) “b.”

This rule is intended to implement Iowa Code sections 249A.2(1), 249A.3(3), and 249A.4.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.7(249A) Records.

81.7(1) Content. The facility shall as a minimum maintain the following records:

a. All records required by the department and the department of inspections, appeals, and licensing.

b. Records of all treatments, drugs, and services for which vendors’ payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

c. Documentation in each resident’s records that will enable the department to verify that each charge is due and proper prior to payment.

d. Financial records maintained in the standard, specified form including the facility’s most recent audited cost report.

e. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

f. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for all residents of the facility.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

g. Resident accounts.

h. In-service education program records.

i. Inspection reports pertaining to conformity with federal, state and local laws.

j. Residents’ personal records.

k. Residents’ medical records.

l. Disaster preparedness reports.

81.7(2) Retention. Records identified in subrule 81.7(1) shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

81.7(3) Change of owner. All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) “a.”

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.8(249A) Payment procedures.

81.8(1) Method of payment. Except for Medicaid accountability measures payment established in paragraph 81.5(16) “g,” facilities will be reimbursed under a modified price-based vendor payment program. A per diem rate will be established based on information submitted according to rule 441—81.5(249A). The per diem rate will include an amount for Medicaid accountability measures.

81.8(2) Authorization of payment. The department will authorize payment for care in a facility. The authorization shall be obtained prior to admission of the resident, whenever possible. For a nursing facility to be eligible for Medicaid payment for a resident, the facility must, when applicable, exhaust all Medicare benefits.

81.8(3) Periods authorized for payment.

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in a nursing facility.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent overnight for purpose of visitation or vacation. The facility will be paid to hold the bed for a period not to exceed 18 days in any calendar year. Additional days shall be based upon a recommendation by the resident's physician in the plan of care that additional days would be rehabilitative.

e. Payment will be approved for a period not to exceed 10 days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for a visit, vacation, or hospitalization will be made at zero percent of the nursing facility's rate, except for special population facilities and state-operated nursing facilities, which will be paid for such periods at 42 percent of the facility's rate.

g. Payment for residents determined by utilization review to require the residential level of care will be made at the maximum state supplementary assistance rate. This rate is effective as of the date of final notice by utilization review that the lower level of care is required.

h. Ventilator patients.

(1) Definition. For purposes of this paragraph only, "ventilator patients" means Medicaid-eligible patients who, as determined by the quality improvement organization, require a ventilator at least six hours every day, are inappropriate for home care, and have medical needs that require skilled care.

(2) Reimbursement. In-state nursing facilities will receive reimbursement for care of ventilator patients equal to the sum of the Medicare-certified hospital-based nursing facility rate plus the Medicare-certified hospital-based nursing facility non-direct care rate component as defined in subparagraph 81.5(16) "f"(3). Facilities may continue to receive this reimbursement at this rate for 30 days after a ventilator patient is weaned from a ventilator if, during the 30 days, the patient continues to reside in the facility and continues to meet skilled care criteria.

i. Payment for residents of a special population facility licensed by the department of inspections, appeals, and licensing as an intermediate care facility for persons with mental illness will be made only when the resident is aged 65 or over. If a resident under the age of 65 is admitted with a payment source other than Medicaid, the facility shall notify the resident, or when applicable the resident's guardian or legal representative, that the department may neither make payment to the facility nor make payment for any other services rendered by any provider while the person resides in the facility, until the resident attains the age of 65.

j. Nonpayment for provider-preventable conditions. Reimbursement will not be made for patient days attributable to preventable conditions identified pursuant to this rule that develop in a nursing facility. Any patient days attributable to a provider-preventable condition must be billed as noncovered days. A provider-preventable condition is one in which any of the following occur:

- (1) The wrong surgical or other invasive procedure is performed on a resident; or
- (2) A surgical or other invasive procedure is performed on the wrong body part; or
- (3) A surgical or other invasive procedure is performed on the wrong resident.

81.8(4) Supplementation. Only the amount of client participation may be billed to the resident for the cost of care, and the facility must accept the combination of client participation and payment made through the department as payment in full for the care of a resident. No additional charges shall be made to residents or family members for any supplies or services required in the facility-developed plan of care for the resident.

Residents may choose to spend their personal funds on items of personal care such as professional beauty or barber services, but the facility shall not require this expenditure and shall not routinely obligate residents to any use of their personal funds.

a. Supplies or services that the facility shall provide:

(1) Nursing services, social work services, activity programs, individual and group therapy, rehabilitation or habilitation programs provided by facility staff in order to carry out the plan of care for the resident.

(2) Services related to the nutrition, comfort, cleanliness and grooming of a resident as required under state licensure and Medicaid survey regulations.

(3) Medical equipment and supplies including wheelchairs except for customized wheelchairs for which separate payment may be made pursuant to 441—paragraph 78.10(2) “d,” medical supplies except for those listed in 441—paragraph 78.10(4) “b,” oxygen except under circumstances specified in 441—paragraph 78.10(2) “a,” and other items required in the facility-developed plan of care.

(4) Nonprescription drugs ordered by the physician.

(5) Fees charged by medical professionals for services requested by the facility that do not meet criteria for direct Medicaid payment.

b. The facility shall arrange for nonemergency transportation for members to receive necessary medical services outside the facility.

(1) If a family member, friend, or volunteer is not available to provide the transportation at no charge, the facility shall arrange and pay for the medically necessary transportation within 30 miles of the facility (one way).

(2) For medically necessary transportation beyond 30 miles from the facility (one way), when no family member, friend, or volunteer is available to provide the transportation at no charge, the facility shall arrange for transportation through the broker designated by the department, with the cost to be paid by the broker pursuant to rule 441—78.13(249A).

c. The department will provide direct payment to relieve the facility of payment responsibility for certain medical equipment and services that meet the Medicare definition of medical necessity and are provided by providers enrolled in the Medicaid programs including:

(1) Physician services.

(2) Ambulance services.

(3) Hospital services.

(4) Hearing aids, braces and prosthetic devices.

(5) Customized wheelchairs for which separate payment may be made pursuant to 441—subparagraph 78.10(2) “a”(4).

d. Other supplies or services for which direct Medicaid payment may be available include:

(1) Drugs covered pursuant to 441—subrule 78.1(2).

(2) Dental services.

(3) Optician and optometrist services.

(4) Repair of medical equipment and appliances that belong to the resident.

(5) Transportation to receive medical services beyond 30 miles from the facility (one way), through the broker designated by the department pursuant to a contract between the department and the broker.

(6) Other medical services specified in 441—Chapter 78.

e. The following supplementation is permitted:

(1) The resident, the resident’s family, or friends may pay to hold the resident’s bed in cases where a resident who is not discharged from the facility is absent overnight. When the resident is discharged, the facility may handle the holding of the bed in the same manner as for a private paying resident.

(2) Payments made by the resident’s family toward cost of care of the resident shall not be considered as supplementation so long as the payments are included in client participation and are not over and above the payment made by the state for care of the resident.

(3) If a physician does not order a nonprescription drug by brand name, the facility may offer a generic. If a resident or family member requests a brand name, the resident or family member may pay for the brand-name nonprescription drug.

(4) Supplementation for provision of a private room not otherwise covered under the medical assistance program, subject to the following conditions, requirements, and limitations:

1. Supplementation for provision of a private room is not permitted for any time period during which the private room is therapeutically required pursuant to 42 CFR 483.10 (as amended to August 1, 2024).

2. Supplementation for provision of a private room is not permitted for a calendar month if no room other than the private room was available as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

3. Supplementation for provision of a private room is not permitted for a calendar month if the facility's occupancy rate was less than 50 percent as of the first day of the month or as of the resident's subsequent initial occupation of the private room.

4. Supplementation for provision of a private room is not permitted if the nursing facility only provides one type of room or all private rooms.

5. If a nursing facility provides for supplementation for provision of a private room, the facility may base the supplementation amount on the difference between the amount paid for a room covered under the medical assistance program and the private pay rate for the private room identified for supplementation. However, the total payment for the private room from all sources for a calendar month shall not be greater than the aggregate average private room rate during that month for the type of rooms covered under the medical assistance program for which the resident would be eligible.

6. If a nursing facility provides for supplementation for provision of a private room, the facility shall notify all residents, prospective residents, and their legal representatives in accordance with Iowa Code section 249A.4(10) "b" (1).

7. For a resident for whom the nursing facility receives supplementation, the nursing facility shall indicate in the resident's record the information set forth in Iowa Code section 249A.4(10) "b" (2).

f. Any medical equipment, supplies, appliances, or devices, personal care items, drugs, or other items of personal property that are paid for directly by the Medicaid program or are paid for by the resident or the resident's family, on a nonrental basis, are the personal property of the resident.

g. The facility shall not charge a resident for days that are not covered under Medicaid due to a provider-preventable condition pursuant to paragraph 81.8(3) "j" and shall not discharge a resident due to nonpayment for such days.

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

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.9(249A) Billing procedures. Claims for service must be sent to the department after the month of service and within 365 days of the date of service. Claims must be submitted electronically through the department's electronic clearinghouse. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system. Adjustments to submitted claims may be made electronically as provided for by the department. A request for an adjustment to a paid claim must be received by the department within one year from the date the claim was paid in accordance with rule 441—80.4(249A).

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.10(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.11(249A) Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

81.11(1) *Procedures for establishing health care facilities as Medicaid facilities.* All survey procedures and certification process shall be in accordance with department of health and human services publication “State Operations Manual” (as amended to August 1, 2024).

81.11(2) *Medicaid provider agreements.*

a. The health care facility shall be recommended for certification by the department of inspections, appeals, and licensing for participation as a nursing facility before a provider agreement may be issued. All survey procedures and certification process shall be in accordance with department of health and human services publication “Providers Certification State Operations Manual” as amended to August 1, 2024. The effective date of a provider agreement may not be earlier than the date of certification.

b. When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents.

81.11(3) *Distinct part requirement.* All facilities that provide nursing facility care and also provide other types of care shall set aside a distinct or identifiable part for the provision of the nursing facility care.

a. The distinct part shall meet the following conditions:

(1) The distinct part shall meet all requirements for a nursing facility.

(2) The distinct part shall be identifiable as a unit such as a designated group of rooms, an entire ward or contiguous wards, wings, floor, or building. It shall consist of all beds and related facilities in the unit for whom payment is being made for nursing facility services. It shall be clearly identified and licensed by the department of inspections, appeals, and licensing.

(3) The appropriate personnel shall be assigned to the identifiable unit and shall work there regularly. Immediate supervision of staff shall be provided in the unit at all times by qualified personnel as required for licensure.

(4) The distinct part may share such central services and facilities as management services, dietary services, building maintenance and laundry with other units.

(5) When members of the staff share time between units of the facility, written records shall be maintained of the time assigned to each unit.

b. Hospitals participating as nursing facilities shall meet all of the same conditions applicable to freestanding nursing facilities.

c. Nothing herein shall be construed as requiring transfer of a resident within or between facilities when in the opinion of the attending physician the transfer might be harmful to the physical or mental health of the resident. The opinion of the physician shall be recorded on the resident’s medical chart and stands as a continuing order unless the circumstances requiring the exception change.

81.11(4) *Civil rights.* The nursing facility shall comply with Title VI of the Civil Rights Act of 1964 (as amended to August 1, 2024) in all areas of administration including admissions, records, services and physical facilities, room assignments and transfers, attending physicians’ privileges and referrals. Written statements of compliance shall be available to residents, employees, attending physicians and other members of the public.

81.11(5) *Resident rights.* The resident has a right to a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. A facility shall protect and promote the rights of each resident in accordance with 42 CFR 483.10 (as amended to August 1, 2024).

81.11(6) *Admission, transfer and discharge rights.*

a. Definition. Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

b. Transfer or discharge requirements. The facility shall permit each resident to remain in the facility, and not transfer or discharge the resident, in accordance with 42 CFR 483.15 (as amended to August 1, 2024).

81.11(7) Resident behavior and facility practices.

a. Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

b. Abuse. The resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion.

c. Staff treatment of residents. The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) Facility staff shall not use verbal, mental, sexual, or physical abuse, including corporal punishment, or involuntary seclusion of residents. The facility shall not employ persons who have been found guilty by a court of law of abusing, neglecting or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

The facility shall report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

(2) The facility shall ensure that all alleged violations involving mistreatment, neglect or abuse including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator of the facility or to other officials (including the department of inspections, appeals, and licensing) in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations conducted by facility staff shall be reported to the administrator or the administrator's designated representative or to other officials (including the department of inspections, appeals, and licensing) in accordance with state law within five working days of the incident and if the alleged violation is verified, take appropriate corrective action.

81.11(8) Quality of life. A facility shall care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life in accordance with 42 CFR 483.10 (as amended to August 1, 2024).

a. Activities. The facility shall provide for an ongoing program of activities designed to meet, based on the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident in accordance with 42 CFR 483.24(c) (as amended to August 1, 2024).

b. Social services.

(1) The facility shall provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident.

(2) A facility with more than 120 beds shall employ a qualified social worker on a full-time basis in accordance with 42 CFR 483.70(p) (as amended to August 1, 2024).

c. Environment. The facility shall provide a safe, clean, comfortable and homelike environment in accordance with 42 CFR 483.10(i) (as amended to August 1, 2024).

81.11(9) Resident assessment. The facility shall conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional ability in accordance with 42 CFR 483.20(a) through (j) (as amended to August 1, 2024).

a. Use of independent assessors. If the department or the department of inspections, appeals, and licensing determines, under a survey or otherwise, that there has been a knowing and willful

certification of false statements in a resident assessment, the department or the department of inspections, appeals, and licensing may require that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the department or the department of inspections, appeals, and licensing for a period specified by the agency.

b. Comprehensive care plans. The facility shall develop a comprehensive care plan for each resident in accordance with 42 CFR 483.21(b) (as amended to August 1, 2024).

c. Discharge summary. When the facility anticipates discharges, a resident shall have a discharge summary in accordance with 42 CFR 483.21(c)(2) (as amended to August 1, 2024).

d. Preadmission resident assessment. The facility shall conduct prior to admission a resident assessment of all persons seeking nursing facility placement. The assessment information gathered shall be similar to the data in the minimum data set (MDS) resident assessment tool.

81.11(10) Quality of care. Each resident shall receive and the facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A facility shall ensure that residents receive treatment in accordance with 42 CFR 483.24 and 483.25 (as amended to August 1, 2024).

a. Behavioral health services. Based on the comprehensive assessment of a resident, the facility shall ensure that residents receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with 42 CFR 483.40 (as amended to August 1, 2024).

b. Unnecessary drugs. Each resident's drug regimen shall be free from unnecessary drugs in accordance with 42 CFR 483.45(d) and (e) (as amended to August 1, 2024).

c. Medication errors. The facility shall ensure that it meets the standards set forth in 42 CFR 483.45(f) (amended to August 1, 2024).

81.11(11) Nursing services. In accordance with 42 CFR 483.35 (as amended to August 1, 2024), the facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

81.11(12) Dietary services. In accordance with 42 CFR 483.60 (as amended to August 1, 2024), the facility shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

81.11(13) Physician services. In accordance with 42 CFR 483.30 (as amended to August 1, 2024), a physician shall personally approve in writing a recommendation that an individual be admitted to a facility. Each resident shall remain under the care of a physician.

81.11(14) Specialized services. When indicated, specialized services shall be provided to residents as follows:

a. Specialized rehabilitative services. Specialized rehabilitative services shall be provided by qualified personnel under the written order of a physician in accordance with 42 CFR 483.65 (as amended to August 1, 2024).

b. Specialized services for mental illness. "Specialized services for mental illness" means services provided in response to an exacerbation of a resident's mental illness that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;
- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;
- (3) Are provided through a professionally developed plan of care with specific goals and interventions;
- (4) May be provided only by a specialized licensed or certified practitioner;
- (5) Are expected to result in specific, identified improvements in the resident's psychiatric status to the level before the exacerbation of the resident's mental illness; and
- (6) May include:

1. Acute inpatient psychiatric treatment. When inpatient psychiatric treatment may be prevented through specialized services provided in the nursing facility, services provided in the nursing facility are preferred.

2. Initial psychiatric evaluation to determine a resident's diagnosis and to develop a plan of care.

3. Follow-up psychiatric services by a psychiatrist to evaluate resident response to psychotropic medications, to modify medication orders and to evaluate the need for ancillary therapy services.

4. Psychological testing required for a specific differential diagnosis that will result in the adoption of appropriate treatment services.

5. Individual or group psychotherapy as part of a plan of care addressing specific symptoms.

6. Any clinically appropriate service that is available for which the member meets eligibility criteria.

c. Specialized services for intellectual disability. "Specialized services for intellectual disability" means services that:

- (1) Are beyond the normal scope and intensity of nursing facility responsibility;

- (2) Involve treatment other than routine nursing care, supportive therapies such as activity therapy, and supportive counseling by nursing facility staff;

- (3) Are provided through a professionally developed plan of care with specific goals and interventions;

- (4) Must be supervised by a qualified intellectual disability professional; and

- (5) May include:

1. A functional assessment of maladaptive behaviors.

2. Development and implementation of a behavioral support plan.

3. Community living skills training for members who desire to live in a community setting and for whom community living is appropriate as determined by the Level II evaluation. Training may include adaptive behavior skills, communication skills, social skills, personal care skills, and self-advocacy skills.

81.11(15) Dental services. In accordance with 42 CFR 483.55 (as amended to August 1, 2024), the facility shall assist residents in obtaining routine and 24-hour emergency dental care.

81.11(16) Pharmacy services. In accordance with 42 CFR 483.45 (as amended to August 1, 2024), the facility shall provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement. The nursing facility may permit a certified medication aide to administer drugs, but only under the general supervision of a licensed nurse.

81.11(17) Infection control. In accordance with 42 CFR 483.80 (as amended to August 1, 2024), the facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

81.11(18) Physical environment. In accordance with 42 CFR 483.90 (as amended to August 1, 2024), the facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public.

81.11(19) Administration. In accordance with 42 CFR 483.70(a) through (d) (as amended to August 1, 2024), a facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

a. Required training of nurse aides.

- (1) Definitions.

"Licensed health professional" means a physician; physician associate; nurse practitioner; physical, speech or occupational therapist; registered professional nurse; licensed practical nurse; or licensed or certified social worker.

"Nurse aide" means any person providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide these services without pay.

(2) General rule. A facility shall not use any person working in the facility as a nurse aide for more than four months, on a permanent basis in accordance with the exceptions and provisions specified in 42 CFR 483.25(d) (as amended to August 1, 2024).

b. Proficiency of nurse aides. The facility shall ensure that nurse aides are able to demonstrate competency in skills and technique necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

c. Staff qualifications. Staff qualifications must be met in accordance with 42 CFR 483.70(f) (as amended to August 1, 2024).

d. Use of outside resources. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility shall have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Omnibus Budget Reconciliation Act of 1987 or an agreement described in 42 CFR 483.70(g) (as amended to August 1, 2024).

e. Medical director. The facility shall designate a physician to serve as medical director in accordance with 42 CFR 483.70(h) (as amended to August 1, 2024).

f. Laboratory, radiology, and other diagnostic services. The facility shall provide or obtain clinical laboratory, radiology, and other diagnostic services to meet the needs of its residents in accordance with 42 CFR 483.50 (as amended to August 1, 2024).

g. Clinical records. The facility shall maintain clinical records on each resident in accordance with 42 CFR 483.70(i) (as amended to August 1, 2024).

h. Disaster and emergency preparedness.

(1) The facility shall have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(2) The facility shall train all employees in emergency procedures when they begin to work in the facility, periodically review the procedures with existing staff, and carry out staff drills using those procedures.

i. Transfer agreement. The facility shall have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs in accordance with 42 CFR 483.70(j) (as amended to August 1, 2024).

j. Quality assessment and assurance. A facility shall maintain a quality assessment and assurance committee in accordance with 42 CFR 483.75(g) through (i) (as amended to August 1, 2024).

k. Disclosure of ownership.

(1) The facility shall comply with the disclosure requirements of 42 CFR 420.206 and 455.104 (as amended to August 1, 2024).

(2) The facility shall provide written notice to the department of inspections, appeals, and licensure at the time of change, if a change occurs in:

1. Persons with an ownership or control interest.
2. The officers, directors, agents, or managing employees.
3. The corporation, association, or other company responsible for the management of the facility.
4. The facility's administrator or director of nursing.

(3) The notice specified in subparagraph (2) above shall include the identity of each new individual or company.

[ARC 9279C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—81.12(249A) Audits.

81.12(1) *Audit of financial and statistical report.* Authorized representatives of the department or the U.S. Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report are reasonable and proper

according to the rules set forth in rule 441—81.5(249A). The aforementioned audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agent(s).

a. When a proper per diem rate cannot be determined, through generally accepted and customary auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing six-month period and if the situation is not remedied on the subsequent Financial and Statistical Report, the health facility shall be suspended and eventually canceled from the nursing facility program, or

b. When a health facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing six-month period. The department may, after considering the seriousness of the exception, make the reduction.

81.12(2) *Audit of proper billing and handling of patient funds.*

a. The department; the department's contracted managed care organizations; field auditors of the department of inspections, appeals, and licensing; and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department; the department's contracted managed care organizations; field auditors of the department of inspections, appeals, and licensing; and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.3(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, any sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation indicating that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph "*d.*," the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code sections 249A.2, 249A.3(2) "*a.*," and 249A.4.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.13(249A) Nurse aide requirements and training and testing programs.

81.13(1) *Deemed meeting of requirements.* A nurse aide is deemed to satisfy the requirement of completing a nurse aide training and competency evaluation approved by the department of inspections, appeals, and licensing if:

a. The nurse aide successfully completed a nurse aide training and competency evaluation program before July 1, 1989, and

(1) At least 60 clock hours were substituted for 75 clock hours, and the person has made up at least the difference in the number of clock hours in the program the person completed and 75 clock hours in supervised practical nurse aide training or in regular in-service nurse aide education, or

(2) The person was found to be competent (whether or not by the state) after completion of a nurse aide training of at least 100 clock hours' duration, or

(3) The person can demonstrate that the person served as a nurse aide at one or more facilities of the same employer in Iowa for at least 24 consecutive months before December 19, 1989, or

(4) The person completed, before July 1, 1989, a nurse aide training and competency evaluation program that the department of inspections, appeals, and licensing determines would have met the requirements for approval at the time it was offered; or

b. The person is a veteran, an active duty service member, or a member of the reserve forces, who has:

(1) Successfully completed a U.S. military training program that includes a curriculum comparable to the nurse aide training program required by this rule and has documented successful completion of that program with either a diploma, certifications, or Form DD 214 showing completion of hospital corpsman or medical service specialist or equivalent training, and

(2) Provided documentation showing that the person has 75 clock hours of practical experience in a nurse aide role, which may include classroom instruction, prior equivalent experience, or a combination of the two, and

(3) Successfully completed the nurse aide training and competency examination.

81.13(2) *State review and approval of nurse aide training and competency evaluation programs or competency evaluation programs.*

a. The department of inspections, appeals, and licensing will, in the course of all surveys, determine whether the nurse aide training and evaluation requirements of paragraph 81.11(19) "b" and subrule 81.13(1) are met.

b. Requirements for approval of programs.

(1) Before the department of inspections, appeals, and licensing approves a nurse aide training and competency evaluation program or competency evaluation program, the department of inspections, appeals, and licensing will determine whether:

1. A nurse aide training and competency evaluation program meets the course requirements of subrule 81.13(3).

2. A nurse aide competency evaluation program meets the requirements of subrule 81.13(4).

(2) Except as provided by paragraph 81.13(2) "f," the department of inspections, appeals, and licensing will not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in a facility that, in the previous two years:

1. Has operated under a nurse staffing waiver for a period in excess of 48 hours per week; or

2. Has been subject to an extended or partial extended survey; or

3. Has been assessed a civil money penalty of not less than \$5,000; or

4. Has operated under temporary management appointed to oversee the operation of the facility and to ensure the health and safety of the facility's residents; or

5. Pursuant to state action, was closed or had its residents transferred; or

6. Has been terminated from participation in the Medicaid or Medicare program; or

7. Has been denied payment.

c. Application process. Applications shall be submitted to the department of inspections, appeals, and licensing before a new program begins and every two years thereafter on a form prescribed by the department. The department of inspections, appeals, and licensing will, within 90 days of the date of a request or receipt of additional information from the requester:

(1) Advise the requester whether or not the program has been approved; or

(2) Request additional information from the requesting entity.

d. Duration of approval. The department of inspections, appeals, and licensing will not grant approval of a nurse aide training and competency evaluation program for a period longer than two

years. A program shall notify the department of inspections, appeals, and licensing and the department of inspections, appeals, and licensing will review that program when there are substantive changes made to that program within the two-year period.

e. Withdrawal of approval. The department of inspection, appeals, and licensing will follow the provision of 42 CFR 483.151(e) (as amended to August 1, 2024) regarding withdrawals of approvals.

f. An exception to subparagraph 81.13(2)“*b*”(2) may be granted by the department of inspections, appeals, and licensing for 75-hour nurse aide training courses offered in (but not by) a facility under the following conditions:

(1) The facility has submitted a Nurse Aide Education Program Waiver Request, to the department of inspections, appeals, and licensing to request a waiver for each 75-hour nurse aide training course to be offered in (but not by) the facility.

(2) The 75-hour nurse aide training is offered in a facility by an approved NATCEP.

(3) No other NATCEP is offered within ten minutes' travel from the facility, unless the facility can demonstrate the distance or program would create a hardship for program participants.

(4) The facility is in substantial compliance with the federal requirements related to nursing care and services.

(5) The facility is not a poor performing facility.

(6) Employees of the facility do not function as instructors for the program unless specifically approved by the department of inspections, appeals, and licensing.

(7) The NATCEP sponsoring the 75-hour nursing aide training course is responsible for program administration and for ensuring that program requirements are met.

(8) The NATCEP has submitted an evaluation to the department of inspections, appeals, and licensing indicating that an adequate teaching and learning environment exists for conducting the course.

(9) The NATCEP has developed policies for communicating and resolving problems encountered during the course, including notice by the facility to the program instructor and students on how to contact the department of inspections, appeals, and licensing to register any concerns encountered during the course.

(10) The NATCEP shall require the program instructor and students to complete an evaluation of the course. The instructor shall return the completed evaluations to the NATCEP that shall return the evaluations to department of inspections, appeals, and licensing.

81.13(3) *Requirements for approval of a nurse aide training and competency evaluation program.* The department has designated the department of inspections, appeals, and licensing to approve required nurse aide training and competency evaluation programs. Policies and procedures governing approval of the programs are set forth in 42 CFR 483.152 (as amended to August 1, 2024).

a. If a person who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a facility no later than 12 months after completing a nurse aide training and competency evaluation program or competency evaluation program, the facility shall reimburse the nurse aide for costs incurred in completing the program or competency evaluation on a pro rata basis during the period in which the person is employed as a nurse aide. The formula for paying the nurse aides on a pro rata basis shall be as follows:

(1) Add all costs incurred by the nurse aide for the course, books, and competency evaluations.

(2) Divide the total arrived at in subparagraph (1) above by 12 to prorate the costs over a one-year period and establish a monthly rate.

(3) The nurse aide shall be reimbursed the monthly rate each month the nurse aide works at the facility until one year from the time the nurse aide completed the course.

b. Setting and equipment. The classroom shall have appropriate equipment, be of adequate size, and not interfere with resident activities.

c. Records and reports. Nurse aide education programs approved by the department of inspections, appeals, and licensing shall:

(1) Notify the department of inspections, appeals, and licensing:

1. Of dates of classroom and clinical sessions as well as location of classrooms and clinical practice sites before each course begins and if the course is canceled.
2. When a facility or other training entity will no longer be offering nurse aide training courses.
3. Whenever the person coordinating the training program is hired or terminates employment.
- (2) Keep a list of faculty members and their qualifications available for department review.
- (3) Provide each nurse aide a record of skills for which the nurse aide has been found competent during the course and which may be performed before completion of the competency evaluation.
- (4) Complete a lesson plan for each unit that includes behavioral objectives, a topic outline and student activities and experiences.
- (5) Provide the student, within 30 days of the last class period, evidence of having successfully completed the course.

81.13(4) *Nurse aide competency evaluation.* Nurse aide competency evaluation program shall be administered in accordance with 42 CFR 483.154 (as amended to August 1, 2024).

a. Successful completion of the competency evaluation program.

(1) A score of 70 percent or above is passing for both the written or oral and skills demonstration parts of the test.

(2) A record of successful completion of the competency evaluation shall be included in the nurse aide registry within 30 days of the date the person is found to be competent.

(3) The competency testing entity shall inform the nurse aide of the test score within 30 calendar days of the completion of the test and shall inform the nurse aide registry of the nurse aide's scores within 20 calendar days after the test is administered.

b. Unsuccessful completion of the competency evaluation program.

(1) If the person does not complete the evaluation satisfactorily, the person shall be advised in writing within ten working days after the test is scored:

1. Of the areas that the person did not pass.

2. That the person has three opportunities to take the evaluation.

(2) Each person shall have three opportunities to pass each part of the test. If one part of the test is failed, only that part need be taken a second or third time. If either part of the test is failed three times, the 75-hour course shall be taken or retaken before the test can be taken again.

c. Storage of evaluation instrument. The person responsible for administering a competency evaluation shall provide secure storage of the evaluation instruments when they are not being administered or processed.

d. Application process. Entities wishing to secure approval for a competency evaluation program shall submit a copy of the evaluation plan and procedures to the department of inspections, appeals, and licensing. The department of inspections, appeals, and licensing shall notify the applicant of its decision within 90 days of receipt of the application. The notification shall include the reason for not giving approval if approval is denied and the applicable rule citation.

81.13(5) *Registry of nurse aides.*

a. Establishment of registry. The department of inspections, appeals, and licensing shall establish and maintain a registry of nurse aides in accordance with 42 CFR 483.156 (as amended to August 1, 2024). In addition, the registry shall contain a record of known convictions by a court of law of a person convicted of abuse, neglect, mistreatment, or misappropriation of resident property.

b. Placement of names on nurse aide registry. The facility shall ensure that the name of each person employed as a nurse aide in a Medicare- or Medicaid-certified nursing facility in Iowa is submitted to the registry.

(1) Persons employed as nurse aides shall complete the Nurse Aide Registry Application within the first 30 days of employment. This form shall be submitted to the department of inspections, appeals, and licensing. The application may be obtained by telephone or by electronic request from the nurse aide registry.

(2) A nurse aide who is not employed may apply for inclusion on the registry by submitting a copy of completed application to the nurse aide registry.

(3) When the registry has received a signed application and entered the required training and testing information on the registry, an electronic notification will be sent to the nurse aide that includes the registry ID number for the nurse aide to use when accessing the online registry. A nurse aide may obtain a copy of the information on the registry by accessing the information on the registry database.

81.13(6) *Hearing.* When there is an allegation of abuse against a nurse aide, the department of inspections, appeals, and licensing will investigate that allegation. When the investigation makes a finding of an act of abuse, the nurse aide named will be notified of this finding and the right to a hearing. The nurse aide shall have 30 days to request a hearing. The request shall be in writing and shall be sent to the department of inspections, appeals, and licensing. The hearing shall be held pursuant to 481—Chapter 10. After 30 days, if the nurse aide fails to appeal, or when all appeals are exhausted, the nurse aide registry will include a notation that the nurse aide has a founded abuse report on record if the final decision indicates the nurse aide performed an abusive act.

81.13(7) *Appeals.* Adverse decisions made by the department of inspections, appeals, and licensing in administering these rules may be appealed pursuant to 481—Chapter 10.

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

[ARC 9279C, IAB 5/14/25, effective 7/1/25; ARC 9859C, IAB 12/24/25, effective 2/1/26]

441—81.14(249A) Sanctions.

81.14(1) *Penalty for falsification of a resident assessment.* An individual, who willfully and knowingly certifies a material and false statement in a resident assessment, is subject to a civil money penalty in accordance with 42 CFR 483.20(j) (as amended to August 1, 2024).

a. Factors determining the size of fine. In determining the monetary amount of the penalty, the director of the department of inspections, appeals, and licensing or the director's designee may consider evidence of the circumstances surrounding the violation, including but not limited to the following factors:

- (1) The number of assessments willingly and knowingly falsified.
- (2) The history of the individual relative to previous assessment falsifications.
- (3) The intent of the individual who falsifies an assessment or causes an assessment to be falsified.
- (4) The areas of assessment falsified or caused to be falsified and the potential for harm to the resident.
- (5) The relationship of the falsification of assessment to falsification of other records at the time of the visit.

b. Notification of a fine imposed for falsification of assessments or causing another individual to falsify an assessment shall be served upon the individual personally or by certified mail.

c. Appeals of fines. Notice of intent to formally contest the fine shall be given to the department of inspections, appeals, and licensing in writing and be postmarked within 20 working days after receipt of the notification of the fine. An administrative hearing will be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 10. An individual who has exhausted all administrative remedies and is aggrieved by the final action of the department of inspections, appeals, and licensing may petition for judicial review in the manner provided by Iowa Code chapter 17A.

81.14(2) *Use of independent assessors.* If the department of inspections, appeals, and licensing determines that there has been a knowing and willful certification of false assessments, or the causation of knowing and willful false assessments, the department of inspections, appeals, and licensing may require that resident assessments be conducted and certified by individuals independent of the facility and who are approved by the state.

a. Criteria used to determine the need for independent assessors shall include:

- (1) The involvement of facility management in the falsification of or causing resident assessments to be falsified.
- (2) The facility's response to the falsification of or causing resident assessments to be falsified.
- (3) The method used to prepare facility staff to do resident assessments.

- (4) The number of individuals involved in the falsification.
- (5) The number of falsified resident assessments.
- (6) The extent of harm to residents caused by the falsifications.

b. The department of inspections, appeals, and licensing will specify the length of time that these independent assessments will be conducted and when they will begin. This determination will be based on the extent of assessments and reassessments needed and the plan submitted by the facility to ensure falsifications will not occur in the future.

c. The individuals or agency chosen by the facility to conduct the independent assessments shall be approved by the department of inspections, appeals, and licensing before conducting any assessments. The approval will be based on the ability of the individual or agency to conduct resident assessments in accordance with the applicable rules. Any costs incurred shall be the responsibility of the facility.

d. Notice of the requirement to obtain independent assessments will be in writing and sent to the facility by certified mail or personal service. The notice shall include the date independent assessors are to begin assessments, information on how independent assessors are to be approved and the anticipated length of time independent assessors will be needed.

e. Criteria for removal of the requirement for independent assessors.

(1) Independent assessors shall be utilized until all residents assessed by the disciplines involved have been reassessed by the independent assessor.

(2) The facility shall submit a plan to the department of inspections, appeals, and licensing for completing its own assessments.

(3) The department of inspections, appeals, and licensing will evaluate the facility's proposal for ensuring assessments will not be falsified in the future.

f. Appeal procedures.

(1) A written notice to appeal shall be postmarked or personally served to the department of inspections, appeals, and licensing within five working days after receipt of the notice requiring independent assessors.

(2) An evidentiary hearing shall be held pursuant to 481—Chapter 10 no later than 15 working days after receipt of the appeal.

(3) The written decision shall be rendered no later than ten working days after the hearing.

(4) The decision rendered is a proposed decision that may be appealed to the director of the department of inspections, appeals, and licensing pursuant to 481—Chapter 50.

(5) A notice of appeal stays the effective date of the requirement for independent assessments pending a final agency decision.

(6) Final agency action may be appealed pursuant to Iowa Code chapter 17A.

81.14(3) *Penalty for notification of time or date of survey.* Any individual who notifies, or causes to be notified, a nursing facility of the time or date on which a survey is scheduled to be conducted shall be subject to a fine not to exceed \$2,000.

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

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

81.15(1) Except for Medicare-certified hospital-based nursing facilities and special population nursing facilities, out-of-state providers shall be reimbursed at the same nursing facility rate they would receive from the Medicaid program in their state of residence or an amount equal to the sum of the Iowa non-state government owned nursing facility direct care rate component limit pursuant to subparagraph 81.5(16)“f”(1) plus the non-direct care rate limit pursuant to subparagraph 81.5(16)“f”(1), whichever is lower.

a. Medicare-certified hospital-based nursing facilities providing skilled care in other states shall be reimbursed at an amount equal to the sum of the Iowa Medicare-certified hospital-based nursing facility direct care rate component limit pursuant to subparagraph 81.5(16)“f”(3) plus the non-direct care rate component limit pursuant to subparagraph 81.5(16)“f”(3) if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

b. Special population nursing facilities shall be reimbursed at the same nursing facility rate they would receive from Medicaid in their state of residence or, if not participating in the Medicaid program in their state, they shall be reimbursed pursuant to subparagraph 81.5(16)“e”(2), if one of the following criteria is met:

(1) The placement is recommended because moving the resident back to Iowa would endanger the resident’s health, because services are not readily available in Iowa, or because the out-of-state placement is cost-effective.

(2) The placement is temporary until services are available to the resident in Iowa or until the program of treatment is completed.

81.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.5(249A).

81.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at zero percent of the rate paid to the facility by the Iowa Medicaid program.

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

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.16(249A) Outpatient services. Medicaid outpatient services provided by certified skilled nursing facilities are defined in the same way as the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 1991 Iowa Acts, chapter 267, section 132(1)“i.”

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.17(249A) Rates for Medicaid eligibles.

81.17(1) Maximum client participation. A nursing facility may not charge more client participation for Medicaid-eligible clients as determined in rule 441—75.16(249A) than the maximum monthly allowable payment for their facility as determined according to 441—subrule 79.1(9) or rule 441—81.5(249A). When the department makes a retroactive increase in the maximum daily rate, the nursing facility can charge the client the increased amount for the retroactive period.

81.17(2) Beginning date of payment. When a resident becomes eligible for Medicaid payments for facility care, the facility shall accept Medicaid rates effective when the resident’s Medicaid eligibility begins. A nursing facility is required to refund any payment received from a resident or family member for any period of time during which the resident is determined to be eligible for Medicaid.

Any refund owing shall be made no later than 15 days after the nursing facility first receives Medicaid payment for the resident for any period of time. Facilities may deduct the resident’s client participation for the month from a refund of the amount paid for a month of Medicaid eligibility.

The beginning and renewal date of eligibility and resident client participation amounts may be obtained through the Iowa Medicaid portal access (IMPA) system. When the beginning Medicaid eligibility date is a future month, the facility shall accept the Medicaid rate effective the first of that future month.

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

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.18(249A) State-funded personal needs supplement. A Medicaid member living in a nursing facility who has countable income for purposes of rule 441—75.16(249A) of less than \$55 per month shall receive a state-funded payment from the department for the difference between that countable income and \$55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

[ARC 9279C, IAB 5/14/25, effective 7/1/25; ARC 9859C, IAB 12/24/25, effective 2/1/26]

441—81.19(249A) Enforcement of compliance. Enforcement of compliance with this chapter shall occur in accordance with 42 CFR 488 (as amended to August 1, 2024).

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.20(249A) Appeal of a determination of noncompliance.

81.20(1) A facility may request a hearing on a determination of noncompliance leading to an enforcement remedy. The affected nursing facility, or its legal representative or other authorized official, shall file the request for hearing in writing to the department of inspections, appeals, and licensing within 60 days from receipt of the notice of the proposed denial, termination, or nonrenewal of participation, or imposition of a civil money penalty or other remedies.

a. A request for a hearing shall be made in writing to the department of inspections, appeals, and licensing within 60 days from receipt of the notice.

b. Hearings shall be conducted pursuant to 481—Chapter 10 and rule 481—50.6(10A), with an administrative law judge appointed as the presiding officer and with the department of inspections, appeals, and licensing as the final decision maker, with subject matter jurisdiction.

81.20(2) A facility may not appeal the choice of remedy, including the factors considered by the department of inspection, appeals, and licensing in selecting the remedy.

81.20(3) A facility may not challenge the level of noncompliance found by the department of inspections, appeals, and licensing, except that in the case of a civil money penalty, a facility may challenge the level of noncompliance found by the department of inspections, appeals, and licensing only if a successful challenge on this issue would affect the range of civil money penalty amounts that the department could collect.

81.20(4) Except when a civil remedy penalty is imposed, the imposition of a remedy shall not be stayed pending an appeal hearing.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.21(249A) Civil money penalties—when penalty is collected. The collection of civil money penalties is made as provided in rule 441—81.24(249A).

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.22(249A) Civil money penalties—settlement authority. The department of inspections, appeals, and licensing has the authority to settle cases at any time before an evidentiary hearing.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.23(249A) Civil money penalties—deduction of penalty from amount owed.

81.23(1) The amount of the penalty, when determined, may be deducted from any sum then or later owing by the department to the facility.

81.23(2) Interest of 10 percent per year is assessed on the unpaid balance of the penalty, beginning on the due date.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

441—81.24(249A) Use of penalties collected by the department. Civil money penalties collected by the department will be applied to the protection of the health or property of residents of facilities that the department of inspections, appeals, and licensing finds deficient. Funds may be used for:

1. Time-limited expenses incurred in the process of relocating residents to home- and community-based settings or other facilities when a facility is closed or downsized pursuant to an agreement with the department;
2. Recovery of state costs related to the operation of a facility pending correction of deficiencies or closure;
3. Support and protection of residents of a facility that closes;
4. Funding of projects to improve the quality of life and quality of care of nursing facility residents through quality improvement initiative grants awarded pursuant to 441—Chapter 166;
5. Projects that support resident and family councils and other consumer involvement in ensuring quality care in facilities; and
6. Reasonable expenses incurred by the department to administer, monitor, or evaluate the effectiveness of grants utilizing civil money penalty funds.

[ARC 9279C, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 249A.4.

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¹ Effective date of 81.16(4) delayed 30 days by the Administrative Rules Review Committee at its September 12, 1990, meeting; at the October 9, 1990, meeting the delay was extended to 70 days. Amendment effective 12/1/90 superseded the 70-day delay.

¹ Effective date of 81.10(5) delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its November 13, 1990, meeting.

¹ Effective date of 81.13(7)"c"(1) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 14, 1992; delay lifted by the Committee at its meeting held August 11, 1992, effective August 12, 1992.

¹ Effective date of 81.6(3), first unnumbered paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 1993.

¹ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS
WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 82]

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

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—82.1(249A) Definitions.

“Intermediate care facility for persons with an intellectual disability” or *“ICF/ID”* means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as amended to August 1, 2024; or has a related condition as defined in 42 CFR 435.1009 as amended to August 1, 2024; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Intermediate care facility for persons with medical complexity” means an intermediate care facility for persons with an intellectual disability that provides health and rehabilitation services to individuals who require a skilled nursing level of care, have either a multiple organ dysfunction or severe single organ dysfunction, and require daily use of medical resources or technology.

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

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as an intermediate care facility for persons with an intellectual disability by the department of inspections, appeals, and licensing pursuant to 481—Chapter 64. The facility shall meet the following conditions of participation.

82.2(1) Governing body and management—disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes that would affect the current accuracy of the information, as to identify:

a. Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

b. Each officer and director of the corporation if the facility is organized as a corporation.

c. Each partner if the facility is organized as a partnership.

82.2(2) Client protections. The facility shall ensure the rights of all clients in accordance with 42 CFR 483.420 as amended to August 1, 2024.

82.2(3) Facility staffing. The facility shall provide adequate, qualified professional staffing in accordance with 42 CFR 483.430 as amended to August 1, 2024.

82.2(4) Active treatment services. Each client shall receive a continuous active treatment program in accordance with 42 CFR 483.440 as amended to August 1, 2024.

82.2(5) *Client behavior and facility practices.* Each facility shall establish and maintain standards for client behavior and facility practices in accordance with 42 CFR 483.450 as amended to August 1, 2024.

82.2(6) *Health care services.* Each facility shall establish and maintain standards for health care services in accordance with 42 CFR 483.460 as amended to August 1, 2024.

82.2(7) *Physical environment.* Each facility shall establish and maintain standards for the physical environment in accordance with 42 CFR 483.470 as amended to August 1, 2024.

82.2(8) *Dietetic services.* Each facility shall establish and maintain standards for dietary services in accordance with 42 CFR 483.480 as amended to August 1, 2024.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability. All intermediate care facilities for persons with an intellectual disability must enter into a contractual agreement with the department that sets forth the terms under which they will participate in the program.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.4(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a financial and statistical report to the department. These reports shall be based on the following rules.

82.4(1) *Failure to maintain records.* Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.4(2) *Accounting procedures.* Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities that are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.4(3) *Submission of reports.* The facility's cost report shall be received by the department no later than September 30 each year except as described in subrule 82.4(14).

a. The submission shall include a working trial balance that corresponds to all financial data contained on the cost report. The working trial balance must provide sufficient detail to enable the department to reconcile accounts reported on the general ledger to those on the financial and statistical report. For reporting costs that are not directly assigned to the facility in the working trial balance, an allocation method must be identified for each line, including the statistics used in the calculation. Reports submitted without a working trial balance shall be considered incomplete, and the facility shall be subject to the rate reductions set forth in paragraph 82.4(3) "c."

b. If the financial statements have been compiled, reviewed or audited by an outside firm, a copy of the compilation, review or audit, including notes, for the reporting period shall be included with the submission of the financial and statistical report.

c. Failure to timely submit the complete report shall reduce payment to 75 percent of the current rate.

(1) The reduced rate shall be effective October 1 and shall remain in effect until the first day of the month after the delinquent report is received by the department.

(2) The reduced rate shall be paid for no longer than three months, after which time no further payments will be made until the first day of the month after the delinquent report is received by the department.

d. Amended reports. The department, in its sole discretion, may reopen a review of a financial and statistical report at any time. No other entity or person has the right to request that the department

or its contractor reopen a review of a financial and statistical report, or submit an amended financial and statistical report for review by the department, after the facility is notified of its per diem payment rate following a review of a financial and statistical report.

e. When an intermediate care facility for persons with an intellectual disability continues to include in the total costs an item or items that had in a prior period been removed through an adjustment made by the department or its contractor, the contractor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the entire quarter beginning the first day of the fourth month after the facility's fiscal year end. If the adjustment has been contested and is still in the appeals process, the facility may include the cost, but must include sufficient detail so the department can determine if a similar adjustment is needed in the current period. The department may, after considering the seriousness of the offense, make the reduction.

f. Nothing in this subrule relieves a facility of its obligation to immediately inform the department that the facility has retained Medicaid funds to which the facility is not entitled as a result of any cost report process. A facility shall notify the department when the facility determines that funds have been incorrectly paid or when an overpayment has been detected.

82.4(4) *Payment at new rate.* When a new rate is established, payment at the new rate will be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments will be included in the payment the third month after the receipt of the report.

82.4(5) *Accrual basis.* Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses pertaining to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.4(6) *Census of Medicaid members.* Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.4(7) *Patient days.* In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.4(8) *Opinion of accountant.* The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.4(9) *Calculating patient days.* When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.4(10) *Revenues.* Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services that include room, board, nursing services, and such services as supervision, feeding, incontinence, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services that are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.4(11) *Limitation of expenses.* Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules:

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid to directors and nonworking officers' salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel that include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. Compensation includes all remuneration, paid currently or accrued, for managerial, administrative, professional and other services rendered during the period. Compensation includes all items that should be reflected on IRS Form W-2, Wage and Tax Statement, including but not limited to salaries, wages, and fringe benefits; the cost of assets and services received; and deferred compensation. Fringe benefits include but are not limited to costs of leave, employee insurance, pensions and unemployment plans. If the facility's fiscal year end does not correlate to the period of the W-2, a reconciliation between the latest issued W-2 and current compensation shall be required to be disclosed to the department. Employer portions of payroll taxes associated with amounts of compensation that exceed the maximum allowed compensation are unallowable for reimbursement. All compensation paid to related parties, including payroll taxes, are required to be reported to the department with the submission of the financial and statistical report. If it is determined that there have been undisclosed related-party salaries, the cost report shall be determined to have been submitted incomplete and the facility shall be subject to the penalties set forth in paragraph 82.4(3) "c."

(2) Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions and depends upon the facts and circumstances of each case.

(3) Necessary requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On an annual basis, the maximum allowed compensation amounts for these administrators will be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

(7) The maximum allowed compensation for employees as set forth in subparagraphs 82.4(11) "e"(4) through 82.4(11) "e"(6) shall be adjusted by the percentage of the average work week that the employee devoted to business activity at the intermediate care facility for persons with an intellectual disability for the fiscal year of the financial and statistical report. The time devoted to the business shall be disclosed on the financial and statistical report and shall correspond to any amounts reported to the Medicare fiscal intermediary. If an owner's or immediate relative's time is allocated to the facility from another entity (e.g., home office), the compensation limit will be adjusted by the percentage of total costs of the entity allocated to the facility. In no case shall the amount of salary for one employee allocated to multiple facilities be more than the maximum allowed compensation for that employee had the salary been allocated to only one facility.

f. Management fees and home office costs are allowed only to the extent they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association's Estimated Useful Lives of Depreciable Hospital Assets (2023 edition), may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment will be made. For change of ownership, refer to subrule 82.4(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) Necessary requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants, whether restricted or unrestricted, and that are held separate and not commingled with other funds.

(3) Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider's qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those that commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

(1) When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report is the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return is defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

(2) When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report is limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

(3) The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility that supplies transportation services as defined in Iowa Code section 324A.1(1) shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation

rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, will result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Reserved.

m. Reasonable legal, accounting, consulting and other professional fees, including association dues, are allowable costs if the fees are directly related to patient care. Legal, accounting, consulting and other professional fees, including association dues, described by the following are not considered to be patient-related and therefore are not allowable expenses:

(1) Any fees or portion of fees used or designated for lobbying.

(2) Nonrefundable and unused retainers.

(3) Fees paid by the facility for the benefit of employees.

(4) Legal fees, expenses related to expert witnesses, accounting fees and other consulting fees incurred in an administrative or judicial proceeding. However, facilities may report the reasonable costs incurred in an administrative or judicial proceeding if all of the following conditions are met. Recognition of any costs will be in the fiscal period when a final determination in the administrative or judicial proceeding is made.

1. The costs have actually been incurred and paid,

2. The costs are reasonable expenditures for the services obtained,

3. The facility has made a good-faith effort to settle the disputed issue before the completion of the administrative or judicial proceeding, and

4. The facility prevails on the disputed issue.

n. Penalties or fines imposed by federal or state agencies are not allowable expenses.

o. Penalties, fines or fees imposed for insufficient funds or delinquent payments are not allowable expenses.

82.4(12) *Termination or change of owner.*

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership that is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership that is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion but terminates with respect to the leased portion.

b. No increase in the value of the property is allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the

previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property are not allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act (as amended to August 1, 2024) regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation that verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next annual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities that have changed or will change ownership shall continue at the rate allowed the previous owner.

82.4(13) Assessed fee. The fee assessed pursuant to 441—Chapter 36 is not an allowable cost for cost reporting and audit purposes. In lieu of treating the fee as an allowable cost, a per diem assessment amount is added to the reimbursement rate calculated under subrule 82.4(14), not subject to the maximum allowable base cost or maximum rate set at the eightieth percentile. The per diem assessment amount will be calculated by dividing the annual assessment paid by the reported total patient days.

82.4(14) Payment to new facility. A facility receiving Medicaid ICF/ID certification on or after July 1, 1992, is subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/ID level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility will be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate will be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year. The state hospital schools are not to be included in the compilation of facility costs. The beginning rates for a new facility will be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/ID, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges that have a value to the enterprise. The services inherent in

organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include but are not limited to legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 through June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 through June 30.

(3) All facilities shall comply with the requirements of subrule 82.4(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/ID as described in subrule 82.4(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the accounting firm under contract with the department. Based on the audited cost report, a rate will be established for the facility. This rate will be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities will be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/ID with established base rates. The eightieth percentile maximum rate will be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities that complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.4(14) "d," will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates will be subject to the prevailing maximum rate.

82.4(15) *Payment to new owner.* An existing facility with a new owner will continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.4(16). The facility may submit a report for the period of July 1 through June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.4(16) *Payment to existing facilities.* The following reimbursement limits apply to all non-state-owned ICFs/ID:

a. Each facility shall file a cost report covering the period from January 1, 1992, through June 30, 1992. This cost report will be used to establish a reimbursement rate to be paid to the facility and will be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 through June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, through June 30, 1992, will be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, through June 30, 1992, cost report will become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.4(14) "*d.*"

d. Facilities that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index will be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year will receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include but are not necessarily limited to the administrative portion of the following:

- (1) Administrator wages.
- (2) Business office wages.
- (3) Advertising and marketing wages.
- (4) Employer's taxes (administrative).
- (5) Group/life and retirement benefits (administrative staff).
- (6) Workers' compensation insurance (administrative staff).
- (7) Employment advertising and recruitment (administrative staff).
- (8) Criminal record checks (administrative staff).
- (9) Education and training (administrative staff).
- (10) Office supplies (administrative staff).
- (11) Telephone.

- (12) Equipment rental.
- (13) Home office costs.
- (14) Management fees.
- (15) Accounting fees.
- (16) Professional organization dues.
- (17) Licensing fees.
- (18) Information technology expenses.
- (19) Legal fees—direct patient-care-related.
- (20) Legal fees—other.
- (21) Working capital interest.
- (22) General liability insurance.
- (23) Travel, entertainment and auto expenses.
- (24) Advertising and public relations.
- (25) Other.

f. Facility rates will be rebased using the cost report for the year covering state fiscal year 1996 and will subsequently be rebased each four years. The department will consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.
- (2) A change in federal regulations occurs that necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes that necessitate the addition of staff or other resources.
- (3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).
- (4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation are inpatient days as determined in subrule 82.4(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate will be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase that will not exceed the percentage change in the Consumer Price Index.

h. State-owned ICFs/ID shall submit annual cost reports and will receive annual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility will receive as reimbursement in the following period the maximum allowable base as calculated.

82.4(17) *Wage add-on factor.* A wage add-on factor of \$8.86 per day for community-based ICFs/ID will be included in rates effective July 1, 2022, and after, not subject to the maximum allowable cost ceiling in paragraph 82.4(14)“e,” until rates are established using the cost reports for the period ending June 30, 2023.

a. In accordance with 2022 Iowa Acts, House File 2578, section 31, the entire wage add-on factor will be used for wages and associated costs specific to wages, benefits, and required withholding of direct support professionals and frontline management.

b. The wage add-on factor of \$8.86 per day will be added to the maximum allowable base rate in subparagraph 82.4(14)“d”(1) until the next rebase using cost reports for the period ending June 30, 2024.

c. The wage add-on factor of \$8.86 per day will be added to the maximum allowable cost ceiling, eightieth percentile of costs of all participating facilities in paragraph 82.4(14) “e,” until the eightieth percentile maximum is established using the December 31, 2023, compilation for rates effective beginning July 1, 2024.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.5(249A) Eligibility for services.

82.5(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

82.5(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for persons with an intellectual disability services are required by an individual whose needs might be met through the use of alternative services that are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual’s record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.5(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility will continue as long as a valid need for the care exists.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.6(249A) Initial approval for ICF/ID care.

82.6(1) *Referral through targeted case management.* Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program will:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.6(2) *Approval of placement by department.*

a. Within 30 days of receipt of a referral, the department will:

(1) Approve ICF/ID placement;

(2) Offer a home- or community-based alternative; or

(3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.6(3), the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

82.6(3) *Approval of level of care.* Medicaid payment will be made for ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the department.

82.6(4) *Appeal rights.* Notice of adverse action and right to appeal will be given in accordance with rule 441—16.3(17A) and 441—Chapter 2506.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

441—82.7(249A) Determination of need for continued stay. For clients not enrolled with a managed care organization, certification of need for continued stay will be made according to procedures established by the department. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client's need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the department for all reviews that indicate a change in the client's level of care. The department will make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.8(249A) Arrangements with residents.

82.8(1) *Resident care agreement.* The ICF/ID Resident Care Agreement shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

82.8(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made. Medicaid will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

82.8(3) *Personal needs account.* When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department will charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections, appeals, and licensing and will meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections, appeals, and licensing representative. Audit certification will be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department will turn the funds over to the member's estate.

82.8(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.9(249A) Discharge and transfer.

82.9(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.9(2) *Case activity report.* A case activity report shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.9(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.9(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified intellectual disability professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.9(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.10(249A) Records.

82.10(1) *Content.* The facility shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections, appeals, and licensing.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act (as amended to August 1, 2024).

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records, which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care that have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.10(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.10(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.11(249A) Payment procedures.

82.11(1) *Method of payment.* Facilities will be reimbursed under a cost-related vendor payment program. A per diem rate will be established based on information submitted according to rule 441—82.4(249A).

82.11(2) *Periods authorized for payment.*

a. Payment will be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for persons with an intellectual disability.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a

resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.11(3) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person. However, the resident or the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over ten days on a hospital stay. When the resident is not discharged from the facility, the payments will not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.12(249A) Billing procedures. Claims for service for clients not enrolled with a managed care organization must be sent to the department after the month of service and within 365 days of the date of service. Such claims must be submitted electronically through the department's electronic clearinghouse.

82.12(1) A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.

82.12(2) Adjustments to claims may be made electronically as provided for by the department.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.13(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the resident's managed care organization or by the department for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.14(249A) Audits.

82.14(1) *Audits of financial and statistical report.* Authorized representatives of the department or the U.S. Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the financial and statistical report are reasonable and proper according to the rules set forth in 441—82.4(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent financial and statistical report, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items that had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the

ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

82.14(2) *Auditing of proper billing and handling of patient funds.*

a. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. The department, the department's contracted managed care organizations, field auditors of the department of inspections, appeals, and licensing and representatives of the U.S. Department of Health and Human Services, upon proper identification, have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.8(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation that would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph 82.14(2) "*d.*," the requested refunds may be withheld from future payments to the facility. The withholding will not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding will continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general's office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit that are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.15(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for persons with an intellectual disability. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.15(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.15(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.56(249A).

82.15(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds will be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

This rule is intended to implement Iowa Code section 249A.12.

[ARC 9066C, IAB 4/2/25, effective 6/1/25]

441—82.16(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with an intellectual disability who has countable income for purposes of rule 441—75.16(249A) of less than \$55 per month will receive a state-funded payment from the department for the difference between that countable income and \$55 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act (as amended to August 1, 2024).

This rule is intended to implement Iowa Code section 249A.30A.

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◇ Two or more ARCs

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWKI) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—86.1(514I) Definitions.

“Administrative error” means an action of the department that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the department.
6. Failure to request essential verification necessary to make an accurate eligibility determination.

7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.

8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.

“Applicant” means anyone in the household, including all adults and children under the age of 19 who are counted in the hawki family size according to the modified adjusted gross income methodology and who are listed on the application or renewal form.

“Capitation rate” means the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

“Client error” means any action or inaction of the enrollee or the enrollee’s representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee’s representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee’s representative failed to timely report a change as defined in rule 441—86.10(514I).

“Contract” means the contract between the department and the participating health or dental plan for the provision of medical or dental services to hawki enrollees for whom the participating health or dental plans assume risk.

“Cost sharing” means the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act, as amended to August 1, 2024, and Iowa Code section 514I.10.

“Countable income” means earned and unearned income of the family according to the modified adjusted gross income methodology.

“Covered services” means all or a part of those medical and dental services set forth in rule 441—86.14(514I).

“Dentist” means a person who is licensed to practice dentistry.

“Eligible child” means an individual who meets the criteria for participation in the hawki program as set forth in rule 441—86.2(514I).

“Emergency dental condition” means an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

“Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average

knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

“Emergency services” means, with respect to an individual enrolled with a plan, covered inpatient and outpatient services that are furnished by a provider qualified to furnish these services and that are needed to evaluate and stabilize an emergency medical or dental condition.

“Enrollee” means a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

“Enrollment broker” means the entity the department uses to enroll eligible children with a managed care organization. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law.

“Family” means anyone in the household, including all adults and children under the age of 19 who are counted in the hawki family size according to the modified adjusted gross income methodology.

“Federal poverty level” means the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

“Good cause” means the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee’s family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee’s control.
4. There was a failure to receive the department’s request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

“Hawki program” or *“program”* means the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

“Health insurance coverage” means health insurance coverage as defined in 45 CFR Section 144.103 as amended to August 1, 2024.

“Health Insurance Marketplace” or *“Exchange”* means the entity authorized under 42 U.S.C. Section 18031(d)(4)(F) (as amended to August 1, 2024) to evaluate and determine eligibility of applicants for Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs.

“Initial application” means the first program application or a subsequent application that is not a renewal.

“Institution for mental diseases” means the same as defined in 42 CFR Section 435.1010 as amended to August 1, 2024.

“Medical Assistance Advisory Council” or *“MAAC”* means the advisory body authorized by Iowa Code section 249A.4B.

“Modified adjusted gross income” means the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603 as amended to August 1, 2024.

“Participating dental plan” means any entity licensed by the division of insurance of the department of insurance and financial services to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

“Participating health plan” or *“PHP”* means any entity licensed by the division of insurance of the department of insurance and financial services to provide health insurance in Iowa or an organized delivery system licensed by the director that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

“Passive enrollment process” means the process by which the department assigns a child to a participating health or dental plan and which seeks to preserve existing provider-enrollee

relationships, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available health or dental plans.

“Physician” means the same as defined in Iowa Code section 135.1(4).

“Provider” means an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the hawki program.

“Public institution” means the same as defined in 42 CFR Section 435.1010 as amended to August 1, 2024.

“Renewal” means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

“Supplemental dental-only coverage” means dental care coverage provided to a child who meets the eligibility requirements for the hawki program except that the child is covered by health insurance through an individual or group health plan.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.2(514I) Eligibility factors. The decision with respect to eligibility will be based primarily on electronic data matches and information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the hawki program:

86.2(1) Age. The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child’s nineteenth birthday.

86.2(2) Income.

a. Countable income. In determining initial and ongoing eligibility for the hawki program, countable income shall not exceed 302 percent of the federal poverty level for a family of the same size. Countable income shall be determined using the modified adjusted gross income methodology.

b. Verification of income. Income shall be verified through electronic data matches when possible or otherwise verified using the best information available.

(1) Pay stubs, tip records, tax records and employers’ statements are acceptable forms of verification of earned income.

(2) If self-employment income cannot be verified through electronic means, business records or income tax returns from the previous year can be used if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

c. Changes in income. Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child’s eligibility to participate in the hawki program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) Family size. For purposes of establishing initial and ongoing eligibility under the hawki program, the family size shall be determined according to the modified adjusted gross income methodology.

86.2(4) Uninsured status. The child must be uninsured as outlined in 42 CFR 457 as amended to August 1, 2024.

86.2(5) Ineligibility for Medicaid. The child shall not be receiving Medicaid or eligible to receive Medicaid except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

86.2(6) Iowa residency. Residency in Iowa is a condition of eligibility for the hawki program. Residency shall be established in accordance with rule 441—75.10(249A).

86.2(7) Citizenship and immigration status. To be eligible for the hawki program, the child shall be a citizen or lawfully admitted immigrant. The criteria established under 441—subrule 75.11(2)

shall be followed when determining whether a lawfully admitted immigrant child is eligible to participate in the hawki program.

a. The citizenship or immigration status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for hawki:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or immigration status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2)“*f*,” applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)“*b*” shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)“*d*,” “*e*,” “*g*,” “*h*,” and “*i*.”

d. An applicant or enrollee shall have a reasonable opportunity period to obtain and provide proof of citizenship and nationality in accordance with 441—paragraph 75.11(2)“*c*.”

e. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the hawki program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. “Nominal amount” means \$10 or less per month.

86.2(9) *Inmates of public institutions.* The child shall not be an inmate of a public institution as defined at 42 CFR Section 435.1010 as amended to August 1, 2024.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1010 as amended to August 1, 2024.

86.2(11) *Furnishing a social security number.* As a condition of eligibility and in accordance with rule 441—75.7(249A), a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under hawki is being requested or received.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply for the hawki program in accordance with rule 441—76.1(249A).

86.3(2) *Place of filing.* An application for the hawki program may be filed with the department through an internet website, by telephone, through other electronic means, or through an exchange, disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided.

86.3(3) *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application will be documented, and the applicant will be sent a notice of decision confirming the request.

86.3(4) *Application not required.*

a. An application will not be required when a child becomes ineligible for Medicaid.

b. A new application will not be required when an eligible child is added to an existing hawki eligible group.

c. A new application will not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

86.3(5) *Information and verification procedure.* The eligibility decision will be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee and verified through electronic data matches whenever possible.

a. The applicant, enrollee, or person acting on behalf of the applicant or enrollee will be notified in writing of additional information or verification that is required to establish eligibility. The notice may be provided personally, by U.S. mail, by email, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the department to secure the information will be a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization will be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee will have 10 working days to supply the information or verification requested. The due date may be extended for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(6) *Time limit for decision.* Decisions regarding the applicant's eligibility to participate in the hawki program will be made within 45 working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department. Day one of the 45-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(7) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(8) *Waiting lists.* When the department has established that all the funds appropriated for this program are obligated, all subsequent applications for hawki coverage will be denied unless Medicaid eligibility exists.

a. The department will mail a notice of decision to the applicant that states:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The applicant does not meet eligibility requirements, in which case the applicant will not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, it must be established that the child is not eligible for Medicaid.

c. Applicants will be placed on the waiting list on the basis of the date an identifiable application form specified in rule 441—76.1(249A) is received.

(1) In the event that more than one application is received on the same day, applicants will be placed on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) Any subsequent ties will be determined by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, applicants will be selected from the waiting list based on the order in which their names appear on the list and will be notified of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within

15 working days, the applicant's name will be deleted from the waiting list and the next applicant on the waiting list will be contacted.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.4(514I) Coordination with Medicaid.

86.4(1) *Hawki applicant eligible for Medicaid.* At the time of initial application, if it is determined the child is eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in the Medicaid program.

86.4(2) *Hawki enrollee eligible for Medicaid.* At the time of the annual review, if the child is determined eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in Medicaid effective the first day following the expiration of the 12-month hawki enrollment period.

86.4(3) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spend down under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in the hawki program if otherwise eligible.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the hawki program on the basis of an initial application for either hawki or Medicaid will be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4) “a,” coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

86.5(2) *Referrals from Medicaid.*

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the hawki program due to cancellation of Medicaid benefits will be effective the first day of the month after Medicaid eligibility is lost in order to ensure that there is no break in coverage.

b. If the child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology, the child may be covered under the hawki program for up to 12 months following the loss of Medicaid eligibility, regardless of the presence of other health insurance coverage.

86.5(3) *Annual renewals.* Coverage for children who are determined eligible for the hawki program on the basis of an annual renewal will be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) *Children added to an existing hawki enrollment period.* Coverage for children who are determined eligible for the hawki program on the basis of a request from the family to add the child to an existing enrollment period will be effective the first day of the month following the month in which the request was made.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.6(514I) Selection of a plan. Upon the child's eligibility effective date, the child will be assigned to a health or dental plan using the department's passive enrollment process. The enrollee may change plans only at the time of the annual review unless the provisions of paragraph 86.6(1) “a” or subrule 86.6(2) apply.

86.6(1) *Period of enrollment.* Once enrolled in a health or dental plan, the child will remain enrolled in the health or dental plan for a period of 12 months.

a. Exceptions. A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child will be enrolled in the health or dental plan from which the child was originally disenrolled.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child will be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraph 86.6(1) “b.”

b. Request to change plan. An enrollee may ask to change the health or dental plan either verbally or in writing to the enrollment broker:

(1) Within 90 days following the date of the enrollee’s initial enrollment with the health or dental plan for any reason.

(2) At any time for cause. “Cause” as defined in 42 CFR 438.56(d)(2) as amended to August 1, 2024, includes but is not limited to:

1. The enrollee moves out of the plan’s service area.

2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.

3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee’s health care needs.

All approved changes shall be made prospectively and shall be effective no later than the first day of the second month beginning after the date on which the change request is received.

86.6(2) *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child will be enrolled in a participating health or dental plan in the new location. The period of enrollment will be the number of months remaining in the original certification period.

86.6(3) *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing to the enrollment broker. The child will remain enrolled in the current health or dental plan if the family does not notify the enrollment broker of a new health or dental plan choice by the end of the current 12-month enrollment period.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.7(514I) Cancellation. The child’s eligibility for the hawki program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) *Age.* The child shall be canceled from the hawki program as of the first day of the month following the month in which the child attained the age of 19.

86.7(2) *Iowa residence abandoned.* The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of 441—subrule 75.10(2).

86.7(3) *Eligible for Medicaid.* The child shall be canceled from the program as of the first day of the month following the month in which Medicaid eligibility is obtained. If there are months during which the child is covered by both the Medicaid and hawki programs, the hawki program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(4) *Enrolled in other health insurance coverage.* The child shall be canceled from the program as of the first day of the month following the month in which the department is notified that

the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the hawki program, the other insurance plan shall be the primary payor and hawki shall be the payor of last resort.

86.7(5) *Admission to a public institution.* The child shall be canceled from the program if the child is in a public institution at the time of the annual review.

86.7(6) *Admission to an institution for mental disease.* The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(7) *Employment with the state of Iowa.* The child shall be canceled from the hawki program as of the first day of the month in which the child's parent became eligible to participate in a health or dental plan available to state of Iowa employees.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The income considered in determining the premium amount will be the family's countable income using the modified adjusted gross income methodology.

86.8(2) *Premium amount.* Except as specified for supplemental dental-only coverage in subrule 86.20(3), premiums under the hawki program will be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaska Native; or

(2) The family's countable income is less than 181 percent of the federal poverty level for a family of the same size.

b. If the family's countable income is equal to or exceeds 181 percent of the federal poverty level for a family of the same size but does not exceed 242 percent of the federal poverty level for a family of that size, the premium is \$10 per child per month with a \$20 monthly maximum per family.

c. If the family's countable income is equal to or exceeds 243 percent of the federal poverty level for a family of the same size, the premium is \$20 per child per month with a \$40 monthly maximum per family.

86.8(3) *Due date.*

a. *Payment upon initial application.* Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. *Payment upon renewal.*

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) When the premium is received, the department will notify the health and dental plans of the enrollment.

c. *Subsequent payments.* All subsequent premiums are due by the fifth day of each month for the next month's coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. *Holiday or weekend.* When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

86.8(4) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the department.

86.8(5) *Copayment.* There will be a \$25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition. A copayment will not be imposed when family income is less than 181 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaska Native.

[ARC 9468C, IAB 8/6/25, effective 10/1/25; ARC 9952C, IAB 1/7/26, effective 3/1/26]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors will be reviewed at least every 12 months to establish ongoing eligibility for the program. “Month one” will be the first month in which coverage is provided.

86.9(1) Review form. The department will send the family a prepopulated review form on which the answers, except for income, have been completed based on the information on file. The family shall review the completed information for accuracy and fill in the income section of the form. If family income cannot be verified through electronic data matches, the family shall be required to provide verification of current income. The family shall sign and date the form attesting to its accuracy as part of the review process.

86.9(2) Failure to provide information. The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information will be acted upon as though they had been received timely. If the fourteenth calendar day falls on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the department. “Timely” shall mean no later than ten working days after the change occurred. The ten working-day period begins the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change unless the child is emancipated, married, or otherwise in an independent living situation, in which case the child shall be responsible for reporting the change.

86.10(1) Iowa residence is abandoned. The abandonment of Iowa residence shall be reported following the move from the state.

86.10(2) Other insurance coverage. Enrollment of the child in other health insurance coverage shall be reported.

86.10(3) Decrease in income. If the family reports a decrease in income, the department will ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(4) Information reported by a third party. Information reported by a third party will not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(5) Cooperation. The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(6) Effective date of change in eligibility.

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action will be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.11(514I) Notice requirements. The applicant will be provided an adequate written notice of the decision regarding the applicant's eligibility for the hawki program. The enrollee will be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice will be timely and adequate as provided in rule 441—16.2(17A).

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision to reduce, cancel or deny participation in the hawki program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 2506.

[ARC 9468C, IAB 8/6/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—86.13(514I) Covered services. The benefits provided under the hawki program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act as amended to August 1, 2024.

86.13(1) Required medical services. The participating health plan shall cover at a minimum the following medically necessary services:

- a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).
- b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).
- c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).
- d. Ambulance services.
- e. Physical therapy.
- f. Nursing care services (including skilled nursing facility services).
- g. Speech therapy.
- h. Durable medical equipment.
- i. Home health care.
- j. Hospice services.
- k. Prescription drugs.
- l. Hearing services.
- m. Vision services (including corrective lenses).
- n. Translation and interpreter services as specified pursuant to 42 U.S.C. Section 1397ee(a)(1) as amended to August 1, 2024.
- o. Chiropractic services.
- p. Occupational therapy.

86.13(2) Abortion. Payment for abortion shall only be made under the following circumstances:

- a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.
- b. The pregnancy was the result of an act of rape or incest.

86.13(3) Required dental services. Participating dental plans shall cover at a minimum the following necessary dental services:

- a. Diagnostic and preventive services.
- b. Routine and restorative services.
- c. Endodontic services.

- d.* Periodontal services.
- e.* Cast restorations.
- f.* Prosthetics.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.14(514I) Participating health and dental plans.

86.14(1) *Licensure.* The participating health or dental plan must:

- a.* Be licensed by the division of insurance of the department of insurance and financial services to provide health or dental care coverage in Iowa; or
- b.* Be an organized delivery system licensed by the director to provide health or dental care coverage.

86.14(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.13(514I) to all children determined eligible.

a. The participating health or dental plan shall make services it provides to hawki enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.

b. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county in which it is licensed and in which a provider network has been established.

86.14(3) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with hawki requirements, which shall include collecting copayments, if applicable.

86.14(4) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.14(5) *Marketing.*

a. Participating health and dental plans may not distribute any marketing materials directly or through an agent or independent contractor.

b. All marketing materials require prior approval from the department.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the hawki enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the health or dental plan.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.14(6) *Appeal process.* The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

a. Is approved by the department prior to use.

b. Acknowledges receipt of the appeal to the enrollee.

c. Establishes time frames that ensure that appeals be resolved within 45 days, except for appeals that involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

d. Ensures the participation of persons with authority to take corrective action.

e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.

f. Ensures the confidentiality of the enrollee.

g. Ensures issuance of a written decision to the enrollee for each appeal, which shall contain an adequate explanation of the action taken and the reason for the decision.

h. Maintains a log of the appeals that is made available to the department at the department's request.

i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.

j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.14(7) *Records and reports.* The participating health and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

(1) Identifies each medical or dental record by hawki enrollee identification number.

(2) Maintains a complete medical or dental record for each enrollee.

(3) Provides a specific medical or dental record on demand.

(4) Meets state and federal reporting requirements applicable to the hawki program.

(5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services that are infrequently used, which provide a support system service to the operation of the health or dental plan, or that are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors that require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.14(2) "b."

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule except that written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the department as follows:

- (1) A list of providers of services under the plan.
- (2) Encounter data on a monthly basis as required by the department.
- (3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

- (1) Information regarding the plan's appeal process.
- (2) A plan for a health improvement program.
- (3) Periodic financial, utilization and statistical reports as required by the department.
- (4) Time-specific reports that define activity for child health care, appeals and other designated activities that may, at the department's discretion, vary among plans, depending on the services covered or other differences.
- (5) Other information as directed by the department.

86.14(8) *Payment to the participating health or dental plan.*

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the hawki program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.15(514I) Use of donations to the hawki program. If an individual or other entity makes a monetary donation to the hawki program, the department will deposit the donation into the hawki trust fund. The department will track all donations separately and will not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to MAAC.

86.15(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.15(2) If the donation is less than \$5,000 and the donor does not specifically identify how it is to be used, the department will use the moneys in the following order:

- a.* For the direct benefit of enrollees (e.g., premium payments).
- b.* For outreach activities.
- c.* For other purposes as determined by MAAC.

86.15(3) If the donation is more than \$5,000 and the donor does not specify how the funds are to be used, MAAC will determine how the funds are to be used.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

441—86.16(514I) Recovery.

86.16(1) *Amount subject to recovery from the enrollee or representative.* The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.

b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.16(2) *Notification.* The enrollee will be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

a. The name of the person for whom funds were incorrectly paid;

b. The period during which the funds were incorrectly paid;

c. The amount subject to recovery; and

d. The reason for the incorrect payment.

86.16(3) *Recovery.*

a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.16(4) *Appeals.* The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 2506.

[ARC 9468C, IAB 8/6/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—86.17(514I) Supplemental dental-only coverage.

86.17(1) *Eligibility.* Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.2(514I) through 441—86.12(514I) and 441—86.17(514I).

86.17(2) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families whose countable income is less than or equal to 167 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology or to an eligible child who is an American Indian or Alaska Native.

b. If the family's countable income is equal to or exceeds 168 percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is \$5 per child per month with a \$10 monthly maximum per family.

c. If the family's countable income exceeds 203 percent of the federal poverty level but does not exceed 254 percent of the federal poverty level for a family of the same size, the premium is \$10 per child per month with a \$15 monthly maximum per family.

d. If the family's countable income exceeds 254 percent of the federal poverty level for a family of the same size, the premium is \$15 per child per month with a \$20 monthly maximum per family.

e. If the family includes uninsured children who are eligible for both medical and dental coverage under hawki and insured children who are eligible only for dental coverage, the premium will be assessed as follows:

(1) The total premium will be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium will be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under hawki because they are covered by health insurance.

f. The provisions of subrules 86.8(3) through 86.8(6) apply to premiums specified in this subrule.

86.17(3) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.

[ARC 9468C, IAB 8/6/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 514I and 2024 Iowa Acts, Senate File 2385.

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- [Editorial change: IAC Supplement 6/10/26]

CHAPTER 91
MEDICARE DRUG SUBSIDY

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

441—91.1(249A) Definitions.

“Applicant” means a person applying for a Medicare drug subsidy through the department and includes a responsible person or authorized representative acting for an applicant, except for the purposes of subrule 91.2(2).

“Application” or *“Medicare drug subsidy application”* means the federal Social Security Administration’s Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs.

“Authorized representative” means a person representing an applicant or recipient as described in 441—subrule 76.9(2).

“Recipient” means a person receiving a Medicare drug subsidy based on an application filed with the department and includes a responsible person or authorized representative acting for a recipient, except for the purposes of subrule 91.2(2).

“Responsible person” means a person acting on an applicant’s or recipient’s behalf as described in 441—subrule 76.9(1).

[ARC 9314C, IAB 5/28/25, effective 8/1/25]

441—91.2(249A) Application.

91.2(1) *Application filing.* Any person may apply for the Medicare drug subsidy through the department in accordance with 441—Chapter 76.

91.2(2) *Identifiable application and signature.*

a. An identifiable application is an application that contains:

(1) The legible name and address of the applicant; and

(2) The signature of the applicant, a responsible person, or an authorized representative on Form SSA-1020B-OCR-SM, Application for Help with Medicare Prescription Drug Plan Costs.

b. If an authorized representative signed the application forms on behalf of an applicant, the applicant or a responsible person must also sign the application forms before the application can be approved.

[ARC 9314C, IAB 5/28/25, effective 8/1/25]

441—91.3(249A) Eligibility determination. The department will determine eligibility for the Medicare drug subsidy pursuant to Section 1860D-14 of the Social Security Act and implement federal regulations at 20 CFR Section 418 as amended to August 1, 2024.

91.3(1) *Cooperation.* An applicant must cooperate with the department in the application process. Cooperation may include providing additional information or verification of information, participating in an interview, or signing documents. Failure to cooperate in the application process shall be a basis for denial of an application.

91.3(2) Reserved.

[ARC 9314C, IAB 5/28/25, effective 8/1/25]

441—91.4(249A) Effective date. The effective date of eligibility will be determined pursuant to 42 CFR Part 423 as amended to August 1, 2024.

[ARC 9314C, IAB 5/28/25, effective 8/1/25]

441—91.5(249A) Changes in circumstances.

91.5(1) *Responsibility to report changes.* A Medicare drug subsidy applicant or recipient shall report to the department in a timely manner any changes in the following circumstances:

a. Care of dependents.

- b. Household composition.
- c. Household income.
- d. Household resources.
- e. Marital status.
- f. Medicare eligibility or enrollment.
- g. Place of residence.

91.5(2) *Effective date of change.* Changes in eligibility or level of subsidy will be effective the month following the month in which the change is reported.

[ARC 9314C, IAB 5/28/25, effective 8/1/25]

441—91.6(249A) Reinvestigation. The department will reinvestigate eligibility as often as the recipient's circumstances indicate, but in no instance will the period between reinvestigations exceed 12 months.

91.6(1) *Application requested.* When requested to do so by the department, the recipient shall complete the Medicare drug subsidy application as part of the reinvestigation process. The application shall be completed within ten working days from the date a written request is issued. Failure to complete the application shall be a basis for cancellation or reduction of the subsidy.

91.6(2) *Additional information requested.* The recipient shall supply additional information needed to establish eligibility or level of subsidy pursuant to 441—Chapter 76.

[ARC 9314C, IAB 5/28/25, effective 8/1/25]

441—91.7(249A) Appeals. An applicant or recipient shall have the right to appeal any adverse action by the department pursuant to 441—Chapter 2506.

[ARC 9314C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 217.6 and 249A.4 and Section 1935(a) of the Social Security Act (42 U.S.C. Section 1396u-5).

[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]

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[Filed ARC 9314C (Notice ARC 8573C, IAB 12/25/24), IAB 5/28/25, effective 8/1/25]

[Editorial change: IAC Supplement 6/10/26]

TITLE IX
 WORK INCENTIVE DEMONSTRATION
 CHAPTER 93
 PROMISE JOBS PROGRAM
 [Prior to 7/1/89, see 441—Chapters 55, 59 and 90]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—93.1(239B) Definitions.

“Applicant” means a child for whom assistance is being requested under the family investment program, any parent living in the home with the child, and any nonparental relative as defined in 441—subrule 41.22(3) who is requesting assistance for the child.

“FaDSS” means the family development and self-sufficiency program operated under 441—Chapter 49, which provides in-home family development services to families at risk of instability or long-term FIP dependency.

“Family investment agreement” or *“FIA”* means the agreement developed with a participant in accordance with Iowa Code section 239B.8.

“FIA-responsible person” means any member of the FIP applicant family unless exempt as described in 441—subrule 41.24(2). More information is contained in subrule 93.4(2).

“FIP” means the family investment program authorized in Iowa Code chapter 239B.

“Limited benefit plan” or *“LBP”* means a period of time in which a participant or member of a participant’s family is either ineligible for any assistance under the FIP or eligible for reduced assistance in accordance with Iowa Code section 239B.9.

“Needy specified relative” means a nonparental specified relative as defined in 441—subrule 41.22(3) who meets all the eligibility requirements to be included in the FIP.

“Participant” for purposes of the PROMISE JOBS program means a person who has signed an FIA and is approved to receive FIP benefits, a parent or relative living in the home of a child approved to receive FIP benefits, or a person reconsidering a subsequent LBP.

“PROMISE JOBS program” means the promoting independence and self-sufficiency through employment, job opportunities, and basic skills program created in Iowa Code section 239B.17.

“TANF” means Title I Block Grants for Temporary Assistance for Needy Families (PL 109-171) (reauthorized 2006 and as amended to August 1, 2024).

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.2(239B) Program administration. The department will administer an employment and training program known as PROMISE JOBS.

93.2(1) Availability of service. PROMISE JOBS services shall include but are not limited to those listed in paragraph 93.4(4)“b.”

a. The program shall be available statewide. If the department determines that sufficient funds are not available to offer services on location in each county, the department will prioritize the availability of services to those counties having the largest FIP populations.

b. Because of state and federal budgetary limitations, federal mandatory work requirements, requirements for minimum participation rates, and other TANF requirements imposed on the PROMISE JOBS program, the department will have the administrative authority to:

- (1) Determine agency and geographical breakdowns for service;
- (2) Designate specific groups for priority services; and
- (3) Designate specific PROMISE JOBS components or supportive service levels for a waiting list.

93.2(2) Contracts with provider agencies. The department may contract with the department of workforce development, the department of economic development, or other appropriate entity to provide PROMISE JOBS services and case management of those services.

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.3(239B) Registration and referral.

93.3(1) *Registration for PROMISE JOBS.* Unless the department determines a person is exempt as specified in 441—subrule 41.24(2), an application for FIP assistance constitutes a registration for the PROMISE JOBS program and acceptance of the requirement to enter into an FIA for all members of the FIP case and all other persons responsible for the FIA as specified in rule 441—41.24(239B).

93.3(2) *Referral.* The department will refer all FIA-responsible persons from FIP applicant and participant households to PROMISE JOBS pursuant to 441—subrule 41.24(4).

93.3(3) *Initial appointment.*

a. FIP applicants. FIP applicants, including those who are in an LBP, will be offered an appointment with the PROMISE JOBS provider agency for orientation, assessment, and FIA development at the earliest available time. The provider agency shall make sufficient appointment times available to allow the applicant to be scheduled no later than ten calendar days after the date of the notice that FIA responsibility has begun as required by rule 441—93.4(239B), 441—paragraphs 41.24(1) “c” and “d,” and 441—paragraph 41.24(10) “g.”

b. Exempt status change. Persons who become FIA-responsible while receiving FIP shall initiate PROMISE JOBS orientation and FIA development by contacting the appropriate PROMISE JOBS office to schedule an appointment within ten calendar days of the mailing date of the letter explaining that exempt status has been lost and FIA responsibility has begun as required by 441—subrule 41.24(5). If the person fails to schedule an appointment or fails to appear for an appointment, PROMISE JOBS shall send one written reminder letter that informs the person that those who do not develop an FIA shall enter into an LBP. If the person fails to schedule an appointment within ten calendar days of the written reminder letter or fails to appear for an appointment scheduled after the written reminder letter is sent, the person shall enter into an LBP as described in 441—paragraph 41.24(8) “c.”

93.3(4) *Orientation.* Every person referred to PROMISE JOBS shall receive orientation services. PROMISE JOBS workers shall provide FIA orientation.

a. During orientation, each applicant shall receive a full explanation of:

- (1) The advantages of employment under the family investment program (FIP), including information on earned income tax credits;
- (2) Services available under PROMISE JOBS;
- (3) Participant rights and responsibilities under the FIA and PROMISE JOBS;
- (4) The LBP as described in 441—subrule 41.24(8);
- (5) The availability of family planning counseling services in the area and the financial implications of newly born children on the participant’s family.

b. Each applicant shall receive a form prescribed by the department, confirming that information described in paragraph 93.3(4) “a” has been provided.

93.3(5) *Initial meeting.* The PROMISE JOBS worker shall meet with each referred person, or with the family if another parent or a child is also referred to PROMISE JOBS, to:

- a.* Determine participation activities,
- b.* Establish expenses and a schedule for supportive payments, and
- c.* Discuss child care needs.

93.3(6) *Workforce development registration.* Each applicant is required to register for work with the department of workforce development, upon request by the PROMISE JOBS worker.

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.4(239B) FIA. The FIA is the condition of and basis for PROMISE JOBS services and is an eligibility requirement for the FIP as specified in rule 441—41.24(239B).

93.4(1) *Development.* An initial FIA shall be developed during the orientation and assessment process through discussion between the FIA-responsible person and the PROMISE JOBS worker. For the FIA to be considered completed, an FIA shall be signed by all of the following:

- a.* The FIA-responsible person or persons.

- b. Other family members who are referred to PROMISE JOBS.
- c. The PROMISE JOBS worker.
- d. The PROMISE JOBS supervisor.

93.4(2) *FIA-responsible persons.* All members of the FIP applicant family shall develop and sign an FIA unless exempt as described in 441—subrule 41.24(2). When an FIA-responsible person is incompetent or incapacitated, someone acting responsibly on that person's behalf may participate in the interview. Responsibility for carrying out the steps of the FIA ends at the point that FIP assistance is not provided to the participant or when a participant becomes exempt.

a. *Parents.* All parents who are not exempt from PROMISE JOBS shall be responsible for signing and carrying out the activities of the FIA. Parents of any age are exempt only if they are receiving Supplemental Security Income (SSI) or they are not U.S. citizens and are not qualified aliens as defined in rule 441—40.21(239B). When the FIP-eligible group includes a minor parent living with one or both parents or a needy specified relative who receives FIP as described in 441—subparagraph 41.28(2)“b”(2) and none is exempt from PROMISE JOBS participation, each parent or needy specified relative is responsible for a separate FIA.

b. *Teens.* Participants aged 16 to the participants' nineteenth birthday shall be responsible for signing and carrying out the activities of the FIA unless they are receiving SSI or they attend school full-time.

(1) When the FIP-eligible group includes one or both parents or a needy specified relative and a child or children and none is exempt from PROMISE JOBS participation, all shall be asked to sign one FIA with the family and to carry out the activities of that FIA rather than signing separate FIAs.

(2) When the FIP-eligible group includes one or both parents or a needy specified relative who is exempt from PROMISE JOBS participation and a child or children who are not exempt, each child is responsible for completing a separate FIA.

(3) A minor nonparental specified relative who is not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

c. *Other adults.* All other adults who are not exempt and whose needs are included in the FIP grant shall be responsible for signing and carrying out the activities of the FIA.

93.4(3) *FIA content.* The FIA shall include the goals of the family for achieving self-sufficiency and shall establish a time frame with a specific ending date, during which the family expects to become self-sufficient and after which FIP benefits will be terminated. For individuals and families with acknowledged barriers, one or more incremental FIAs may be written.

a. All FIAs shall:

- (1) Outline the expectations of the PROMISE JOBS program and of the family;
- (2) Clearly establish interim goals and FIA activities necessary to reach long-term goals and self-sufficiency;
- (3) Identify barriers to participation so that the FIA may include a plan, appropriate referrals, and supportive services necessary to eliminate or manage the barriers;
- (4) Stipulate specific services to be provided by the PROMISE JOBS program, including child care assistance, transportation assistance, family development services, and other supportive services;
- (5) Include the participant's responsibility to provide verification of hours of participation, and how and when the verification will be submitted;
- (6) Record a participant's response to the option of referral for family planning counseling as described in subrule 93.9(3).

b. *Plans from other agencies.* The FIA may incorporate a self-sufficiency plan that the family has developed with another agency or person, subject to the following requirements:

- (1) The participant shall authorize PROMISE JOBS to obtain the self-sufficiency plan and to arrange coordination with the manager of the self-sufficiency plan by signing a release of information prescribed by the department.

(2) The self-sufficiency plan may be included in the participant's FIA if the self-sufficiency plan meets the requirements of this chapter and is deemed by the PROMISE JOBS worker to be appropriate to the family circumstances.

93.4(4) Participation requirements. The FIA shall require the FIA-responsible persons and family members who are referred to PROMISE JOBS to choose participation in one or more activities as described in this subrule.

a. Goals. It is expected that employment leading to economic self-sufficiency is the eventual goal of the FIA.

(1) To the maximum extent possible, the FIA shall reflect the goals of the family, subject to program rules; funding; the capability, experience, and aptitudes of family members; and the potential market for the job skills currently possessed or to be developed.

(2) The program goal for all participants is to be involved in PROMISE JOBS activities on a full-time basis unless problems or barriers prohibit this level of involvement. "Full-time" is considered an average of at least 30 hours per week. Exceptions to full-time involvement are identified in rule 441—93.14(239B) and subrule 93.4(5).

b. Activities. Except as specified in 441—paragraph 93.4(4)"c," PROMISE JOBS activities may include but are not limited to any combination of the following activities:

(1) Orientation as described in subrule 93.3(4).

(2) Assessment as described in rule 441—93.5(239B).

(3) Job readiness and job search activities, including job readiness skills training and other activities that prepare a participant to search for or obtain employment, individual and structured job search, unplanned job opportunities, mental health treatment, substance use disorder treatment, or other rehabilitative activities, as described in rule 441—93.6(239B).

(4) Work activities, including part-time or full-time employment, self-employment, on-the-job training, work experience placement, or unpaid community service as described in 441—93.7(239B).

(5) Educational activities, including high school completion, high school equivalency diploma (HSED) certification, adult basic education (ABE), English as a second language (ESL) training, vocational training, or postsecondary training up to and including a baccalaureate degree as described in 441—93.8(239B).

(6) Parenting skills training as described in subrule 93.9(1).

(7) Participation in the FaDSS program or other family development programs as described in subrule 93.9(2).

(8) Referral for family planning counseling as described in subrule 93.9(3).

(9) Family violence option as described in subparagraph 93.4(5)"b"(4).

(10) Services provided by other agencies.

c. FIA activities for participants aged 16 to 19. Development of FIA activities shall follow these guidelines for participants aged 16 to 19.

(1) Participants aged 16 to 19 who are not parents and who have not completed high school shall be strongly encouraged to participate in educational activities to obtain a high school diploma or the equivalent. A high school education is recognized as important to achieving self-sufficiency. Participants shall be given information on the earning power of people with a high school education compared to those who do not so that participants are able to make an informed choice. If high school or high school equivalency completion is not included in a teenager's FIA, other FIA activities shall be required. High school or high school equivalency completion shall be proposed and reconsidered at the next FIA review.

(2) Parents under the age of 18 who are not married and who have not completed high school shall be expected to use enrollment or continued attendance in high school or involvement in a high school equivalency program as a first step in the FIA, except when the parent is deemed incapable of participating in these activities by the local education agency.

(3) Parents aged 19 and younger shall include parenting skills training as described in subrule 93.9(1) in their FIA, or the case file shall include documentation that this requirement has been fulfilled.

(4) Parents under the age of 18 who are not married and who do not live with a parent or legal guardian shall include FaDSS, as described in 441—Chapter 49, or other family development services as described in subrule 93.9(2) in the FIA. The FaDSS or other family development services shall continue after the parent reaches the age of 18 only when the participant and the family development worker believe that the services are needed for the family to reach self-sufficiency.

d. FIA activities for participants convicted of a drug-related felony after August 22, 1996. A participant convicted of a drug-related felony after August 22, 1996, shall include drug rehabilitation activities in the participant's FIA to verify that the participant does not illegally possess, use, or distribute a controlled substance except when:

(1) The participant successfully completed any applicable drug rehabilitation and court-ordered probation or parole resulting from the drug felony conviction, or

(2) The participant is currently on probation or parole and successfully completed all drug rehabilitation requirements resulting from the drug felony conviction, whether court-ordered or required by probation or parole.

e. Waiting lists. The department of health and human services reserves the authority to prioritize services to FIP applicants and participants in the order that best fits the needs of FIP applicants and recipients and PROMISE JOBS program participants. Participants who are placed on a waiting list for a PROMISE JOBS component shall include other appropriate activities in the FIA while waiting unless family circumstances indicate otherwise.

(1) Persons shall be removed from these waiting lists and placed in components at the discretion of state-level PROMISE JOBS administrators in order to help participants achieve self-sufficiency in the shortest possible time, meet budgetary limitations, enable participants to make maximum use of other programs, fulfill the federal minimum participation rate requirements, and meet other TANF requirements.

(2) Persons who were enrolled in approved postsecondary training at the time of FIP cancellation shall not be placed on a postsecondary training waiting list if the participant is still satisfactorily participating in approvable training at the time that FIP eligibility is regained.

f. Unavailability of funding. If funding for the PROMISE JOBS activities included in a participant's FIA or required supportive payments are not available, the participant's FIA shall be renegotiated to include different activities.

93.4(5) Barriers to participation. Problems with participation of a permanent or long-term nature shall be considered barriers to participation and shall be identified in the FIA as issues to be resolved or managed so that maximum participation can result.

a. Barriers defined. Barriers to participation include anything identified by an FIA-responsible person that prevents them from fully participating in PROMISE JOBS.

b. Inclusion in FIA.

(1) When barriers are identified by the applicant during initial assessment, removal or management of the barrier shall be part of the FIA from the beginning.

(2) When barriers are revealed by the participant or are identified by problems that develop after the FIA is signed, the FIA shall be renegotiated and amended to provide for removal or management of the barriers.

(3) In limited instances where special-needs care for a child or adult is not available, it may be most practical for the participant to develop the FIA to identify providing the care as part of the FIA.

(4) Victims of domestic violence may include in their FIA the family violence option, which is a plan to address or attempt to prevent domestic violence. The family violence option may allow for a temporary waiver from participation in PROMISE JOBS activities when appropriate for the participant or participant's situation.

(5) The PROMISE JOBS worker shall review the need for inclusion of a barrier to participation in the FIA at least once every six months to determine if the barrier continues to exist.

c. Cooperation with removing or managing barriers.

(1) Applicants. An FIA-responsible applicant who chooses not to cooperate in removing or managing barriers to participation identified during FIA development shall be denied FIP.

(2) Participants. A participant who chooses not to cooperate in removing or managing identified barriers to participation shall be considered to have chosen the LBP. If the participant claims a cognitive or physical disability or mental illness that is expected to last for more than 12 consecutive months, the participant is required to apply for social security disability and supplemental security income benefits. When the participant refuses to apply for those benefits, the FIP household is ineligible for FIP as described at 441—subrule 41.27(1), and the LBP does not apply.

93.4(6) *Failure to complete an FIA.*

a. FIP applicants. An applicant's failure to develop or sign an FIA will result in denial of the family's application for FIP assistance as described in 441—paragraphs 41.24(4) "a" through "c."

b. FIP participants. FIP participants who choose not to enter into an FIA or who choose not to continue its activities after signing an FIA shall enter into the LBP as described in 441—subrule 41.24(8).

93.4(7) *Progress reviews.* The PROMISE JOBS worker shall review all FIAs at least once every six months with input from at least one family member. FIA goals and, if appropriate, the needs for child care, transportation, and other supports shall be reviewed for continued appropriateness.

93.4(8) *Renegotiation.*

a. The FIA shall be renegotiated to reflect a new plan for self-sufficiency if:

(1) The participant has participated satisfactorily in the current FIA activities but is not self-sufficient by the end date specified in the FIA; or

(2) The participant demonstrates effort in carrying out the steps of the FIA but is unable to participate satisfactorily in the current FIA activities due to a barrier as described in subrule 93.4(5); or

(3) The participant's circumstances change to such an extent that the current FIA activities are no longer appropriate.

b. Participants who choose not to cooperate in the renegotiation process when requested by PROMISE JOBS shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.4(9) *Reinstatement.* When a participant who has signed an FIA loses FIP eligibility and has not become exempt from PROMISE JOBS at the time of FIP reapplication, the contents of the original FIA and the participant's responsibility for carrying out the steps of that FIA may be reinstated when the steps of the FIA fit the family's current circumstances. The FIA shall be renegotiated and amended if needed to accommodate changed family circumstances.

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.5(239B) Assessment. The purpose of assessment is to provide an evaluation of the FIP applicant or participant family that furnishes a basis for the PROMISE JOBS worker to determine: (1) family members' employability and educational potential, so that participants can make well-informed choices; and (2) the services that will be needed for the family to achieve self-sufficiency, so that the worker can provide appropriate guidance.

93.5(1) *Initial assessment.* All persons referred to PROMISE JOBS shall complete an initial assessment, which includes a form prescribed by the department and shall review, at a minimum, the family's basic needs as determined by the department. This initial assessment shall be used to develop the initial FIA. The PROMISE JOBS worker shall meet individually with FIA-responsible persons.

93.5(2) *Additional assessments.* Additional assessments may include but are not limited to literacy and aptitude testing, educational level and basic skills assessment, evaluation of job interests or job skills, occupation-specific assessment or testing, or an evaluation of past pertinent information.

An additional assessment may be used by mutual agreement between the PROMISE JOBS worker and the participant as a tool and to help explore possible FIA development. For a specific additional assessment to be required, completion of the assessment must be specified in the FIA.

a. Additional information on applicants. If information identified during the initial assessment indicates that further information is needed to help the participant and PROMISE JOBS worker identify appropriate FIA activities and level of involvement, the applicant shall complete additional assessments as determined by the PROMISE JOBS worker. Completion of this assessment may be the first step in the initial FIA.

b. Medical examination. The PROMISE JOBS worker may require a person to complete a medical examination before including a particular PROMISE JOBS activity in the FIA when a participant specifies or exhibits any condition that might jeopardize successful participation in the program. The worker shall ask the health practitioner to indicate to the best of the practitioner's knowledge whether the person is capable of completing the FIA activity or continuing with appropriate employment.

c. Rehabilitation assessments. At any time during the assessment process or as more information is revealed, a referral may be made for professional assessments in physical health, mental health, substance use disorder, or other rehabilitative services.

d. Additional information on participants. Assessments may be completed or redone at any time throughout the development and duration of the FIA if the information is needed to help the participant and the PROMISE JOBS worker make decisions concerning the type or level of the participant's involvement in PROMISE JOBS activities.

93.5(3) *Postsecondary educational evaluation.* Participants who wish to include postsecondary education in their FIA shall complete an educational evaluation to determine the likelihood of success.

a. Request for education resulting in a vocational certificate or certificate of completion. Vocational certificate or certification of completion training programs offer short-term training in a specific vocational area. The PROMISE JOBS worker shall determine the likelihood of success using the following types of tools or information:

- (1) A review of information from past training situations,
- (2) Past job performance in comparable positions,
- (3) Basic skills tests,
- (4) Career-specific assessments,
- (5) A specific standardized test, or
- (6) Other key historical information.

b. Request for education resulting in an associate or baccalaureate degree. The PROMISE JOBS worker shall determine the likelihood of academic success through an educational evaluation. The evaluation may include use of the following types of tools or information:

- (1) Standardized assessments in reading comprehension, math, and writing skills;
- (2) Occupation-specific skills assessments;
- (3) Interest inventories;
- (4) Current or past grades; and
- (5) Other pertinent historical information.

c. Documenting educational evaluation results. When a participant has requested education to be included in the FIA, the PROMISE JOBS worker shall document:

- (1) What formal assessments were completed, if any, and what the results were;
- (2) What other information was reviewed;
- (3) How the evaluation information was used by the PROMISE JOBS worker in either approving or denying the inclusion of education in the participant's FIA; and
- (4) Whether the request is approved or denied. If the request is denied, PROMISE JOBS shall issue a Notice of Decision: Services to the participant as required in paragraph 93.10(1) "b."

93.5(4) *Substituting or supplementing an assessment.*

a. Substituting assessment information. If the FIA-responsible person's mental status, physical status, and life situation have not changed significantly, comparable assessment information completed with another agency or person within the past two years may be used instead of performing new assessments.

(1) Examples of agencies or persons that may complete comparable assessment information include but are not limited to the department of workforce development, Head Start, public housing authorities, child welfare workers, vocational rehabilitation services, an educational institution or testing service, or family development services.

(2) The FIA-responsible person may authorize PROMISE JOBS to obtain these assessment results by signing a release of information prescribed by the department.

b. Supplementing assessment information. In order to ensure that the FIA activities do not conflict with any case plans that have already been established for the family, the FIA-responsible person may:

(1) Supplement assessment information, and

(2) Establish communication between the PROMISE JOBS worker and other agencies or persons.

c. Use of key historical information. When key historical information, such as a review of the participant's job history or past training outcomes, relays a clear picture of the participant's skills and abilities, a formal, standardized educational assessment may not be needed.

(1) If a participant is currently enrolled in or has been enrolled in comparable training or an academic program in the past two years, the evaluation of the participant's performance, including grades received, may be substituted for a formal, standardized educational assessment.

(2) When using historical information as an indicator of future success, changes in the participant's mental status, physical status, life circumstances, and motivation shall be given consideration.

93.5(5) *Assessment after FIP cancellation or LBP.* FIP participants who previously participated in either a basic or additional assessment and then were canceled from FIP or entered an LBP may be required to complete an assessment again when the PROMISE JOBS worker determines that updated information is needed for development or amendment of the FIA.

93.5(6) *Participants with FaDSS services only.* For participants with FaDSS services as the only activity in their FIA, the PROMISE JOBS worker shall use information provided by the FaDSS worker to help assess when a participant is ready to participate in other PROMISE JOBS activities. The PROMISE JOBS worker may require additional assessments to be completed if more information is needed to decide the type or level of the participant's involvement in other PROMISE JOBS activities.

93.5(7) *Documenting participation.* The participant shall provide documentation of participation in assessments as described in subrule 93.10(2). Persons who miss any portion of a scheduled assessment may be required to make up the missed portion, based on worker judgment and participant needs.

93.5(8) *Supportive payments allowed.* Except for assessment activities that occur on the same day as orientation, persons participating in assessment activities are eligible for child care assistance and transportation payments needed to allow the scheduled participation as described in rule 441—93.11(239B). When make-up sessions are required, the participant shall not receive an additional transportation payment, but necessary child care assistance shall be paid.

93.5(9) *Failure to complete assessment.* Participants who do not complete assessments that are written into their FIA shall be considered to have chosen the LBP unless they have good cause. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.6(239B) Job readiness and job search activities. Job readiness and job search activities include job readiness skills training and other activities that prepare a participant to search for or

obtain employment, individual and structured job search, unplanned job opportunities, substance use disorder treatment, mental health treatment, and other rehabilitation activities. The participant and the PROMISE JOBS worker shall incorporate into the FIA the job readiness and job search activities that are appropriate for the goals, work history, skill level, and life circumstances of the participant.

93.6(1) *Job readiness.* Job readiness prepares participants to search for or obtain employment. Job readiness consists of job readiness skills training and other activities completed outside of a training session that prepare a participant to search for or obtain employment.

a. Delivery of job readiness skills training. Job readiness skills training is provided in scheduled sessions consisting of up to 30 hours of structured activity per week.

b. Job readiness skills training. Job readiness skills training may include but is not limited to:

- (1) Interests and skills assessment;
- (2) Self-esteem building and motivational exercises;
- (3) Identifying and eliminating employment barriers;
- (4) Résumé development;
- (5) Completing job applications and follow-up letters;
- (6) Obtaining interviews and communication skills;
- (7) Interviewing skills development;
- (8) Goal attainment planning;
- (9) Soft skills and life skills;
- (10) Job market trends and finding job leads;
- (11) Self-marketing and positive attitude building; and
- (12) Job retention skills.

c. Other job readiness activities. Job readiness may include activities that prepare the participant to search for or obtain employment and are completed outside of a training session.

d. Attendance. Attendance is required when a participant is scheduled for job readiness skills training or other job readiness activities unless the participant has good cause as described in rule 441—93.14(239B) or a barrier as described in subrule 93.4(5). Participants who miss any portion of job readiness skills training may be required to either make up the missed portion of the sessions or to retake the entire week of training based on practical worker judgment and participant need.

e. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed to participate in job readiness skills training or other job readiness activities. The transportation payment shall be paid before the first scheduled day of participation.

(1) Participants who must repeat or make up any portion of job readiness skills training because of absence due to reasons as described in rule 441—93.14(239B) shall receive an additional transportation payment as described in subrule 93.11(3) for each day that must be repeated and child care assistance. This rule applies only when the participant will have transportation costs that exceed the participant's original payment because of repeating or making up a portion of job readiness skills training.

(2) Participants who must repeat or make up any portion of job readiness skills training as a result of absences due to reasons other than those described at rule 441—93.14(239B) shall not receive an additional transportation payment.

f. Documenting job readiness skills training or other job readiness participation. Hours of participation in job readiness skills training or other job readiness activities shall be documented as described in subrule 93.10(2).

g. Failure to participate in job readiness skills training activities. Participants who without good cause do not appear for scheduled job readiness skills training activities as stated in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.6(2) *Individual job search.* Individual job search shall be available to all participants, particularly those who have recent ties with the workforce, have successfully removed or reduced

barriers to work, have completed job readiness skills training, or have completed education or training activities and are now ready to work. Participants are not required to participate in individual job search full-time. Individual job search may be combined with other FIA activities to reach full-time equivalency. Hours of participation in individual job search shall be determined according to the participant's individual circumstances and be at a level that will reasonably allow the participant to successfully find full-time employment. If after three calendar months the participant still has not found employment, the worker shall review the participant's situation for possible barriers to employment or possible need for training to increase the participant's employability. Job search may continue if appropriate, but linking with other activities should be considered.

a. Job search plan. A written job search plan using a form prescribed by the department shall be developed with input from the PROMISE JOBS participant and the PROMISE JOBS worker. A copy shall be provided to the participant. The plan shall:

(1) Contain a designated period for job search not to exceed five weeks ending on a Friday within the same calendar month and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for each week of the designated period so as to provide the most effective use of transportation funds.

(3) Specify due dates for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interest, employers to be contacted, and other pertinent factors.

b. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed for participation in an individual job search. The transportation payment shall be paid in full prior to the start of each designated period of the individual job search. Transportation payments for any missed days of job search activity shall be subject to transportation overpayment policies as described in subrule 93.11(3).

c. Documenting job search participation. The participant shall document the actual hours spent on job contacts and other job search activities. Participant documentation shall be provided as described in subrule 93.10(2).

d. Failure to participate in individual job search. Participants who without good cause do not participate in the steps of the job search plan described at paragraph 93.6(2) "a" shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.6(3) Unplanned job opportunity. PROMISE JOBS participants who have an unplanned opportunity to interview or apply for a job shall be encouraged to take advantage of the opportunity.

a. Supportive payments allowed. Child care assistance and transportation payments needed to make an unplanned job contact shall be provided as described in rule 441—93.11(239B) when the following conditions are met:

(1) The participant has a signed FIA,

(2) The job contact requires transportation to complete an application or to attend an interview, and

(3) The participant provides documentation as described in paragraph 93.6(3) "b." Payment shall be issued after documentation is received.

b. Documenting participation. The participant shall provide documentation of the actual time spent making the specific job contact. Documentation shall be provided as described in subrule 93.10(2).

c. LBP. An LBP does not apply when a participant fails to complete a job contact that is not part of a structured or individual job search plan.

93.6(4) Structured job search. Structured job search is designed with scheduled activities and required hours of participation to reflect proven job search techniques and the employment environment of the PROMISE JOBS service area. A PROMISE JOBS worker is available to monitor the participant's progress in the participant's job search and to provide assistance and support. Structured job search provides up to 30 hours of scheduled activity. Hours of participation in

structured job search shall be determined according to the participant's individual circumstance and may be full-time or at a level that will reasonably allow the participant to successfully find full-time employment.

a. Attendance. Participants are scheduled to appear daily at the PROMISE JOBS site to access resources for job leads. Participants who miss any portion of scheduled structured job search may be required to either make up the missed portion of the session or to retake the entire week of training based on practical worker judgment and participant need.

(1) Participants who obtain employment averaging 30 hours or more per week may discontinue structured job search.

(2) Participants who obtain employment averaging 20 hours or more per week, but less than 30 hours per week, may discontinue structured job search if part-time employment was the FIA goal or the scheduled job search hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with employment hours.

(3) Participants who obtain employment averaging less than 20 hours per week shall continue structured job search unless the scheduled job search hours conflict with the scheduled hours of employment. The participant may be required to participate in other FIA activities during the hours that do not conflict with employment hours.

b. Job search plan. A written job search plan using a form prescribed by the department shall be developed with input from the PROMISE JOBS participant and the PROMISE JOBS worker. A copy shall be provided to the participant. The plan shall:

(1) Contain a designated period for job search and the specific methods for finding job openings.

(2) Specify the number of hours to be committed for the designated period so as to provide the most effective use of transportation funds.

(3) Specify the due date for providing documentation of job search activities.

(4) Contain information as specific as possible about areas of employment interests, employers to be contacted, and other pertinent factors.

c. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed to participate in structured job search.

d. Documenting participation. The PROMISE JOBS worker shall verify and document each participant's monthly hours of actual participation in structured job search. Participant documentation shall be provided as described in subrule 93.10(2).

e. Failure to participate in structured job search. Participants who without good cause do not complete structured job search as identified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.6(5) *Substance use disorder treatment, mental health treatment, and other rehabilitative activities.* Substance use disorder or mental health treatment or other rehabilitative activities are available when needed for a participant to be successful in participating in other FIA activities.

a. Treatment determination. The need for treatment or rehabilitative activities must be determined by a qualified medical professional, substance use disorder professional, or mental health professional. The qualified professional must document that treatment or rehabilitative activities are needed for the participant to obtain or retain employment.

b. Supportive payments allowed. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed to participate in substance use disorder treatment, mental health treatment, or other rehabilitative activities.

c. Documenting participation. The service provider shall verify actual hours of participation in treatment. Documentation of participation shall be provided as described in subrule 93.10(2).

d. Failure to participate in treatment or other rehabilitative activities. Participants who without good cause do not participate in substance use disorder treatment, mental health treatment, or other rehabilitative activities as specified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.7(239B) Work activities. Work activities include full-time employment, part-time employment, self-employment, on-the-job training, work experience placement, and unpaid community service. The participant and the PROMISE JOBS worker shall incorporate into the FIA employment activities that are appropriate for the work history, skill level, and life circumstances of the participant. If the FIA activity is so hazardous that safety glasses, hard hats, or other safety equipment is needed, participation shall not be arranged or approved unless these safety precautions are available.

93.7(1) Full-time or part-time employment. FIAs may include full-time employment or part-time employment. Employment that does not lead to economic self-sufficiency may be included in the FIA only if the employment situation leads to better employment opportunities through building work skills and work history. More information about additional policies applicable to self-employment is contained in subrule 93.7(2).

a. Full-time employment. The goal for all participants is to participate in full-time employment. “Full-time employment” is defined as being employed an average of 30 or more hours per week.

(1) Persons who have not achieved self-sufficiency through full-time employment before the end date of the FIA may have the FIA extended.

(2) Persons who choose not to enter into the renegotiation process to extend the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

b. Part-time employment. Part-time employment is defined as being employed an average of less than 30 hours per week. An FIA that includes part-time employment shall also include participation in other PROMISE JOBS activities, including additional part-time employment, unless barriers to participation exist as defined in rule 441—93.14(239B) and subrule 93.4(5).

c. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care assistance shall be provided as described in rule 441—93.11(239B) when needed for employment.

d. Verification of employment hours. Participants must provide verification of employment hours as described in subrule 93.10(2).

e. Failure to provide verification. Failure to provide verification of work hours after receiving a written reminder letter will result in an LBP.

f. Failure to maintain employment. A participant who without good cause does not maintain employment as identified in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(2) Self-employment.

a. Calculation of hours. Hours of participation for persons who are self-employed shall be calculated using actual gross income less business expenses divided by the federal minimum wage. PROMISE JOBS shall use the same income as used for FIP eligibility and benefits.

(1) Participants with self-employment income that equates to 30 or more hours per week are considered to be working full-time.

(2) Participants with self-employment income that equates to less than 30 hours per week are considered to be working part-time.

b. Review of participation. The PROMISE JOBS worker shall review calculated hours:

(1) When income changes, or

(2) At least once every six months.

c. Progress toward self-sufficiency. At the participant’s FIA review, the participant’s progress is determined by noting incremental increases in income and calculated work hours. In order to maintain self-employment as the only FIA activity, participants must:

(1) Reach full-time employment as defined in subparagraph 93.7(2) “a”(1), or

(2) Show progress toward self-sufficiency.

d. Requiring other FIA activities. When a participant has been self-employed for more than 12 months and has not shown progress toward self-sufficiency, the FIA shall include the part-time self-employment in combination with participation in other PROMISE JOBS activities unless barriers to participation exist as defined in subrule 93.4(5) and rule 441—93.14(239B).

(1) The other activities could include additional part-time employment.

(2) When the determination that a participant has not shown progress toward self-sufficiency is made after the initial FIA is developed, the FIA shall be renegotiated to include the other PROMISE JOBS activities. Participants who choose not to enter into the FIA renegotiation process shall enter into an LBP as described in 441—subrule 41.24(8). Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

e. Supportive payments allowed. Transportation expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care assistance shall be provided as described in subrule 93.11(2) when needed for participation in self-employment.

f. Supportive payments not allowed. Funds may not be used to purchase supplies to enable a participant to begin a private business.

g. Documenting participation. Hours of participation in self-employment shall be calculated as specified in paragraph 93.7(2) “a” and documented in the case file. Participant documentation shall be provided as described in subrule 93.10(2).

h. Failure to maintain employment. Participants who without good cause do not maintain employment as identified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(3) On-the-job training.

a. Definition. “On-the-job training” is defined as training in the public or private sector that:

- (1) Is given to a paid employee while the employee is engaged in productive work, and
- (2) Provides knowledge and skills essential to the full and adequate performance of the job.

b. Supportive payments. Transportation for on-the-job training is treated in the same manner as transportation for employment. Expenses are not paid through PROMISE JOBS but are covered by FIP earned income deductions. Child care assistance shall be provided as described in subrule 93.11(2) when needed for participation in on-the-job training.

c. Documenting participation. Documentation of participation shall be provided as described in subrule 93.10(2).

d. Failure to participate in on-the-job training. Participants who without good cause do not participate in on-the-job training as identified in their FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(4) Work experience program. Work experience sites shall provide participants with work experience.

a. Sponsors. Employers who participate in the work experience program are referred to as sponsors. Work experience sponsors may be public sector, private sector, community-based, faith-based, or nonprofit employers.

(1) Participants may be placed at work sites with religious institutions only when the work performed is nonsectarian and not in support of sectarian activities.

(2) Participants may not be used to replace regular employees in the performance of nonsectarian work for the purpose of enabling regular employees to engage in sectarian activities.

(3) Each work experience program sponsor shall provide to the PROMISE JOBS service provider a copy of the sponsor’s safety rules before participants are referred for work-site placement.

b. Positions. To request a work experience placement, the sponsor shall complete a form prescribed by the department for each type of position the sponsor wishes to fill. The request shall include a complete job description that specifies all tasks to be performed by the participant. PROMISE JOBS has final authority to determine suitability of any work experience position offered by a sponsor. Work experience positions:

- (1) Must contain the same job description and performance requirements that would exist if the sponsor were hiring an employee for the same position;
- (2) Shall not be related to political, electoral, or partisan activities;
- (3) Shall not be developed in response to or in any way be associated with the existence of a strike, lockout, or other bona fide labor dispute;
- (4) Shall not violate any existing labor agreement between employees and employers;
- (5) Shall comply with applicable state and federal health and safety standards;
- (6) Shall not be used by sponsors to displace current employees or to infringe on the promotional opportunities of current employees;
- (7) Shall not be used in place of hiring staff for established vacant positions; and
- (8) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

c. Participant selection. A participant's vocational skills and interests shall be matched as closely as possible with the job description and skills required by the sponsor.

(1) Participant responsibility. Participants shall interview for and accept positions offered by work experience sponsors. Participants shall present a form prescribed by the department to the sponsor at the interview. The form shall be completed by the sponsor and returned to PROMISE JOBS.

(2) Sponsor responsibility. Although sponsors are expected to accept work experience referrals made by PROMISE JOBS, sponsors may refuse any referrals they deem inappropriate for the available position. Sponsors shall not discriminate against any program participant because of race, color, religion, sex, age, creed, physical or mental disability, political affiliation, or national origin. Sponsors who refuse a referral must notify PROMISE JOBS in writing of the reason for the refusal.

d. Hours of participation. When a participant is involved in work experience that is subject to the Fair Labor Standards Act (FLSA) as amended to August 1, 2024, the participant cannot be required to work more hours than the amount of the monthly FIP grant divided by federal or state minimum wage, whichever is higher. Exception: To determine the maximum hours that can be required of a single-parent family on FIP with a child under the age of six, add the value of the family's Supplemental Nutrition Assistance Program (SNAP) benefits to the FIP grant amount before dividing by the minimum wage.

(1) A participant cannot be required to work more hours than those calculated under paragraph 93.7(4) "d." Only hours up to or less than that calculation can be included in the participant's FIA.

(2) If two or more members of the same household participate in work experience, the total required hours of participation of the household cannot exceed the hours calculated according to paragraph 93.7(4) "d."

(3) Each work experience assignment shall not exceed six months in duration.

e. Participant performance evaluations.

(1) Monthly evaluations. Sponsors shall complete a monthly evaluation of the participant's performance using a form prescribed by the department and provide a copy to PROMISE JOBS and to the participant.

(2) Final evaluations. Sponsors shall complete a form prescribed by the department at the time of termination for each work experience participant. When termination occurs at the sponsor's request, the sponsor shall specify the reason for termination and identify those areas of unsatisfactory performance. For participants who leave to accept regular employment or reach their work experience placement time limit, the sponsor's evaluation shall indicate whether or not a positive job reference would be provided if the participant requested one.

f. Supportive payments for work experience placements.

(1) Child care and transportation. Child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed for participation in work experience.

(2) Required clothing and equipment. The sponsor will provide a documented list of clothing and equipment required by the work experience site. A participant may receive a one-time supportive

expense payment per work-site assignment for clothing or equipment that is documented by the sponsor and that cannot be obtained from the sponsor or other resources.

(3) Workers' compensation. The department will provide workers' compensation coverage for all PROMISE JOBS work experience participants.

g. *Documenting participation.* Documentation of participation shall be provided as described in subrule 93.10(2).

h. *Completion of work experience.* Persons who complete a work experience assignment may move to another activity as provided under the FIA, be assigned to a different work site, or be reassigned to the same work site, whichever is appropriate under the FIA.

i. *Failure to participate in work experience.* A participant who without good cause does not participate in work experience as identified in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.7(5) Unpaid community service.

a. *Work sites.* Unpaid community service work sites shall be public or private nonprofit organizations. The PROMISE JOBS provider agencies shall provide community service work sites a written explanation of the following placement criteria. The placement:

- (1) Shall comply with applicable state and federal health and safety standards;
- (2) Shall not be related to political, electoral or partisan activities;
- (3) Shall not be developed in response to or in any way associated with the existence of a strike, lockout, or other bona fide labor dispute;
- (4) Shall not violate any existing labor agreement between employees and employers;
- (5) Shall not be used to displace current employees or to infringe on their promotional opportunities;
- (6) Shall not be used in place of hiring staff for established vacant positions; and
- (7) Shall not result in placement of a participant in a position when any other person is on layoff from the same or an equivalent position in the same unit.

b. *Locating the work site.* When a participant and the PROMISE JOBS worker agree that an unpaid community service placement is appropriate, PROMISE JOBS shall assist the participant in identifying potential work sites. The participant is responsible for locating and making arrangements with the work site. Formal interviews are not required to establish the relationship between the participant and the work-site organization.

c. *Length of assignment and weekly hours.* The length of the work-site assignment and the weekly hours of participation shall be determined through agreement among the work-site organization, the participant, and the PROMISE JOBS worker. When a participant is involved in community service that is subject to the FLSA as amended to August 1, 2024, the participant cannot be required to work more hours than the amount of the participant's monthly FIP grant divided by federal or state minimum wage, whichever is higher. Only hours up to or less than the maximum calculated may be included in the participant's FIA. Exceptions are as follows:

(1) For a participant who is a single parent with a child under the age of six, the maximum hours that can be required are determined by adding the value of the participant's SNAP to the FIP grant amount before dividing by the minimum wage.

(2) Participants who are court-ordered to do community service shall work the number of hours required by the court.

d. *Supportive payments.* Child care assistance and a transportation payment for each month of participation or part thereof shall be paid as described in rule 441—93.11(239B) when needed for participation in unpaid community service.

e. *Documenting participation.* Documentation of participation shall be provided as described in subrule 93.10(2).

f. *Failure to complete unpaid community service.* Participants who without good cause do not participate in unpaid community service as specified in their FIA shall be considered to have chosen

the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

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441—93.8(239B) Education and training activities. Education refers to any academic or vocational course of study that enables a participant to complete high school, improves a participant's ability to read and speak English, or prepares a participant for a specific professional or vocational area of employment. Though employment leading to economic self-sufficiency is the eventual goal of all FIAs, it is recognized that education increases a person's chance of finding employment, particularly employment that leads to economic self-sufficiency. Any participant who requests participation in educational activities shall be evaluated to determine the likelihood of success. If the request is approved, a training plan shall be developed and included in the participant's FIA.

93.8(1) Participant requirements. The decision to include education in an FIA shall take into account the results of the educational evaluation pursuant to paragraph 93.8(1)“b” and the current educational level of the participant. Prior academic or vocational training is not, in itself, a reason for denial or approval of educational services. All family members who are approved for education shall be eligible for all program benefits, even when two or more family members are simultaneously participating and even if participation is at the same educational facility and in the same program. For education to be approved for inclusion in an FIA, the following requirements shall be met.

a. Vocational goal. For a participant enrolled in postsecondary education, the education must lead to a specific vocational goal. A degree in general studies or programs not leading to specific occupational outcomes cannot be included in a participant's FIA.

(1) Except as provided in subparagraph 93.8(1)“a”(2), a vocational goal must be in an occupational field for which available labor market information or emerging business trends in the participant's local area indicate employment potential. These trends or statistics must be provided by a legitimate source.

(2) Information to support employment potential in the participant's local area is not required when:

1. The participant has a documented job offer in the field before entering the training; or
2. The participant is willing to relocate after training to an area where there is employment potential. Documentation for the new location shall meet the requirements in subparagraph 93.8(1)“a”(1).

(3) For participants attending high school or high school equivalency activities, adult basic education or English as a second language, the vocational goal is to improve employability by successfully completing the activity.

b. Educational evaluation. An educational evaluation shall be completed according to subrule 93.5(3) before postsecondary education is included as an FIA activity. A participant under the age of 19 does not need to complete an educational evaluation in order to have high school completion included in the FIA.

(1) A participant who chooses to enter educational activities before obtaining approval is not eligible to receive supports as described in subrule 93.8(6), cannot use that activity to meet the FIA participation obligation, and shall be expected to participate in other FIA activities.

(2) A participant who is already involved in education at the time of FIP application or enters education before approval must meet the requirements in this rule before the educational activities can be included in the FIA. Once approved, the current educational activity may then be included in the participant's FIA, and the participant will be eligible to receive supports as described in subrule 93.8(6).

93.8(2) Provider requirements. Both public and private agencies may provide educational activities.

a. Type of provider. Education may be included in the FIA if obtained from a provider that is approved or registered with the state or is accredited by an appropriate accrediting agency. Training

provided by a community action program, church, or other agency may be included in the FIA only if PROMISE JOBS determines that:

- (1) The training is adequate and leads to the completion of the participant's vocational goal; and
- (2) The training provider possesses appropriate and up-to-date equipment; has qualified instructors, adequate facilities, a complete curriculum, acceptable evaluation methods, and a good job-placement history; and demonstrates expenses of training that are reasonable and comparable to the costs of similar programs.

b. Time and attendance. The provider must verify the participant's actual hours of attendance in an educational activity with a form prescribed by the department pursuant to subrule 93.10(2). If the educational activity is structured in such a way that verification cannot be obtained or the educational provider is unwilling to provide time and attendance verification, the educational activity cannot be included in the participant's FIA. Exceptions apply for online or distance learning as described in paragraph 93.10(2) "f" and for participants under age 20 as described in subparagraph 93.10(2) "b"(3).

93.8(3) Approvable activities. Training plans shall include only training activities that can be considered as meeting the FIA obligations for participation. The following activities may be included in a training plan:

- a.* Adult basic education.
- b.* Continuing education units when needed for the participant to be recertified or retrained to reenter a field in which the participant was previously trained or employed or to maintain certification needed to remain employed.
- c.* Correspondence courses when the courses are required but not offered by an educational facility attended by the participant.
- d.* English as a second language.
- e.* High school or high school equivalency completion. Any participant who does not have a high school diploma or high school equivalency diploma (HSED) shall be encouraged to obtain a diploma. A participant who is 18 years of age or older may be approved to return to regular high school only when the participant can graduate within one year of the normal graduation date. High school equivalency or high school courses and other types of vocational training may run concurrently.
- f.* Online or distance learning. The training:
 - (1) Must include interaction between the instructor and the student;
 - (2) Must include mechanisms for evaluation and measurement of student achievement; and
 - (3) Must be offered in Iowa unless the conditions in paragraph 93.8(3) "g" apply. An online training program shall be considered an out-of-state training program when any of the required training or testing occurs out-of-state.
- g.* Out-of-state training. Out-of-state training is approvable only when:
 - (1) Similar training is not available in Iowa,
 - (2) Relocation required to attend an in-state facility would be unnecessary if attending an out-of-state facility, or
 - (3) The only in-state facilities within commuting distance are private schools where tuition costs are higher than at an out-of-state facility within commuting distance.
- h.* Postsecondary education up to and including a baccalaureate degree program.
 - (1) A participant with no postsecondary education may be approved for training resulting in a certificate of program completion or an academic degree, such as an associate or baccalaureate degree. Participants who have not completed a high school education or received a high school equivalency diploma (HSED) may be required to do so before courses leading to an associate degree or higher are approved.
 - (2) A participant who has a baccalaureate degree or higher is considered employable. No further training shall be approved unless the participant's physical or mental status has changed to such an extent that the past education is no longer appropriate. The participant must provide supportive

evidence from either a qualified medical or mental health professional or the state rehabilitation agency.

(3) A participant who has successfully completed a postsecondary educational program that provides less than a baccalaureate degree may be approved for further training if the participant meets one of the following criteria:

1. The previous training is in an occupation that is outdated.
2. The previous training is in a field where current labor market information or emerging business trends show little or no employment opportunity.
3. The training requested is a progression in a specific career that moves a participant from entry-level positions to higher levels of pay, skill, responsibility, or authority.
4. The participant's background makes employment in the area in which the participant is trained impossible.
5. Changes in the participant's physical or mental status make the past training no longer appropriate. The participant must provide supportive evidence from a qualified medical or mental health professional or the state rehabilitation agency.
 - i. Prerequisite courses required by the selected training program.
 - j. Remedial coursework for one term when needed as determined by testing conducted by the training facility.
 - k. Summer school.

93.8(4) *Nonapprovable training activities.* Nonapprovable training activities shall not be included in the FIA. When an activity in which the participant is enrolled becomes nonapprovable, PROMISE JOBS shall cancel the current training plan and require the participant to renegotiate the FIA to include other activities. A form prescribed by the department shall be issued to inform the participant that the request for education is canceled. Nonapprovable activities include the following:

- a. A course or training that the participant has previously completed.
- b. Any course or training in a field in which the participant does not intend to seek employment after the training is completed. An exception may be made when the reason for not seeking employment is to receive further education when the education:
 - (1) Is a planned progression in a specific career path; and
 - (2) Will not lead to an advanced degree beyond a baccalaureate.
- c. A training program that does not relate to the identified vocational goal.
- d. Educational activities for which the participant has failed to earn the grades required for admission.
- e. Education in a field in which the participant will not be able to be employed due to known criminal convictions or founded child or dependent adult abuse.
- f. Out-of-state training except as allowed under paragraph 93.8(3) "g."
- g. Training for jobs paying less than state minimum wage.
- h. Training that will not be completed until after the participant leaves FIP. Training programs that exceed the known length of time during which the participant will remain eligible for FIP assistance shall be approved only if:
 - (1) The time remaining in the training is minimal and tuition has already been paid.
 - (2) There is a reasonable plan for how the program will be completed without the assistance and support from FIP or PROMISE JOBS. A reasonable plan may include but not be limited to school loans, grants, and scholarships.

93.8(5) *Training plan content.* Once a participant is approved for training, a training plan shall be developed and written into the participant's FIA. The training plan shall include:

- a. Academic enrollment hours. Participants are encouraged to maintain as full an academic workload as is possible in order to complete their education in a timely manner. However, a person may choose to participate in education along with other activities such as employment, job readiness skills training, other job readiness activities, or other FIA activities.
- b. Approved training plan activities.

- c. The specific educational goal as defined in paragraph 93.8(1) “a.”
- d. A date by which the participant expects to complete training. This end date depends on:
 - (1) Time frames specified for a program as established by the educational facility.
 - (2) Whether the participant is attending full-time or part-time.
 - (3) Problems or barriers to involvement as identified in subrule 93.4(5) or 93.14(1).
- e. Testing schedule. Participants enrolled in ABE or ESL programs must be able to complete training in the time determined by the testing schedule unless the PROMISE JOBS worker and, if appropriate, the participant’s academic advisor or instructor agree that additional time may be allowed. Under no circumstances, however, shall more than 6 additional months be allowed. Additional time shall not be allowed if, as a result, months required to complete training would exceed 24 months for ABE or 12 months for ESL.

93.8(6) Supportive payments. PROMISE JOBS may provide payment for certain expenses when needed to participate in approved education and training activities as described in this subrule and in subrule 93.11(4).

a. Eligibility.

(1) Eligibility for PROMISE JOBS supportive payments for education and training begins with the date when the participant begins training under an approved plan or is removed from a waiting list as described in paragraph 93.4(4) “e,” whichever is later.

(2) Participant eligibility for child care assistance and transportation payments begins as described in subparagraph 93.8(6) “a”(1) and shall be terminated when a training plan is canceled.

(3) Each participant in postsecondary vocational training is limited to 24 fiscal months of PROMISE JOBS payment of expenses needed for participation. The 24 fiscal months do not have to be consecutive. More information about additional limits on child care expenses is contained in paragraph 93.8(6) “b.”

(4) When more than one facility offers a particular program, payment is limited to the amount required to attend the nearest educational facility except when attending a facility that is farther away will allow the family to reach self-sufficiency earlier.

b. Child care. Child care assistance shall be provided as described in subrule 93.11(2) and 441—Chapter 170 when needed for participation in education and training activities except as described in subparagraphs 93.8(6) “b”(1) and (2).

(1) Child care assistance payments needed for participation in postsecondary education activities are limited to 24 fiscal months.

(2) All child care assistance payments issued for child care for participation in postsecondary education activities count toward this limit, including payments issued while the person was not a PROMISE JOBS participant, pursuant to 441—subparagraph 170.2(2) “b”(1).

c. Transportation. Transportation payments shall be provided as described in subrule 93.11(3) when needed for participation in educational activities unless transportation payments are available from another source. Transportation needed for participation in education activities is subject to the limits described in paragraph 93.8(6) “a.”

(1) When a participant receives a transportation payment from another program that equals or exceeds that possible under PROMISE JOBS, transportation shall not be paid by PROMISE JOBS for any month covered by the other program.

(2) When the amount received from another program is less than that possible under PROMISE JOBS, a supplemental payment may be made as long as the combined payment does not exceed that normally paid by PROMISE JOBS.

(3) When a participant is enrolled in high school, a transportation payment shall not be allowed if transportation is available from another source, such as the school district. If child care needs or the needs of the child or the participant make it impractical or inappropriate for the participant to use transportation provided by the school district, a transportation payment may be authorized.

d. Training expenses. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or postsecondary vocational training may be eligible for payment of the following expenses of training when required for participation, subject to limits in subrule 93.11(4):

- (1) Enrollment fees,
- (2) School application fees,
- (3) Educational grant or scholarship application fees,
- (4) Licensing, certification and testing fees,
- (5) Travel costs required for certification or testing, and
- (6) Certain practicum expenses as described in subparagraph 93.11(4) "a"(3).

e. Direct education costs. Participants enrolled in high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less may also be eligible for payment for direct education costs, including:

- (1) Tuition,
- (2) Books,
- (3) Fees including graduation,
- (4) Basic school supplies,
- (5) Specific supplies related to obtaining credit for a course and required of all students in a course, and
- (6) Required uniforms.

f. Supplies purchased with PROMISE JOBS funds. Participants may keep any books or supplies, including tools, that were purchased with PROMISE JOBS funds.

93.8(7) Documentation.

a. Plan. The following information shall be documented in the participant's file.

- (1) Evaluation results, pursuant to paragraph 93.8(1) "b."
- (2) Current educational level.
- (3) Justification for approval of additional postsecondary education pursuant to subrule 93.5(3).
- (4) Academic probationary status pursuant to subrule 93.8(8).
- (5) Justification for denial of education. Notice of Decision: Services shall be issued to the participant to deny the request for education.

b. Participation. A participant shall provide documentation of the actual hours of participation in education and homework and of grades and academic progress as described in subrule 93.10(2).

93.8(8) Academic probation. A participant may be placed on academic probation for at least one term, or a comparable time limit appropriate to the educational program, after which the participant shall be reevaluated for continued inclusion in education activities. This subrule does not apply to parents under the age of 18 who are attending high school completion programs.

a. Placing a participant on academic probation. The PROMISE JOBS worker may choose to place a participant on academic probation in the following circumstances:

(1) The educational evaluation completed according to paragraph 93.8(1) "b" identifies some factors with the participant's ability or past circumstances that could make successful completion of the training difficult but the participant's motivation is high and changes in the participant's life situation indicate a realistic probability of success.

(2) The participant was previously unable to maintain the cumulative grade point average required by a training facility in training comparable to that being requested.

(3) The participant enrolled but did not complete a previous education activity without good cause.

(4) At the end of a term, or of a comparable period applicable to the educational program, the participant is receiving less than a 2.0 grade point average or less than a higher average that is required by the specific training facility or curriculum.

b. Probation outcomes. The participant shall be removed from probation for satisfactory performance if, by the end of the established probationary period, the participant is receiving at least a 2.0 grade point average or a higher average as required by the specific training facility or curriculum.

(1) **Reevaluation.** If the participant is not receiving the required grade point by the end of the probationary period, the participant shall be reevaluated to determine continued eligibility for participation in education using the same type of information used to originally evaluate the likelihood of academic success as identified in paragraph 93.8(1)“b.” Documentation shall meet the requirements as stated in subrule 93.8(7).

(2) **Continued probation.** Probation may be continued when reevaluation indicates that education is appropriate. The PROMISE JOBS worker may also consider continued probation when:

1. Temporary barriers such as illness or family emergencies that interfered with successful participation have been resolved.

2. Long-term barriers to successful participation have been identified and accommodations developed and implemented.

3. The counselor or the lead instructor in the educational program verifies that there is an excellent likelihood the student will raise the grade point to the acceptable level in the next term or a comparable time limit appropriate to the educational program.

(3) **Cancellation of a training plan.** The participant’s current training plan shall be canceled if the participant has failed to maintain at least a 2.0 grade point average or a higher average required by the specific training facility or curriculum, and reevaluation indicates no mitigating circumstances as listed in subparagraph 93.8(8)“b”(2). When a training plan is canceled, the participant will be required to renegotiate the FIA to include either a new, more appropriate training plan or other FIA activities. Notice of Decision: Services shall be issued to the participant to inform the participant that the approval for education is canceled.

93.8(9) LBP. Participants in education choose an LBP through the following actions:

a. Failure to participate. The participant fails to maintain education activities or follow training plan requirements as specified in the participant’s FIA, and the participant does not have good cause. Procedures in subrule 93.4(5) and 441—93.13(239B) and 441—93.14(239B) shall apply.

b. Misuse of payments. The participant misuses expense payments to the extent that the training plan is no longer achievable or knowingly provides receipts or any other written statements that have been altered, forged, or, in any way, are not authentic.

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441—93.9(239B) Other FIA activities.

93.9(1) Parenting skills training.

a. Parents aged 20 or older. For parents who are aged 20 or older when the FIA is signed, activities that strengthen the participant’s ability to be a better parent can be considered approvable training under PROMISE JOBS and may be included in the FIA as long as the participant is active in at least one other PROMISE JOBS component. Parents aged 20 or older who do not carry out the parenting skills training described in the FIA shall be considered to have chosen the LBP unless good cause exists or family circumstances warrant renegotiation and amendment of the FIA. Procedures in subrule 93.4(5) and 441—93.13(239B) and 441—93.14(239B) shall apply.

b. Parents aged 19 or younger. Parents aged 19 or younger when the FIA is signed are required to include parenting skills training in the FIA, but may be excused from the requirement when documentation of satisfactory completion of parenting skills training is provided before the FIA is signed.

(1) **Priority for orientation or assessment.** In any month, PROMISE JOBS shall give priority for orientation or assessment services to parents who are already aged 19 in order to establish their responsibility for parenting classes before they are aged 20. This applies to those who are scheduled for orientation, to those who are still in assessment, and to those who have an FIA that must be renegotiated and amended.

(2) **FIA requirement.** The FIA shall be written or renegotiated and amended to include specific plans for parenting skills training and shall identify the training provider’s name and beginning and ending dates of the training. The scheduled training may be in the future to accommodate availability

of provider resources. However, it shall occur as soon as is compatible with the circumstances of the family, the other activities in the FIA, and the availability of provider resources, except as specified in paragraph 93.4(4)“e.”

(3) Parents aged 19 or younger who are participating in a parenting skills training program at the time the FIA is signed shall be allowed to continue in that program, if they choose, as long as the provider is listed in paragraph 93.9(1)“c” or meets the requirements of paragraph 93.9(1)“d” and documentation of enrollment is provided. The time frames as described in paragraph 93.9(1)“d” shall be used to determine the remaining training time to be included in the FIA.

(4) Participation in other activities. Parents aged 19 or younger are not required to be participating in another PROMISE JOBS component to be eligible for parenting skills training. Other PROMISE JOBS components are included in the FIA according to policies in subrule 93.4(4).

c. Approved providers. The sources listed in this paragraph are approved providers for parenting skills training.

(1) High school departments of family and consumer sciences that offer child development, family relationships, or parenting classes and alternative high school programs for pregnant and parenting teens. Services shall be limited to a minimum of one semester and a maximum of two semesters.

(2) Community colleges, other associate-degree institutions, and baccalaureate-degree institutions that offer child development, family relationships, or parenting classes. Services shall be limited to one semester or two quarters.

(3) Area education agencies; child abuse prevention programs; child and adult food program sponsors; child care resource and referral agencies; family resource centers; maternal and child health centers; family development and self-sufficiency program grantees and other family development providers; Head Start, Head Start parent and child centers, and Early Head Start programs; Iowa State University Extension services; private nonprofit social service agencies; and young parent support and information organizations. Services shall be limited to:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
 2. A maximum of 26 contact hours or six calendar months, whichever comes first.
- d. Other providers of parenting skills training are approved as long as they:

(1) Have five of these six elements: child growth and development, child health and nutrition, child safety, positive discipline, relationships, and life skills.

(2) Offer training within the following time frames:

1. A minimum of 6 contact hours or six weeks, whichever comes first, and
2. A maximum of 26 contact hours or six calendar months, whichever comes first.

e. Supportive payments. For participants described in paragraphs 93.9(1)“a” and “b,” child care assistance and transportation payments shall be provided as described in rule 441—93.11(239B) when needed for participation in parenting skills training and not available from another source.

(1) Other expenses. Payment for tuition, fees, or books and supplies shall be made only when parenting skills training is not available from a free source in the local area. PROMISE JOBS shall not pay for any expenses that are covered by student financial aid in postsecondary educational institutions as provided elsewhere in these rules.

(2) Continuation of payments. If the participant chooses to continue with the parenting skills training program beyond the designated period of participation described in paragraphs 93.9(1)“c” and “d,” PROMISE JOBS responsibility for payment of expense payments shall not extend beyond the designated period unless completion is delayed by acceptable instances for nonparticipation as stipulated in rule 441—93.14(239B) or barriers to participation in subrule 93.4(5).

f. Participation in parenting skills training. The planned duration of the parenting skills training shall be determined by agreement between the participant and the training provider within the limits described in paragraphs 93.9(1)“c” and “d.”

(1) In consultation with the PROMISE JOBS worker, the participant and the provider shall design a written agreement and provide a copy to PROMISE JOBS. The agreement shall designate the

period during which the mandatory parenting skills training requirement will be fulfilled. The period specified in the agreement or notice of decision shall be included in the FIA.

(2) Participants who fail to carry out this step in the FIA shall be considered to have chosen the LBP.

g. Failure to complete parenting skills training. Parents aged 19 or younger who do not include parenting skills training in the FIA or do not carry out the parenting skills training described in the FIA shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.9(2) *Family development.* Family development services are support services for PROMISE JOBS families in need of additional assistance, primarily provided by the FaDSS program operated by the department. The services are designed to promote, empower, and nurture the family to self-sufficiency and healthy reintegration into the community.

a. PROMISE JOBS may arrange for these services from entities that meet one of the following criteria wherever these are available. Family development services shall be:

(1) Provided by a FaDSS grantee; or

(2) Provided by a specialist that has been certified through the National Resource Center on Family Based Services at the University of Iowa College of Social Work or the National Family Support Certification Exam through the Institute for the Advancement of Family Support Professionals.

b. Inclusion of family development services by participants as an FIA activity is voluntary except for parents under the age of 18 who are not married and who do not live with a parent or legal guardian as described in subparagraph 93.4(4) “c”(4).

93.9(3) *Family planning counseling.* Referral for family planning counseling is an optional service that shall be offered to each applicant or participant. It is not a component of PROMISE JOBS.

a. The PROMISE JOBS worker shall:

(1) Discuss orally and in writing the financial implications of newly born children on the participant’s family during PROMISE JOBS orientation or assessment, using a form approved by the department; and

(2) Assist the participant in locating local resources.

b. The FIA shall record participant response to the option of referral for family planning counseling. It is not acceptable for the FIA to have family planning counseling as the only step of the FIA.

c. Supportive payments. No supportive payments are allowed for family planning counseling.

d. Participation. LBP policies do not apply to participants who choose not to include family planning counseling in the FIA or who do not carry out the steps of family planning counseling.

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441—93.10(239B) Required documentation and verification.

93.10(1) *Written notification to participants.*

a. *Notice of meetings, assignments, and issues.* PROMISE JOBS shall notify participants in writing of all scheduled meetings, of FIA activity and work-site assignments, and of any participation issues as described in rule 441—93.13(239B). PROMISE JOBS shall also notify the participant in writing when the participant is required to provide medical documentation, verification of hours of participation, employment verification, or any other verification.

(1) PROMISE JOBS shall allow a participant ten calendar days from the date notice is mailed to appear for scheduled meetings unless the participant agrees to an appointment that is scheduled to take place in less than ten calendar days. If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

(2) PROMISE JOBS shall allow a participant ten calendar days from the date notice is mailed to appear for an FIA activity or work-site assignment or to provide medical documentation, employment

verification, or any other verification, except as otherwise specified in subrule 93.10(2). If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

(3) PROMISE JOBS shall allow additional time upon request from the participant when the participant is making every effort but is unable to fulfill requirements within the established time frame.

b. Notice of decision. PROMISE JOBS shall send written notice to each participant in accordance with 441—Chapter 16 when services are approved, rejected, renewed, changed, canceled, or terminated for failure to cooperate or participate. PROMISE JOBS services are approved when the participant is assigned to begin participation in an activity as written in the FIA.

93.10(2) *Verification of participation and progress.* Hours of participation and a participant's progress in FIA activities must be documented and verified. When the participant is responsible for providing the verification, PROMISE JOBS shall notify the participant in writing as required in subrule 93.10(1).

a. FIA activities directly monitored by PROMISE JOBS. When the FIA activities are provided or directly monitored by PROMISE JOBS staff, such as job readiness skills training or structured job search, the staff shall document the participant's hours of attendance and progress in the case file.

b. FIA activities not directly monitored by PROMISE JOBS. When FIA activities are provided by a service provider other than PROMISE JOBS, the provider shall verify the participant's hours of attendance with a form prescribed by the department unless another method is required by this rule.

(1) The provider is expected to specify the participant's hours of attendance and to sign and date the Time and Attendance form.

(2) The participant is responsible for providing the signed and dated Time and Attendance form to PROMISE JOBS within ten calendar days following the end of each month, unless the provider provides the form to PROMISE JOBS within this time frame.

(3) Exception: If the participant is under age 20 and in high school or high school equivalency classes, the participant may verify the hours by completing and submitting a form prescribed by the department, Time and Attendance, monthly. The training provider does not need to sign the form.

c. Documentation of job search. The participant shall complete and provide documentation of any job search activities that cannot be verified by the PROMISE JOBS worker. The participant shall provide a form prescribed by the department within ten calendar days following the end of each month during which the participant has made a job search. The PROMISE JOBS worker shall consider the Job Search Activity Log complete if the form includes:

(1) Sufficient information to identify the employer that was contacted or the activity that was completed,

(2) The date that the contact was made or the date the activity was completed,

(3) The amount of time spent, and

(4) The participant's signature.

d. Employment verification. Participants shall verify actual hours of employment at the time that employment begins, upon FIP approval if employed at the time of application, when changes in hours occur, and no less than once every six months thereafter. Participants may use copies of pay stubs, an employer statement of earnings, or may sign a release of information prescribed by the department so that the employer may provide information directly to the PROMISE JOBS worker. Participants shall provide verification of actual hours of employment within ten calendar days of the written request from PROMISE JOBS.

e. Documentation of self-employment. At the time of the participant's FIA review, a self-employed participant shall provide documentation of actual hours worked and gross income and business expenses from the last 30 days. Data from more than 30 days may be requested if the last month is not indicative of normal business. The participant shall provide documentation within ten calendar days of the written request from PROMISE JOBS.

f. Distance learning. When a participant is involved in a distance-learning program, PROMISE JOBS will accept the documentation issued by the distance-learning institution verifying that the student participated in the sessions.

(1) Documentation may include the attendance records or log-in and log-out records available online or in an electronic format. Documentation may also be obtained through an agreement with a support agency that monitors the student's actual participation.

(2) The participant is responsible for providing the documentation within ten calendar days following the end of each month unless the institution provides the documentation to PROMISE JOBS within this time frame.

g. Failure to provide required documentation or verification. Participants who fail to provide documentation or verification as described in this subrule after written notification from PROMISE JOBS as described in subrule 93.10(1) shall be considered to have chosen the LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

93.10(3) Verification of problems or barriers. Participants may be required to provide written verification or supporting documentation of reported problems or barriers to participation.

a. Medical documentation. A participant shall secure and provide written documentation signed by a qualified medical or mental health professional to verify a claimed illness or disability within ten calendar days of a written request by PROMISE JOBS. This time limit may be extended due to individual circumstances, such as the need to obtain an updated evaluation. Acceptable verification includes a form prescribed by the department or other statement signed by a qualified medical or mental health professional to verify the existence of an illness, disability, or limitation. If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

b. Other documentation. A participant shall secure and provide written documentation to verify a claimed problem or barrier to participation within ten calendar days of a written request by PROMISE JOBS. Acceptable documentation may include a signed statement from a third party with knowledge of the problem or barrier. If the tenth calendar day falls on a weekend or state holiday, the participant has until the next working day.

c. Failure to verify problem or barrier or to provide medical documentation. Failure to provide verification of a problem or barrier or to provide medical documentation as described in subrule 93.10(3) does not directly result in the imposition of an LBP. Examples of actions that do not directly result in LBP include but are not limited to failure to provide a form prescribed by the department or other statement from a medical or mental health professional to verify the existence of an illness or disability, or a statement from a third party with knowledge about the problem or barrier.

(1) Participants who claim an inability to participate on a full-time basis due to a claimed problem or barrier and who fail to provide verification or medical documentation upon written request may be required to renegotiate the FIA to include full-time participation in FIA activities. Failure to renegotiate the FIA may result in an LBP. Procedures in subrule 93.4(5) and rules 441—93.13(239B) and 441—93.14(239B) shall apply.

(2) Participants who claim a problem or barrier caused their failure to participate for the full number of hours identified in their FIA and who fail to provide verification of the problem or barrier or medical documentation upon written request may not be excused for the failure to participate. If the failure is not excused, the failure will result in imposition of an LBP if the failure meets the criteria described in subrule 93.13(2).

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441—93.11(239B) Supportive payments. In order to facilitate successful participation, PROMISE JOBS may provide payment for the expenses listed in this rule. Upon written request from PROMISE JOBS, participants shall submit a form prescribed by the department, or other acceptable estimate of costs, to initiate payments or change the amount of payment for expenses other than child care.

93.11(1) Eligibility. Participants are eligible for supportive payments needed for participation in activities in their FIA, subject to the limits in this chapter.

a. Applicants in an LBP who must complete significant contact with or action in regard to PROMISE JOBS for FIP eligibility to be considered as described in paragraphs 441—41.24(8) “*a*” and “*e*” are eligible for expense payments for the 20 hours of activity. However, PROMISE JOBS services and supportive payments are only available when it appears the applicant will otherwise be eligible for FIP.

b. Applicants who have received 60 months of FIP are eligible for PROMISE JOBS services and payments under the circumstances described in 441—subrule 41.30(3).

93.11(2) *Child care.* Payments for child care shall be issued through the child care assistance program as described in 441—Chapter 170.

a. Payment shall be provided for child care if:

(1) Care is needed for participation in any PROMISE JOBS activity other than orientation or assessment activities that occur before the FIA is signed,

(2) Payment is not specifically prohibited elsewhere in these rules, and

(3) Payment is not available from another source.

b. Payment shall be issued to the child care provider after the service has been received, as described in 441—subrule 170.4(7).

93.11(3) *Transportation.* Participants may receive a transportation payment for each day that transportation is needed for participation in a PROMISE JOBS activity. Transportation payments shall be determined according to the circumstances of each participant. If necessary, payments shall cover transportation for the participant and child from the participant’s home to the child care provider and to the PROMISE JOBS site or activity.

a. Exclusions.

(1) A transportation payment is not available for orientation or for assessment activities that occur before the FIA is signed.

(2) A transportation payment is not available for employment. Participants who are employed shall be entitled to the earned income deduction described at 441—paragraph 41.27(2) “*a*” to cover transportation costs associated with employment.

b. Rate of payment. Payments shall not exceed the rate that the provider would charge a private individual.

(1) Public transportation. For those who use public transportation, the payment shall be based on the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment, using the rate schedules of the local transit authority to the greatest advantage, including use of weekly and monthly passes or other rate reduction opportunities.

(2) Private transportation. For participants who use a privately owned motor vehicle or who hire private transportation, the transportation payment shall be based on a formula that uses the normally scheduled days of participation in the PROMISE JOBS activity for the period covered by the payment multiplied by the participant’s anticipated daily round-trip miles and then multiplied by the current state employee reimbursement rate.

c. Special transportation needs. Participants who require, due to a mental or physical disability, a mode of transportation other than a vehicle they operate themselves shall be eligible for payment of a supplemental transportation payment when documented actual transportation costs are greater than transportation payments provided under these rules and transportation is not available from another source.

(1) Medical evidence. To be eligible for a supplemental payment, the participant must provide medical evidence of the need for an alternate mode of transportation due to disability or incapacity. The evidence must be from a qualified medical or mental health professional, the state rehabilitation agency, or proof that the participant receives SSI or social security benefits due to disability or blindness.

(2) Payment rates. Actual costs of transportation by a public or private agency shall be allowed. Costs of transportation provided by private automobile shall be allowed as described in subparagraph 93.11(3) “*b*”(2).

d. Issuance of payments. The transportation payment shall be issued before the first scheduled day of participation in an activity. For participants in the same activity for more than one month, transportation payments shall be issued before the first day of the month of scheduled participation except as described below.

(1) Payments for the third and subsequent months of an ongoing activity shall not be authorized before receipt of time and attendance verification, as described in subrule 93.10(2), for the month before the issuance month. Example: A transportation payment for June, normally issued after May 15 to be available to the participant by June 1, will not be authorized until time and attendance verification for the month of April has been received in the PROMISE JOBS office.

(2) The amounts of payments for the third and subsequent months of an ongoing activity shall be adjusted by subtracting from normally scheduled days any number of days that represents a difference between the number of scheduled days of activity in the month before the issuance month and the number of actual days attended in that month. Example: A transportation payment is issued in May based on 16 scheduled days of participation for June. The participant attends only 14 days of the activity. When preparing to issue the August transportation allowance, the worker subtracts two days from the normally scheduled August activities to calculate the payment. If ten days of participation are scheduled, the transportation payment issued in July for August is calculated using eight days.

(3) Because adjustment for actual attendance is not possible in the last two months of an ongoing activity, transportation payments for the last two months of an ongoing activity will be subject to transportation overpayment provisions of subrule 93.12(1).

EXCEPTION: A transportation overpayment does not occur for any month in which the participant leaves the PROMISE JOBS activity in order to enter employment.

93.11(4) Training and education expenses. Participants shall use PROMISE JOBS payments that they receive to pay authorized expenses.

a. Classroom training. PROMISE JOBS payments for classroom training are limited as follows:

(1) Tuition payments for high school or high school equivalency completion, ABE, ESL, or short-term training programs of 29 weeks or less shall not exceed the rate charged by the Iowa community college located nearest the participant's residence that offers a course or program comparable to the one in which the participant plans to enroll. If an Iowa community college does not offer a comparable program, the maximum tuition rate payment shall not exceed the Iowa resident rate charged by the out-of-state area school located nearest the participant's residence.

(2) A standard payment for actual costs of basic school supplies once per term shall be allowed for those participants who request it. Actual costs must be verified by receipts.

(3) A per diem payment of \$10 for living costs during a practicum shall be allowed when the practicum is required by the curriculum of the training facility, would require a round-trip commuting time of three hours or more per day, and is not available closer to the participant's home. If practicum earnings or other assistance is available to meet practicum living costs, no payment shall be made.

(4) Payments may be authorized to meet the costs of travel required for certification and testing, not to exceed the transportation payment as described in subrule 93.11(3) and the current state employee reimbursement rate for meals and lodging.

(5) No payment shall be made for jewelry, pictures, rental of graduation gowns, elective courses that require expenditures for field trips or special equipment, such as photography or art supplies, or other items that are not required to complete training for a vocational goal.

b. Retroactive payments. Retroactive payments for transportation and allowable direct education costs shall be allowed only under the following conditions:

(1) If plan approval or removal from a waiting list occurs after the start of the term due to administrative delay or worker delay, payments shall be approved retroactive to the start of the term for which the plan is approved or removal from the waiting list is authorized. If the participant has already paid costs with private resources, the participant shall be reimbursed.

(2) If plan approval is delayed due to the fault of the participant, payment eligibility shall begin with the first day of the month during which the plan is approved or the month in which the participant

is removed from a waiting list as described in paragraph 93.4(4)“e,” whichever is later. In this instance, there shall be no reimbursement for costs already paid by the participant.

c. Receipts. Participants shall furnish receipts for expenditures that they pay, except for transportation payments. Failure to provide receipts will preclude additional payments. Receipts may be requested for payments paid directly to the training provider if the PROMISE JOBS worker determines it is appropriate.

d. Payments directly to facility. PROMISE JOBS is authorized to provide payment for expenses allowable under these rules to the training facility for the educational expenses of tuition and fees and books and supplies that are provided by the facility and billed to the PROMISE JOBS participant. Payment may also be made to the participant in those situations where payment to the participant is determined to be appropriate by the PROMISE JOBS worker.

93.11(5) Other expenses.

a. Birth certificates. PROMISE JOBS funds shall be used to pay costs of obtaining a birth certificate when the birth certificate is needed in order for the participant to complete the workforce development registration process described in subrule 93.3(6).

b. Resources for examination. When an examination is required and other resources are not available to meet the expense of the examination, the PROMISE JOBS worker shall authorize the examination and submit a claim for payment on a form prescribed by the department.

c. Workforce Innovation and Opportunity Act. PROMISE JOBS funds may also be used to pay expenses for PROMISE JOBS participants enrolled in federal Workforce Innovation and Opportunity Act (WIOA) as amended to August 1, 2024, funded services or activities when those expenses are allowable under these rules.

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.12(239B) Recovery of PROMISE JOBS expense payments. When an applicant, a participant, or a provider receives an expense payment for transportation or other supportive expenses that is greater than allowed under these rules or receives a duplicate payment of an expense payment, an overpayment is considered to have occurred and recovery is required. There are two categories of PROMISE JOBS expense payments subject to recovery: (1) transportation, and (2) other supportive expense payments.

93.12(1) Payment for transportation will be considered an overpayment subject to recovery in the following instances:

a. When the participant attends none of the scheduled days of participation in a PROMISE JOBS activity, the entire transportation payment will be considered an overpayment. Recovery of the overpayment will be initiated when it becomes clear that subsequent participation in the activity is not possible.

b. When the participant fails to attend 75 percent of the normally scheduled days of participation in either of the last two months of an ongoing PROMISE JOBS activity or in any transportation payment period of an activity that has not been used for payment adjustment as described in paragraph 93.11(3)“d,” an overpayment is considered to have occurred. The amount to recover will be the difference between the amount for the actual number of days attended and the amount for 75 percent of normally scheduled days.

93.12(2) The PROMISE JOBS worker shall make the referral to the department of inspections, appeals, and licensing by recording the overpayment in the overpayment recovery system.

93.12(3) The department of inspections, appeals, and licensing shall notify the participant or the provider when it is determined that an overpayment exists as described in 441—subrule 11.2(2).

a. Notification shall include the amount, date, and reason for the overpayment. Upon the participant’s request, PROMISE JOBS shall provide additional information regarding the computation of the overpayment.

b. The participant may appeal the computation of the overpayment and any action to recover the overpayment through benefit reduction in accordance with 441—Chapter 2506.

93.12(4) A PROMISE JOBS overpayment shall be recovered through repayment in part or in full. Repayments received by PROMISE JOBS shall be transmitted to the department.

a. Overpayments of child care assistance issued for July 1999 and any month thereafter are subject to recovery rules of the child care assistance program set forth in rule 441—170.9(237A).

b. Reserved.

93.12(5) When a participant or a provider offers repayment in part or in full before the end of the 30-day appeal period, PROMISE JOBS or the department's local office will accept the payment. The amount of the voluntary repayment shall not be returned to the participant or provider unless the final decision on the appeal directs the department to do so. If a subsequent appeal request is received, the PROMISE JOBS unit shall notify the department of inspections, appeals, and licensing and shall not accept any further payments on the claim.

93.12(6) When a participant or a provider has been referred to the department of inspections, appeals, and licensing to initiate recovery, the department of inspections, appeals, and licensing shall use the same methods of recovery as are used for the FIP program as described in 481—Chapter 90, except that the FIP grant shall not be reduced to effect recovery without the participant's written permission.

a. When the participant requests grant reduction on a form prescribed by the department, the grant will be reduced for repayment as described in rule 441—46.25(239B).

b. The department of inspections, appeals, and licensing is authorized to take any reasonable action to effect recovery of provider overpayments, such as but not limited to informal agreements, civil action, or criminal prosecution. However, the department of inspections, appeals, and licensing shall not take any collection action on a provider overpayment that would jeopardize the participant's continued participation in the PROMISE JOBS program.

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441—93.13(239B) Resolution of participation issues. PROMISE JOBS participants who do not carry out the responsibilities of the FIA shall be considered to have chosen the LBP as described in 441—subrule 41.24(8). The participation issues listed in this rule are those that are important for effective functioning in the workplace or training facility and for the completion of the FIA.

93.13(1) *Notification of participation issue.* When participants appear to be choosing an LBP by not carrying out the FIA responsibilities, the PROMISE JOBS worker shall send one written reminder letter as specified in subrule 93.10(1). The written reminder letter shall:

- a.* Clearly identify the participation issue and the specific action needed to resolve it,
- b.* Clarify expectations,
- c.* Attempt to identify barriers to participation that should be addressed in the FIA,
- d.* Explain the consequences of the LBP, and
- e.* Offer supervisory intervention.

93.13(2) *Participation issues.* Actions that may cause participants to be considered as having chosen the LBP when the participant does not have a problem or barrier to participation as defined at paragraph 93.4(5) "a" or rule 441—93.14(239B) are:

a. *Tardiness.* Participants who, for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence, are more than 15 minutes late to a scheduled FIA activity without good cause or a barrier to participation.

b. *Failure to attend scheduled activities.* Participants who do not, for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence, appear for scheduled appointments, participate in assessment activities, including taking required vocational or aptitude tests, complete or provide required forms other than those described in subrule 93.10(3) or are absent from activities designated in the FIA.

c. *Absence from work experience.* Participants who do not, for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence, notify

work experience sponsors or the PROMISE JOBS worker of an absence within one hour of the time at which they are due to appear.

d. Disruptive behavior. Participants who exhibit disruptive behavior for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence. “Disruptive behavior” means the participant hinders the performance of other participants or staff, refuses to follow instructions, uses abusive language, or is under the influence of alcohol or drugs.

e. Unsatisfactory performance or participation. Participants whose performance or participation in an FIA activity continues to be unsatisfactory after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

f. Physical threats. Participants who make physical threats to other participants or staff and have not provided written documentation from a doctor, licensed psychologist, probation officer, or law enforcement official after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

(1) “Physical threat” means having a dangerous weapon in one’s possession and either threatening with or using the weapon or committing assault.

(2) The documentation must verify that the act was caused by either a temporary problem or a serious problem or barrier that needs to be included in the FIA. The documentation must also provide reasonable assurance that the threatening behavior will not occur again.

g. Accepting work experience assignments. Participants who do not accept work experience assignments when the work experience is part of the FIA and do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

h. Work experience interviews. Participants who do not appear for work experience interviews for a second time after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1) at the first occurrence.

i. Employment and other work activity issues. Participants who do not follow up on job referrals, who refuse offers of employment or other work activity, who reduce hours of employment or other work activity, who terminate employment or other work activity, or who are discharged from employment or other work activity.

(1) At the time of the occurrence, PROMISE JOBS shall send a letter to the participant. The letter shall give the participant an opportunity to resolve the issue by accepting a previously refused employment offer if available, returning to previously terminated employment, if available, obtaining comparable employment, or demonstrating a problem or barrier that caused the failure.

(2) Reserved.

j. Failure to secure child care. Participants who do not secure adequate child care when registered or licensed facilities are available after PROMISE JOBS sends one written reminder as described in subrule 93.13(1) and when PROMISE JOBS has provided the participant with resources for locating adequate child care.

k. Inappropriate use of funds. Participants for whom child care, transportation, or educational services become unavailable as a result of failure to use PROMISE JOBS funds or child care assistance funds to pay the provider or failure to provide required receipts and who do not demonstrate a problem or barrier that caused the failure after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1).

l. Failure to follow training plan. Education participants who do not follow the requirements of a training plan in the FIA as described in rule 441—93.8(239B).

m. Failure to renegotiate the FIA. When a participant fails to respond to the PROMISE JOBS worker’s request to renegotiate the FIA because the participant has not attained self-sufficiency by the date established in the FIA, after PROMISE JOBS sends one written reminder letter as described in subrule 93.13(1), an LBP shall be imposed regardless of whether the request to renegotiate is made before or after expiration of the FIA.

93.13(3) Choosing an LBP.

a. Before determining that a participant has chosen the LBP due to a potential participation issue, the PROMISE JOBS worker shall make every effort to negotiate a solution and determine:

(1) Whether the participant has a problem that provides good cause for the participation issue as described in rule 441—93.14(239B). If so, the participant shall be encouraged to take actions to fulfill the FIA.

(2) Whether participant circumstances indicate that a barrier to participation exists as described in subrule 93.4(5). If so, the FIA shall be negotiated to address the barrier.

b. The participant may be considered to have chosen the LBP when all of the following occur:

(1) The participant is notified of a participation issue as described in subrule 93.13(1);

(2) The participant does not resolve the participation issue;

(3) The participant does not present acceptable evidence of a problem providing good cause for the issue as described in rule 441—93.14(239B); and

(4) The participant does not present acceptable evidence of a barrier to participation as described in subrule 93.4(5) or fails to renegotiate the FIA to address the identified barrier.

c. If the resolution process does not lead to fulfillment of the FIA, the case shall be referred for review.

(1) The department retains control and oversees review procedures even when another agency is contracted with to provide PROMISE JOBS services.

(2) Reserved.

d. If the above steps do not lead to fulfillment of the FIA, the FIP participant is considered to have chosen the LBP and the notice of decision will be initiated. The notice of decision will inform the participant of:

(1) The action needed to reconsider the LBP as described in 441—subparagraph 41.24(8)“d”(1) and 41.24(8)“e”(3).

(2) Appeal rights under the LBP are described in rule 441—93.15(239B).

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.14(239B) Problems that may provide good cause for participation issues.

93.14(1) Problems leading to less than full participation. Problems affecting participation shall be considered to be of a temporary or incidental nature when the participation can easily be resumed. The following problems may provide good cause for participation of less than the full number of hours identified in the FIA. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described in subrule 93.10(3):

a. Illness of the participant. When a participant is ill more than three consecutive days or if illness is habitual, the PROMISE JOBS worker may require medical documentation of the illness.

b. Illness of family member. When a participant is required in the home due to illness of another family member, the PROMISE JOBS worker may require medical documentation.

c. Family emergency, using reasonable standards of an employer.

d. Bad weather, using reasonable standards of an employer.

e. Absence or tardiness due to participant's or spouse's job interview. When possible, the participant shall provide notice of the interview at least 24 hours in advance including the name and address of the employer conducting the interview. When 24-hour notice is not possible, notice must be given as soon as possible and before the interview.

f. Leave due to the birth of a child. When a child is born after referral, necessary absence shall be determined in accordance with the Family Leave Act of 1993 as amended to August 1, 2024.

g. Court appearance.

h. Attendance at school functions of the participant's children or children in the participant's household.

i. Attendance at required meetings with the department or PROMISE JOBS.

j. Absence due to up to ten holidays per year.

(1) The participant must normally have been scheduled to work, or participate in an unpaid work activity on the given day and the work site or facility is closed due to a holiday, or open but the participant is allowed to take the participant's normally scheduled hours off on a different day.

(2) The holidays included are New Year's Day, Martin Luther King Day, President's Day, Memorial Day, Fourth of July, Labor Day, Veterans Day, Thanksgiving, the day after Thanksgiving, and Christmas.

93.14(2) *Problems leading to refusing or quitting a job or limiting or reducing hours.* The following problems may provide good cause for participation issues of refusing or quitting a job or limiting or reducing hours. PROMISE JOBS may require the participant to provide verification of the problem or barrier as described in subrule 93.10(3):

a. Required travel time from home to the job or available work experience or unpaid community service site exceeds one hour each way. This includes additional travel time necessary to take a child to a child care provider.

b. Except as described in 441—subrule 41.25(5), work offered is at a site subject to a strike or lockout, unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A, commonly known as the Taft-Hartley Act) as amended to August 1, 2024, or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160) as amended to August 1, 2024.

c. The work site violates applicable state or federal health and safety standards or workers' compensation insurance is not provided.

d. The job is contrary to the participant's religious or ethical beliefs.

e. The participant is required to join, resign from or refrain from joining a legitimate labor organization.

f. Work requirements are beyond the mental or physical capabilities as documented by medical evidence or other reliable sources.

g. Discrimination by an employer based on age, race, sex, color, disability, religion, national origin or political beliefs.

h. Work demands or conditions render continued employment unreasonable, such as working without being paid on schedule.

i. Circumstances beyond the control of the participant, such as interruption of regular mail delivery or other disruptions of services.

j. Employment change or termination is part of the FIA.

k. Job does not pay at least the minimum amount customary for the same work in the community.

l. The participant terminates employment in order to take a better-paying job, even though hours of the new job may be less than those in the previous job.

m. The employment would result in the family of the participant experiencing a net loss of cash income. Net loss of cash income results if the family's gross income less necessary work-related expenses is less than the cash assistance the person was receiving at the time the offer of employment is made. Gross income includes, but is not limited to, earnings, unearned income, and cash assistance. Gross income does not include SNAP benefits and in-kind income.

n. The employment changes substantially from the terms of hire, such as a change in work hours or work shift or a decrease in pay rate.

93.14(3) *Other problems.* The PROMISE JOBS worker may identify circumstances that could negatively impact the participant's achievement of self-sufficiency that are not described in subrule 93.14(1) or 93.14(2). When this occurs, the case shall be referred to the department for a determination as to whether the problems are acceptable reasons for:

a. Not participating,

b. Refusing or quitting a job, or

c. Discharge from employment due to misconduct as described in paragraph 93.13(2) "i."

441—93.15(239B) Right of appeal. In accordance with 441—Chapter 2506, each applicant or participant is entitled to appeal and to be granted a hearing over disputes regarding: (1) services being received; (2) services that have been requested and denied, reduced, canceled, or inadequately provided; and (3) overpayments of PROMISE JOBS expense payments.

93.15(1) *Informal resolution process.* When there is a disagreement between the participant and the immediate PROMISE JOBS worker regarding the participant's FIA or participation in PROMISE JOBS components, the participant may request an interview with the supervisor and a decision on the dispute. The supervisor shall schedule a face-to-face interview with the participant within 7 days and issue a decision in writing within 14 days of the participant's request.

93.15(2) *Appeal on the content of the FIA.* A participant shall have the right to appeal the content of the FIA when the informal resolution process described in subrule 93.15(1) does not resolve a disagreement between the participant and the PROMISE JOBS worker.

93.15(3) *Appeal of an alleged violation of PROMISE JOBS program policy.* Participants shall have the right to file a written appeal concerning any alleged violation of a PROMISE JOBS program policy that is imposed as a condition of participation. PROMISE JOBS shall provide the participant with written documentation that specifies the participation requirement in dispute.

93.15(4) *Appeal rights under the LBP.* A participant has the right to appeal the establishment of the LBP only once, at the time the department issues the timely and adequate notice that establishes the LBP. However, when the reason for the appeal is based on incorrect grant computation, an error in determining the eligible group, or another worker error, a hearing shall be granted when the appeal otherwise meets the criteria for hearing.

93.15(5) *Recovery of assistance when a new LBP is established.* Assistance issued pending the final decision of the appeal is not subject to recovery when a new LBP period is established. A new LBP period shall be established when the department is affirmed in a timely appeal of the establishment of the LBP. 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 LBP, or

(2) Within ten days from the date on which a notice establishing the beginning date of the LBP is received. The date on which notice is received is considered to be five days after the date on the notice, unless the intended recipient shows that the recipient 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.

93.15(6) *Request for a hearing on work conditions or availability of workers' compensation coverage.* A participant who is enrolled in the PROMISE JOBS program may request a hearing if dissatisfied with working conditions, the availability of workers' compensation coverage or the wage rate used in determining hours of work experience program participation.

a. When any involved party is dissatisfied with the department's final decision, the dissatisfied party shall be informed of the right to appeal the issue to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, within 20 days of receipt of the decision. The department may assist with the appeal upon request.

b. For the purposes of this rule, the department's final decision shall be considered received the second day after the date that the written decision was mailed, unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery day.

c. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review provided in Iowa Code chapter 17A or as described in 441—Chapter 2506.

[ARC 9281C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—93.16(239B) Resolution of an LBP.

93.16(1) *Resolution process for a first LBP.* For participants who choose a first LBP, the notice of decision shall inform the participant of the action needed to reconsider the LBP as described in 441—subparagraph 41.24(8) “d”(1).

a. The notice of decision establishing a first LBP will inform the FIP participant that the participant may reconsider at any time from the date timely and adequate notice is issued establishing the LBP. The notice of decision will inform the participant that the participant shall contact the department or appropriate PROMISE JOBS office to reconsider the LBP.

b. When the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to begin or resume development of the FIA as described elsewhere in these rules.

c. When the FIA is signed, the PROMISE JOBS worker shall notify the department and the LBP shall be terminated. FIP benefits shall be effective as described in 441—subparagraph 41.24(8) “d”(1).

93.16(2) *Resolution process for a subsequent LBP.* The notice of decision establishing a subsequent LBP will inform the FIP participant of the six-month ineligibility period and that the participant may reconsider at any time following the six-month ineligibility period. To reconsider, the participant must complete significant contact with or action in regard to the PROMISE JOBS program as described in 441—subparagraph 41.24(8) “e”(3).

a. When the six-month ineligibility period ends and the participant contacts either the income maintenance worker or the PROMISE JOBS office, the participant shall be scheduled to sign a new or updated FIA and to begin significant action as described in 441—subparagraph 41.24(8) “e”(3).

b. When the FIA is signed and the participant has satisfactorily completed the significant action, the PROMISE JOBS worker shall notify the department and the LBP shall be terminated. FIP benefits shall be effective as described in 441—subparagraph 41.24(8) “e”(4).

[ARC 9281C, IAB 5/14/25, effective 7/1/25]

441—93.17(239B) Worker displacement grievance procedure. The PROMISE JOBS program shall provide a grievance procedure to address and resolve public complaints regarding the displacement of regular workers with program participants in a work experience placement.

93.17(1) The procedure shall provide that:

a. Complaints must be filed in writing and received by the PROMISE JOBS service provider within one year of the alleged violation.

b. A representative of the PROMISE JOBS service provider must schedule a face-to-face interview with the complainant within 7 days of the date the complaint is filed, to provide the opportunity for informal resolution of the complaint.

c. Written notice of the location, date and time of the face-to-face interview must be provided.

d. An opportunity must be provided to present evidence at the face-to-face interview.

e. The representative of the PROMISE JOBS service provider shall issue a decision in writing within 14 days of the date a complaint is filed.

f. A written explanation must be provided to all involved parties of the right to file a written appeal, according to 441—Chapter 2506, if the opportunity for informal resolution is declined, if a party receives an adverse decision from the PROMISE JOBS service provider, or if there is no decision within the 14-day period.

(1) To be considered, an appeal must be filed with the department within 10 days of the mailing date of the adverse decision or within 24 days of the date a complaint is filed.

(2) An appeal hearing will not be granted until informal resolution procedures have been exhausted, unless a decision has not been issued within 24 days of the complaint filing date.

93.17(2) The department will issue a final decision within 90 days of the date the complaint was filed with the PROMISE JOBS service provider.

93.17(3) Any dissatisfied party will be informed of the right to appeal the decision of the department to the Secretary of Labor, Office of Administrative Law Judges, U.S. Department of Labor, within 20 days of the receipt of the department's final decision.

a. For the purposes of this rule, the department's final decision will be considered received the second day after the date that the written decision was mailed unless the intended recipient can demonstrate that it was not received on the second day after the mailing date. When the second day falls on a Sunday or legal holiday, the time shall be extended to the next mail delivery date.

b. The option to appeal to the Secretary of Labor does not preclude an individual from exercising any right to judicial review as provided in Iowa Code chapter 17A or as described in 441—Chapter 2506.

93.17(4) Upon notice of a complaint or grievance, the PROMISE JOBS office must provide the complaining party with a copy of the grievance procedures, notification of the right to file a formal complaint and instruction on how to file a complaint.

93.17(5) Upon filing a complaint, and at each stage thereafter, each complainant must be notified in writing of the next step in the complaint procedure.

93.17(6) The identity of any person who has furnished information relating to, or assisting in, an investigation of a possible violation must be kept confidential to the extent possible, consistent with due process and a fair determination of the issues.

93.17(7) All employers who participate in the PROMISE JOBS program shall provide assurances that all regular employees are aware of this grievance procedure.

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[Editorial change: IAC Supplement 6/10/26]

TITLE X
SUPPORT RECOVERYCHAPTER 94
CHILD SUPPORT PROMOTING OPPORTUNITIES FOR PARENTS PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—94.1(252B) Definitions.

“Assigned support arrearages” means support arrearages for which all rights have been and will remain assigned to the state of Iowa.

“Designated provider” means any project approved in whole or in part by child support services and approved by the department to assist parents in overcoming the barriers that interfere with fulfilling obligations to their children. Each project must have a project plan approved by the department.

“Incentives” means satisfaction of support obligations and bypass of select enforcement tools, such as license sanction, administrative levy, and contempt.

“Participant” means a person who receives services or incentives through a project.

“Periodic support payment” means the total support payment due in each time period in accordance with the established support obligation. If no current support is due, the periodic support payment is equivalent to the last current support amount as would be ordered under 441—Chapter 98.

“Project plan” means the written policies, procedures, eligibility criteria and other components as described in subrule 94.3(2).

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.2(252B) Purpose and incentives. Child support services may partner with community providers and resources to offer incentives to participants to assist in overcoming barriers to fulfilling their obligations and to encourage participants’ completion of the project. The available incentives include the following:

94.2(1) *Satisfaction of the assigned support arrearages.*

a. A participant will be granted a partial satisfaction of the assigned support arrearages that are and that will remain owed by that participant to the state after that participant’s successful completion of the project and payment of that participant’s periodic support payments. Satisfactions granted under this subrule will apply only to those cases for which periodic support payment is credited.

b. Each satisfaction will be an amount equal to a percentage of that participant’s support arrearages, which are and which will remain owed to the state, according to the following schedule:

(1) A one-time satisfaction after six consecutive months from the participant’s completion of the project. The amount of satisfaction will be a percentage based on the amount of periodic support paid on all qualifying cases as follows:

1. When 100 percent of the periodic support is paid, the satisfaction amount will equal 50 percent of the amount owed to the state.

2. When 99 to 80 percent of the periodic support is paid, the satisfaction amount will equal 40 percent of the amount owed to the state.

3. When 79 to 60 percent of the periodic support is paid, the satisfaction amount will equal 30 percent of the amount owed to the state.

4. When 59 to 40 percent of the periodic support is paid, the satisfaction amount will equal 20 percent of the amount owed to the state.

5. When 39 to 20 percent of the periodic support is paid, the satisfaction amount will equal 10 percent of the amount owed to the state.

6. When 19 to 0 percent of the periodic support is paid, the satisfaction amount will equal 0 percent of the amount owed to the state.

(2) A one-time satisfaction after 12 consecutive months from the participant's completion of the project. The amount of satisfaction will be a percentage based on the amount of periodic support paid on all qualifying cases as follows:

1. When 100 percent of the periodic support is paid, the satisfaction amount will equal 100 percent of the amount owed to the state.
2. When 99 to 80 percent of the periodic support is paid, the satisfaction amount will equal 80 percent of the amount owed to the state.
3. When 79 to 60 percent of the periodic support is paid, the satisfaction amount will equal 60 percent of the amount owed to the state.
4. When 59 to 40 percent of the periodic support is paid, the satisfaction amount will equal 40 percent of the amount owed to the state.
5. When 39 to 20 percent of the periodic support is paid, the satisfaction amount will equal 20 percent of the amount owed to the state.
6. When 19 to 0 percent of the periodic support is paid, the satisfaction amount will equal 0 percent of the amount owed to the state.

c. A participant subject to an income withholding order will be eligible for the satisfaction in this subrule if the sole reason for ineligibility is a disparity between the schedules of the participant's pay date and the scheduled date the payment is due.

d. A participant will be eligible for a satisfaction under this subrule if the participant is no longer a participant but has continued to pay the participant's periodic support payment without interruption.

94.2(2) *Enforcement processes.* Child support services may bypass select enforcement tools if the participant is actively in the project.

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.3(252B) Establishment of designated providers. Child support services may initiate a request for project plans to become designated providers.

94.3(1) *Contents of a request for project plans.* The request for project plans will contain the requirements for contents of the project plan and any other parameter for the specific project being advertised. The request will also contain a deadline by which project plans must be submitted to the department.

94.3(2) *Contents of project plans.* Each project will have and maintain a project plan. At a minimum, the project plan will contain or address the following:

- a. The applicant's experience and success at integrating collaborations and services essential to the project.
- b. The geographic area to be served and community need for projected services.
- c. The projected number of participants to be served and the criteria to be used for the selection and termination of participants.
- d. The specific parenting curriculum to be used. The curriculum must be well-established, have a track record of use and be field-tested.
- e. A description of the components of the curriculum. The components of the curriculum should include personal development, responsible parenting, parenting skills, financial responsibilities, communication skills, and domestic violence prevention.
- f. The schedule, location, hours of instruction and format for administering the curriculum.
- g. A description of the organization and identification of staff responsible for delivering the curriculum. The staff should have experience in group facilitation and be certified trainers in the curriculum.
- h. A clear explanation of how the curriculum and services will be monitored and evaluated, including how the participants will be tracked and what data will be collected.
- i. Project duration.

94.3(3) Amendments to project plan. Participants may submit proposed amendments to their project plan in writing to the department. The department will have the option, after review, of approving or disapproving all proposed amendments to the project plan.

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.4(252B) Selection of designated providers. The department will have sole authority to select designated providers. The department will select which of the project plans received on or before the deadline date will be granted the status of designated providers. The selection of designated providers will be based upon the content of the project plan and must include the following:

1. Applicant's experience.
2. Geographic area selected and community need for the project.
3. Participants to be served and criteria to be used to select participants and terminate their participation.
4. The parenting curriculum to be used.
5. A description of the components of the curriculum.
6. The schedule, location, hours of instruction and format for administering the curriculum.
7. A description of the organization and identification of staff.
8. An explanation of monitoring and evaluation.
9. Project duration.

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.5(252B) Termination of designated providers. The department may immediately terminate child support services' participation with a designated provider if the designated provider is not fulfilling the terms of its project plan or the designated provider is not fulfilling the terms for child support services' participation in the project plan.

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.6(252B) Reports and records.

94.6(1) Reports. Designated providers established under these rules must report to child support services at least monthly unless otherwise mandated by the project plan. These reports must include the following:

- a. Attendance documentation with the names of participants served.
- b. Signed voluntary consent of participants seeking incentives.
- c. Certification of participants completing the curriculum.
- d. Other information as specified in the project plan.

94.6(2) Records retention. Designated providers must retain all records as necessary to meet the requirements of these rules.

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.7(252B) Receipt of incentives. Participants receiving incentives under these rules may continue to receive the incentives after the termination of these rules or after they are no longer participants only under subrule 94.2(1). Subrule 94.2(1) will apply to a participant or former participant for the full time period allowed in that subrule.

[ARC 8960C, IAB 2/19/25, effective 4/1/25]

441—94.8(17A) Right of appeal. Child support services actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8960C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 252B.3(5) and chapter 17A.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 95
CHILD SUPPORT SERVICES

[Prior to 7/1/83, Social Services[770] Ch 95]

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

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—95.1(252B) Definitions.

“*Caretaker*” means a custodial parent, relative, or guardian whose needs are included in an assistance grant paid according to Iowa Code chapter 239B, who is receiving this assistance on behalf of a dependent child, or who is a recipient of nonassistance child support services.

“*Current support*” means those payments received in the amount, manner, and frequency as specified by an order for support and that are paid to the clerk of the district court, the public agency designated as the distributor of support payments as in interstate cases, or another designated agency. Payments to persons other than the clerk of the district court or other designated agency do not satisfy the definition of support pursuant to Iowa Code section 598.22.

“*Date of collection*” means the date that a support payment is received by the department or the legal entity of any state or political subdivision actually making the collection, or the date that a support payment is withheld from the income of a responsible person by an employer or other income provider, whichever is earlier.

“*Dependent child*” means a person who meets the eligibility criteria established in Iowa Code chapter 234 or 239B, and whose support is required by Iowa Code chapter 234, 239B, 252A, 252C, 252F, 252H, 252K, 598 or 600B, and any other comparable chapter.

“*Obligee*” means any person or entity entitled to child support or medical support for a child.

“*Obligor*” means a parent, relative, or guardian or any other designated person who is legally liable for the support of a child or a child’s caretaker.

“*Prepayment*” means payment toward an ongoing support obligation when the payment exceeds the current support obligation and amounts due for past months are fully paid.

“*Public assistance*” means assistance provided according to Iowa Code chapter 239B or 249A, the cost of foster care provided by the department according to Iowa Code chapter 234, or assistance provided under comparable laws of other states.

“*Responsible person*” means a parent, relative, or guardian or any other designated person who is or may be declared to be legally liable for the support of a child or a child’s caretaker. For the purposes of calculating a support obligation pursuant to the mandatory child support guidelines prescribed by the Iowa Supreme Court in accordance with Iowa Code section 598.21B, this means the person from whom support is sought.

“*Support*” means child support or medical support or both for purposes of establishing, modifying, or enforcing orders and means spousal support for purposes of enforcing an order.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.2(252B) Child support eligibility and services.

95.2(1) *Public assistance cases.* Child support services will provide paternity establishment and support establishment, modification and enforcement services as appropriate, under federal and state laws and rules for children and families referred to child support services who have applied for or are receiving public assistance. Referrals under this subrule may be made by the family investment program (FIP), the Medicaid program, the foster care program, or agencies of other states providing child support services under Title IV-D of the Social Security Act as amended to August 1, 2024, for recipients of public assistance.

95.2(2) *Nonpublic assistance cases.* The same services provided by child support services for public assistance cases will also be made available to any person not otherwise eligible for public assistance. A person who is not on public assistance requesting services under this chapter will complete and submit to child support services a form prescribed by the department, or an electronic

version of such application, for each parent from whom the person is seeking support. The person requesting services has the option to seek support from one or both of a child's parents. Child support services will not require an application from the following:

- a.* Persons not receiving public assistance for whom an agency of another state providing Title IV-D child support services has requested services.
- b.* Persons for whom a foreign country as defined in Iowa Code chapter 252K has requested services.
- c.* Persons who are eligible for continued services upon termination of assistance under the family investment program or Medicaid.

95.2(3) *Services available.* Except as provided by separate rule, child support services will provide the same services to persons receiving public assistance and persons not receiving public assistance. Child support services will determine the appropriate enforcement procedure to be used. The services are limited to the establishment of paternity, the establishment and enforcement of child support obligations and medical support obligations, and the enforcement of spousal support orders if the spouse is the custodial parent of a child for whom the department is enforcing a child support or medical support order.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.3(252B) Crediting of current and delinquent support. The amounts received as support from the obligor will be credited as the required support obligation for the month in which they are collected. Any excess will be credited as delinquent payments, will be applied to the immediately preceding month, and then will be applied to the next immediately preceding month until all excess has been applied. Funds received as a result of federal tax offsets will be credited according to rule 441—98.30(252B).

The date of collection will be determined as follows:

95.3(1) *Payments from income withholding.* Payments collected as the result of income withholding are considered collected in the month in which the income was withheld by the income provider. The date of collection will be the date on which the income was withheld.

a. For the purpose of reporting the date the income was withheld, the department will notify income providers of the requirement to report the date income was withheld and will provide a form prescribed by the department to those income providers who manually remit payments. When reported on this form or through other electronic means or multiple account listings, the date of collection will be used to determine support distributions. When the date of collection is not reported, support distributions will initially be issued based on the date of the check. If proof of the date of collection is subsequently provided, any additional payments due the recipient will be issued.

b. When the collection services center (CSC) is notified or otherwise becomes aware that a payment received from an income provider pursuant to 441—Chapter 98 includes payment amounts such as vacation pay or severance pay, these amounts are considered irrevocably withheld in the months documented by the income provider. When the income provider does not document the months for which the sums are withheld, the amounts will initially be distributed based on the date of the check. If documentation is subsequently provided, any additional payments due the recipient will be issued.

95.3(2) *Payments from state or political subdivisions.* Payments collected from any state or political subdivision are considered collected in the same month the payments were actually received by that legal entity or the month withheld by an income provider, whichever is earlier. Any state or political subdivision transmitting payments to the department will be responsible for reporting the date the payments were collected. When the date of collection is not reported, support distributions will be initially issued based on the date of the state's or political subdivision's check. If proof of the date of collection is subsequently provided, any additional payments due the recipient will be issued.

95.3(3) *Additional payments.* An additional payment in the month that is received within five calendar days prior to the end of the month will be considered collected in the next month if:

- a.* CSC is notified or otherwise becomes aware that the payment is for the next month, and
- b.* Support for the current month is fully paid.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.4(252B) Prepayment of support. Prepayment that is due to the obligee will be sent to the obligee upon receipt by the department and will be credited as payment of future months' support. Prepayment that is due the state will be distributed as if it were received in the month when due. Support is prepaid when amounts have been collected that fully satisfy the ongoing support obligation for the current month and all past months.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.5(252B) Lump sum settlement.

95.5(1) Any lump sum settlement of child support involving an assignment of child support payments will be negotiated in conjunction with child support services. Child support services will be responsible for the determination of the amount due the department, including any accrued interest on the support debt computed in accordance with Iowa Code section 535.3 for court judgments. This determination of the amount due will be made in accordance with 45 CFR Section 302.51 (as amended to August 1, 2024). The department may waive collection of the accrued interest when negotiating a lump sum settlement of a support debt if the waiver will facilitate the collection of the support debt.

95.5(2) Child support services is responsible for the determination of the department's entitlement to all or any of the lump sum payment in a paternity action.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.6(17A) Appeals. Nonreceipt of support collected by the department that is to be paid to the obligee may be appealed pursuant to the procedures provided in this rule if the obligee claims that the payment was credited to the incorrect month in accordance with subrules 95.3(1), 95.3(2), and 95.3(3).

95.6(1) Contact. Obligees who believe they have not received all or part of a support payment to which they are entitled in accordance with subrules 95.3(1), 95.3(2), and 95.3(3) must first contact a customer service representative and indicate that they have not received the payment.

- a.* An obligee may contact a customer service representative by telephone or in writing.
- b.* The department will acknowledge this contact in writing, indicating the months at issue.

95.6(2) Written decision. Within 30 days of the contact, the department will issue a written decision on all contested support distributions based on the date of collection.

95.6(3) Initiation of appeal. If the department denies some or all support payments that are claimed based on the date of collection, the obligee may initiate an administrative appeal.

a. To initiate an administrative appeal, the obligee will make a written request to child support services indicating an intent to appeal.

b. The time limit for initiating an administrative appeal is governed by 441—subrule 2506.4(7). The time limit provided in 441—subrule 2506.4(7) will start with the date that a written decision as required by subrule 95.6(2) is issued.

c. If no written decision has been issued after 30 days, the obligee may appeal the failure to issue a written decision. The appeal may be initiated at any time after 30 days and before a written decision is issued.

95.6(4) Limitation of appeals. Appeals will be limited to claims based on child support received by the department during the nine-month period before the month in which the appeal is initiated.

95.6(5) Appeal process. Except as specifically provided in this rule, administrative appeals are governed by 441—Chapter 2506.

95.6(6) Appeal issue. The issue in appeals held pursuant to these procedures will be limited to the obligee's entitlement to a support payment that has been collected by the department.

[ARC 8961C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—95.7(252B) Termination of services.**95.7(1) Case closure criteria.**

a. Child support services may terminate services when a case meets at least one of the following case closure criteria and child support services maintains supporting documentation for the case closure decision in the record:

(1) There is no ongoing support obligation and arrearages are under \$500 or unenforceable under state law.

(2) The noncustodial parent or alleged father is deceased and no further action, including a levy against the estate, can be taken.

(3) The noncustodial parent is living with the minor child as the primary caregiver, the custodial parent is deceased, and there is no assignment to the state of support or of arrearages that accrued under the support order.

(4) Child support services cannot establish paternity because:

1. The child is at least 18 years old and the statute of limitations bars an action to establish paternity;

2. A genetic test or a court or administrative process has excluded the alleged father and no other alleged father can be identified;

3. Child support services has determined that it would not be in the best interest of the child to establish paternity in a case that involves incest or rape or a case in which legal proceedings for adoption are pending; or

4. The identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview by child support services with the recipient of services.

(5) The noncustodial parent's location is unknown and child support services has made diligent efforts to locate the noncustodial parent using multiple sources, in accordance with regulations in 45 CFR Section 303.3 (as amended to August 1, 2024), all of which have been unsuccessful, within the applicable time frame:

1. Over a three-year period when there is sufficient information to initiate an automated locate effort.

2. Over a one-year period when there is not sufficient information to initiate an automated locate effort.

(6) Child support services has determined that, throughout the duration of the child's minority (or after the child has reached the age of majority), the noncustodial parent cannot pay support and shows no evidence of support potential because the parent has been institutionalized in a psychiatric facility, is incarcerated, or has a medically verified total and permanent disability. Child support services must also determine that the noncustodial parent has no income or assets available above the subsistence level that could be levied or attached for support.

(7) The noncustodial parent's sole income is from supplemental security income (SSI) payments.

(8) The noncustodial parent is a citizen of and lives in a foreign country, does not work for the federal government or a company with headquarters or offices in the United States, and has no reachable domestic income or assets and there is no federal or state treaty or reciprocity with the country.

(9) In a case involving child support services to a person who is not a recipient of public assistance, child support services has provided location-only services.

(10) Child support services has received a written or verbal request from the recipient of services to close the case and there is no assignment to the state of support or of arrearages that accrued under the support order.

(11) In a case involving child support services to a recipient of public assistance, there has been a finding of good cause or other exception in a public assistance case as specified in 441—subrules 41.3(6) through 41.6(10) and 75.14(3), including a determination that support enforcement may not proceed without risk or harm to the child or caretaker relative.

(12) In a case involving child support services to a person who is not a recipient of public assistance or who is a recipient of public assistance receiving Medicaid only, child support services has received information that the address in child support services' record is no longer current and child support services is unable to contact or otherwise locate the recipient within 60 days following receipt of this information despite a good-faith effort to contact the recipient through at least two different methods.

(13) In a case involving child support services to a person who is not a recipient of public assistance or who is a recipient of public assistance receiving Medicaid only, the recipient of services has failed to cooperate with child support services, which documented the circumstances of the noncooperation, and an action by the recipient of services is essential for the next step in providing services. More information is contained in rule 441—95.11(252B).

(14) Child support services documents failure by the initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), to take an action that is essential for the next step in providing services.

(15) The initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), has notified child support services that the initiating agency has closed its case.

(16) The initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), has notified child support services that its intergovernmental services are no longer needed.

(17) Another assistance program, including IV-A, IV-E, SNAP, and Medicaid, has referred to child support services a case for which it is inappropriate to establish, enforce, or continue to enforce a child support order and the custodial or noncustodial parent has not applied for child support services.

(18) The case meets any other basis for case closure based upon federal law.

b. Child support services may terminate services when no support or arrearages that accrued under the support order are assigned to the state and the recipient of services requested child support services to close the case to allow the tribal IV-D agency to start providing services under that program.

c. Child support services will close a case and maintain supporting documentation for the case closure decision when the following criteria have been met:

(1) Child support services is notified that the child is eligible for health care services from the Indian Health Service (IHS); and

1. The IV-D case was opened because of a Medicaid referral based solely upon health care services, including the Purchased/Referred Care Program, provided through an Indian health program as defined in 25 U.S.C. Section 1603(12) (as amended to August 1, 2024); and

2. The recipient of services requests that child support services close the case.

(2) Child support services receives instructions for case closure from an initiating agency as defined under 45 CFR Section 301.1 (as amended to August 1, 2024). Within ten working days, child support services will stop the income withholding order or notice and close the intergovernmental IV-D case.

95.7(2) Case closure notifications. In cases meeting one of the criteria of subrule 95.7(1), except subparagraph 95.7(1)“a”(9), 95.7(1)“a”(10), or 95.7(1)“a”(11), child support services will send notification of its intent to close the case to the recipient of services or the initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), in writing 60 calendar days before case closure. The notice will be sent to the recipient of services or the state requesting services at the last-known address stating the reason for denying or terminating services, the effective date, and an explanation of the right to request a hearing according to 441—Chapter 2506. Closure of the case following notification is subject to the following:

a. If, in response to the notice, the recipient of services or the initiating agency, as defined under 45 CFR Section 301.1 (as amended to August 1, 2024), supplies information that could lead to the establishment of paternity or a support order or enforcement of an order, the case will be kept open.

b. If the case is to be closed because child support services was unable to contact the recipient of services, as provided in subparagraph 95.7(1)“a”(12), the case shall be kept open if contact is reestablished with the recipient of services before the effective date of the closure.

c. The recipient of services may request to have child support services reopen the case at a later date if there is a change in circumstances that could lead to the establishment of paternity or a support order or enforcement of an order by completing a new application and paying any applicable fee.

d. If the recipient of services specifically authorizes consent for electronic notifications, child support services may elect to notify the recipient of services electronically of child support services' intent to close the case. Child support services must maintain documentation of the recipient's consent in the case record.

[ARC 8961C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—95.8(252B) Child support services attorney.

95.8(1) *State's representative.* An assistant attorney general, assistant county attorney, or independent contract attorney employed by or under contract with child support services represents only the state of Iowa. The sole attorney-client relationship for the child support services attorney is between the attorney and the state of Iowa. A private attorney acting under Iowa Code section 252B.6A is not a child support services attorney and is not a party to the action.

95.8(2) *Provision of services.* The special role of the child support services attorney is limited by the attorney-client relationship between the attorney and the state of Iowa. The provision of legal services by the child support services attorney is limited as follows:

a. The child support services attorney will not represent any person or entity other than the state of Iowa in the course of the attorney's employment by or contractual relationship with child support services.

b. Child support services will issue written disclosure of the attorney-client relationship between the attorney and the state of Iowa to recipients of child support services and to all parties in a review and adjustment proceeding.

95.8(3) *Communication concerning case circumstances.*

a. Child support services will provide case status information upon written request by any recipient of child support enforcement services or any party under the review and adjustment procedure unless otherwise prohibited by state or federal statute or rules pertaining to confidentiality.

b. All communications with other parties will be directed to those parties personally unless a licensed attorney has entered an appearance or notified child support services in writing that the attorney is representing a party. If any party is represented by counsel, all communications will be directed to counsel for that party.

c. When a party is receiving public assistance, child support services will refer any suspected fraud or questionable FIP expenditures to the appropriate governmental agencies.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.9(252B) Effective date of support. For all original orders established by child support services, the effective date of the support obligation under the orders will be the twentieth day following the date the order is prepared by child support services unless otherwise specified.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.10(252B) Continued services available to canceled FIP or Medicaid recipients. Support services will automatically be provided to persons who were eligible to receive support services as recipients of FIP or Medicaid and who were canceled from FIP or Medicaid. Continued support services will not be provided to a person who has been canceled from FIP or Medicaid when a claim of good cause, as defined at 441—Chapter 41 or 75, as appropriate, was valid at the time assistance was canceled or when one of the reasons for termination of services included in rule 441—95.7(252B) applies to the case.

Support services will be provided to eligible persons without application or application fee, subject to applicable enforcement fees.

95.10(1) *Notice of services.* When a family is no longer eligible for public assistance, the department will forward a form prescribed by the department to the family's last-known address within five working days of the notification of ineligibility to inform the family of the following:

- a. Unless the family notifies the department to the contrary, services will continue.
- b. The effect of continuing to receive support services, including the available services and the state's policies on fees, cost recovery, and distribution.

95.10(2) *Termination of services.*

a. A person may request that the department terminate support services at any time by completing and returning a form prescribed by the department, or in any other form of written communication, to child support services.

b. Continued support services may be terminated at any time for any of the reasons included in rule 441—95.7(252B).

95.10(3) *Reapplication for services.* A person whose services were denied or terminated may reapply for services by completing the application process described in subrule 95.2(2).

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.11(252B) Cooperation of public assistance recipients in establishing and obtaining support. If a person who is a recipient of FIP or Medicaid is required to cooperate with child support services in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the following apply:

95.11(1) *Cooperation defined.* The person will cooperate in good faith in obtaining support for persons whose needs are included in the assistance grant or Medicaid household, except when good cause or other exception as defined in 441—Chapter 41 or 75 for refusal to cooperate is established.

a. The person will cooperate in the following areas:

- (1) Identifying and locating the parent of the child for whom assistance or Medicaid is claimed.
- (2) Establishing the paternity of a child born out of wedlock for whom assistance or Medicaid is claimed.
- (3) Obtaining support payments for the person and the child for whom assistance is claimed and obtaining medical support for the person and child for whom Medicaid is claimed.

b. Cooperation includes the following actions by the person if the action is requested by child support services:

- (1) Providing the name of the noncustodial parent and additional necessary information.
- (2) Appearing at child support services to provide verbal or written information or documentary evidence known to, possessed by, or reasonably obtained by the person that is relevant to achieving the objectives of the child support program.
- (3) Appearing at judicial or other hearings, proceedings, or interviews.
- (4) Providing information or attesting to the lack of information under penalty of perjury.
- (5) If the paternity of the child has not been legally established, submitting to blood or genetic tests pursuant to a judicial or administrative order. The person may be requested to sign a voluntary affidavit of paternity after being given notice of the rights and consequences of signing such an affidavit as required by Iowa Code section 252A.3A. However, the person will not be required to sign an affidavit or otherwise relinquish the right to blood or genetic tests.

c. The person will cooperate with child support services to the extent of supplying all known information and documents pertaining to the location of the noncustodial parent and taking action as may be necessary to secure or enforce a support obligation, establish paternity, or secure medical support. A person's cooperation with child support services includes completing and signing a form prescribed by the department, if requested, as well as documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

95.11(2) *Failure to cooperate.* Child support services will make the determination of whether a person has cooperated. Child support services will promptly send notice of a determination of noncooperation to the person on a form prescribed by the department and notify the FIP and Medicaid programs, as appropriate, of the noncooperation determination and the reason for the determination. The FIP and Medicaid programs will take appropriate sanctioning actions as provided in statute and rules.

95.11(3) *Good cause or other exception.*

a. A person who is a recipient of FIP assistance may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—Chapter 41.

b. A person who is a recipient of Medicaid may claim a good cause or other exception for not cooperating, taking into consideration the best interests of the child as provided in 441—Chapter 75.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.12(252B) Cooperation of public assistance applicants in establishing and obtaining support. If a person who is an applicant of FIP or Medicaid is required to cooperate in establishing paternity; in establishing, modifying, or enforcing child or medical support; or in enforcing spousal support, the requirements in 441—Chapters 41 and 75 apply. The appropriate staff in the FIP and Medicaid programs are designees of child support services to determine noncooperation and issue notices of that determination until the referral to child support services is completed.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.13(252B) Cooperation in establishing and obtaining support in nonpublic assistance cases.

95.13(1) *Requirements.* The person receiving nonpublic assistance support services will cooperate with child support services by meeting all the requirements of rule 441—95.11(252B), except that the person may not claim good cause or other exception for not cooperating.

95.13(2) *Failure to cooperate.* Child support services will make the determination of whether or not the nonpublic assistance applicant or recipient of services has cooperated. Noncooperation will result in termination of support services. An applicant or recipient may also request termination of services under subparagraph 95.7(1) “a”(10).

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.14(252B) Charging pass-through fees. Pass-through fees are fees or costs incurred by the department for service of process, genetic testing, and court costs if the entity providing the service charges a fee for services. Child support services may charge pass-through fees to persons who receive continued services according to 441—95.10(252B) and to other persons receiving nonassistance services, except no fees may be charged to an obligee residing in a foreign country or to a foreign country if child support services is providing services under paragraph 95.2(2) “b.”

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.15(252B) Reimbursing assistance with collections of assigned support. For an obligee and child who currently receive assistance under FIP, the full amount of any assigned support collection that the department receives will be distributed according to rule 441—95.10(252B) and retained by the department to reimburse the FIP assistance.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.16(252B) Child support account. Child support services will maintain a child support account for each client. The account, representing money due the department, will cover all periods of time public assistance has been paid, commencing with the date of the assignment. Child support services will not maintain an interest-bearing account.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.17(252B) Emancipation verification. Child support services may verify whether a child will emancipate according to the provisions established in the court order prior to the child's eighteenth birthday.

95.17(1) Verification process. Child support services will send a form prescribed by the department to the obligor and obligee on a case if child support services has an address.

95.17(2) Return information. The obligor and obligee will be asked to complete and return the form to child support services. Child support services will use the information provided by the obligor or obligee to determine if the status of the child indicates that any previously ordered adjustments related to the obligation and a child's emancipation are necessary on the case.

95.17(3) Failure to return information. If the obligor and obligee fail to return the questionnaire, child support services will apply the earliest emancipation date established in the support order to the case and implement changes in support amounts required in the support order.

95.17(4) Conflicting information returned. If conflicting information is returned or made known to child support services, child support services will have the right to verify the child's status through sources other than the obligor and obligee.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

441—95.18(17A) Right of appeal.

95.18(1) Under this chapter, an administrative appeal pursuant to 441—Chapter 2506 will be limited to the following issues:

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—95.6(17A), or a dispute based on the date of collection has not been acted on in a timely manner.

b. A termination in services has occurred as provided in rule 441—95.7(252B).

95.18(2) A hearing will not be granted under 441—Chapter 2506 when an appellant has a complaint about child support services collections actions other than those described in this rule. This includes the collection of an annual fee for child support services as specified in Iowa Code chapter 252B.

[ARC 8961C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—95.19(17A) Appeal record. The record in an administrative appeal under this rule will include, in addition to those materials specified in Iowa Code section 17A.12(6), the notice of appeal and the verbatim record of the hearing.

[ARC 8961C, IAB 2/19/25, effective 4/1/25]

These rules are intended to implement Iowa Code chapters 252B, 252C, 252D and 17A.

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 [Editorial change: IAC Supplement 6/10/26]

◇ Two or more ARCs

¹ Effective date of 95.1, definition of “Date of collection,” and 95.3 delayed 70 days by the Administrative Rules Review Committee at its meeting held September 15, 1999; delayed until the end of the 2000 Session of the General Assembly at its meeting held October 11, 1999.

CHAPTER 96 INFORMATION AND RECORDS

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—96.1(252B) Access to information and records from other sources. In addition to statutes and other rules, the following entities shall provide information and records based on the following methods of requesting the information and within the following time frame:

96.1(1) *Oral or written request.* All persons and entities, including all for-profit, nonprofit, and governmental employers, must, within 15 days of receipt of a request, provide child support services or a child support agency of another state information on the employment, compensation, and benefits of any individual employed by the person or entity as an employee or contractor if child support services or the agency is providing services in relation to that individual. The request may be made orally, by letter, by form or by other written request listed in subrule 96.1(3); however, the fine and procedures described in rules 441—96.2(252B) through 441—96.6(252B) only apply if the request was by a written request listed in subrule 96.1(3).

96.1(2) *Subpoena.* All persons and entities shall comply with a child support services subpoena, issued by child support services, or an Administrative Subpoena, OMB Control No. 0970-0152, or its successor, issued by child support services or a child support agency of another state, as provided in Iowa Code section 252B.9. Child support services or a child support agency of another state may issue a subpoena regarding more than one individual. The person or entity must provide the information and records as directed in a form prescribed by the department or the Administrative Subpoena.

96.1(3) *Time to reply to a written request.* A person or entity who is sent any of the following must provide the information and records requested in the manner requested to child support services or child support agency of another state, as appropriate, within 15 days of the date of the request:

a. Any form prescribed by the department that requests information described in subrule 96.1(1).

b. A child support services subpoena, or an Administrative Subpoena, OMB Control No. 0970-0152, or its successor, as provided in subrule 96.1(2), from child support services or from a child support agency of another state.

c. A written request or form as provided in subrule 96.1(1) from a child support agency of another state.

[ARC 8962C, IAB 2/19/25, effective 4/1/25]

441—96.2(252B) Refusal to comply with written request or subpoena.

96.2(1) A parent or putative father in a support or paternity proceeding in which child support services or a child support agency of another state is providing services who fails to comply with a request or subpoena as provided in subrule 96.1(3) shall be subject to license sanctioning as provided in 441—Chapter 98.

96.2(2) An entity or a person who is not a parent or putative father as described in subrule 96.2(1) may refuse to comply under the circumstances provided in rule 441—96.3(252B).

[ARC 8962C, IAB 2/19/25, effective 4/1/25]

441—96.3(252B) Procedure for refusal.

96.3(1) *No information.* A person or entity who does not have any information or records requested or subpoenaed must respond as follows:

a. If the request or subpoena is a form from child support services under paragraph 96.1(3) “a” or “b,” the person or entity must sign and return to child support services the appropriate portion of the form indicating the lack of information or records.

b. If the request or subpoena is one listed in paragraph 96.1(3) “c,” the person or entity must send the child support agency of the other state a signed and dated written statement indicating the lack of information or records.

96.3(2) *Good cause.* The person or entity may claim good cause for refusing to comply as required in Iowa Code section 252B.9.

a. To claim good cause, the person or entity must file a request for a conference by mailing or submitting a written request to child support services that issued the request or subpoena within 15 days of the issuance of the request or subpoena.

b. If a child support agency of another state issued the request or subpoena, the person or entity may request a conference with child support services or with the child support agency of the other state. The person or entity shall request a conference with child support services by mailing or submitting a written request and a copy of the subpoena or document received from the child support agency of the other state to child support services. The person or entity must request a conference with the child support agency of the other state by following the requirements of that state's laws and regulations.

[ARC 8962C, IAB 2/19/25, effective 4/1/25]

441—96.4(252B) Conference conducted.

96.4(1) *Request or subpoena issued by child support services.* If child support services issued the request or subpoena, child support services will notify the person or entity and conduct a conference within ten days of receipt of the request for a conference. At the request of either child support services or the person or entity, the conference may be rescheduled one time. The conference may be conducted in person or by telephone.

96.4(2) *Request or subpoena issued by other state.* If a conference with child support services is requested based upon a request or subpoena issued by a child support agency of another state, the department will request that agency send an interstate referral and appropriate information to child support services or central registry.

a. Child support services will notify the person or entity and conduct a conference within ten days of opening a case based upon an interstate referral and appropriate information. If child support services does not receive an interstate referral and appropriate information within 60 days of the department's request, the request or subpoena received under subrule 96.1(3) shall be void, and child support services will notify the person or entity that the request or subpoena is void.

b. The voiding of a request or subpoena under this subrule does not prevent the issuance of subsequent requests or subpoenas.

96.4(3) *Submission of information.* On or before the conference date, the person or entity must submit information to child support services that demonstrates a mistake in the identity of the person or entity, or a mistake in the identity of the individual who is the subject of the request or subpoena, or that demonstrates a specific prohibition under federal law to release the information or records. Child support services may extend the time to conduct the conference an additional ten days to allow time for the person or entity to provide the information.

96.4(4) *Notice of findings.* Following the conference, child support services will issue a notice pursuant to Iowa Code section 252B.9.

[ARC 8962C, IAB 2/19/25, effective 4/1/25]

441—96.5(252B) Fine assessed.

96.5(1) *Conditions resulting in fine.* Child support services will assess a fine of \$100 per refusal and notify the person or entity of the fine if any one of the following applies:

a. Ten days have passed since child support services issued a notice under subrule 96.4(4) stating child support services determined there is no good cause to refuse to comply with the request or subpoena, and the information or records have not been received.

b. Fifteen days have passed since child support services issued the request or subpoena and the information or records have not been received, nor has the person or entity filed a request for a conference.

c. Fifteen days have passed since a child support agency of another state has issued the request or subpoena, and that agency sends an interstate referral to child support services requesting enforcement of the request or subpoena because the information or records were not received.

96.5(2) *Definition of refusal.* One refusal is a refusal to supply information or records based on one written request, or one subpoena regarding one or more individuals.

96.5(3) *Notification of fine.* If child support services assesses a fine, child support services will notify the person or entity by regular mail with proof of service completed according to Rule of Civil Procedure 1.442. The person or entity shall have 30 days from the date of the notice to pay the fine.

[ARC 8962C, IAB 2/19/25, effective 4/1/25]

441—96.6(252B) Objection to fine or failure to pay.

96.6(1) *Objection filed.* The person or entity may object to the imposition of the fine by filing an application for judicial review in district court within 30 days of issuance of the notice of the fine and sending a copy of the application to child support services.

96.6(2) *Petition to compel.* If the person or entity fails to pay the fine imposed and does not file an application for judicial review within the time provided in this rule, child support services may file a petition to compel the person or entity to comply with the request, subpoena or fine in district court in the county in which the underlying support order or pending matter is filed. If there is no support order or pending matter filed in district court in Iowa, then child support services may file the petition in the county in which the person resides or the person or entity has its principal place of business.

96.6(3) *Certification to court.* If the person, entity, or child support services files an action in district court, child support services will certify a copy of the following, as appropriate, to the court prior to a hearing:

- a. Proof of service of the request or subpoena.
- b. Proof of service of the notice of assessment of a fine.
- c. Written decision following a conference.

96.6(4) *Failure to comply with court order.* Failure of the person or entity to comply with an order of the district court will be subject to enforcement through contempt of court.

[ARC 8962C, IAB 2/19/25, effective 4/1/25]

441—96.7(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8962C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

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CHAPTER 97
COLLECTION SERVICES CENTER

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—97.1(252B) Definitions. The definitions of terms used in this chapter will follow those terms defined in rule 441—95.1(252B) with the exception or addition of the following:

“Collection services center” means the public agency designated to receive, record, monitor, and disburse support payments as defined in Iowa Code section 598.1, 252B.15 or 252D.16, in accordance with Iowa Code sections 252B.13A and 252B.14.

“Correlated non-IV-D case” means a non-IV-D case where income withholding information must be maintained by child support services in order to properly process an income withholding payment because the obligor has both a non-IV-D and a current or former IV-D case.

“Electronic funds transmission” means, for purposes of this chapter, the use of a NACHA-approved child support format for the electronic transmission of funds to the collection services center.

“Employee” means the same as defined in Iowa Code section 252G.1.

“Former IV-D case” means a case that previously received services from child support services under rule 441—95.2(252B) but currently receives only payment processing services from the collection services center.

“Insufficient funds payment” means a support payment by check or other financial instrument that is dishonored, not paid, or the funding of the payment is determined to be inadequate.

“IV-D case” means a case that receives services from child support services under rule 441—95.2(252B), including payment processing services from the collection services center.

“NACHA-approved child support format” means a child support payment transmission format approved by the National Automated Clearing House Association (NACHA).

“Non-IV-D case” means a support order that never received services from child support services under rule 441—95.2(252B) but that receives payment processing services from the collection services center for income withholding payments.

“Obligee” means the guardian, custodial parent, person, or entity entitled to receive support payments.

“Obligor” means a parent, relative, or any other person declared to be legally liable for the support of a child or the custodial parent or guardian of the child.

“Payor of income” means the same as defined in Iowa Code section 252D.16.

“Support payment” means the same as “support” or “support payments” as defined in Iowa Code section 252D.16.

“Website” means the website operated by the department for the purpose of allowing a payor of income to make a support payment through electronic transmission to the collection services center.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.2(252B) Transfer of records and payments. For non-IV-D cases, the clerk of court shall provide core case information to child support services upon the filing of a new income withholding order or upon the request of child support services. “Core case information” means information listed in paragraphs 97.2(1) “a” and “b” and subrule 97.2(2). For IV-D and correlated non-IV-D cases, the clerk of court shall provide detailed case information to child support services upon request. After the establishment of a case, child support services will send notices of transfer to obligors and obligees based upon case type.

97.2(1) Transfer of information on non-IV-D and correlated non-IV-D cases.

a. In non-IV-D cases, child support services will request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:

- (1) The obligor’s name and address.
- (2) The obligee’s name and address.

- (3) The court order numbers.
- b.* In correlated non-IV-D cases, child support services will request the following information necessary for the receipt, recording and disbursement of payments from the clerk of the district court:
 - (1) The obligor's name and address.
 - (2) The obligee's name and address.
 - (3) The court order numbers.
 - (4) The income withholding order.
- c.* The clerk of the district court must provide case information to child support services on a regular basis when an income withholding order is filed with a clerk of court or when child support services requests the information in order to process a payment.
- d.* Child support services will automatically create cases for payment processing based upon the information received from the clerks of court.

97.2(2) *Transfer of information on IV-D cases.* In IV-D cases, the clerk of the district court shall provide child support services with the following information if the information has been provided to the clerk upon request of child support services:

- a.* The obligee's name, date of birth, last-known mailing address, the social security number if known and, if different in whole or part, the names of the persons to whom the obligation of support is owed by the obligor.
- b.* The name, birth date, social security number, and last-known mailing address of the obligor.
- c.* A copy of all support orders that establish or modify a support amount.
- d.* The names, social security numbers, and dates of birth of any minor dependents for whom support is ordered, if available.
- e.* A record of any support payments received by the clerk of district court prior to the transfer of case information and any payments received by the collection services center and the date of transfer to the collection services center.
- f.* A record of any determination of controlling order under the Uniform Interstate Family Support Act.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.3(252B) Support payment records. Each IV-D, former IV-D and non-IV-D case type shall have an official payment record.

97.3(1) *Official records for cases.* The official payment records for each case type are maintained by a designated entity.

- a.* The collection services center will establish, maintain and certify the official support payment records for IV-D or former IV-D cases.
- b.* The clerk of the district court shall establish, maintain and certify the official support payment records for non-IV-D and correlated non-IV-D cases. The collection services center will establish and maintain records for receipt and disbursement of income withholding payments for these cases but will not certify these records as the complete payment record.

97.3(2) *Informal conference for payment records.* Child support services will provide an informal conference or desk review regarding the contents of any support payment record to the obligor or obligee upon request.

- a.* In IV-D or former IV-D cases, the conference shall be available to review the payment record and to answer questions of the obligee or obligor regarding the accuracy of the record.
- b.* In non-IV-D and correlated non-IV-D cases, the conference shall be available to review the accuracy of the contents of any record of income withholding payments.

97.3(3) *Certified payment records.* Child support services will provide certified copies of the official support payment records as described in paragraph 97.3(1) "a" in accordance with Iowa Code section 252B.9.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.4(252B) Method of payment. Payments will be accepted in specific forms from obligors and payors of income.

97.4(1) Form of payment. Except as otherwise provided in this rule and in rule 441—97.5(252D), support payments may be paid in the form of cash, check, bank draft, money order, preauthorized withdrawal of funds, or other financial instrument, and sent by mail to the collection services center or by electronic transmission of funds.

97.4(2) Treatment of insufficient funds payments. Child support services will have a process in place to handle insufficient funds payments.

a. An obligor submitting an insufficient funds support payment to the collection services center will be required to submit payments by cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

b. A payor of income submitting an insufficient funds support payment to the collection services center is required to submit payments through electronic funds transmission, cash, bank draft, or money order for a period of up to 12 months unless waived by the collection services center.

c. Insufficient funds payments will not be credited to the collection services center account for the obligor or will be removed from the account if credited before sufficiency was verified. Insufficient funds support payments will be subject to additional collection by the collection services center for the dishonored amount.

d. The collection services center may not process additional payments other than cash, bank drafts or money orders from an obligor or payor of income who has previously submitted insufficient funds payments without first verifying the payment. The collection services center will have a process in place to allow the obligor or the payor of income the opportunity to replace any additional moneys submitted for payment of support before processing in order to avoid additional insufficient funds entries into the official payment records on the affected cases.

97.4(3) Distribution of payment. Nonincome withholding support payments received by the collection services center in IV-D, former IV-D, non-IV-D, or correlated non-IV-D cases that are not directed to a specific account or support obligation will first be applied proportionately to the current support obligation on all cases for the obligor and, secondly, to the support arrearages owed by the obligor.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.5(252D) Electronic transmission of payments. Payors of income must electronically transmit to the collection services center the amounts withheld under an income withholding order.

97.5(1) Thresholds for electronic funds transmission. A payor of income must transmit payment through electronic funds transmission if either of the following applies:

a. The payor of income employs 100 or more employees and uses an agent for payroll processing.

b. The payor of income employs 200 or more employees.

97.5(2) Use of the website. Unless paragraph 97.4(2) “*b*” applies, a payor of income required to use electronic funds transmission under subrule 97.5(1) may elect to submit payments electronically by using the website if the payor of income determines that using electronic funds transmission would cause undue hardship.

97.5(3) Implementing electronic funds transmission. A payor of income implementing electronic funds transmission shall complete all the following in advance of transmitting payments electronically:

a. Contact child support services to obtain file layout and case reconciliation information.

b. Provide to the collection services center:

(1) The contact information for the person responsible for electronic funds transmission for the payor of income or the payor of income’s agent for payroll processing;

(2) The contact information for the person responsible for payroll accounts for the payor of income or the payor of income’s agent for payroll processing;

(3) The name and address of the authorized financial institution from which the payment will be withheld; and

(4) A sample file layout in a NACHA-approved child support format and, if necessary, a test file in a NACHA-approved child support format.

c. If needed upon review by the collection services center:

(1) Make corrections to the file layout to meet a NACHA-approved child support format, and

(2) Provide a corrected copy to the collection services center for review.

d. Upon approval of the file layout by the collection services center, provide an implementation date before the first submission of payment through electronic funds transmission.

97.5(4) *Maintaining information and file format after implementation.* A payor of income that has implemented electronic funds transmission shall:

a. Transmit both payment amounts and detailed information records in accordance with a NACHA-approved child support format.

b. Advise the collection services center of a payment error within two business days.

c. Provide the collection services center ten working days' advance notice when changing between NACHA-approved child support formats.

d. Correct case number or file problems identified by the collection services center before sending any additional files.

97.5(5) *Exemption from electronic transmission.* To avoid undue hardship, a payor of income that has fewer than 200 employees or a payor of income that has fewer than 100 employees and uses an agent for payroll processing is exempt from using electronic transmission unless subrule 97.4(2) applies.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.6(252B) Authorization of payment. The collection services center must authorize the generation of payments for support paid. The collection services center will issue payments as follows:

97.6(1) *Submittal of information to department of administrative services.* In order to disburse payments to the obligee within two working days, the collection services center will submit information daily to the department of administrative services to issue a warrant or electronic file transfer (EFT) payment to the obligee.

97.6(2) *Release of funds.* The following workday, an electronic transfer of funds will be sent to the designated account of the obligee or an alternate account to be accessed by the obligee through an electronic access card, or if subrule 97.6(5) applies, a state warrant may be sent by regular mail to the last-known address of the obligee.

97.6(3) *Electronic transfer.* Obligees who want electronic transfer of support payments to a designated account shall complete a form prescribed by the department and submit it to the collection services center. Unless subrule 97.6(5) applies, any obligee not using automatic deposit to a designated account will be issued an electronic access card for receipt of support payments.

97.6(4) *Walk-ins.* Support payments will not be hand-delivered to the obligee on a walk-in basis.

97.6(5) *Warrants.* The collection services center may authorize generation of a warrant if any one of the following conditions applies:

a. Generation of a warrant is necessary to meet federal requirements to disburse a payment to an obligee within two working days when electronic transfer is not feasible.

b. The obligee has not requested automatic deposit to a designated account of the obligee, and payment is from a source that is nonrecurring or is not expected to continue in a 12-month period.

c. The obligee has not requested automatic deposit to a designated account of the obligee and has asserted in writing on a form prescribed by the department that one of the exemptions listed in this paragraph applies. To claim an exemption, the obligee must return the form prescribed by the department to the collection services center within ten days of the date the form was issued. An

exemption granted under this paragraph is subject to periodic review by the collection services center. The exemptions available under this paragraph are:

- (1) A physical disability imposes a hardship in accessing an electronically transferred payment.
- (2) A mental disability imposes a hardship in accessing an electronically transferred payment.
- (3) A language barrier imposes a hardship in accessing an electronically transferred payment.
- (4) A literacy barrier imposes a hardship in accessing an electronically transferred payment.
- (5) The obligee's home and work addresses are more than 30 miles from an automated teller machine and more than 30 miles from a financial institution where the account funds can be accessed.

d. The representative payee, court appointee, or trustee notifies the collection services center or unit in writing that one of the following applies:

- (1) The obligee is under a court-ordered guardianship or conservatorship.
- (2) The obligee is involved in other legal proceedings, including bankruptcy, which require payments to be sent to a trustee or other representative payee.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.7(252B) Processing misdirected payments. If the collection services center receives a payment for which a corresponding obligee cannot be identified, the collection services center will contact the person or entity that directed the payment to obtain additional information. Payments inappropriately directed to the collection services center will be returned to the person or entity sending the payment.

[ARC 8963C, IAB 2/19/25, effective 4/1/25]

441—97.8(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8963C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 17A and sections 252B.13A through 252B.17 and 252D.17.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—98.1(252E) Definitions.

“Current support” means an amount for the ongoing support of a child and means the same as “support” as defined in Iowa Code section 252D.16.

“Delinquent support” means a payment, or portion of a payment, including interest, not received by the clerk of the district court or other designated agency at the time it was due. In addition, delinquent support will also include payments for parental liabilities not received as specified pursuant to 441—Chapter 156.

“Federal nontax payment” means an amount payable by the federal government that is subject to administrative offset for support under the federal Debt Collection Improvement Act, PL 104-134 (April 26, 1996).

“Medical support” means the same as defined in Iowa Code section 252E.1.

“Mistake of fact” means a mistake in the identity of the obligor or whether the delinquency meets the criteria for referral.

“Obligee” means the same as defined in Iowa Code section 252E.1.

“Obligor” means the same as defined in Iowa Code section 252E.1.

“Offsets” means a federal income tax refund or federal nontax payment as described in rule 441—98.30(252B).

“Setoffs” means a state income tax refund, rebate or payment owed to a person by a state agency as described in the process found at 701—Chapter 26 and in rules 441—98.28(252B) and 441—98.29(252B).

[ARC 8964C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—98.2(252E) Medical support health benefit plan information.

98.2(1) *Information from an employer.* Child support services will gather information concerning a health benefit plan an employer may offer an obligor as follows:

a. Child support services may send a form prescribed by the department whenever a potential employer is identified.

b. Child support services will secure information about health care coverage from a known employer on a form prescribed by the department when a form prescribed by the department or an order has been forwarded to the employer pursuant to Iowa Code section 252E.4.

98.2(2) *Information from an obligor.* Child support services may secure medical support information from an obligor on a form prescribed by the department.

98.2(3) *Disposition of information.* Child support services will provide the information:

a. To the Medicaid agency and to the obligee, when requested, when the dependent is a recipient of Medicaid.

b. To the obligee, when requested, when the dependent is not a recipient of Medicaid.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.3(252E) Medical support insurer authorization. When the obligor does not provide to the insurer the signed documents necessary to enroll and process claims for the dependent for whom support is ordered, the insurer is authorized to accept the signature of the obligee or the department’s designee on necessary forms. For purposes of this chapter, the third-party liability unit is the department’s designee when support is assigned.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.4(252E) Medical support enforcement.

98.4(1) *Medical support enforcement.* Medical support may be enforced pursuant to Iowa Code section 252E.12.

98.4(2) *Health care coverage.*

a. If an obligor was ordered to provide health care coverage under an order but did not comply with the order, child support services may implement the order by forwarding to the employer a copy of the order, an ex parte order as provided in Iowa Code section 252E.4, or on a form prescribed by the department.

b. If child support services implements an order under this subrule, child support services will send a notice to the obligor at the last-known address of the obligor by regular mail. The notice will contain the following information:

- (1) A statement of the obligor's right to an informal conference.
- (2) The process to request an informal conference.
- (3) The obligor's right to file a motion to quash with the district court.

98.4(3) *Termination of employment.* When child support services receives information indicating the obligor's employment has terminated, child support services will secure the status of the health benefit plan by sending a form prescribed by the department to the employer.

If no response is received within 30 days of sending a form prescribed by the department, child support services will send a second request on a form prescribed by the department to the employer.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.5(252E) Contesting enforcement of medical support. The obligor may contest the enforcement of medical support by means of an informal conference with child support services, or by filing a motion to quash.

98.5(1) *Motion to quash.* Procedures for filing a motion to quash the order are specified under Iowa Code sections 252D.31 and 252E.6A.

98.5(2) *Informal conference.*

a. The obligor will be entitled to only one informal conference for each new employer to which child support services has forwarded a form prescribed by the department or an order under Iowa Code section 252E.4 to enforce medical support.

b. Procedures for the informal conference are as follows:

(1) Child support services will inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with child support services if the obligor believes the enforcement was entered in error.

(3) The obligor shall request an informal conference in writing, within 15 calendar days from the date of the notice of the right to an informal conference, or at any time if a mistake of fact regarding the identity of the obligor is believed to have been made.

(4) Child support services will schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) Child support services may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time will be scheduled by child support services.

(7) Child support services will issue a written decision to the obligor within ten calendar days of the conference.

c. The issues to be reviewed at the conference shall be as follows:

- (1) Whether the identity of the obligor is in error.
- (2) Whether the obligor is already providing health care coverage for the dependent.
- (3) Whether the availability of dependent health care coverage is in error.
- (4) Whether the obligor was ordered to provide health care coverage under the support order.

d. The results in an informal conference will in no way affect the right of the obligor to file a motion to quash the order under Iowa Code section 252E.6A.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.6(252D) Income withholding of delinquent support. When there is a delinquency in an amount equal to the support payable for one month as specified by an order for support or reimbursement order and child support services is providing services under 441—Chapter 95, child support services will enter an order to withhold the obligor's income not exempt by state or federal law to require the income withheld to be paid to the collection services center to pay the support obligation. An income withholding order will also be entered to collect the unpaid balance of a judgment for the reimbursement of a support debt when a repayment schedule is not specified in the order establishing the judgment.

[ARC 8964C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—98.7(252D) Income withholding amounts. Child support services will determine the amount to be withheld by the employer or other income providers as follows:

98.7(1) *Current support obligation exists.* When a current support obligation exists, the amount withheld will be an amount equal to the current support obligation, and an additional amount equal to 20 percent of the current support obligation to be applied toward the liquidation of any delinquency.

98.7(2) *Current obligation ended.* When the current support obligation has ended or has been suspended, the income withholding order will remain in effect until any delinquency has been satisfied. The amount withheld will be equal to the amount of the most recent prior current support obligation that is greater than zero. However, in the following circumstances, the amount withheld will be 20 percent of the amount owed for current support at the time the obligation ended or was suspended:

- a.* There has been a change of court-ordered physical care from the obligee to the obligor.
- b.* The obligee and obligor have reconciled and have obtained a modification ending the current support obligation.
- c.* The current obligation is suspended through the suspension process.
- d.* In a foster care case, the order for parental liability ended when the child left placement, or an order ending the liability has been entered and the child in foster care has returned to the home of a parent ordered to pay parental liability. In this situation, the amount withheld will be reduced to 20 percent of the current support amount when the obligation ended, but only for the parent with whom the child resides.

98.7(3) *No support ordered.* When there is no current child support ordered and the obligation is solely the result of a judgment that does not specify a repayment schedule, the withholding amount will be set at the amount for one person from the family investment program (FIP) schedule of basic needs.

98.7(4) *Lump-sum income source.* Notwithstanding subrules 98.7(1), 98.7(2), and 98.7(3), when the obligor is paid by a lump-sum income source, the withholding amount may include all current and delinquent support due through the current month. Lump-sum income includes income received in a sole payment or in payments that occur at two-month or greater intervals.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.8(252D) Amendment of amount of withholding due to hardship.

98.8(1) *Request for amendment.* If subrule 98.7(2) or 98.7(3) applies, the obligor may request at any time an amendment of the amount withheld as payment toward the delinquency or reimbursement on the grounds of hardship. The obligor must submit the request in writing to child support services.

98.8(2) *Hardship criterion.* Hardship exists if the obligor's income is equal to or less than 200 percent of the poverty level for one person according to the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. Section 9902(2) (as amended to August 1, 2024).

- a.* If hardship is claimed by the obligor, child support services may verify income from:
 - (1) The employer or other income provider of the obligor.
 - (2) The obligor.
 - (3) The state employment security agency.
 - (4) Other records available in accordance with Iowa Code section 252B.9.
- b.* If the hardship criterion is met, the amount withheld as payment toward the delinquency may be amended as follows:

(1) The obligor's gross yearly income will be divided by 200 percent of the established yearly gross poverty level income for one person. That amount will be multiplied by .5. The resulting figure will be multiplied by the most recent prior current support obligation or the amount determined pursuant to subrule 98.7(3), as applicable, to determine the amended amount. Notwithstanding this calculation, the amended amount will not be less than \$15 per month.

(2) If criteria for withholding 20 percent toward liquidation of any delinquency are also met, the lesser of 20 percent or the amended amount determined in subparagraph 98.8(2)“b”(1) is to be withheld.

98.8(3) *Hardship period.* If the hardship criterion in subrule 98.8(2) is met, child support services will grant the amended amount of withholding for a period of two years, subject to the provisions of subrule 98.8(6). However, if the obligor is receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits, the obligor is deemed to continue to meet the hardship criterion for the duration of those benefits.

98.8(4) *Denying requests.* A hardship request may be denied if:

- a.* The criterion in subrule 98.8(2) is not met.
- b.* The obligor has been granted an amended amount of withholding based on this rule within the last two years and that hardship period will not expire in less than 30 days.
- c.* The obligor's previous hardship period expired within the last six months and, within 30 days prior to the expiration date of the previous hardship period, the obligor did not submit the following to child support services:

- (1) A written request for hardship; or
- (2) Verification of the obligor's income, and child support services was not able to verify the obligor's income as described in paragraph 98.8(2)“a.”

98.8(5) *Notice requirements.* Child support services will provide written notification to the obligor of the result of the hardship request.

a. When a hardship request is granted, the written notification will include the amended amount of withholding and the date the hardship period will expire.

b. When a hardship request is denied, the written notification will include the reason for denial.

98.8(6) *Termination of hardship prior to expiration date.* The hardship period will automatically end, regardless of expiration date, if any of the following occurs:

- a.* A current support obligation is added to the support order.
- b.* The current support obligation was previously suspended and is reinstated.
- c.* The delinquency has been paid in full.
- d.* The obligor was receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits at the time the hardship request was granted, and child support services has verified that the obligor is no longer receiving social security disability benefits, social security retirement benefits, or supplemental security income disability benefits.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.9(252D) Immediate income withholding. Immediate withholding of income pursuant to Iowa Code section 252D.8 is automatic without additional notice to the obligor unless:

98.9(1) *Good cause exists.* Good cause is found to exist by the court or child support services. For purposes of this rule, “good cause” is defined as the posting of a secured bond by the obligor

sufficient to pay all current and future child support obligations, including any delinquency that may accrue.

98.9(2) *Written agreement exists.* A written agreement is reached between both parties that provides for an alternative arrangement for payment of child support subject to the following conditions:

a. Unless approved by child support services, written agreements between the obligee and obligor to waive immediate income withholding become void when child support is assigned to this state or to another state pursuant to a statute of that jurisdiction.

b. All payments pursuant to any written agreement will be paid as directed in Iowa Code sections 252B.14 and 598.22.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.10(252D) Approval of request for immediate income withholding. When the obligee or other party to the proceeding requests immediate withholding, child support services will determine whether the request will be approved.

98.10(1) *Basis for approval.* Approval of a request for immediate income withholding by child support services may be based on:

a. Past payment record of the obligor that demonstrates an inconsistent compliance with the support order.

b. Whether the state of Iowa is providing public assistance.

98.10(2) *Request denied.* Child support services may not approve a request for immediate income withholding on cases where no public assistance has been expended and there is a prior written agreement between the obligee and obligor that has been approved by court order.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.11(252D) Immediate income withholding amounts. The amount withheld will be the amount of the current support obligation as specified in the support order. If a judgment for accrued support is established in the support order, the amount withheld will be the amount due for current support and the periodic payment amount due for the accrued support as specified in the order. If no periodic payment for the accrued support is established in the support order, the amount withheld will be the amount due for current support plus 10 percent of the amount of the current obligation to be applied to the accrued support.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.12(252D) Immediate income withholding amounts when current support has ended. When the child support obligation has ended, the amounts to be withheld will be in accordance with subrule 98.7(2).

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.13(252D,252E) Income withholding for medical support. An income withholding order or notice of income withholding may also include provisions for enforcement of medical support when medical support is included in the support order. The income withholding order or notice of income withholding may require implementation of dependent health care coverage pursuant to Iowa Code chapter 252E or the withholding of a dollar amount for medical support. Amounts withheld for medical support will be determined in the same manner as amounts withheld for child support.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.14(252D,252E) Maximum amounts to be withheld for income withholding. An income withholding order or a notice issued by child support services will require that the employer or other income provider withhold no more than the maximum amounts allowed under the Federal Consumer Credit Protection Act, 15 U.S.C. Section 1673(b) (as amended to August 1, 2024).

98.14(1) The amount of income subject to withholding will be limited to 50 percent of the nonexempt disposable income of the obligor unless there is more than one support order for which the

obligor is obligated and the criteria of 15 U.S.C. Section 1673(b) (as amended to August 1, 2024) are met, or the obligor agrees to a greater amount within these limits.

98.14(2) Disposable income means that part of the earnings of any individual remaining after the deduction from those earnings of any amounts mandated by law to be withheld.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.15(252D) Income withholding for multiple obligations. In the event that an obligor has more than one support obligation that is being enforced by child support services, child support services may enter an income withholding order to enforce each obligation. The amount specified to be withheld on the delinquency under the income withholding order or notice will be determined in accordance with rule 441—98.7(252D).

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.16(252D) Income withholding notice to employer and obligor. Child support services will send the obligor and the employer or other income provider a notice of income withholding as follows:

98.16(1) Notice to employer. Child support services may send notice to the employer or other income provider by regular mail or by electronic means in accordance with Iowa Code chapter 252D. If child support services is sending notice by regular mail, it will send a form prescribed by the department or a notice in the standard format prescribed by 42 U.S.C. Section 666(b)(6)(A) (as amended to August 1, 2024). If child support services is sending the notice by electronic means, it may include notice of more than one obligor's order and need only state once provisions that are applicable to all obligors, such as the information in paragraphs 98.16(1) "d," "f," "g," and "i." The statement of provisions applicable to all obligors may be sent by regular mail or electronic means. The notice of income withholding will contain information such as the following:

- a. The obligor's name and social security number.
- b. The amount of current support to withhold.
- c. The amount of support to withhold for payment of delinquent support, if any.
- d. The amount an income provider may deduct for costs of processing each support payment.
- e. The child support case number.
- f. The location to which payments are sent.
- g. The maximum amount that can be withheld for payment of support as specified in rule 441—98.14(252D,252E).
- h. The method to calculate net income.
- i. Responsibilities of the income provider as specified in Iowa Code section 252D.17.
- j. Responsibility, if any, of the income provider to enroll the obligor's dependent for coverage under a health benefit plan.

98.16(2) Notice to obligor. A form prescribed by the department will be sent to the last-known address of the obligor by regular mail. The notice will contain the following information:

- a. A statement of the obligor's right to an informal conference.
- b. The process to request an informal conference.
- c. The obligor's right to claim hardship criteria and the process for a claim.
- d. The obligor's right to file a motion to quash the income withholding order or notice with the district court.
- e. The information provided to the employer or other income provider, or a copy of the notice sent to the employer or other income provider.
- f. The amount of any delinquency.

98.16(3) Standard format. As provided in Iowa Code section 252D.17, an order or notice of an order for income withholding will be in a standard format and on a form prescribed by the department. Child support services will make a copy of the form available to the state court administrator and the Iowa state bar association.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.17(252D) Contesting the income withholding. The obligor may contest the income withholding by means of an informal conference with child support services or by filing a motion to quash.

98.17(1) *Motion to quash.* Procedures for filing a motion to quash the order or the notice of income withholding are specified in Iowa Code chapter 252D.

98.17(2) *Informal conference.*

a. The obligor will be entitled to only one informal conference for each new or modified income withholding order or notice issued by child support services that specifies a new or modified total amount to withhold.

b. Procedures for the informal conference are as follows:

(1) Child support services will inform the obligor in writing of the right to request an informal conference.

(2) The obligor may request an informal conference with child support services if the obligor believes the withholding is in error.

(3) The obligor will request an informal conference in writing.

(4) Child support services will schedule an informal conference within 15 calendar days of the receipt of a written request from the obligor or the obligor's representative.

(5) Child support services may conduct the conference in person or by telephone.

(6) If the obligor fails to attend the conference, only one alternative time will be scheduled by child support services.

(7) Child support services will issue a written decision to the obligor within ten calendar days of the conference.

(8) If child support services has not complied with rule 441—98.7(252D), it will then adjust the income withholding amount.

c. The issues to be reviewed at the conference will be as follows:

(1) For all income withholding orders or notices, whether:

1. The identity of the obligor is in error.

2. The amount of the current support obligation is in error.

(2) For orders or notices resulting from the existence of a delinquency, whether:

1. The amount of delinquent support is in error.

2. For income withholding orders or notices, whether the guidelines described at rule 441—98.7(252D) were followed.

(3) For immediate income withholding orders or notices, whether the criteria of rules 441—98.9(252D) and 441—98.10(252D) were appropriately applied.

d. The results of an informal conference will in no way affect the right of the obligor to file a motion to quash the income withholding order or notice with the court.

98.17(3) *Income withholding issued from another state.* Child support services will follow procedures for a motion to quash or a request for hardship or conduct an informal conference based on an income withholding order or notice issued in another state only if child support services is providing services under 441—Chapter 95.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.18(252D) Termination of income withholding. Child support services may, by ex parte order, terminate an income withholding order under the following conditions:

98.18(1) *Order entered in error.* Child support services will terminate an income withholding order upon determination that the order was entered in error as follows:

a. The person named as the obligor in the income withholding order is not the person required to provide support under the support order being enforced.

b. For orders resulting from the existence of a delinquency, the required minimum delinquency did not exist at the time the income withholding order was entered.

98.18(2) *No support due.* In cases for which services are being provided by child support services, child support services will terminate an income withholding order previously entered by child support services when the current support obligation has terminated and when the delinquent support obligation has been fully satisfied as applicable to all of the children covered by the income withholding order. In no case will payment of overdue support be the sole basis for termination of withholding.

98.18(3) *Other circumstances.* Child support services may revoke an income withholding order under other circumstances provided the conditions of Iowa Code chapter 252D are met.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.19(252D) Modification of income withholding. Child support services may modify a previously issued income withholding order or notice according to the guidelines established under rule 441—98.7(252D) if it is determined that:

98.19(1) *Current support obligation changed.* There has been a change in the amount of the current support obligation.

98.19(2) *Amount in error.* The amount required to be withheld under the income withholding order or notice is in error as follows:

a. The amount required to be withheld as current support is not the amount specified in the order for support being enforced.

b. The guidelines established in rule 441—98.7(252D) were not followed.

98.19(3) *Past-due support paid.* Any past-due support debt has been paid in full. The withholding order or notice will be modified to require that only the current support obligation be withheld from the income of the obligor. Should a delinquency later accrue, the withholding order or notice may again be modified to secure an additional payment toward the delinquency. The amount of the arrears payment will be set at 20 percent of the current support amount.

98.19(4) *Income withholding and determination of controlling orders.* An obligation amount different from what child support services has been enforcing is established upon the determination of controlling order as allowed in Iowa Code section 252K.207. Upon the change to the new obligation amount, the amount withheld to be applied toward the liquidation of any delinquency will be 20 percent.

98.19(5) *Income withholding and review and adjustment of orders.* Child support services has conducted a review of the obligation pursuant to 441—Chapter 99. Child support services will modify the amount withheld to be applied toward the liquidation of any delinquency to 20 percent upon completion of the review and adjustment process.

98.19(6) *Implementation or termination of amended amount of withholding due to hardship.* Child support services has determined that the withholding order should be modified based upon the hardship provisions in rule 441—98.8(252D).

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.20(252D) Refunds of amounts improperly withheld. Child support services will refund to the obligor any amounts improperly withheld and received by the department under an income withholding order or notice issued by child support services, subject to the following:

98.20(1) *Services provided by the department.* Only those amounts received by the department during the period enforcement services are being provided are subject to refund.

98.20(2) *Satisfaction of amount to withhold.* No refund will be made unless amounts have been collected that fully satisfy the amount specified in the income withholding order or notice for the withholding period during which income has been generated.

98.20(3) *When issued.* Any amounts received in excess of the amounts specified in the order or notice to withhold will be issued to the obligor within 30 days of discovery by child support services unless the obligor requests in writing that these amounts be credited toward the delinquency or future child support. If there is a dispute regarding whether there is an overpayment, the obligor may request

an informal conference by following the procedures set out in subparagraphs 98.17(2) “b”(3) through (7). This procedure will not preclude the obligor from utilizing other civil remedies.

98.20(4) *Recovery by child support services.* The department may recover payments from the obligee in excess of those described in subrule 98.20(2) that have been received by the department and improperly forwarded to the obligee.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.21(96) Child support intercept of unemployment insurance benefits. When the department of workforce development notifies child support services that an individual who owes a child support obligation being enforced by child support services has been determined to be eligible for unemployment insurance benefits, child support services will enforce a child support obligation that is owed by an obligor but is not being met by intercept of unemployment insurance benefits. “Owed but not being met” means either current child support not being met or arrearages that are owed.

98.21(1) *Withholding.* Child support services will intercept unemployment insurance benefits by initiating a withholding of income pursuant to Iowa Code chapter 252D and this chapter. The amount to be withheld through a withholding of unemployment insurance benefits will not exceed the amount specified in 15 U.S.C. Section 1673(b) (as amended to August 1, 2024).

98.21(2) Reserved.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.22(252B) Administrative seek employment order. Child support services may enter an ex parte order requiring the obligor to seek employment in accordance with Iowa Code section 252B.21.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.23(252B) Effective date of seek employment order. The seek employment order will be effective 15 days after issuance of the order to the obligor. This 15-day period will serve as advance notice to the obligor.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.24(252B) Method and requirements of reporting for administrative seek employment order. The obligor shall complete a form prescribed by the department, which will be submitted to child support services on a weekly basis throughout the duration of the order unless the obligor has a valid reason for not complying with the order. The obligor will document at least five new attempts to find employment on the form each week. The same employer may not be reported more than once per week.

The obligor will include the names, addresses, and the telephone numbers of each of the five employers or businesses with whom the obligor attempted to seek employment and the name of the individual contact to whom the obligor made application for employment or to whom the inquiry was directed.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.25(252B) Reasons for noncompliance of administrative seek employment. Upon verification, certain conditions will be considered valid reasons for noncompliance. At the request of child support services, the obligor will provide verification of any reason for noncompliance with the order when the information is not available to child support services through online sources. Valid reasons for noncompliance and acceptable verification are:

98.25(1) *Receipt of social security, supplemental security income (SSI), or FIP.* Receipt of social security, SSI, or FIP is considered a valid reason for noncompliance when verified by information contained in online sources available to child support services or written verification from the agency providing the benefits.

98.25(2) *Temporary illness or disability.* Temporary illness or disability of the obligor or other household member is considered a valid reason upon receipt of a completed form prescribed by the department verifying the obligor's inability to seek or accept employment.

98.25(3) *High school student.* Attending high school is considered a valid reason upon verification from the high school.

98.25(4) *Incarceration.* Incarceration is considered a valid reason when verified through online information available to child support services or on receipt of verification from the institution.

98.25(5) *Substance use disorder treatment.* Participating in a supervised substance use disorder treatment program that is associated with a treatment center is considered a valid reason upon verification from the treatment center.

98.25(6) *Job training.* Participation in a job-training or job-seeking program through the department of employment services as a result of receiving benefits from the Supplemental Nutrition Assistance Program is considered a valid reason upon receipt of verification from the department of employment services.

98.25(7) *Employment or self-employment.* Employment or self-employment is considered a valid reason upon verification through the employer for those employed or through tax documents or business records for those self-employed.

98.25(8) *Payment of support.* Payment on the account equal to the amounts prescribed for income withholding in accordance with rule 441—98.7(252D) throughout the duration of the seek employment order is considered a valid reason upon verification of payments posted to the Iowa collection and reporting (ICAR) system.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.26(252B) Administrative seek employment method of service. The seek employment order will be served on the obligor by regular mail. Proof of service will be completed according to Rule of Civil Procedure 1.442.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.27(252B) Administrative seek employment order duration of order. The seek employment order will remain in effect for three months from the date of issuance unless child support services determines the obligor has a valid reason for noncompliance as specified at rule 441—98.25(252B), at which time the order becomes unenforceable.

Upon acceptance of the reason for noncompliance, child support services will notify the obligor that the obligor is no longer required to comply with the seek employment order. Upon denial of the reason for noncompliance, child support services will notify the obligor that the obligor will comply with the existing seek employment order. The notice will be filed with the clerk of the district court. If the obligor disputes this decision, the obligor will have recourse through the district court.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.28(252B) Setoff against payment owed to a person by a state agency. The department will make a claim pursuant to 701—Chapter 26 against a payment owed to an obligor by a state agency when support is delinquent and the case qualifies for setoff. Any setoff received as the result of a claim against a payment owed to an obligor will be applied to court-ordered support that the department is attempting to collect pursuant to Iowa Code chapter 252B.

98.28(1) *Case selection.* The department will submit periodically a list of obligors who are delinquent at least \$50 in support payments to the department of revenue.

98.28(2) *Distribution of setoff amount.* Setoffs will be applied in accordance with rules 441—95.3(252B) and 441—95.4(252B).

98.28(3) *Percentage of payment setoff.* The amount of setoff will be 50 percent of the total payment due the obligor unless the payment results from lottery winnings, from gambling winnings, from sports wagering winnings, or from a payment for a claim under treasurer of state rules on

unclaimed property at 781—Chapter 9, in which case the amount of setoff will be 100 percent of the payment. The amount taken will not exceed the delinquent amount owed by the obligor.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.29(252B) Setoff against state income tax refund or rebate. The department will make a claim pursuant to 701—Chapter 26 against an obligor's state income tax refund or rebate when support is delinquent and the case qualifies for setoff. Any setoff received as the result of a claim against an obligor's state income tax refund or rebate will apply to support that the department is attempting to collect pursuant to Iowa Code chapter 252B.

98.29(1) Case selection. The department will submit periodically a list of obligors who are delinquent at least \$50 in support payments to the department of revenue.

98.29(2) Refunds. The department will refund any amount incorrectly setoff to the department of revenue or to the obligor pursuant to 701—subrule 26.7(6). The obligor may agree in writing to apply the refund of the incorrect setoff to any other support obligation due in cases where child support services would otherwise refund the setoff directly to the obligor.

98.29(3) Distribution of setoff amount. Setoffs will be applied as provided in rule 441—95.3(252B).

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.30(252B) Offset against federal income tax refund and federal nontax payment. The department will make a claim against an obligor's federal income tax refund or federal nontax payment when delinquent support is owed. For purposes of this offset, delinquent support will include the entire balance of a judgment for accrued support, as provided in Iowa Code section 252B.5(4). Any offset received as the result of a claim against an obligor's federal income tax refund or federal nontax payment will apply to support that child support services is attempting to collect pursuant to Iowa Code chapter 252B.

98.30(1) Amount of assigned support. If the delinquent support is assigned to the department, the amount of delinquent support will be at least \$150, calculated by combining the assigned delinquent support in all of the obligor's cases in which the assigned delinquent support is at least \$50.

98.30(2) Amount of nonassigned support. If delinquent support is not assigned to the department, the claim will be made if the amount of delinquent support is at least \$500, calculated by combining the nonassigned delinquent support in all of the obligor's cases in which the nonassigned delinquent support is at least \$50.

a. The amount distributed to an obligee will be the amount remaining following payment of a support delinquency assigned to the department. The department will distribute to an obligee the amount collected from an offset according to subrule 98.30(9) within the following time frames:

(1) Within six months from the date the department applies an offset amount from a joint income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 98.30(8), whichever is later, or

(2) Within 30 days from the date the department applies an offset amount from a single income tax refund to the child support account of the responsible person, or within 15 days of the date of resolution of an appeal under subrule 98.30(8), whichever is later.

(3) However, the department is not mandated to distribute until it has received the amount collected from an offset from the federal Department of the Treasury.

b. Federal nontax payment offsets will be applied as provided in rule 441—95.3(252B).

98.30(3) Notification to federal agency. The department will, as permitted or specified by federal regulations, submit notification(s) of liability for delinquent support to the federal Office of Child Support Services.

98.30(4) Preoffset notice and review. Each obligor who does not have an existing support debt on record with the federal Office of Child Support Services will be sent a preoffset notice in writing, using address information provided to the federal Office of Child Support Services, stating the amount of the delinquent support certified for offset.

a. Individuals whose names were submitted for federal offset who wish to dispute the offset must notify the department in writing within the time period specified in the preoffset notice.

b. Upon receipt of a complaint from the individual disputing the submission for offset, child support services will conduct a review to determine if there is a mistake of fact and respond to the individual in writing within ten days.

98.30(5) *Recalculation of delinquency.* When the records of the department differ from those of the obligor for determining the amount of the delinquent support, the obligor may provide and the department will accept documents verifying modifications of the order, records of payments made pursuant to state law, and will recalculate the delinquency.

98.30(6) *Notification of modification or elimination.* The department will notify the federal Office of Child Support Services, within time frames established by the federal Office of Child Support Services, of any modification or elimination of an amount referred for offset.

98.30(7) *Failure to timely respond.* When an individual does not respond to the preoffset notice within the specified time even though the department later agrees a certification error was made, the individual must wait for corrective action as specified in subrule 98.30(8).

98.30(8) *Offset notice, appeal, and refund.* The federal Department of the Treasury will send notice that a federal income tax refund or federal nontax payment owed to the obligor has been intercepted. When child support services receives information from the federal Office of Child Support Services regarding the offset, or when the individual whose name was submitted for federal offset notifies the department that the individual has received an offset notice, the department will issue to that individual a form prescribed by the department.

a. The individual whose name was submitted for federal offset will have 15 days from the date of the notice to contest the offset by initiating an administrative appeal pursuant to 441—Chapter 2506. Except as specifically provided in this rule, administrative appeals will be governed by 441—Chapter 2506. The issue on appeal will be limited to a mistake of fact. Any other issue may be determined only by a court of competent jurisdiction.

b. The department will refund the incorrect portion of a federal income tax offset or federal nontax payment offset within 30 days following verification of the offset amount. Verification means a listing from the federal Office of Child Support Services containing the obligor's name and the amount of tax refund or nontax payment to which the obligor is entitled. The date the department receives the federal listing will be the beginning day of the 30-day period in which to make a refund.

c. The department will refund the amount incorrectly set off to the obligor unless the obligor agrees in writing to apply the refund of the incorrect offset to any other support obligation due.

98.30(9) *Application of offsets.* Offsets of federal income tax refunds will be applied to delinquent support only. The department will first apply the amount collected from an offset to delinquent support assigned to the department under Iowa Code chapters 234 and 239B. The department will then apply any amount remaining in equal proportions to delinquent support due individuals receiving nonassistance services.

[ARC 8964C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

441—98.31(252I) Administrative levy. When there is a delinquency in an amount equal to the ordered support payable for one month, child support services may issue an administrative levy pursuant to Iowa Code chapter 252I and according to Rule of Civil Procedure 1.442.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.32(252J) Referral for license sanction. In the process referred to as license sanction, child support services may refer an individual to a licensing agency for the suspension, revocation, nonissuance, or nonrenewal of a variety of licenses, including but not limited to motor vehicle registrations; driver's licenses; business and professional licenses; and licenses for hunting, fishing, boating, or other recreational activity. In order to be referred to a licensing agency for license sanction, one of the following must apply:

98.32(1) *Delinquent support payments.* An obligor's support payments must be delinquent in an amount equal to the support payment for three months. Child support services will not refer obligors whose support payments are being made under an income withholding order.

98.32(2) *Subpoena or warrant.* An individual must have failed to comply with a subpoena or warrant, as defined in Iowa Code chapter 252J, relating to a paternity or support proceeding. If a subpoena was issued, the individual must have failed to comply with a form prescribed by the department or an Interstate Subpoena as provided in 441—subrule 96.2(1) within 15 days of the issuance of the subpoena, and proof of service of the subpoena was completed according to Rule of Civil Procedure 1.442.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.33(252J) Reasons for exemption from license sanction. Certain conditions will be considered valid reasons for exemption from the license sanction process. Upon verification of these conditions, child support services will bypass, exempt, or withdraw the individual's name from referral to licensing agencies for the purpose of applying a license sanction. When the information to verify the exemption is not available to child support services through online sources, child support services will request, and the individual will provide, verification of the reason for exemption. Valid reasons for exemption for failure to comply with a subpoena or warrant and acceptable verification are those listed in subrules 98.33(2), 98.33(3), 98.33(5), and 98.33(6). Valid reasons for exemption for delinquent support payments and acceptable verification are any of the following:

98.33(1) *Receipt of social security, supplemental security income (SSI) or FIP.* Receipt of social security, SSI, FIP, or county assistance (general relief, general assistance, community services, and veteran's assistance), based upon the eligibility of the obligor, is considered a valid reason for exemption when verified by information contained in online sources available to child support services or written verification from the agency providing the benefits.

98.33(2) *Temporary illness or disability.* Temporary illness or disability of the individual or illness or disability of another household member that requires the presence of the individual in the home as caretaker is considered a valid reason for exemption upon receipt of a completed form prescribed by the department verifying the individual's or household member's inability to work.

98.33(3) *Incarceration.* Incarceration is considered a valid reason for exemption when verified through online information available to child support services or upon receipt of verification from the institution.

98.33(4) *Job training.* Participation in a job-training or job-seeking program through the department of employment services as a result of receiving benefits from the Supplemental Nutrition Assistance Program is considered a valid reason for exemption upon receipt of verification from the department of employment services or verification through online information available to child support services or upon receipt of a written statement from an income maintenance worker.

98.33(5) *Chemical dependency treatment.* Participation in a chemical dependency treatment program that is licensed by the department or the joint commission (TJC) is considered a valid reason for exemption upon receipt of written verification from the professional staff of the program that participation in the program precludes the individual from working.

98.33(6) *Contempt process.* Involvement in a contempt action dealing with support issues is considered a valid reason for exemption from the license sanction process during the pendency of the contempt action.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.34(252J) Notice of potential sanction of license. When an individual meets the criteria for selection, child support services may issue a notice to the individual of the potential sanction of any license held by the individual pursuant to Iowa Code chapter 252J using a form prescribed by the department.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.35(252J) License sanction conference.

98.35(1) *Scheduling of conference.* Upon receipt from an individual of a written request for a conference, child support services will schedule a conference not more than 30 days in the future. At the request of either child support services or the individual, the conference may be rescheduled one time. When setting the date and time of the conference, if notice was sent to an obligor under rule 441—98.34(252J), child support services will request the completion of a form prescribed by the department and other financial information from both the obligor and the obligee as may be necessary to determine the obligor's ability to comply with the support obligation.

98.35(2) *Payment calculation.* If notice was sent to an obligor under rule 441—98.34(252J) during the conference held in compliance with the provisions of Iowa Code section 252J.4, child support services will determine if the obligor's ability to pay varies from the current support order by applying the mandatory supreme court guidelines as contained in 441—Chapter 99, with the exception of 441—subrules 99.4(3) and 99.5(5). If further information from the obligor is necessary for the calculation, child support services may schedule an additional conference no less than ten days in the future in order to allow the obligor to present additional information as may be necessary to calculate the amount of the payment. If, at that time, the obligor fails to provide the required information, child support services will issue a certificate of noncompliance to applicable licensing authorities. If the obligee fails to provide the necessary information to complete the calculation, child support services will use whatever information is available. If no income information is available for the obligee, child support services will determine the obligee's income in accordance with 441—subrules 99.1(2) and 99.1(4). This calculation is for determining the amount of payment for the license sanction process only and does not modify the amount of support obligation contained in the underlying court order.

98.35(3) *Referral for review and adjustment.* If the amount calculated in subrule 98.35(2) meets the criteria for review and adjustment as specified in rule 441—101.4(252B,252H), or administrative modification as specified in rule 441—101.12(252H) and 441—subrules 101.13(1), 101.13(2) and 101.13(6) at the time child support services provides the payment agreement to the obligor, child support services will also provide the obligor with any necessary forms to request a review and adjustment or administrative modification of the support obligation. The payment agreement remains in effect during the review and adjustment or administrative modification process.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.36(252J) License Sanction Payment Agreement. The License Sanction Payment Agreement will require the obligor to pay the lower of the amount calculated in subrule 98.35(2) or the maximum amount payable under an income withholding order as specified in rule 441—98.7(252D).

98.36(1) *Duration of payment agreement.* The License Sanction Payment Agreement signed under this chapter will remain in effect for at least one year from the date of issuance unless child support services determines the obligor has a valid reason for exemption as specified in rule 441—98.33(252J). Except in those cases in which review and adjustment are in process, child support services may, at the end of the year, begin the process of reviewing the case so that the payment amount continues to accurately reflect the obligor's ability to pay as calculated in subrule 98.35(1).

98.36(2) *Failure to comply.* If at any time following the signing of a payment agreement the obligor fails to comply with all the terms of the agreement, child support services will issue a form prescribed by the department to applicable licensing authorities in accordance with the provisions of Iowa Code chapter 252J.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.37(252J) Staying the process of license sanction due to full payment of support. If the obligor, at any time, pays the total support owed, both current and past due, or an individual complies with the subpoena or warrant, child support services will stay the process, and any form issued by the department will be withdrawn by child support services.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.38(252J) Duration of license sanction. Forms issued by the department will remain in effect until the obligor pays all support owed, both arrears and current; or the obligor enters into a payment agreement with child support services; or the obligor meets one of the criteria for exemption specified at subrules 98.33(1), 98.33(2), and 98.33(4); or the individual complies with the subpoena or warrant.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.39(252B) Procedures for providing information to consumer reporting agencies. Child support services may make information available to consumer reporting agencies regarding the amount of delinquent support owed by a responsible person, but only in cases where the delinquent support exceeds \$1,000. However, before child support services will release the information to a consumer reporting agency, the agency must meet the requirements for a nationwide consumer reporting agency under Iowa Code section 252B.9(3) “j.”

98.39(1) Request of information. Agencies may request the information from the department. Requests for information about an individual shall include the individual’s name and identifying information such as a social security number or birth date. Agencies may also request a listing of all obligors owing support in excess of \$1,000.

98.39(2) Notice of proposed release of information. A notice of proposed release of information will be sent to the last-known address of the responsible person 30 calendar days prior to the release of the support arrearage information to a consumer reporting agency. This notice will explain the information to be released and the methods available for contesting the accuracy of the information.

98.39(3) Contesting proposed release of information. The responsible person may, within 15 calendar days of the date of the notice of proposed release of information, request a conference with child support services to contest the accuracy of the information to be given to the consumer reporting agency. In contested cases, no referral will be made to the consumer reporting agency until after the amount of overdue support has been confirmed to exceed \$1,000.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.40(252B) Difficult-to-collect arrearages. Child support services may refer difficult-to-collect arrearages to a collection entity under contract with child support services or with another state entity. Upon referral, a surcharge, in addition to the support, shall be due and payable by the obligor as provided in Iowa Code chapter 252B.

98.40(1) Difficult-to-collect arrearage. A difficult-to-collect arrearage is one based upon a court or administrative order that meets all the following criteria:

- a. There is no order for current support and only an arrearage is owing.
- b. There has been no payment, except for federal or state tax refund offset payments, in the past three months.
- c. There is no valid reason for exemption from the referral and surcharge process. Valid reasons for exemption and acceptable verification are those listed in subrules 98.33(1), 98.33(3), and 98.33(6). Upon verification of those conditions, child support services will bypass or exempt the obligor’s arrearages from the referral and surcharge process. When the information to verify the exemption is not available to child support services through online sources, child support services will request, and the obligor will provide, verification of the reason for exemption.

98.40(2) Notice of the possibility of referral and surcharge. Child support services will provide notice of the possibility of a referral and surcharge to the obligor as mandated by Iowa Code chapter 252B. The notice will be provided at least 15 days before child support services sends the notice of referral and surcharge to the obligor, subject to the following:

- a. *Notification contained in order.* When the support order under which the arrearage has accrued contains language advising of statutory provisions for referral and surcharge, no other preliminary notice will be required.
- b. *Notification issued by child support services.* When the support order under which the arrearage has accrued does not contain language regarding the statutory provisions for referral and

surcharge, or was entered under a foreign jurisdiction and notification was not included in the support order or provided as a separate written notice, child support services will issue a notice to the obligor pursuant to Iowa Code section 252B.23.

98.40(3) *Notice of referral and surcharge.* Child support services will send notice of a referral and surcharge to the obligor by regular mail to the obligor's last-known address, with proof of service completed according to Rule of Civil Procedure 1.442. The notice will contain all the information mandated by Iowa Code chapter 252B. The notice will be sent at least 30 days before child support services refers the arrearage to the collection entity.

98.40(4) *Contesting the referral and surcharge.* An obligor may contest the referral and surcharge. The right to contest is limited to a mistake of fact, including but not limited to a mistake in the identity of the obligor, a mistake as to whether there was a payment in the three months before the date of the notice specified in subrule 98.40(3), a mistake as to whether an exemption in paragraph 98.40(1) "c" applies, or a mistake in the amount of arrearages.

a. An obligor may contest the referral and surcharge by submitting a written request for a review to child support services within 20 days of the date on the notice of referral and surcharge specified in subrule 98.40(3). Upon receipt of a written request for review, child support services will follow the criteria and procedures specified in Iowa Code chapter 252B for resolving the request.

(1) If child support services determines there is a mistake in the identity of the obligor, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.40(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, child support services will issue a written notice to the contestant or obligor of the determination and not refer the arrearages. If child support services later determines an arrearage may be subject to referral, it will issue a new notice as provided in subrule 98.40(3).

(2) If child support services determines there was a mistake in the amount of arrearages, but the corrected amount of arrearages will still be referred, or if child support services determines there is no mistake of fact, child support services will issue a written notice of the determination of the review to the obligor by regular mail to the last-known address of the obligor. The notice will include the amount of the arrearages that will be referred and the surcharge that will be assessed. The notice will also include information on requesting an additional review by the department, and on requesting a judicial hearing.

b. An obligor may contest the notice of determination of review by submitting a written request for an additional review by the department within 20 days of the date of the notice of determination of the review issued under paragraph 98.40(4) "a." Upon receipt of the written request for additional review, child support services will review the facts of the case.

(1) If the department determines a mistake in the identity of the obligor has occurred, if there was a payment, other than a federal or state income tax offset, within the three months before the date of the notice specified in subrule 98.40(3), or if there is another mistake of fact and the arrearage does not meet the criteria for referral, the department will issue a written notice to the contestant or obligor of the determination and the arrearages will not be referred. If child support services later determines an arrearage may be subject to referral, it will issue a new notice as provided in subrule 98.40(3).

(2) If the department determines that there was a mistake in the amount of the arrearage but the corrected amount of arrearages will still be referred, or if there is no mistake of fact, the department will send a written notice of the additional review determination to the obligor by regular mail to the last-known address of the obligor. The notice will include the amount of the arrearage that will be referred and the surcharge that will be assessed. The notice will also include information on requesting a judicial hearing.

c. Following the issuance of a notice of determination of a review under paragraph 98.40(4) "a," or issuance of a notice of determination of an additional review under paragraph 98.40(4) "b," the obligor may request a district court hearing. The obligor will make a request by sending a written request for a hearing to child support services within ten days of the date of the department's written determination of the review, or within ten days of the date of child support services' written

determination of an additional review, whichever is later. Procedures for a district court hearing are specified in Iowa Code chapter 252B.

d. Child support services will not refer arrearages and assess a surcharge until after completion of any review, additional review or judicial hearing process.

98.40(5) Referral and surcharge.

a. If the obligor has not paid the arrearage, has not contested the referral, or if, following child support services review, the department's additional review, and any judicial hearing, child support services, or court does not find a mistake of fact, the arrearage will be referred to the collection entity.

b. The amount of the arrearage referred will be the amount that is unpaid as of the date of the referral. The amount of the surcharge will be an amount equal to the amount of the arrearage unpaid as of the date of the referral, multiplied by the percentage specified in the contract with the collection entity.

c. Child support services will file a notice of the surcharge with the clerk of the district court in the county in which the underlying support order is filed.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.41(252B) Enforcement services by private attorney entitled to state compensation. An attorney licensed to practice law in Iowa may utilize judicial proceedings to collect support, at least a portion of which is assigned support, and be entitled to compensation by the state as provided in Iowa Code chapter 252B.

98.41(1) Eligible cases. To be eligible for attorney services with compensation under this rule, a case must meet all of the following:

a. Child support services is providing services under Iowa Code chapter 252B.

b. The current support obligation is terminated and only arrearages are due under the administrative or court order.

c. There has been no payment under any order in the case for at least a 12-month period prior to the provision of the notice from the attorney to child support services under paragraph 98.41(1) "f."

d. At least a portion of the arrearages due under any order in the case is assigned to the state because cash assistance was paid under Iowa Code chapter 252B.

e. The case does not have any of the following characteristics:

(1) There has been a finding of good cause or other exception pursuant to Iowa Code section 252B.3.

(2) A portion of the arrears is assigned to another state because of public assistance provided by that state.

(3) Another attorney has already notified child support services of the intent to initiate a judicial proceeding to collect support due under any order in the same case under this rule, and either the time to receive the collection has not expired or child support services has not received a notice from the other attorney that the judicial proceeding has concluded prior to the expiration of the time period.

(4) If the notice from the attorney under paragraph 98.41(1) "f" specifies contempt of court as the judicial proceeding, and child support services has generated an administrative seek employment order to the obligor under Iowa Code section 252B.21 less than nine months prior to the date on the notice from the attorney.

(5) The case or arrearages have been referred by child support services to a collection entity under Iowa Code section 252B.5(3) less than nine months prior to the date on the notice from the attorney.

(6) The obligor has filed for bankruptcy and collection activities are stayed.

(7) The notice from the attorney under paragraph 98.41(1) "f" lists a specific judicial proceeding and child support services has already initiated the same type of proceeding in court.

(8) The case has been referred to the U.S. Attorney's office and is still pending at that office.

f. The attorney has provided written notice to the central office of child support services, and to the last-known address of the obligee of the intent to initiate a specified judicial proceeding to collect support on any identified court or administrative order involving the obligor and obligee in the case.

g. The attorney has provided documentation of insurance to child support services as mandated by Iowa Code chapter 252B.

h. The collection must be received by the collection services center within 90 days of the notice from the attorney in paragraph 98.41(1)“*f*,” or within a subsequent 90-day extension period.

98.41(2) Procedure.

a. To begin the process under this rule, the attorney shall submit the following to the department at least 30 days prior to initiating the specified judicial proceeding:

(1) A dated, written statement that lists the specific judicial proceeding that the attorney intends to initiate, any court or administrative order under which the arrearages accrued identified by the order number, and the names of the obligor and obligee.

(2) Documentation that the attorney is insured as mandated by the statute. Documentation shall be either a copy of the attorney’s policy from the insurer, or a letter from the insurer verifying insurance coverage as mandated by the statute.

(3) Documentation that the attorney is licensed to practice law in Iowa.

b. Child support services will mail a response to the attorney within ten days of receipt of the notice from the attorney. All of the following will apply to the child support services response:

(1) If the case meets the requirements of this rule, the notice will list the case number, any order numbers, the judicial proceeding specified by the attorney, the balance due the state of Iowa, the balance due an obligee, and the date that is 90 days from the date of the notice from the attorney. The notice will also contain a statement that any compensation due the attorney as a result of application of this rule will be calculated on the amount of support credited to arrearages due the state at the time the support paid as a result of the judicial proceeding is received by the collection services center. The notice will also contain a statement that any support collected will be disbursed in accordance with federal requirements, and any support due the obligee will be disbursed to the obligee prior to disbursement to the attorney as compensation.

(2) If the case does not meet the requirements of this rule, the notice will list the case number, any order number, and the reason the case does not meet the requirements.

c. If the case is eligible under this rule, the attorney may initiate judicial proceedings after 30 days after providing the notice to child support services in paragraph 98.41(2)“*a*.” Iowa Code chapter 252B defines “judicial proceedings.”

d. The attorney may extend the time to complete the judicial proceeding or to allow for receipt of the collection by the collection services center by submitting a notice requesting a 90-day extension to the address in paragraph 98.41(2)“*a*.” This or any subsequent notice must be received by child support services before expiration of the current 90-day time frame. Child support services will acknowledge receipt of the subsequent notice and list on the acknowledgment the date that is 90 days from the date of the attorney’s subsequent notice.

98.41(3) Collection and payment to attorney.

a. Upon compliance with the requirements of Iowa Code chapter 252B and this rule, the attorney will be entitled to compensation from the state as provided for in this rule.

b. Upon receipt of a file-stamped copy of a court order that identifies the amount of support collected as a result of the judicial proceeding and that does not order the payment of attorney fees by the obligor, and the receipt of the collection by the collection services center, all the following apply:

(1) Iowa Code chapter 252B specifies the formula to calculate the compensation due the attorney from the state. Child support services will calculate the compensation due the attorney based upon the amount of support that is credited to arrearages due the state at the time the collection is received by the collection services center. After calculating the amount due the attorney, child support services will reduce the amount due the attorney by the amount of any penalty or sanction imposed upon the state as a result of any other judicial proceeding initiated by that attorney under Iowa Code chapter 252B.

Child support services will send the attorney a notice of the amount of the compensation due from the state.

(2) The collection services center will disburse any support due an obligee prior to payment of compensation to the attorney.

(3) Child support services will not authorize disbursement of compensation to the attorney until the later of 30 days after receipt of the collection and the file-stamped copy of the order, or resolution of any timely appeal by the obligor or obligee.

(4) The amount of compensation due the attorney is subject to judicial review upon application to the court by the attorney.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

441—98.42(17A) Right of appeal.

98.42(1) Under this chapter, an administrative appeal pursuant to 441—Chapter 2506 will be limited to the following issues:

a. A claim or offset is contested as provided in subrule 98.30(8) by a person's alleging a mistake of fact.

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

98.42(2) A hearing will not be granted under 441—Chapter 2506 when the appellant has a complaint about child support services enforcement matters other than those described in this rule.

[ARC 8964C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

441—98.43(17A) Appeal record. The record in an administrative appeal under this rule will include, in addition to those materials specified in Iowa Code section 17A.12(6), the notice of appeal and the verbatim record of the hearing.

[ARC 8964C, IAB 2/19/25, effective 4/1/25]

These rules are intended to implement Iowa Code sections 96.3, 252B.9, 252B.21, 252B.5, 252B.3, 252B.4, and 421.65; chapters 252D, 252E, 252I, 252J, and 17A; and 15 U.S.C. Section 1673(b).

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CHAPTER 99
CHILD SUPPORT GUIDELINES

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—99.1(234,252B,252H) Income considered. Child support services will consider all regularly recurring income of both legal parents to determine the amount of the support award in accordance with the child support guidelines prescribed by the Iowa Supreme Court. Spousal support will be considered as specified in the Iowa Supreme Court guidelines and prior obligation spousal support actually paid or received will be calculated in the same manner as the deductions for support in subrule 99.2(1). These rules on child support guidelines will not apply if child support services is determining the support amount by a cost-of-living alteration as provided in Iowa Code chapter 252H, subchapter IV.

99.1(1) Exempt income. The following income of the parent is exempt in the establishment or modification of support:

- a. Income received by the parent under the family investment program (FIP).
- b. Income or other benefits derived from public assistance programs funded by a federal, state, or local governmental agency or entity that are listed in 441—41.27(239B) as exempt from consideration in determining eligibility under FIP.
- c. Income such as child support, social security dependent benefits received by a parent for a child because of the other parent's disability, and veteran's dependent benefits received by a parent on behalf of a child.
- d. Stepparent's income.
- e. Income of a guardian who is not the child's parent.
- f. Income of the child's siblings.
- g. Earned income tax credit.

99.1(2) Determining income. Any of the following may be used in determining a parent's income for establishing or modifying a support obligation:

- a. Income reported by the parent in a financial statement.
- b. Income established by any of the following:
 - (1) Income verified by an employer or other source of income.
 - (2) Income reported to the department of workforce development.
 - (3) For a public assistance recipient, income reported to the department of health and human services caseworker assigned to the public assistance case.
 - (4) Other written documentation that identifies income.
- c. Income as determined through occupational wage rate information published by the Iowa workforce development department or other state or federal agencies.
- d. The median income for parents on the child support services caseload, calculated annually.
- e. Social security dependent benefits. Social security dependent benefits paid for a child because of a parent's disability will be included in the disabled parent's income. Social security dependent benefits paid for a parent due to the other parent's disability will be included in the receiving parent's income.

99.1(3) Verification of income. Verification of income and allowable deductions from each parent will be requested.

- a. Verification of income may include but is not limited to the following:
 - (1) Federal and state income tax returns.
 - (2) W-2 statements.
 - (3) Pay stubs.
 - (4) Signed statements from an employer or other source of income.
 - (5) Self-employment bookkeeping records.

(6) Award letters confirming entitlement to benefits under a program administered by a government or private agency such as social security, veterans' or unemployment benefits, military or civil service retirement or pension plans, or workers' compensation.

b. Cases in which the information or verification provided by a parent is questionable or inconsistent with other circumstances of the case may be investigated. If the investigation does not reveal any inconsistencies, the financial statement and other documentation provided by the parent will be used to establish income.

c. If discrepancies exist in the financial statement provided by the parent and additional income information is not available, child support services may:

(1) Request a hearing before the court if attempting to establish a support order through administrative process.

(2) Conduct discovery if a parent places the matter before the court by answering a petition or requesting a hearing before the court.

(3) When attempting to establish a default order, provide the court with a copy of the parent's financial information and the reasons the information may be questionable.

d. If child support services is unable to obtain verification of a parent's income, the financial statement provided by the parent may be used to establish support.

99.1(4) *Use of occupational wage rate information or median income for parents on the child support services caseload.* Child support services will use occupational wage rate information or median income for parents on the child support services caseload to determine a parent's income when the parent has failed to return a completed financial statement when requested, and when complete and accurate income information from other readily available sources cannot be secured. If a parent's most recent residential address is in Iowa, child support services will use Iowa workforce development regional data to determine income. If a parent's most recent residential address is in another state, the District of Columbia, or Puerto Rico, child support services will use wage data from the place of the parent's most recent residence to determine income. For all other cases, child support services will use Iowa statewide occupational wage rate or median income for parents on the child support services caseload to determine income.

a. Occupation known. When child support services can reasonably ascertain the current or last-known occupation of a parent, child support services will use occupational wage rate information to determine income. Wage rate information will be converted to a monthly amount in accordance with subrule 99.3(1).

b. Occupation unknown. When child support services cannot reasonably ascertain the current or last-known occupation of a parent, child support services will determine the income of a parent using the median income amount for parents on the child support services caseload, based upon the parent's most recent residential address.

99.1(5) *Self-employment income.* A self-employed parent's adjusted gross income, rather than the net taxable income, will be used in determining net income. The adjusted gross income will be computed by deducting business expenses involving actual cash expenditures that affect the actual dollar income of the parent.

a. A person is 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 (IRS).

b. In calculating net income from self-employment, child support services will deduct only those items allowed by the child support guidelines. Amounts from a prior period claimed as net losses will not be allowed as deductions.

c. Net profits from self-employment may be determined through a review of self-employment bookkeeping records, sales and expenditure records, quarterly reports filed with the IRS, previous

year's federal or state income tax returns, or other documentation. The parent must provide records of bookkeeping, sales, and expenditures for the most recent 12-month period or, if the self-employment is less than 12 months old, for the period since the self-employment began.

99.1(6) *Fluctuating income.* A person has a fluctuating income when the calculated gross income or the adjusted gross income, as defined in subrule 99.1(5), for the current year varies from the gross or adjusted gross income of the previous year by more than 20 percent.

a. If requested, child support services will average the income of a person whose income fluctuated because the nature of the person's occupation is of a type that normally experiences fluctuations in income.

b. In determining a person's average income, the following procedures will be used:

(1) For non-self-employed persons, child support services will estimate the gross income for the current year and add the amount to the gross income from relevant years that would accurately depict fluctuations in the person's income. Child support services will divide this sum by the number of years added, prior and current, to arrive at an average gross annual income. Child support services will divide the average gross annual income by 12 to arrive at the person's average gross monthly income.

(2) For income from self-employment, child support services will compute the adjusted gross annual income as defined in subrule 99.1(5) for the relevant years that would accurately depict fluctuations in the person's income. Child support services will use the adjusted gross annual income to compute the average adjusted gross monthly income in the same manner as the computation of average gross monthly income for a non-self-employed person.

[ARC 8965C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—99.2(234,252B) Allowable deductions. The deductions specified in the Iowa Supreme Court child support guidelines will be allowed when determining the amount of income subject to application of the guidelines. The parent claiming the deduction must provide the documentation necessary for computing allowable deductions. When applying the deductions specified in the Iowa Supreme Court guidelines, the following will also apply:

99.2(1) In determining the amount of child support actually paid pursuant to a prior court or administrative order, the date of the original court or administrative order, rather than the date of any modifications, will determine whether it is a prior order. Support paid under an order established subsequent to the order being modified will not be deducted. All support payments will be verified before being allowed as a deduction. Child support services will calculate deductions for support as follows:

a. If the obligation is one year old or older, child support services will add together all verified amounts paid during the past 12 months preceding the current month up to the total of the current support obligation that accrued during this 12-month period, and divide by 12. All amounts collected will be included, regardless of the source.

b. If the support obligation is less than one year old, child support services will add together the verified amounts paid since the obligation began up to the total of the current support obligation that accrued during this period, and divide by the number of months that the obligation has existed.

c. When a parent has more than one prior support order, child support services will calculate the allowable deduction for each obligation separately, and then add the amounts together to determine the parent's total allowable deduction.

99.2(2) Health insurance premium costs will be verified before being allowed as a deduction.

99.2(3) A qualified additional dependent deduction will be allowed for dependents of the custodial or noncustodial father or mother, whether in or out of the parent's home. The father may establish the deduction by providing written verification of a legal obligation to the child through one of the actions enumerated in the guidelines. The mother may establish the deduction by providing written verification of a legal obligation to the child, including a written statement by the mother or a birth certificate.

99.2(4) All cash medical support payments for other children, not in the pending matter, will be verified before being allowed as a deduction and will be calculated in the same manner as the deductions for support in subrule 99.2(1).

[ARC 8965C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—99.3(234,252B) Determining net income. Unless otherwise specified in these rules, child support services will determine net income as prescribed by the Iowa Supreme Court guidelines.

99.3(1) *Calculating net income.* All allowable income and allowable deductions will be expressed in monthly amounts. Income and corresponding deductions received at a frequency other than monthly will be converted to equivalent monthly amounts by multiplying the income and corresponding deductions received on a weekly basis by 4.33, on a biweekly basis by 2.17, and on a semimonthly basis by 2.

99.3(2) *Estimating net income.*

a. The estimated net income of a parent will be 80 percent of the reported income or the estimated income as determined from occupational wage rate information or derived from the median income of parents on the child support services caseload, as appropriate, to account for an estimate of the Iowa Supreme Court guidelines deductions for federal and state taxes and Social Security and Medicare taxes. The parent will also be entitled to additional deductions allowed by the guidelines when the information to calculate these deductions is readily available through automated or other sources.

b. The net income of a parent will be estimated under the following conditions:

(1) Gross earned income information was obtained from a source that did not provide itemized deductions allowed by the mandatory support guidelines.

(2) Occupational wage rate information or median income of parents on the child support services caseload was used to determine a parent's income.

[ARC 8965C, IAB 2/19/25, effective 4/1/25]

441—99.4(234,252B) Applying the guidelines.

99.4(1) *Applying the guidelines.* Child support services will use the child support guidelines schedule as prescribed by the Iowa Supreme Court only for the number of children for whom support is being sought sharing the same two legal parents.

Exception: For foster care recovery cases, the guidelines schedule will be used as set forth in subrule 99.5(4).

99.4(2) *Establishing current support.*

a. Calculation. Child support services will calculate the amount of support as prescribed by the Iowa Supreme Court guidelines. Round amount of support to the nearest whole dollar.

b. Additional factors.

(1) In all cases other than foster care, child support services will establish current support payable in monthly frequencies.

(2) In foster care cases, child support services may establish current support payable in monthly or weekly frequencies. To establish a weekly amount, child support services will divide the figure in paragraph 99.4(2) "a" by 4.33 and round to the nearest whole dollar.

(3) If the court orders joint (equally shared) physical care of a child or split or divided physical care of multiple children, child support services will calculate current support according to the Iowa Supreme Court guidelines for each parent assuming the other is the custodial parent. If a child begins receiving family investment program (FIP) benefits or if foster care funds are expended, an offset of the two amounts as a method of payment will be disallowed.

(4) The amount of support will be zero if the noncustodial parent's only income is Supplemental Security Income paid pursuant to 42 U.S.C. 1381a (as amended to August 1, 2024).

c. Child care expense add-on. When requested by a parent and if applicable, child support services will calculate the amount of the child care add-on as prescribed by the Iowa Supreme Court guidelines.

(1) Actual child care expenses will be verified by a copy of the custodial parent's federal or state income tax return or by a signed statement from the persons or agencies providing the child care showing the total expenses and the time period the expenses represent. The child care expenses must be reasonably expected to continue.

(2) If the child care expense verification submitted represents a period that is less than 12 months, child support services will convert the expenses provided to an annual expense amount for the calculation.

(3) If the child care expense verification submitted shows varying levels of care during the year, such as full-time summer care and part-time care before and after school during the school year, child support services will average the applicable expenses to determine an annual expense amount for the calculation.

(4) Child support services will round the calculated amount of the child care add-on to the nearest whole dollar.

(5) Any child care add-on recommended by child support services will end on the first date that the next periodic support payment becomes due after the youngest child's thirteenth birthday. Child support services may recommend an earlier end date if the custodial parent provides a date that child care expenses are reasonably expected to end prior to the youngest child's thirteenth birthday.

99.4(3) *Establishing accrued support debt amount.*

a. Support debt created. The payment of public assistance to or for the benefit of a dependent child or a dependent child's caretaker creates an accrued support debt due and owing by the child's parent to the department. The amount of the accrued support debt is based on the period of time public assistance payment or foster care funds were expended, but is not created for the period of receipt of public assistance on the parent's own behalf for the benefit of the dependent child or the child's caretaker.

b. Calculating accrued support debt. Child support services will calculate the accrued support debt as follows:

(1) For FIP benefits, child support services will use the period for which FIP was paid during the 36 months preceding the date the notice of support debt is prepared or the date the petition is filed. For foster care assistance, child support services will use the three-month period for which foster care assistance was paid prior to the date the initial notice to the noncustodial parent of the amount of support obligation is prepared, or the date a written request for a court hearing is received, whichever is earlier.

(2) Child support services will exclude periods the noncustodial parent received public assistance as a part of this eligible group.

(3) Child support services may extend the period to include any additional periods public assistance is expended prior to the entry of the order.

(4) Child support services will calculate the amount of the obligation by using the current net income of both parents, the guidelines in effect at the time the order is entered, and the number of children of the noncustodial parent who were receiving public assistance for each month for which accrued support is sought.

(5) Child support services will calculate the total amount of the FIP support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount, excluding any applicable child care add-on amount.

(6) Child support services may calculate the total amount of the foster care support debt by multiplying the number of months for which assistance was paid times the determined guidelines amount, excluding any applicable child care add-on amount, and will adjust this amount for weeks in which no foster care benefits were paid.

c. *Establishing the accrued support repayment amount.*

(1) In cases other than foster care, child support services will establish the repayment amount as follows:

1. When there is an ongoing obligation, the monthly repayment amount will be 10 percent of the ongoing amount, including any child support, child care add-on and cash medical support ordered, unless the noncustodial parent agrees to a higher amount.

2. When the order does not include ongoing support, the monthly repayment amount will be the same as the amount for ongoing child support that would have been due if such an obligation had been established. However, when all of the children for whom accrued support debt is sought are residing with the noncustodial parent, the monthly repayment amount will be set at 10 percent of this amount.

(2) In foster care cases, child support services will establish the repayment amount in the same manner as subparagraph 99.4(3)“c”(1), but may establish weekly amounts and if the order does not include ongoing support, the repayment amount will be set at 10 percent of the amount for ongoing child support that would have been due if such an obligation had been established.

99.4(4) *Children in nonparental homes or foster care.* The parents of a child in a nonparental home or in foster care are severally liable for the support of the child. A support obligation will be established separately for each parent.

a. Parents' location known. When the location is known for both parents having a legal obligation to provide support for their children, the income of both parents will be used to determine the amount of ongoing support in accordance with the child support guidelines.

(1) Calculating support amount. There will be a separate calculation of each parent's child support amount, regardless of whether the parents are married and living together, or living separately. Each calculation will assume that the parent for whom support is being calculated is the noncustodial parent and the other parent is the custodial parent.

(2) Prior orders. If only one parent is paying support under a prior order for the children for whom support is being calculated, the amount of support paid will not be deducted from that parent's net monthly income in computing the support amount for the other parent.

b. One parent's location unknown. When the location of one parent is not known, procedures will be initiated to establish a support order against the parent whose location is known in accordance with the mandatory support guidelines as follows:

(1) The parent whose location is known will be considered the noncustodial parent and that parent's income will be used to calculate child support.

(2) The income of the parent whose location is unknown will be determined by using the estimated median income for parents on the child support services caseload and that parent will be considered the custodial parent in calculating child support.

c. When one parent is deceased or has had parental rights terminated, the method used to calculate support when one parent's location is not known will be used. The parent who is deceased or has had parental rights terminated will be considered the custodial parent with zero income.

99.4(5) *Adjustment for extraordinary visitation or parenting time.* Child support services will calculate an extraordinary visitation or parenting time credit as specified in the Iowa Supreme Court guidelines. The credit will not reduce the child support below the amount required by the Iowa Supreme Court guidelines.

The extraordinary visitation adjustment or parenting time credit will be given if all of the following apply:

a. There is an existing order for the noncustodial parent that meets the criteria for extraordinary visitation or parenting time in excess of 127 overnights per year on an annual basis for the child for whom support is sought. The order granting visitation or parenting time can be a different order than the child support order. If a controlling order is determined pursuant to Iowa Code chapter 252K and that controlling support order does not meet the criteria for extraordinary visitation or parenting time, there is another order that meets the criteria.

b. The noncustodial parent has provided child support services with a file-stamped or certified copy of the order.

c. The court has not ordered equally shared physical care.

99.4(6) *Establishing medical support.* Child support services will calculate medical support as required by Iowa Code chapter 252E and the Iowa Supreme Court guidelines. The cost of the health insurance premium for the child is added to the basic support obligation and prorated between the parents as provided in the Iowa Supreme Court guidelines and the parent ordered to provide health insurance must provide verification of this expense or anticipated expense.

[ARC 8965C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—99.5(234,252B) Deviation from guidelines.

99.5(1) *Criteria for deviation.* The court will not vary from the amount of child support that would result from application of the guidelines without a written finding as required by the Iowa Supreme Court guidelines.

99.5(2) *Supporting financial and legal documentation.*

a. The party requesting a deviation from the guidelines must provide supporting documentation. The supporting documentation must include an itemized list identifying the amount and nature of each adjustment requested. Failure to provide supporting documentation for a request for deviation will result in a denial of the request.

b. Legal documents prepared for the court's approval, such as stipulations and orders for support, will include language to identify the following:

- (1) The amount of support calculated under the guidelines without allowance for deviations.
- (2) The reasons for deviating from the guidelines.
- (3) The amount of support calculated after allowing for the deviation.

99.5(3) *Depreciation.* A parent may request a deduction for depreciation of machinery, equipment, or other property used to earn income. Straight-line depreciation will be the only type of depreciation that will be allowed as a deduction. Child support services will allow the straight-line depreciation amount as a deduction if the parent provides documentation from a tax preparer verifying the amount of straight-line depreciation being claimed. Straight-line depreciation is computed by deducting the property's estimated salvage value from the cost of the property, and deducting that figure in equal yearly amounts over the period of the property's remaining estimated useful life.

99.5(4) *Foster care case.* In a foster care case, child support services may deviate from the guidelines by applying a 30 percent flat rate deduction for parents who provide financial documentation. The flat rate deduction represents expenses under the case permanency plan and financial hardship allowances or other circumstances contemplated in Iowa Code section 234.39.

Child support services will calculate the support obligation of the parents of children in foster care when the parents have a legal obligation for additional dependents in the home, as follows: The support obligation of each parent will be calculated by allowing all deductions the parent is eligible for under the child support guidelines as provided in rule 441—99.2(234,252B) and by using the guidelines schedule corresponding to the sum of the children in the home for whom the parent has a legal obligation and the children in foster care. The calculated support amount will be divided by the total number of children in foster care and in the home to compute the support obligation of the parent for each child in foster care.

99.5(5) *Negotiation of accrued support debt.* Child Support Services may negotiate with a parent to establish the amount of accrued support debt owed to the department. In negotiating accrued support, the state does not represent the custodial parent. The custodial parent may intervene at any time prior to the filing of the order to contest the amount of the debt or request the entry of a judgment in the parent's behalf that may otherwise be relinquished through negotiation or entry of a judgment.

[ARC 8965C, IAB 2/19/25, effective 4/1/25]

441—99.6(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8965C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 234.39, 252B.3, 252B.5, 252B.7A, and 598.21(4).

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 100
ESTABLISHMENT OF PATERNITY AND SUPPORT

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—100.1(598,600B) Definitions.

“Disestablishment” means paternity that is legally overcome under the conditions specified in Iowa Code section 600B.41A, 232.3A, or 598.21E.

“Nonrequesting parent” means a parent who is not filing a petition to overcome paternity.

“Requesting parent” means a parent who files a petition to overcome paternity.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.2(252A) Temporary support. If a court ordered a putative father to pay temporary support before entering an order making a final determination of paternity under Iowa Code section 252A.6A, but then the court determines that the putative father is not the legal father and enters an order terminating the temporary support, all the following apply:

100.2(1) Satisfaction of accrued support. Upon receipt of a file-stamped copy of the order terminating the support order, child support services will take the following actions concerning unpaid support assigned to the department:

- a. Child support services will satisfy only unpaid support assigned to the department.
- b. Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver or notice, child support services is not prevented from satisfying amounts due the department.
- c. Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate district court.

100.2(2) Previously collected moneys. Child support services will not return any moneys previously paid on the temporary support judgment.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.3(252F) When paternity may be established administratively. Child support services may seek to administratively establish paternity and accrued or accruing child support and medical support obligations against an alleged father when the conditions specified in Iowa Code chapter 252F are met.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.4(252F) Mother’s certified statement. Before initiating an action under Iowa Code chapter 252F, child support services may obtain a form prescribed by the department or a similar document from the child’s caretaker. Child support services will obtain a form prescribed by the department from the child’s mother certifying, in accordance with Iowa Code section 622.1, that the man named is or may be the child’s biological father. Government records, including but not limited to an application for public assistance, that substantially meet the requirements of Iowa Code section 622.1 may also be used. In signing a form prescribed by the department, the mother acknowledges that child support services may initiate a paternity action against the alleged father. The mother must sign and return the form prescribed by the department to child support services within ten days of the date of child support services’ request.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.5(252F) Notice of alleged paternity and support debt. Following receipt of a form prescribed by the department or government records, including but not limited to an application for public assistance, that substantially meet the requirements of Iowa Code section 622.1, child support

services will serve a notice of alleged paternity and support debt as provided in Iowa Code section 252F.3.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.6(252F) Conference to discuss paternity and support issues. A party may request a conference as provided in Iowa Code section 252F.3(1) with the office that issued the notice to discuss paternity establishment and the amount of support the father may be required to pay.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.7(252F) Amount of support obligation. Child support services will determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.8(252F) Paternity contested. The alleged father may contest the paternity establishment by submitting, within 20 calendar days after service of the notice upon him, as provided in rule 441—100.5(252F), a written statement contesting paternity to the address of child support services as set forth in the notice. The mother may contest paternity establishment by submitting, within 20 calendar days after child support services mailed her notice of the action or within 20 calendar days after the alleged father is served with the original notice, whichever is later, a written statement contesting paternity to the address of child support services as set forth in the notice. When paternity is contested, or at child support services' initiative, child support services will issue ex parte administrative orders requiring the alleged father, the mother and the child to submit to paternity testing. If the mother and child or children previously submitted blood or genetic specimens in a prior action to establish paternity against a different alleged father, the previously submitted specimens and prior results, if available, may be used for testing in this action.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.9(252F) Paternity test results challenge. Either party or child support services may challenge the results of the paternity test by filing a written notice with the district court within 20 calendar days after child support services issues or mails the paternity test results to the parties. When a party challenges the paternity test results, and requests an additional paternity test, child support services will order an additional blood or genetic test, if the party requesting the additional test pays for the additional testing in advance. If the party challenges the first paternity test results, but does not request additional tests, child support services may order additional blood or genetic tests.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.10(252F) Agreement to entry of paternity and support order. If the alleged father admits paternity and reaches agreement with child support services on the entry of an order for support, the father may acknowledge his consent on a form prescribed by the department. If the mother does not contest paternity within the allowed time period or if the mother waives the time period for contesting paternity, child support services may file the form, if applicable, and Administrative Paternity Order with the court in accordance with Iowa Code section 252F.6.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.11(252F) Entry of order establishing paternity only. If a party requests a court hearing on support issues and paternity is not contested, or if paternity was contested but neither party filed a timely challenge of the paternity test results, child support services will prepare an order establishing paternity and reserving the support issues for determination by the court. Child support services will present the order and other documents supporting the entry of the ex parte paternity-only order to the court for review and approval prior to the hearing on the support issues.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.12(252F) Exception to time limit. Child support services may accept and respond to written requests for court hearings beyond the time limits allowed in this part.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.13(252F) Genetic test costs assessed.

100.13(1) *Paternity established.* If genetic testing of an alleged father is conducted and that man is established as the child's father, child support services will assess the costs of the genetic testing to the father who denied paternity and enter an order for repayment of these costs.

100.13(2) *Paternity not established.* If genetic testing of an alleged father is conducted and that man is not established as the child's father, the costs of the genetic testing will not be assessed to any of the parties.

100.13(3) *Results contested.* If the results of the genetic testing are timely challenged and the challenging party requests additional testing, the party contesting the results must advance the cost of the additional testing. If the challenging party does not advance payment for the additional testing, child support services will certify the case to district court.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.14(598,600B) Communication between parents. When a parent who has filed a petition to disestablish paternity requests assistance from child support services in contacting the other parent, child support services will take the following actions if services are being provided by child support services, the location of the nonrequesting party is known, and child support services has been provided a copy of the petition to disestablish paternity:

100.14(1) *Written contact.* Child support services will send written notification to the nonrequesting parent of the requesting parent's desire to disestablish paternity and of the requesting parent's whereabouts. The notice will state that the nonrequesting parent may cooperate in this action by filing a statement of the nonrequesting parent's current address or the name and address of the nonrequesting parent's attorney in the court file, or may contact the requesting parent with this information.

100.14(2) *Notification of requesting parent.* Child support services will provide notification to the requesting party that contact was made with the nonrequesting party and that the nonrequesting parent may file a statement in the court file or may contact the requesting parent directly.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.15(598,600B) Continuation of enforcement. Child support services will continue all enforcement actions to collect current and accrued support as ordered until child support services receives a file-stamped copy of the order disestablishing paternity.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.16(598,600B) Satisfaction of accrued support.

100.16(1) *Disestablishment orders entered before May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity that was entered before May 21, 1997, child support services will take the following actions concerning unpaid support assigned to the department:

a. Child support services will satisfy only unpaid support assigned to the department and only if:

(1) For actions under Iowa Code section 600B.41A or 232.3A, blood or genetic testing was done and a guardian ad litem was appointed for the child.

(2) For actions under Iowa Code section 598.21E, the written statement was filed and a guardian ad litem was appointed for the child.

b. Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, child support services is not prevented from satisfying amounts due the department.

c. Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate district court. If the court later determines that paternity was incorrectly disestablished, child support services may attempt to reinstate and enforce the prior judgment.

100.16(2) *Disestablishment orders entered on or after May 21, 1997.* Upon receipt of a file-stamped copy of an order disestablishing paternity that was entered on or after May 21, 1997, child support services will take the following actions concerning unpaid support:

a. If the order also contains a provision satisfying unpaid support, child support services will adjust its records to show unpaid support is paid.

b. If the order does not contain a provision satisfying unpaid support, child support services will satisfy only unpaid support assigned to the department. Child support services will notify the party who petitioned the court for disestablishment that this is the only support child support services can satisfy.

(1) Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver notice, child support services is not prevented from satisfying amounts due the department.

(2) Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate court. If the court later determines that paternity was incorrectly disestablished, child support services may attempt to reinstate and enforce the prior judgment.

100.16(3) *Termination of paternity.* If the court entered an order dismissing a disestablishment of paternity action on or before May 21, 1997, this subrule applies. Upon receipt of a file-stamped copy of an order terminating paternity under the requirements of Iowa Code section 600B.41A, child support services will take the following actions concerning unpaid support assigned to the department:

a. Child support services will satisfy only unpaid support assigned to the department.

b. Child support services will ask the obligee to sign the satisfaction acknowledging the obligee has no right to support owed the department and waive notice of hearing on a subsequent satisfaction order. If the obligee does not sign the satisfaction and waiver of notice, child support services is not prevented from satisfying amounts due the department.

c. Child support services will prepare the required documents to satisfy any amounts owed the department and will file them with the appropriate district court. If the court later determines that paternity was incorrectly terminated, child support services may attempt to reinstate and enforce the prior judgment.

100.16(4) *Previously collected moneys.* Child support services will not return any moneys previously paid on the judgment.

[ARC 8966C, IAB 2/19/25, effective 4/1/25]

441—100.17(252C) Establishment of an administrative order.

100.17(1) *When order may be established.* The department may establish a child or medical support obligation against a responsible person through the administrative process. This does not preclude child support services from pursuing the establishment of an ongoing support obligation through other available legal proceedings. When gathering information to establish a support order, child support services may obtain a form prescribed by the department or a similar document from the child's caretaker.

100.17(2) *Support debt.* When public assistance is paid to or Medicaid is received by a child of the responsible person, or the dependent child's caretaker, a support debt is created and assigned to the department. When no public assistance is paid or Medicaid is received, the debt is owed to the individual caretaker.

100.17(3) *Notice to responsible person.* When the department establishes a support debt against a responsible person, a notice of child support debt will be served in accordance with the Iowa

Rules of Civil Procedure or Iowa Code section 252B.26. The notice will include all of the rights and responsibilities shown in Iowa Code section 252C.3. The notice will also inform the responsible person that these rights may be waived pursuant to Iowa Code section 252C.12, and the procedures for and effect of waiving these rights. The notice will include a statement that failure to respond within the time limits given and to provide information and verification of financial circumstances will result in the entry of a default judgment for support.

100.17(4) *Negotiation conference.* The responsible person may, within ten calendar days after being served the notice of child support debt, request a negotiation conference with the office of child support services that sent the notice.

100.17(5) *Amount of support obligation.* Child support services will determine the amount of the child support obligation accrued and accruing using the child support guidelines established by the Iowa Supreme Court, and pursuant to the provisions of Iowa Code section 252B.7A.

a. Any deviation from the guidelines will require a written finding by the department.

b. Reserved.

100.17(6) *Court hearing.* Either the responsible person or child support services may request a court hearing regarding the establishment of a support obligation through the administrative process.

a. The request for a hearing by the responsible person must be in writing and sent to the office of child support services that sent the original notice of the support debt by the latest of the following:

- (1) Thirty days from the date of service of the first notice of support debt.
- (2) Ten days from the date of the negotiation conference.
- (3) Thirty days from the date the second notice and finding of financial responsibility is issued.
- (4) Ten days from the date of issuance of the conference report if the department does not issue a second notice and finding of financial responsibility after a conference was requested.

b. When a request for a court hearing is received from the responsible person, within the time limits allowed, or is made by child support services, the department will schedule or request that the hearing be scheduled in the district court in the county:

- (1) Where the dependent child resides if the child resides in Iowa.
- (2) Where the responsible person resides if the child for whom support is sought resides in another state or the sole purpose of the administrative order is to secure a judgment for the time period that public assistance was expended by the state on behalf of the family or child.

100.17(7) *Exception to time limit.* The department may accept and respond to written requests for a court hearing beyond the time limits allowed in this rule.

100.17(8) *Entry of order.* If no request for a hearing is received from the responsible person at the local office of child support services, or made by child support services, the department may prepare an order for support and have it presented ex parte to the court for approval.

a. The attorney for child support services will present the order and other documents supporting the entry of the ex parte order to the court for review and approval. Pursuant to Iowa Code chapter 252C, the court will approve the order unless defects appear in the order or supporting documents.

b. The department will file a copy of the approved order with the clerk of the district court.

c. The department will send a copy of the filed order by regular mail, to the caretaker's last-known address, to the responsible person's last-known address or the caretaker's or the responsible person's attorney pursuant to the provisions of Iowa Code chapter 252C within 14 days after approval and issuance of the order by the court.

100.17(9) *Force and effect.* Once the order has been signed by the judge and filed, it will have all the force and effect of an order or decree entered by the court. Unless otherwise specified, the effective date of the support obligation will be the twentieth day following the date the order is prepared by child support services.

100.17(10) *Modification by department.* The department may petition an appropriate court for modification of a court order on the same grounds as a party to the court order can petition the court for modification.

441—100.18(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8966C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 252C and 252F and sections 252A.6A, 598.21, and 600B.41A.

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CHAPTER 101
ADJUSTMENT AND MODIFICATION OF SUPPORT

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—101.1(252B,252H) Definitions.

“Additional child” means a child to be added to an existing support order covering another child of the same parents.

“Born of a marriage” means a child was born of a woman who was married at the time of conception, birth, or at any time during the period between conception and birth of the child pursuant to Iowa Code chapter 252A and section 144.13.

“Cost-of-living alteration” means the same as defined in Iowa Code section 252H.2.

“Guidelines” means the most current guidelines and criteria prescribed by the Iowa Supreme Court for determining the amount of child support to be awarded.

“Parent” means a person who is a responsible person or a caretaker, as those terms are defined in rule 441—95.1(252B).

“Recipient of service” means a person receiving foster care services, or a recipient of family investment program assistance or Medicaid benefits whose child support or medical support is assigned, or a person who is not receiving public assistance but who is entitled to child support enforcement services pursuant to Iowa Code section 252B.4.

“Substantial change of circumstances,” means:

1. There has been a change of 50 percent or more in the net income of a parent, as determined by comparing the new net income with the net income upon which the current child support obligation was based, and
2. The change is due to financial circumstances that have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months, pursuant to Iowa Code section 252H.18A.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.2(252H) Confidentiality of financial information. Financial information provided to child support services by either parent for the purpose of facilitating the modification or review and adjustment processes may be disclosed to the other parties to the case, or the district court, as follows:

101.2(1) Financial statements. The financial statement or affidavit may be disclosed to either party.

101.2(2) Other documentation. Supporting financial documentation such as state and federal income tax returns, paycheck stubs, IRS Form W-2, bank statements, and other written evidence of financial status may be disclosed to the court unless otherwise prohibited by state or federal law.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.3(252H) Payment of fees.

101.3(1) Payment of service of process and other costs associated with the modification or review and adjustment processes is the responsibility of the party requesting the action unless the court orders otherwise or the requesting party, as a condition of eligibility for receiving public assistance benefits, has assigned the rights to child or medical support for the order to be modified.

101.3(2) A requesting party who is indigent or receiving public assistance may request deferral of fees and costs. For the purposes of this chapter, “indigent” means that the requesting party’s income is 200 percent or less than the poverty level for one person 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 as amended to August 1, 2024.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.4(252B,252H) Review of permanent child support obligations. Permanent child support obligations that are ongoing and being enforced by child support services or the child support agency of another state will be reviewed by child support services to determine whether or not to adjust the obligation. Child support services will determine the appropriate obligation amount using the child support guidelines. Iowa must have continuing, exclusive jurisdiction to modify the order under Iowa Code chapter 252K.

101.4(1) Periodic review. A permanent child support obligation being enforced by child support services and meeting the conditions in Iowa Code section 252H.12 may be reviewed upon the initiative of child support services if:

a. The right to any ongoing child support obligation is currently assigned to the state due to the receipt of public assistance.

b. The support order does not already contain medical support provisions.

c. A review is otherwise necessary to comply with state or federal law.

101.4(2) Review by request. A review will be conducted upon the request of the child support agency of another state or upon the written request of either parent subject to the order submitted on a form prescribed by the department. One review may be conducted every two years when the review is being conducted at the request of either parent. The request for review may be no earlier than two years from the filing date of the support order or most recent modification or the last completed review, whichever is later.

101.4(3) Review outcome.

a. Procedures to adjust the support obligation will be initiated only when the financial and other information available to child support services indicates that the:

(1) Present child support obligation varies from the Iowa Supreme Court mandatory child support guidelines by more than 20 percent, and

(2) Variation is due to a change in financial circumstances that has lasted at least three months and can reasonably be expected to last for an additional three months.

b. Procedures to modify a support order may be initiated when the order does not include provisions for medical support.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.5(252B,252H) Notice requirements—review and adjustment. Child support services will provide written notification to each parent affected by a permanent child support obligation being enforced by child support services as follows:

101.5(1) Notice of right to request review. Child support services will notify each parent of the right to request review of the order and the appropriate place and manner in which the request should be made. Notification will be provided on forms prescribed by the department or through another printed or electronic format.

101.5(2) Notice of review. One of the following will apply:

a. At least 15 days before the review is conducted, child support services will serve notice of its intent to review the order on each parent affected by the child support obligation. This notice will include a request that the parties complete a financial statement and provide verification of income. The notice will be served in accordance with Iowa Code section 252B.26 or 252H.15.

b. If the conditions of Iowa Code section 252H.14A(1) are met, child support services may conduct a review using information accessible to child support services without:

(1) Issuing a notice under paragraph 101.5(2) “a,” or

(2) Requesting additional information from the parent.

101.5(3) Notice of decision. After child support services completes the review of the child support obligation in accordance with rule 441—101.4(252B,252H), child support services will issue a notice of decision in accordance with Iowa Code section 252H.14A or 252H.16 stating whether or not an adjustment is appropriate and, if so, child support services’ intent to enter an administrative order for adjustment.

101.5(4) Challenges to outcome of review. Each parent will be allowed to request a second review challenging the determination of child support services. The procedure for challenging the determination is as follows:

a. The parent challenging the determination must submit the request for a second review in writing to child support services stating the reasons for the request and providing written evidence necessary to support the challenge. The request must be submitted:

(1) Within 10 days from the date of a notice of decision issued pursuant to Iowa Code section 252H.16, or

(2) Within 30 days from service of a notice of decision issued pursuant to Iowa Code section 252H.14A.

b. Child support services will review the written evidence submitted with the request and all financial information available to child support services and make a determination of one of the following:

(1) To enter an administrative order for adjustment of the obligation.

(2) That adjustment of the child support obligation is inappropriate.

c. Child support services will send written notice of the outcome of the second review to each parent affected by the child support obligation at the parent's last-known mailing address.

d. For a review initiated under Iowa Code section 252H.15, if either parent disputes the second decision, the objecting parent may request a court hearing within 15 days from the date the notice of decision is issued or within 10 days of the date the second notice of decision is issued, whichever is later.

e. For a review initiated under Iowa Code section 252H.14A, either parent may request a court hearing within 10 days of the issuance of the second notice of decision.

f. If child support services receives a timely written request or child support services determines that a court hearing is necessary, child support services will certify the matter to the district court. An objecting parent may seek recourse by filing a private petition for modification through the district court.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.6(252B,252H) Financial information—review and adjustment. Child support services will attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be reviewed necessary to conduct the review.

101.6(1) Financial statements. Except for a review initiated under Iowa Code section 252H.14A, both parents subject to the order to be reviewed must provide a financial statement and verification of income within ten days of service of the notice of child support services' intent to review the obligation. If a review is initiated under Iowa Code section 252H.14A and the first notice of decision is challenged as described in subrule 101.5(4), both parents will be requested to provide a financial statement and verification of income within ten days of child support services' request.

a. Verification of income will include but not be limited to the following: copies of state and federal income tax returns, W-2 statements, pay stubs, or a signed statement from an employer or other source of income.

b. Child support services may also request that the parent requesting review provide an affidavit regarding the financial circumstances of the nonrequesting parent when child support services is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent must complete the affidavit if the parent possesses sufficient information to do so.

101.6(2) Independent sources. Child support services may utilize other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be reviewed.

a. These resources include but are not limited to the following: the Iowa workforce development department, the Iowa department of revenue, the Internal Revenue Service, the employment, revenue, and child support recovery agencies of other states, and the Social Security Administration.

b. In the absence of other verification of income and deductions allowed under the mandatory support guidelines, child support services may estimate the net earned income of a parent for the purpose of determining the amount of support that would be due under the guidelines by deducting 20 percent from the gross earned income confirmed by an independent source. A parent may challenge this estimate by providing verification of actual earned income deductions.

101.6(3) *Availability of medical insurance.* Both parents subject to the order to be reviewed must provide documentation regarding the availability of health insurance coverage for the children covered under the order, and the cost of the coverage, within ten days of a written request by child support services. Verification may include but not be limited to: a copy of the health benefit plan including the effective date of the plan, a letter from the employer detailing the availability of health insurance, or any other source that will serve to verify health insurance information and the cost of the coverage.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.7(252B,252H) Review and adjustment of a child support obligation.

101.7(1) *Conducting the review.* Child support services will review the case for administrative adjustment of a child support obligation unless it is determined that any of the following exist:

- a.* The location of one or both of the parents is unknown.
- b.* The variation from the Iowa Supreme Court mandatory child support guidelines is based on any material misrepresentation of fact concerning any financial information submitted to child support services.
- c.* The criteria of rule 441—101.4(252B,252H) are not met.
- d.* The end date of the order is less than 12 months in the future or the youngest child is 17½ years of age.

101.7(2) *Civil action.* The review and adjustment action that is certified to court for hearing will proceed as an ordinary civil action in equity, and child support services attorney will represent the state of Iowa in those proceedings.

101.7(3) *Private counsel.* After the notice has been issued as described in subrule 101.5(2) or 101.5(3), any party may choose to be represented personally by private counsel. Any party who retains private counsel must notify child support services of this fact in writing.

[ARC 8967C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—101.8(252B,252H) Medical support—review and adjustment. Child support services will review the medical support provisions contained in any permanent child support order that is subject to review under rule 441—101.7(252B,252H) and will include in any adjustment order a provision for medical support as defined in Iowa Code chapter 252E, and as set forth in 441—Chapter 98, or other appropriate provisions pertaining to medical support for all children affected directly by the child support order under review.

[ARC 8967C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—101.9(252B,252H) Denying requests—review and adjustment. A request for review by a parent subject to the order may be denied for the following reasons:

101.9(1) It has been less than two years since the support order was filed with the court, last modified, or last reviewed for the purpose of adjustment.

101.9(2) Child support services or a child support agency of another state is not providing enforcement services for an ongoing support obligation under the order for which the review has been requested.

101.9(3) The request is based entirely on issues such as custody, visitation, or parenting time rights, which are not directly related to child support.

101.9(4) The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

101.9(5) The request is for the review of a temporary support order.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.10(252B,252H) Withdrawing requests — review and adjustment. If the requesting party contacts child support services to withdraw the request, child support services will proceed as follows:

101.10(1) *Consent of both parties.* Child support services will notify the nonrequesting party of the requesting party's desire to withdraw the request.

a. If the nonrequesting party indicates a desire to continue the review, child support services will proceed with the review and adjust the obligation, if appropriate.

b. If the nonrequestor indicates a desire to stop the process or fails to respond within ten days to the notification of the request to withdraw, child support services will notify all parties that the review and adjustment process has been terminated.

101.10(2) *Effect of withdrawal.* If a request is successfully withdrawn pursuant to subrule 101.10(1), a later request by either party will be subject to the limitations of subrule 101.4(2).

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.11(252H) Effective date of review and adjustment. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation amount will be effective on the first date that the periodic payment is due under the order being modified after child support services files the adjustment order with the court.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.12(252H) Availability of service—administrative modification. Child support services will provide administrative modification services for a support order originally entered or a foreign order registered in the state of Iowa. The order must be one that:

101.12(1) Involves at least one child born of a marriage or one child for whom paternity has been legally established.

101.12(2) Is being enforced by child support services in accordance with Iowa Code chapter 252B.

101.12(3) Is subject to the jurisdiction of this state for the purposes of modification.

101.12(4) Is not subject to or is not appropriate for review and adjustment.

101.12(5) Provides for support of at least one child under the age of 18 or a child between the ages of 18 and 19 years who is engaged full-time in completing high school graduation or equivalency requirements in a manner that is reasonably expected to result in completion of the requirements prior to the person's reaching 19 years of age.

101.12(6) Has an obligation ending more than 12 months in the future.

101.12(7) Involves parents for whom the location of both parents is known.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.13(252H) Modification of child support obligations. Permanent child support obligations meeting the criteria set forth in rule 441—101.12(252H) may be modified at the initiative of child support services, or upon written request of either parent subject to the order submitted on a form prescribed by the department. Any action will be limited to adjustment, modification, or alteration of the child support or medical provisions of the support order. The duration of the underlying order will not be modified. The procedures used by child support services to determine if a modification is appropriate are as follows:

101.13(1) *Substantial change of circumstances.* Procedures to modify the support obligation may be initiated outside the minimum time frame described in subrule 101.4(2) if a request is received from either parent and if the parent has submitted verified documentation of a substantial change in circumstances that indicates both of the following:

a. A change of at least 50 percent in the net income of a parent as defined by guidelines. The new net income will be compared to the net income upon which the current child support obligation was based.

b. The change is due to financial circumstances that have existed for a minimum period of three months and can reasonably be expected to exist for an additional three months.

Child support services will review the request and documentation and, if appropriate, issue a notice of intent to modify as described in subrule 101.14(1).

101.13(2) *Adding provisions for additional children.* Procedures to modify the support obligation may be initiated if:

- a.* A parent requests, in writing, or child support services determines that it is appropriate to add an additional child to the support order and modify the obligation amount according to the guidelines pursuant to Iowa Code sections 598.21B and 252B.7A; and
- b.* Paternity has been legally established.

When adding a child to an order through administrative modification, medical support provisions will apply to the additional child.

101.13(3) *Reserved, zero-dollar-amount, or medical-provisions-only orders.* Procedures to modify the support obligation may be initiated if:

- a.* A parent requests a modification in writing or child support services determines that it is appropriate to include a support amount based on the guidelines; and
- b.* The original order:
 - (1) Reserved establishment of an ongoing, dollar-amount support obligation giving a specific reason other than lack of personal jurisdiction over the obligor, or
 - (2) Set the amount at zero, or
 - (3) Was for medical provisions only.

101.13(4) *Corrections.* Procedures to modify the support obligation may be initiated if:

- a.* An error or omission pertaining to child support or medical provisions was made during preparation or filing of a support order; and
- b.* A necessary party requests a modification or child support services determines that a modification to correct an error or omission is appropriate.

101.13(5) *Noncompliance by minor obligors.* The unit may initiate procedures to modify a support order if a parent requests modification in writing or the unit determines that it is appropriate when:

- a.* An obligor who is under 18 years of age fails to comply with the requirement to attend parenting classes pursuant to Iowa Code section 598.21G; or
- b.* An obligor who is 19 years of age or younger fails to provide proof of compliance with education requirements described in Iowa Code section 598.21B(2) “e”; or
- c.* The obligor no longer meets the age requirements as defined in Iowa Code section 598.21B(2) “e” or 598.21G.

101.13(6) *Cost-of-living alteration.* A support order may be modified to provide a cost-of-living alteration if all the following criteria are met:

- a.* Those criteria established in Iowa Code section 252H.23.
- b.* At least two years have passed since the order was filed with the court or last reviewed, modified, or altered.
- c.* The current support order addresses medical support for the children.
- d.* A copy of each affected order is provided, if child support services does not already have copies in its files.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.14(252H) Notice requirements—administrative modification. Child support services will provide written notification to parents affected by a permanent child support obligation being enforced by child support services as follows:

101.14(1) *Notice of intent to modify.* When a request for administrative modification is received or child support services initiates an administrative modification, child support services will provide written notice to each parent of its intent to modify.

- a.* The notice will include the legal basis and purpose for the action; a request for income or other information necessary for the application of guidelines (if applicable); an explanation of the

legal rights and responsibilities of the affected parties, including time frames; and procedures for contesting the action.

b. Child support services will take the following actions to notify parents:

(1) If the modification is based on subrules 101.13(1) through 101.13(5), notice will be provided to each parent. The notice will be served in accordance with the Iowa Rules of Civil Procedure or Iowa Code section 252B.26 or 252H.19.

(2) If the modification is based on provision of a cost-of-living alteration as established at subrule 101.13(6) and the required documentation is included, child support services will notify each parent of the amount of the cost-of-living alteration by regular mail to the last-known address of each parent or, if applicable, each parent's attorney. The notice will include:

1. The method of determining the amount of the alteration pursuant to Iowa Code section 252H.21.

2. The procedure for contesting a cost-of-living alteration by making a request for review of a support order as provided in Iowa Code section 252H.24.

3. A statement that either parent may waive the 30-day notice waiting period. If both parents waive the notice waiting period, child support services may prepare an administrative order altering the support obligation.

101.14(2) *Notice of decision to modify.* Child support services will issue a notice of its decision to modify the support order to each parent affected by the support obligation at each parent's (or attorney's) last-known address. The notice will contain information about whether child support services will continue or terminate the action and the procedures and time frames for contesting the action by requesting a court hearing pursuant to subrule 101.16(2).

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.15(252H) Financial information—administrative modification. Child support services may attempt to obtain and verify information concerning the financial circumstances of the parents subject to the order to be modified that is necessary to conduct an analysis and determine support. Child support services does not require financial information if the request is for a cost-of-living alteration.

101.15(1) *Financial statements.* Parents subject to the order must provide a financial statement and verification of income within ten days of a written request by child support services.

a. If the modification action is based on a substantial change of circumstances:

(1) The requesting party must provide a form prescribed by the department, and documentation that proves the amount of change in net income and the date the change took place, such as:

1. Copies of state and federal income tax returns, W-2 statements, or pay stubs, or
2. A signed statement from an employer or other source of income.

(2) Child support services will review the request and documentation. If appropriate, child support services will issue to each parent a notice of intent to modify the order as stated in subrule 101.14(1) and a financial statement. Each parent must complete and sign the financial statement and return it to child support services with verification of income and deductions as described in subrule 99.1(3).

b. Child support services may require a completed and signed financial statement and verification of income from each parent as described in subrule 99.1(3) if the modification is based on:

- (1) Addition of a child;
- (2) Changing a reserved or zero-dollar-amount obligation;
- (3) Changing a medical-provisions-only obligation;
- (4) Making a correction (if financial information is needed); or
- (5) Noncompliance by a minor obligor as defined in Iowa Code section 598.21B(2)“e” or 598.21G.

c. Child support services may also request that a parent requesting a modification provide an affidavit regarding the financial circumstances of the nonrequesting parent when child support

services is otherwise unable to obtain financial information concerning the nonrequesting parent. The requesting parent must complete the affidavit if the parent possesses sufficient information to do so.

d. Child support services may also use occupational wage rate information or the median income for parents on child support services' caseload to determine the gross income of a parent when a parent has failed to return a completed financial statement when requested and complete and accurate information is not readily available from other sources.

e. Self-employment income will be determined as described in subrule 99.1(5).

101.15(2) *Independent sources.* Child support services may use other resources to obtain or confirm information concerning the financial circumstances of the parents subject to the order to be modified as described in rule 441—99.1(234,252B,252H).

101.15(3) *Guidelines calculations.* Child support services will determine:

a. The appropriate amount of the child support obligation (excluding cost-of-living alteration amounts) as described in rules 441—99.1(234,252B,252H) through 441—99.5(234,252B), and

b. Medical support provisions as described in Iowa Code chapter 252E and rules 441—98.2(252E) through 441—98.5(252E) and 441—75.14(249A).

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.16(252H) Challenges to the proposed modification action. For modification actions based on subrules 101.13(1) through 101.13(5), each parent will have the right to request a conference to contest the proposed modification. Either parent, or child support services, may also request a court hearing. For requests made based on subrule 101.13(6), either parent may contest the cost-of-living alteration by making a request for a review and adjustment of the support order.

101.16(1) *Conference.* Either parent may contest the proposed modification based on subrules 101.13(1) through 101.13(5) by means of a conference with the office of child support services that issued the notice of intent to modify.

a. Only one conference will be held per parent.

b. The request must be made within ten days of the date of service of the notice of intent to modify.

c. The office that issued the notice of intent to modify will schedule a conference with the parent and advise the parent of the date, time, place, and procedural aspects of the conference.

d. Reasons for contesting the modification include but are not limited to mistake of fact regarding the identity of one of the parties or the amount or terms of the modification.

e. Child support services may conduct the conference in person or by telephone.

f. If the party who requested the conference fails to attend the conference, only one alternative time will be scheduled by child support services.

g. The results of a conference will in no way affect the right of either party to request a court hearing pursuant to subrule 101.16(2).

h. Upon completion of the conference, child support services will issue a notice of decision to modify as described in subrule 101.14(2).

101.16(2) *Court hearing.*

a. Either parent, or child support services, may contest the proposed modification, based on subrules 101.13(1) through 101.13(5), by requesting a court hearing within the latest of any of the following time periods:

(1) Twenty days from the date of successful service of the notice of intent to modify,

(2) Ten days from the date scheduled for a conference, or

(3) Ten days from the date of issuance of a notice of decision to modify.

b. If child support services receives a timely written request, child support services will certify the matter to the district court as described in Iowa Code section 252H.8.

c. If a timely request is not received, if waiting periods have been waived, or if the notice periods have expired, child support services will prepare an administrative order as provided in Iowa Code section 252H.9.

101.16(3) *Contesting a proposed cost-of-living alteration.* Either parent may contest a cost-of-living alteration within 30 days of the date of the notice of intent to modify by making a request for a review of the support order as provided in Iowa Code section 252H.13.

a. If child support services receives a timely written request for review, child support services will terminate the cost-of-living alteration process and proceed with the review and adjustment process.

b. If a timely request is not made, or the notice waiting period has been waived by both parties, or the notice period has expired, child support services will prepare an administrative order as provided in Iowa Code section 252H.24.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.17(252H) Misrepresentation of fact—administrative modification.

101.17(1) Child support services will not modify the support order based on a substantial change of circumstances if a change in income is due to any material misrepresentation of fact concerning any financial information submitted to child support services.

101.17(2) Child support services may request verification that all facts concerning financial information are true. Verification may include but is not limited to a statement from the employer, a doctor, or other person with knowledge of the situation.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.18(252H) Effective date of modification. Unless subject to court action or reconciliation of multiple Iowa orders, the new obligation will be effective on the first date that the periodic payment is due under the order being modified after child support services files the modification order with the court. If the modification is based on a reserved, zero-dollar-amount, or medical-provisions-only obligation, the new obligation will be effective 20 days after generation of the administrative modification order.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.19(252H) Denying requests—administrative modification. A request for modification by a parent subject to the order may be denied if the criteria in rule 441—101.12(252H) are not met or the following conditions exist:

101.19(1) *Nonsupport issues.* The request is based entirely on issues such as custody, visitation, or parenting time rights.

101.19(2) *Request only for delinquent support.* The request is for the sole purpose of modifying the amount of delinquent support that has accrued under a support order.

101.19(3) *Temporary order.* The request is for the modification of a temporary support order.

101.19(4) *Two-year time frame.* The request is for a cost-of-living alteration and it has been less than two years since the order was filed with the court or last reviewed, modified, or altered.

101.19(5) *Change of circumstances.* The request is based on a substantial change in circumstances and:

a. The requestor's net income has not changed by at least 50 percent, as required in paragraph 101.13(1) "a," or

b. The requestor has not provided adequate documentation of the change in income, as required in subrule 101.15(1), or

c. The change in income has not yet lasted for three months, as required in paragraph 101.13(1) "b," or

d. The change in income is not expected to last another three months, as required in paragraph 101.13(1) "b," or

e. The change in income is due to material misrepresentation of fact, as explained in rule 441—101.17(252H).

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.20(252H) Withdrawing requests—administrative modification. If the requesting party contacts child support services to withdraw the request, child support services will notify the nonrequesting party of the requesting party's desire to withdraw the modification request. If the nonrequesting party indicates, in writing, a desire to continue with the modification process, child support services will proceed, and if appropriate, modify the support order. If there is no response from the nonrequesting party or if the nonrequesting party also wants the process to end, child support services will end the modification process. If child support services initiated the modification action, child support services may terminate the process if, after notifying both parents, neither parent indicates a desire to continue with the modification.

[ARC 8967C, IAB 2/19/25, effective 4/1/25]

441—101.21(252B,252H) Child care add-on. Child support services will review a child care add-on or expense agreement contained in any permanent child support order that is subject to review under rule 441—101.7(252B,252H) or 441—101.13(252H) as follows:

101.21(1) *Order with child care add-on.*

a. If the custodial parent provides the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)“c,” child support services will review the information and apply the child care add-on based on the guidelines, if appropriate. Any resulting child care add-on will replace the existing child care add-on.

b. If the custodial parent does not provide the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)“c,” the resulting modified child support amount will no longer include an added amount for child care expenses.

101.21(2) *Order with child care expense agreement.* Child support services will review an order with an existing child care expense agreement entered in lieu of a child care add-on as follows:

a. If the custodial parent provides the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)“c,” child support services will review the information and apply the child care add-on based on the guidelines, if appropriate. Any resulting child care add-on will replace the existing child care expense agreement.

b. If the custodial parent does not provide the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)“c,” child support services will recommend that any existing child care expense agreement remain unchanged.

101.21(3) *Order without a child care add-on or expense agreement.* If the custodial parent provides the necessary information to determine the amount of child care expenses as described in 441—paragraph 99.4(2)“c” and there is no current child care expense agreement or child care add-on, child support services will review the information and apply the appropriate child care add-on based on the guidelines.

[ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—101.22(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8967C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 252H and sections 252B.5, 252B.7, and 598.21C(2).

[Filed ARC 8967C (Notice ARC 8556C, IAB 12/25/24), IAB 2/19/25, effective 4/1/25]

[Filed ARC 9764C (Notice ARC 9582C, IAB 10/1/25), IAB 11/26/25, effective 1/1/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 102
SUSPENSION AND REINSTATEMENT OF SUPPORT

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

441—102.1(252B) Definitions.

“*Caretaker*” means a natural person with whom a child is residing and who is not legally entitled to receive support for that child pursuant to the order that is the subject of the pending suspension request.

“*Child*” means the same as defined in Iowa Code section 252E.1.

“*Obligee*” means a custodial parent or other natural person legally entitled to receive a support payment on behalf of a child.

“*Obligor*” means a noncustodial parent or other natural person who is ordered to pay support pursuant to the order that is the subject of the pending suspension request.

“*Public assistance*” means the same as defined in Iowa Code section 252H.2.

“*Spousal support*” means either a set amount of monetary support, or medical support as defined in Iowa Code section 252E.1, for the benefit of a spouse or former spouse, including alimony, maintenance, or any other term used to describe these obligations.

“*Step change*” means a change designated in a support order that specifies the amount of the child support obligation as the number of children entitled to support under the order changes.

“*Support*” means the same as defined in Iowa Code section 252D.16 and will include support for a child.

“*Support for a child*” means either a set amount of monetary support (child support and any applicable child care add-on), or medical support as defined in Iowa Code section 252E.1, for the benefit of a child. This term does not include spousal support as defined in this rule.

“*Support order*” means the same as a “court order” as defined in Iowa Code section 252C.1.

[ARC 8968C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—102.2(252B) Availability of service—suspension by mutual consent. Child support services will provide suspension by mutual consent only with respect to support orders entered or registered in this state for which child support services is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

102.2(1) Suspension by mutual consent will only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order under Iowa Code chapter 252K.

102.2(2) Suspension by mutual consent will be provided only if no prior request for suspension of all or part of a support order has been filed with child support services pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by child support services pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.3(252B) Basis for suspension of support by mutual consent.

102.3(1) *Reconciliation.* Child support services will assist an obligor and obligee in suspending support for a child and, if contained in a child support order, spousal support, when the obligor and obligee are reconciled and are residing together, with at least one child entitled to support under the order, in the same household.

102.3(2) *Change in residency.* Child support services will assist an obligor and obligee in suspending support for a child when the child is residing with the obligor; however, child support services will not assist in suspending any spousal support provisions of a support order on this basis. Child support services will also assist an obligor and obligee in suspending support for a child residing with a caretaker who has not requested services, if the child is not receiving public assistance.

102.3(3) *Affected children.* Child support services will assist an obligor and obligee in suspending by mutual consent all or part of a support order if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, child support services will assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, child support services will assist in suspending the support obligations for children for whom the basis for suspension applies.

c. If the basis for suspension applies to at least one but not all of the children and if the support order includes a child care add-on, child support services will assist in suspending the child care add-on if child support is being suspended for all of the children who are then subject to the child care add-on. If child support is not being suspended for all of the children who are then subject to the child care add-on and the support order does not apportion the child care add-on between those children, child support services will not assist in suspending the child care add-on. If the support order does not state whether a specific child care add-on amount is included in the step change amounts, child support services will assist in suspending support as set forth in paragraph 102.3(3) “*b.*”

102.3(4) *Limited to current support.* The provisions for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

102.3(5) *Duration of conditions.* The basis for suspension of support as provided in subrule 102.3(2) and subrule 102.3(3) must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by child support services.

[ARC 8968C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—102.4(252B) Request for assistance to suspend by mutual consent.

102.4(1) *Submitting a request.* The obligor and obligee subject to a support order being enforced by child support services may request that child support services assist in having the ongoing support provisions suspended as follows:

a. A request for suspension must be submitted to child support services using a request and affidavit form prescribed by the department.

b. Child support services will provide the request and affidavit form prescribed by the department to the obligor and obligee upon request.

c. Both forms must be signed by both the obligor and the obligee affected by the order to be suspended. In the event that current support payments are assigned to an individual or entity other than the obligee named in the original order, but may revert to the original obligee at a future date without court action, both the original obligee and the current assignee must sign both forms.

d. The affidavit form prescribed by the department must be notarized.

e. The request must contain sufficient information to allow child support services to identify the court order and parties involved, and a statement that the obligor and obligee expect the basis for suspension to continue for not less than six months.

f. If the obligor and obligee are requesting suspension of more than one order at the same time, the obligor and obligee will be required to submit only one copy of the request form prescribed by the department, identifying each order the request involves; however, the obligor and obligee will be required to submit a separate, signed and notarized affidavit form prescribed by the department for each order.

102.4(2) *Denying a request.* Child support services will issue a written notice to the obligor and obligee indicating that a properly completed request is denied.

a. This notice will be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor’s or obligee’s attorney.

b. If the basis for suspension is reconciliation, one notice will be sent to the address shared by the obligor and obligee. If the basis for suspension is a change in residency of the children entitled

to support, a separate notice will be issued to the obligor and obligee at their respective last-known addresses.

c. The notice denying a request will indicate the reason for denial.

d. A request for suspension will be denied when the conditions specified in Iowa Code section 252B.20 or rule 441—102.2(252B) or 441—102.3(252B) are not met.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.5(252B) Order suspending support by mutual consent. To approve a request to suspend support, child support services will prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20.

102.5(1) When the basis for suspension is reconciliation, the suspension will apply to any ongoing support provisions of the order, including medical support, with respect to any child residing with the parents and with respect to any spouse or former spouse entitled to support under the order to be suspended.

102.5(2) When the basis for suspension is a change in residency of one or more of the children entitled to support, the suspension will apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor. Any spousal support also ordered in the same support order will remain unaffected by this action.

102.5(3) A copy of the filed order will be sent by first-class regular mail to the last known address of the obligor and obligee, or, if applicable, to the last known address of the obligor's or obligee's attorney.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.6(252B) Suspension of enforcement of current support—suspension by mutual consent. Child support services will suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. Child support services will continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.7(252B) Availability of service—suspension by payor's request. Child support services will provide suspension by payor's request only with respect to support orders entered pursuant to Iowa Code chapter 252A, 252C or 252F for which child support services is providing enforcement services in accordance with Iowa Code chapter 252B to collect current or accrued support.

102.7(1) Suspension by payor's request will only be provided if a court in this state would have continuing, exclusive jurisdiction to suspend and reinstate the order pursuant to Iowa Code chapter 252K.

102.7(2) Suspension by payor's request will be provided only if no prior request for suspension of all or part of a support order has been filed with child support services pursuant to Iowa Code section 252B.20 and no prior request for suspension of all or part of a support order has been served by child support services pursuant to Iowa Code section 252B.20A during the two-year period preceding the request.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.8(252B) Basis for suspension of support by payor's request.

102.8(1) *Child residing with obligor or caretaker.* Child support services will assist an obligor in suspending support for a child residing with the obligor or with a caretaker who has not requested unit services, if the child has been residing with the obligor or caretaker for more than 60 consecutive days.

102.8(2) *Orders eligible for suspension.*

a. Child support services will assist an obligor in suspending support for a child only when there is no order in effect regarding legal custody, physical care, visitation, or parenting time for the child.

b. If an order exists that contains language regarding legal custody, physical care, visitation, or parenting time for the child, child support services will deny the suspension request.

102.8(3) *Children on public assistance.* The children for whom ongoing support is being suspended must not be receiving public assistance pursuant to Iowa Code chapter 239B or 249A or a comparable law of another state or foreign country, or if the children are receiving public assistance, the obligor must be considered to be a member of the same household as the children for the purposes of public assistance eligibility.

102.8(4) *Duration of conditions.* The basis for suspension of support must reasonably be expected to continue for not less than six months from the date a request for assistance to suspend is received by child support services.

102.8(5) *Affected children.* Child support services will assist an obligor in suspending by payor's request all or part of a support order if the basis for suspension as described in this rule applies to the children entitled to support under the order to be suspended as follows:

a. If the basis for suspension applies to all of the children, child support services will assist in suspending support obligations for all of the children.

b. If the basis for suspension applies to at least one but not all of the children and if the support order includes a step change, child support services will assist in suspending the support obligations for children for whom the basis for suspension applies.

c. If the basis for suspension applies to at least one but not all of the children and if the support order includes a child care add-on, child support services will assist in suspending the child care add-on if child support is being suspended for all of the children who are then subject to the child care add-on. If child support is not being suspended for all of the children who are then subject to the child care add-on and the support order does not apportion the child care add-on between those children, child support services will not assist in suspending the child care add-on. If the support order does not state whether a specific child care add-on amount is included in the step change amounts, child support services will assist in suspending support as set forth in paragraph 102.8(5) "b."

102.8(6) *Limited to current support.* The provisions for suspending support apply only toward ongoing or current support. Any support that has accrued prior to the entry of an order suspending support, including judgments for past periods of time, is unaffected by the suspension.

[ARC 8968C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—102.9(252B) Request for assistance to suspend by payor's request. The obligor subject to a support order being enforced by child support services may request that child support services assist in having the ongoing support provisions suspended as follows:

102.9(1) *Submitting a request.*

a. A request for suspension must be submitted to child support services using a form prescribed by the department.

b. Child support services will provide the request form prescribed by the department to the obligor upon request.

c. The request form must be signed by the obligor affected by the order to be suspended.

d. The request must contain sufficient information to allow child support services to identify the court order and parties involved and must attest that the children have lived in the obligor's household or the caretaker's household for more than 60 consecutive days and are expected to live there for at least six months.

102.9(2) *Submitting an affidavit.* After receiving a valid request for suspension, child support services will provide the requestor with an affidavit form prescribed by the department.

a. The obligor must submit the affidavit for suspension to child support services. If the request for suspension is made pursuant to Iowa Code section 252B.20A(17), the caretaker must also submit an affidavit form prescribed by the department.

b. The affidavit prescribed by the department must be signed, attesting to the existence of the conditions under subrules 102.8(1) through 102.8(4). The affidavit must be notarized.

c. If the obligor is requesting suspension of more than one order at the same time, the obligor will be required to submit only one copy of the request form prescribed by the department, identifying each order the request involves; however, the obligor will be required to submit a separate, signed and notarized affidavit form prescribed by the department for each order.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.10(252B) Determining eligibility for suspension by payor's request. Upon receipt of the request for suspension and the properly executed and notarized affidavit, child support services will review the request and the affidavit to determine that the criteria have been met.

102.10(1) *If the criteria are not met.* If the criteria have not been met, child support services will issue a written notice to the obligor indicating that the request is denied.

a. The notice will be sent by first-class regular mail to the last-known address of the obligor or, if applicable, to the last-known address of the obligor's attorney.

b. The notice will indicate the reason for denial and notify the obligor of the right to proceed through private counsel.

102.10(2) *If the criteria are met.* If the criteria are met, child support services will proceed as follows:

a. Child support services will serve forms prescribed by the department and supporting documents on the obligee by any means provided in Iowa Code section 252B.26. The notice to the obligee will include all of the following:

(1) Information sufficient to identify the parties and the support order affected.

(2) An explanation of the procedure for suspension and reinstatement of support in this chapter.

(3) An explanation of the rights and responsibilities of the obligee to respond to the action.

(4) A statement that, within 20 days of service, the obligee must submit a signed and notarized response to child support services objecting to at least one of the assertions in subrules 102.8(1) through 102.8(4). The statement will inform the obligee that if, within 20 days of service, the obligee fails to submit a response as specified in this subparagraph, notwithstanding Rules of Civil Procedure 1.972(2) and 1.972(3), child support services will prepare and submit an order.

b. No sooner than 30 days after service on the obligee, child support services will do one of the following:

(1) If the obligee submits a signed and notarized objection to at least one of the assertions in subrules 102.8(1) through 102.8(4), deny the request and notify the parties in writing that the request is denied, providing reasons for the denial, and notifying the parties of the right to proceed through private counsel.

(2) If the obligee cannot be served, child support services will issue a written notice to the obligor indicating the request is denied, following the procedure described in subrule 102.10(2).

(3) If the obligee does not timely submit a signed and notarized objection to child support services, prepare an order following the procedure described in rule 441—102.11(252B).

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.11(252B) Order suspending support by payor's request. After approving a request to suspend support and properly serving the obligee, child support services will prepare and present to the district court an order suspending support as provided in Iowa Code section 252B.20A.

102.11(1) The suspension will apply to ongoing support provisions, including medical support, with respect to only the children entitled to support under the order who are residing with the obligor or caretaker.

102.11(2) A copy of the filed order will be sent by first-class regular mail to the last-known address of the obligor and obligee or, if applicable, to the last-known address of the obligor's or obligee's attorney.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.12(252B) Suspension of enforcement of current support—suspension by payor’s request. Child support services will suspend enforcement actions intended to collect or enforce any current support obligation that would have accrued during the time the support obligation is suspended. Child support services will continue to provide all appropriate enforcement services to collect any support not suspended and any arrearages that accrued before the effective date of the suspension.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.13(252B) Request for reinstatement. Child support services may request that the court reinstate the suspended support obligation in accordance with the procedures found in Iowa Code sections 252B.20 and 252B.20A.

102.13(1) Either the obligor or the obligee affected by the suspended order may request reinstatement by submitting a written request for reinstatement to child support services. The request must indicate that reinstatement is being requested and the reason for reinstatement and must contain sufficient information to identify the court order and parties involved. The request must also be signed by the requesting party.

102.13(2) Child support services may, at its own initiative, request that the court reinstate a support obligation when it is determined that a child for whom the obligation was suspended is receiving public assistance benefits.

102.13(3) Child support services will issue a written notice approving or denying the request to any obligor or obligee requesting reinstatement. This notice will be sent by first-class regular mail to the last-known address of the requesting party and will indicate any reason for denial.

102.13(4) A properly completed request for reinstatement will be denied when any of the following conditions exist:

- a.* The request is made by someone other than the obligor, the obligee, or the obligor’s or obligee’s attorney.
- b.* Child support services is no longer providing enforcement services for the suspended order.
- c.* The request is received more than six months after the date of the filing of the order suspending support.
- d.* The request is for partial reinstatement of the suspended support order for some but not all of the children, and the order does not contain a step change.
- e.* A court in this state would not have continuing, exclusive jurisdiction to reinstate the order under Iowa Code chapter 252K.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.14(252B) Reinstatement. Child support services will follow the procedures in Iowa Code sections 252B.20 and 252B.20A in seeking to have the court reinstate a support order.

102.14(1) Child support services will request that the court reinstate a spousal support provision previously suspended if the provision was included in the suspension in accordance with subrule 102.5(1) and if child support services receives a properly completed request from the obligor or the obligee.

102.14(2) Child support services will seek to have the previously suspended support for a child reinstated when the conditions in paragraph 102.14(2) “a” or “b” are met. This provision will not prohibit any party, including child support services, from taking other action to establish support as provided for by law.

- a.* The basis for suspension no longer applies to any of the children for whom support was suspended; or
- b.* The basis for suspension continues to apply to some but not all of the children for whom support was suspended, and there is a step change in the order.

102.14(3) Child support services will seek to have a previously suspended child care add-on reinstated when seeking to reinstate child support for one or more children who are subject to the child care add-on.

[ARC 8968C, IAB 2/19/25, effective 4/1/25; ARC 9764C, IAB 11/26/25, effective 1/1/26]

441—102.15(252B) Reinstatement of enforcement of support. If a suspended support obligation is reinstated, child support services will also reinstate all appropriate enforcement measures to enforce all reinstated ongoing support provisions of the support order.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.16(252B) Temporary suspension becomes final. The temporary suspension of a support order under this chapter will become final if not reinstated in accordance with Iowa Code sections 252B.20 and 252B.20A.

[ARC 8968C, IAB 2/19/25, effective 4/1/25]

441—102.17(17A) Right of appeal. Department actions under this chapter are not subject to administrative appeal under 441—Chapter 2506.

[ARC 8968C, IAB 2/19/25, effective 4/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 252B.

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[Filed ARC 9764C (Notice ARC 9582C, IAB 10/1/25), IAB 11/26/25, effective 1/1/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 109 CHILD CARE CENTERS

[Filed as Chapter 108, 2/14/75 and renumbered 7/1/75]

[Prior to 7/1/83, Social Services[770] Ch 109]

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

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—109.1(237A) Definitions.

“Adult” means a person 18 years of age or older.

“Child” means the same as defined in Iowa Code section 237A.1.

“Child care” means the same as defined in Iowa Code section 237A.1.

“Child care center” or *“center”* means the same as defined in Iowa Code section 237A.1. For the purposes of this chapter, the word “center” applies to a child care center or preschool unless otherwise specified.

“Child care facility” or *“facility”* means the same as defined in Iowa Code section 237A.1.

“Coaching” means a relationship-based process led by an expert to build capacity for specific professional dispositions, skills and behaviors and is focused on performance-based outcomes.

“Education” means formal coursework offered through a state-approved accredited secondary school, college or university.

“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 the same as defined in Iowa Code section 237A.1.

“Parent” means parent or legal guardian.

“Person subject to an evaluation” means the same as defined in Iowa Code section 237A.5.

“Preschool” means the same as defined in Iowa Code section 237A.1.

“Professional development” means a continuum of learning activities designed to prepare and support individuals for work with children and families, including coaching, education, and training.

“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 section 237A.1.

“Serious injury” means the same as defined in Iowa Code section 702.18.

“Training” means a learning experience that addresses a specific topic of professional relevance that builds or enhances knowledge.

“Transgression” means the same as defined in Iowa Code section 237A.5.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

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 must 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, will be furnished to the department upon application and renewal.

c. A center must submit all required fingerprints to the department of public safety before the issuance or renewal of the center’s license.

d. When a center makes a sufficient application for an initial license, the center may operate for a period of up to 120 calendar days from the date of issuance of the form granting permission to open

without a license, pending a final licensing decision. A center has made a sufficient application when it has had an on-site visit and has submitted the following to the department:

- (1) An application for a license.
- (2) An approved fire marshal's report.
- (3) A floor plan indicating room descriptions and dimensions, including location of windows and doors.
- (4) Information sufficient to determine that the center director meets minimum personnel qualifications.

e. Applicants must submit the regulatory fee as specified in subrule 109.2(5) to the department.

f. Applicants must 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 must be notified of approval or denial within 120 calendar days of the date of issuance of the form.

(2) No full or provisional license will be issued before payment of the applicable regulatory fee as determined pursuant to subrule 109.2(5).

g. The department will not act on a licensing application for 12 months after an applicant's child care center license has been denied or revoked.

h. When the department has denied or revoked a license, the applicant or person is 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(5) 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 will make the final decision.

b. A new license must be applied for when the center moves, expands, or the facility is remodeled to change licensed capacity.

c. A new license must be applied for when another adult or agency assumes ownership or legal responsibility for the center.

d. A provisional license may be issued or reduced pursuant to Iowa Code section 237A.2.

109.2(3) Denial. Initial applications or renewals will 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 that 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(5) is not received by the department within 60 calendar days from the due date on the invoice.

109.2(4) Revocation and suspension. A license will 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 that 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, 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(5) is not paid in full due to insufficient funds to cover a check submitted to the department for the fee.

109.2(5) Regulatory fees. A fee based upon center capacity is due to the department at the time of issuance of the license in accordance with this subrule.

a. *Fee structure.* The amount of the fee is based on the capacity of the center as indicated below:

<u>Center Capacity</u>	<u>Fee Amount</u>
0 to 20 children	\$50
21 to 50 children	\$75
51 to 100 children	\$100
101 to 150 children	\$125
151 or more children	\$150

b. *Determination of capacity.* The licensing consultant must 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). 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) are maintained.

c. *Notification.* Upon final determination of center capacity by the licensing consultant, the licensing consultant or designee must sign and provide the child care center licensing fee invoice to the center.

d. *Payment.* The center must return the child care center licensing fee invoice to the department with the licensing fee payment within 60 calendar days from the date on the invoice. Regulatory fees are nonrefundable and nontransferable.

109.2(6) Adverse actions.

a. Notice of adverse actions for a denial, revocation, or suspension and the right to appeal the licensing decision will be given to applicants and licensees in accordance with 441—Chapter 2506 and 441—subrule 16.2(3).

b. A letter received by an owner or director of a licensed center initiating action to deny, suspend, or revoke the facility's license must be conspicuously posted at the main entrance to the facility. The letter will 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 must return the license to the department.

c. If the center's license is denied, suspended, or revoked, the department will notify the parent, guardian, or legal custodian of each child for whom the facility provides child care.

d. The center must cooperate with the department in providing the names and addresses of the parent, guardian, or legal custodian of each child for whom the facility provides child care.

[ARC 9021C, IAB 3/19/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—109.3(237A) Inspection and evaluation. The department will conduct an unannounced on-site visit in order to make a licensing recommendation for all initial and renewal applications for licensure and will determine compliance with licensing standards imposed by licensing laws and these rules when a valid complaint is received.

109.3(1) At least one unannounced on-site visit will be conducted each calendar year.

109.3(2) After each visit and valid complaint, the department will 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 valid complaints will be available to the public. However, the identity of the complainant will be withheld unless expressly waived by the complainant.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.4(237A) Administration.

109.4(1) *Required written policies.* The child care center owner, board or director shall:

a. Develop and implement policies for enrollment and discharge of children, field trips and noncenter activities, discipline/behavior, nutrition, health and safety policies and, if transporting children, transportation policy.

b. 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.

c. Develop and implement a written plan for staff orientation to the center's policies and to the provisions of this chapter.

d. Make available for review a copy of the center policies and programs 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.

e. When serving children under the age of three, develop and implement a policy for responding to incidents of biting.

f. Develop and implement a policy to ensure that people do not have unauthorized access to children at the center.

g. Develop and implement a policy for protection of each child's confidentiality.

h. Develop and implement procedures for medical and dental emergencies, and ensure through orientation and training that all staff are knowledgeable of and able to implement the procedures.

109.4(2) *Required postings.* The following postings must be conspicuously posted in an area frequented by parents or the public:

a. Certificate of license at the main entrance of the center.

b. Notice of exposure of children to a communicable disease. The notice of exposure of children to a communicable disease will include the symptoms and the period of communicability.

c. Notice of decision to deny, suspend, or revoke the center's license or reduce the center's license to a provisional status, if applicable.

d. Mandatory reporter requirements.

e. Notice of availability of the handbook "Child Care Centers and Preschools Licensing Standards and Procedures (August 1, 2024)."

f. Name and contact information of the department's child care licensing consultant.

g. Program activities and menu.

109.4(3) *Mandatory reporters.* Methods of identifying and reporting suspected child abuse and neglect shall be discussed with all staff within 30 days of employment.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.5(237A) Parental participation. Parents must 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 will inform all parents of this policy in writing at the time the child is admitted to the center.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.6(237A) Personnel. The director of the center must 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 must 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 program administration. The director must ensure services are provided for the children within the framework of the licensing requirements. The center director must have overall responsibility for carrying out the program and ensuring the safety and protection of the children. The following minimum qualifications must be submitted to the child care consultant for final approval prior to the start of employment. The center director:

- 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, recordkeeping, or budgeting, or has one year of administrative-related experience.
- d. Has certification in pediatric cardiopulmonary resuscitation (CPR), pediatric 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	25	One point per contact hour of training
Associate's degree in child development or bachelor's degree in a child-related field	60	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	45	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	25	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 must 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 must 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 required to be present when the program has multiple sites or when a director is not routinely present for six hours daily. The center director

must identify a person in charge during the on-site supervisor's absence. 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 six hours of the center's hours of operation. The following minimum qualifications will be submitted to the child care consultant for final approval prior to the start of employment. The on-site supervisor:

- a. Is at least 18 years of age.
- b. Has obtained a high school diploma or passed a general education development test.
- c. Has certification in infant, child, and adult CPR; infant, child, and adult 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 chart and calculation described in subrule 109.6(1). 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 must be obtained from the experience category.

109.6(3) *Volunteers.* A volunteer must be at least 16 years of age. All volunteers 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 has been informed of the volunteer's responsibilities as a mandatory reporter.
- c. Undergo the record check process when any of the following criteria are met:
 - (1) The volunteer is included in meeting the required child-to-staff ratio;
 - (2) The volunteer has direct responsibility for a child or children; or
 - (3) The volunteer 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(3)"a" and "b" and documentation of any record check process. The record must be maintained as required in paragraph 109.9(1)"a."

109.6(4) *Record checks.*

a. *Criminal and child abuse record checks.* Criminal and child abuse record checks shall be conducted for:

- (1) Each owner, director, staff member, 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.

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 department's 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, must be completed before the person's involvement with child care at the center. Iowa records checks must 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 will 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 109.6(4)"c"(1), the department must conduct a criminal and child abuse record check in Iowa for a person who is subject to a record check. The department may access SING to conduct the record

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.

d. National criminal history checks. National criminal history checks based on fingerprints are required for all persons subject to record checks. The national criminal history check must 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.

(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 will provide fingerprints to the department of public safety prior to a person's involvement with child care at the center. The center will 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 must be submitted on a form prescribed by the department to the address listed on the form.

(5) 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 that information in writing upon a center's request, using a form prescribed by the department. If the person being considered for employment has not had involvement with child care in the past six months, a new national criminal history check must be completed.

(6) 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, must send a copy of the results to the department for evaluation. The department will determine whether or not the person may be involved with child care.

e. Mandatory and mandatory time-limited prohibition. A person with any convictions or founded abuse reports as defined in Iowa Code section 237A.5(2) "i" is prohibited from involvement with child care.

f. Evaluation required. For all other transgressions, and as requested under paragraph 109.6(4) "e," the department will 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 must complete the record check evaluation form. The requesting entity must provide the form and any other documents to the department within ten calendar days of the date on the form. The department will 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 will result in denial or revocation of the license or denial of employment. The department will 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.

(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 will consider all of the factors established in Iowa Code section 237A.5(2) "h."

(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 provisions established in Iowa Code section 237A.5(2) "g."

g. Evaluation decision. Within 30 days of receipt of a completed record check evaluation, the department will 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 will 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 will 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 will 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 will inform the employer of any conditions and corrective action plan relating to the person's involvement with child care.

h. Notice to parents. The department will provide notification of founded child abuse committed by an owner, director, or staff member of the child care center pursuant to Iowa Code section 237A.5(2) "k." The center must 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(5) *Use of controlled substances and medications.* All owners, personnel, and volunteers must be free of the use of illegal drugs and not be under the influence of alcohol or of any prescription or nonprescription drug that could impair their ability to function.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.7(237A) Professional growth and development. Professional development will 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. The center director, on-site supervisor, and staff counted as part of the staff ratio must 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 must receive the following training:

- a.* Iowa's training for mandatory reporting of child abuse.
- b.* At least one hour of training regarding universal precautions.
- c.* Certification in infant, child, and adult CPR. A valid certificate indicating the date of training and expiration date will be maintained.
- d.* Certification in infant, child, and adult first aid. A valid certificate indicating the date of training and expiration date must be maintained.
- e.* Essential child care pre-service or equivalent minimum health and safety training 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, abusive head trauma, and child maltreatment.
- (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.

Essential child care pre-service or equivalent minimum health and safety training may be required if content has significant changes that warrant that the training be renewed.

Child care staff employed in programs that only serve children over the age of three are exempt from taking health and safety trainings under subparagraphs 109.7(1)“e”(2) and 109.7(1)“e”(6).

109.7(2) Center directors and all staff.

a. During their first year of employment, all center directors and all staff will receive the following training:

- (1) Ten contact hours of training from approved subject areas from the Council for Professional Recognition or approved content areas from the National Afterschool Association.
- (2) Training received for CPR, first aid, mandatory reporting of child abuse, and universal precautions shall not count toward the ten contact hours.
- (3) A provider shall not use a specific training or class to meet minimum continuing education requirements more than one time every five years.

b. Following their first year of employment, all center directors and all staff must:

- (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) Staff must receive six contact hours of professional development annually from one or more of the subject areas under subparagraph 109.7(2)“a”(1).
- (3) Center directors and on-site supervisors must receive eight contact hours of training annually from one or more approved subject areas under subparagraph 109.7(2)“a”(1).

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. Iowa’s training for mandatory reporting of child abuse.
- b. At least one hour of training regarding universal precautions.
- c. Certification in infant, child, and adult CPR. A valid certificate indicating the date of training and expiration date shall be maintained.
- d. Certification in infant, child, and adult first aid. A valid certificate indicating the date of training and expiration date shall be maintained.
- e. Essential child care pre-service or equivalent minimum health and safety training 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, abusive head trauma, and child maltreatment.
- (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.

Child care staff employed in programs that only serve children over the age of three are exempt from taking health and safety trainings under subparagraphs 109.7(3)“e”(2) and 109.7(3)“e”(6).

109.7(4) 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) (August 1, 2024), or Early Childhood-Positive Behavior Interventions and Supports (EC-PBIS) training series (August 1, 2024) may use those hours to fulfill a maximum of two years’ professional development requirements, not including preservice, first-aid, CPR and mandatory reporter training.

109.7(5) Approved professional development.

a. Professional development contact hours can be coaching, education, or training provided by a department-approved entity.

b. Coaching contact hours may only be used to meet up to half of an individual’s annual professional development requirement.

c. The department may randomly monitor any state-approved professional development for quality control purposes.

d. Professional development conducted with staff during the hours of operation of the facility, during staff lunch hours, or while children are resting must not diminish the required staff ratio coverage. Staff must not be actively engaged in care and supervision and simultaneously participate in training.

e. A professional development 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 will issue its decision within 30 business days of receipt of a complete request.

f. Department-approved entities must provide participants a professional development certificate for approved professional development contact hours.

109.7(6) Professional development for supervisors and designees. The director, on-site supervisor, and any person designated as a lead in the absence of supervisory staff must have completed all preservice/orientation training outlined in subrule 109.7(1).

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.8(237A) Staff ratio requirements.

109.8(1) Staff requirements. Persons counted as part of the staff ratio must meet the following requirements:

- a.* Staff persons must be at least 16 years of age.
- b.* Those staff persons who are under the age of 18 shall meet the following requirements:
 - (1) May not be the sole provider on the premises of a child care facility.
 - (2) Shall not provide transportation to children in care.
 - (3) If staff persons under the age of 18 are providing child care services without an adult, they shall only provide care to school-aged children.
 - (4) May be utilized for brief periods of absence as identified in paragraph 109.8(2)“g” and scheduled nap periods of children over two years of age as identified in paragraph 109.8(2)“h.”

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 4 children
Two years	One to every 7 children
Three years	One to every 10 children
Four years	One to every 12 children
Five years to ten years	One to every 15 children
Ten years and over	One to every 20 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.
- b.* Combinations of age groupings for children three, four, and five years of age may be allowed with a ratio of one staff member to every 12 children.
- c.* Children between 18 months and three years of age may be combined, if appropriate to the developmental needs of the child. If a child under two years of age is in a combined age group, the staff ratio of one to seven will be maintained. Otherwise, staff ratio may be determined by the age of the majority of the children in the group.
- d.* Combinations of age groupings that do not meet paragraphs 109.8(2) “*a*” through “*c*” may be approved by a child care licensing consultant when a program can show developmentally appropriate curriculum for all age groups and can provide sufficient supervision.
- e.* Combinations of age groupings for children five years of age and older must have a ratio consistent with the age of majority.
- f.* 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.
- g.* Every child-occupied program room must have supervision present in the room. Brief absences of a staff member may be allowed for no more than five minutes when another staff person is present.
- h.* During nap time, at least one staff member must be present in every room where children are resting. Staff ratio requirements may be reduced to one staff member per room where children are resting and staff ratio coverage can be maintained in the center. The staff ratio must always be maintained for children under two years of age.
- i.* When more than eight children are present on the licensed premises, at least two staff members shall be present.
- j.* For a period of two hours or less at the beginning and end of the center’s hours of operation, one staff member may care for eight or fewer children, provided no more than four of the children are under two years of age and there are no more than eight children in the center.
- k.* When more than eight children are being transported in one vehicle, at least two staff members must be present, one of which is over 18 years of age.
 - (1) 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.
 - (2) When a center contracts with another entity to provide transportation other than for the purpose of transporting children to or from school, at least one adult staff in addition to the driver must be present if at least eight children provided care by the center are transported.
- l.* Any child care center-sponsored program activity involving six 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. At least one staff present on field trips must be over 18 years of age.
- m.* For centers 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 or canceled 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.

109.8(3) Group size. Group size is determined in collaboration with the state fire marshal and will be assigned based on the review of health and safety requirements. Maximum capacity allowed shall be included on the certificate of license. Group sizes by age group must be included in annual inspection reports.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.9(237A) Records.

109.9(1) *Personnel records.* The center will 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 must contain, at a minimum, the following:

a. Copies of all record checks kept in accordance with state and federal law regarding confidentiality of record checks. These records shall include:

(1) A copy of a department 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 record 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 record check, regardless of findings.

b. A physical examination report. As required in Iowa Code section 237A.5(1), personnel shall have good health as evidenced by a preemployment physical examination. Acceptable physical examinations shall be documented on a form prescribed by the department. The examination shall be performed within six months prior to beginning employment and shall be repeated at least every three years. A physical examination may be requested if the employer has reason to believe an employee would not be able to perform a job successfully or safely due to a medical condition.

c. Documentation showing the minimum staff training requirements as outlined in rule 441—109.7(237A) are met, including current certifications in first aid and CPR and Iowa's training for the mandatory reporting of child abuse.

d. 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 must maintain current and sufficient information in a file for each child that includes:

a. Child enrollment information, including name, age, date of birth, and address.

b. Parent/guardian contact information.

c. Emergency contacts and persons who can pick up the child as authorized by the parent.

d. Contact information and authorization of emergency medical and dental services.

e. Health and medical needs of a child, including any allergies or special health needs, a written emergency plan and prescribed treatment.

f. Incident reports of injuries, accidents, or other incidents, as applicable.

g. Parent authorization for a child to attend center-sponsored field trips and noncenter activities.

h. Signed and dated valid Certificate of Immunization, Certificate of Immunization Exemption, or Provisional Certificate of Immunization, provided by the department must be on file for each child enrolled as required by 641—Chapter 7.

i. For each child not yet enrolled in kindergarten, the child care center must require a physical examination submitted at enrollment but no later than within four weeks of admission. The physical should include a health history and status of present health, including allergies, medications, acute or chronic conditions, and care plan when needed. The physical should be completed and signed by the child's primary health care provider (MD, DO, chiropractor, PA, or ARNP). The date of the physical examination shall be no more than 12 months prior to the first day of admission and annually thereafter until kindergarten entry.

j. For school-aged children, the child care center must have a statement of health signed by the parent indicating the child's health status, allergies, medications, acute or chronic conditions and care plan when needed.

k. For a child who has a special health need, there must be a written care plan completed and signed by the child's primary health care provider (MD, DO, chiropractor, PA, or ARNP) or parent or guardian. The care plan should include the care needed, when the care is to be given, and any possible complications or side effects, including required interventions. Documentation of special needs provided should be in a manner similar to documentation for medication administration.

109.9(3) *Daily activities.* For each child under two years of age, the center must 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 9021C, IAB 3/19/25, effective 7/1/25]

441—109.10(237A) Health and safety policies. The child care center will establish definite health policies, including the criteria for excluding a sick child from a center. The child care center may be provided guidance from the child care center's child care nurse consultant or the department regarding exclusion of an exposed child or staff during a communicable disease outbreak.

109.10(1) *Medications.* The center shall have written procedures for the dispensing, storage, authorization, and recording of all prescription medications, nonprescription medications, and nonmedicated topical products, including the following:

- a. Staff must be over 18 to administer medication.
- b. All medications must be stored in their original containers, with accompanying physician or pharmacist's directions and label intact and stored so the medications are inaccessible to children and the public. Nonprescription medications must be labeled with the child's name.
- c. 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.
- d. In the case of medications that are administered on an ongoing, long-term basis, authorization must be obtained for a period not to exceed the duration of the prescription.
- e. 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(2) *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 that may adversely affect the child or the group.

109.10(3) *Infectious disease control.* Centers must establish policies and procedures related to infectious disease control and the use of universal precautions with the handling of any bodily fluids that include blood, bodily excrement or discharge. Soiled diapers shall be stored in containers separate from other waste. 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.

109.10(4) *Quiet area for ill or injured.* The center will provide a quiet area under supervision for a child who appears to be ill or injured. The parents or a designated person will be notified of the child's status in the event of a serious illness or emergency.

109.10(5) *Staff hand washing.* The center must ensure that staff demonstrate clean personal hygiene sufficient to prevent or minimize the transmission of illness or disease.

109.10(6) *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, one for rinsing, and one for drying may be used in place of running water.

109.10(7) *First-aid kit.* The center must 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 must be sufficient to address first aid related to minor injury or trauma and stored in an area inaccessible to children.

109.10(8) *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.

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 must be verbally reported to the parents, guardians, and legal custodians immediately.

(1) Serious injuries must be reported to the department within 24 hours of the incident.

(2) Serious injuries must 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 must be notified immediately after the incident. A written report fully documenting every incident will 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 will be retained in the child's file.

109.10(9) *Smoking.* Smoking and the use of tobacco products must be prohibited and nonsmoking signs must be posted pursuant to Iowa Code chapter 142D.

109.10(10) *Transportation.* Children must be transported pursuant to Iowa Code section 321.446.

109.10(11) *Field trips.* Emergency telephone numbers and emergency health plans, as applicable, for each child must 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(12) *Pets.* Animals kept on site must 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 can be kept on site. Pets are not allowed in the kitchen or food preparation areas.

109.10(13) *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 intoxicated parents and lost or abducted children. Emergency plans must 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 that includes 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) must be visibly posted by all program and outdoor exits. Emergency plan

procedures must be practiced and documented at least once a month for fire and for tornado. Records on the practice of fire and tornado drills must be maintained for the current and previous year.

c. The center must develop procedures for annual staff and volunteer training on these emergency plans and 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 must conduct a daily check to ensure that all exits are unobstructed.

109.10(14) *Supervision and access.*

a. The center director and on-site supervisor must ensure that each staff member or volunteer knows the number and names of children assigned to that staff member or volunteer for care. Assigned staff and volunteers must provide careful supervision.

b. Any person in the center who is not an owner, staff member, or volunteer who has a record check and department approval to be involved with child care must not have unrestricted access to children for whom that person is not the parent, guardian, or custodian.

c. A parent who is a registered sex offender under Iowa Code chapter 692A cannot be present upon the property of a child care center except for the time reasonably necessary to transport the offender's own minor child or ward to and from the center. Under limited circumstances, a center director may give written permission to be on the property. Before giving written permission, the center director will consult with the center licensing consultant. The written permission must be signed and dated by the center director and the sex offender and kept on file for review by the center licensing consultant.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.11(237A) Physical facilities.

109.11(1) *Room size.* The program room size must 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 must 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 cannot be used as regular program space or counted as useable floor space.

109.11(2) *Play equipment, materials and furniture.*

a. The center will provide sufficient and safe indoor play equipment, materials, and furniture that conform with the standards or recommendations of the Consumer Product Safety Commission (CPSC) (August 1, 2024) or the American Society for Testing and Materials (ASTM) (August 1, 2024) for juvenile products. Play equipment, materials, and furniture must meet the developmental, activity, and special needs of the children.

b. Rooms must be arranged so as not to obstruct the direct observation of children by staff. Individual covered mats, beds, or cots and appropriate bedding will be provided for all children who nap. The center will develop procedures to ensure that all equipment and materials are maintained in a sanitary manner. Sufficient spacing must be maintained. The center shall provide sufficient toilet articles for each child for hand washing.

109.11(3) *Indoor facility requirements.*

a. The center shall ensure that:

(1) The facility and premises are sanitary, safe and hazard-free.

(2) The facility has sufficient:

1. Lighting.

2. Ventilation.

3. Heating and cooling.

(3) Equipment placed in a program area is maintained so as not to result in injury to children.

109.11(4) *Outdoor facility requirements.*

a. Centers must have a safe outdoor program area adjacent to the center, with sufficient square footage to accommodate at least 30 percent of the enrollment capacity at any one time at 75 square feet per child. The outdoor area must:

(1) Be free from litter and unsafe materials and free from contamination by the drainage or ponding of sewage or storm water.

(2) Include safe play equipment and an area of shade.

(3) Include fencing to protect from bodies of water and vehicular traffic.

b. The director or designated person must complete and keep a record of at least monthly inspections of the outdoor play 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 must complete and document an inspection prior to resuming use of the area.

c. 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.

d. 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.

109.11(5) Bathroom facilities. At least one functioning toilet and one sink per 15 children two years of age and older must be provided in a room with natural or artificial ventilation. New construction after November 1, 1995, must 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 must 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(6) Telephone. A working nonpay telephone must be available in the center with emergency telephone numbers for police or 911, fire, ambulance, and poison control center posted in a conspicuous area. The street address and telephone number of the center must be included in the posting. A separate file or listing of emergency telephone numbers for each child shall be maintained.

109.11(7) Kitchen appliances. 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 must be sectioned off and shall not be counted as useable floor space for room size.

109.11(8) Environmental hazards.

a. Within one year of being issued an initial or renewal license, centers operating in facilities built prior to 1978 shall conduct a visual assessment for lead hazards that exist in the form of peeling, cracking or chipping paint or painted surfaces in need of repair. If these lead hazards are found, it shall be assumed that lead-based paint is present on the surfaces, and the surfaces shall be repaired by an Iowa certified lead-safe renovator before a full license will be 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 following the National Consensus Standards as outlined in 641—Chapter 43.

c. To reduce the risk of carbon monoxide poisoning, all centers shall, on an annual basis, 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 (August 7, 2024).

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.12(237A) Activity program requirements.

109.12(1) Activities. The center shall have a written curriculum 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 supports development of self-esteem, self-regulation, positive social interactions, communication skills, curiosity, problem-solving, creative expression, and gross motor and fine motor development.
- b. A balance of active and quiet activities, individual and group activities, indoor and outdoor activities, and staff-initiated and child-initiated activities.
- c. Experiences in harmony with the ethnic and cultural backgrounds of the children.
- d. A supervised nap or quiet time for all children under six years of age 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 that shall be provided to staff at the start of employment and to parents at the time of admission. The center shall not use as a form of discipline:

- a. Corporal punishment, including spanking, shaking, and slapping.
- b. Punishment that is humiliating or frightening or that causes pain to the child. Children shall never be locked in a room or closet.
- c. 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.
- d. Punishment or threat of punishment associated with a child's illness, lack of progress in toilet training, or in connection with food or rest.
- e. No child shall be subjected to verbal abuse, threats, or derogatory remarks about the child or the child's family.

109.12(3) Children requiring special accommodations. Reasonable accommodations, based on the special needs of the child, must be made in providing care to a child with a disability.

109.12(4) Infant environment.

- a. An area shall be provided that is properly and safely equipped for the use of infants and free from the intrusion of children two years of age and older.
- 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 that 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 for infants under one year of age.
 - (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 (August 1, 2024) and ASTM federal standards (August 1, 2024).
 - (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 infant sleeping, including but not limited to an infant seat, car seat, swing, or bouncy seat.
 - (4) No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.
 - (5) No co-sleeping shall be allowed.
 - (6) Sleeping infants shall be actively observed by sight and sound.
 - (7) If an alternate sleeping position is needed, a signed physician or physician associate authorization with statement of medical reason is required and an expiration date.
- f. A crib or crib-like furniture that has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and that meets the current standards or recommendations from the U.S. Consumer Product Safety Commission (August 1, 2024) or ASTM International (August 1,

2024) 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 crib-like furniture shall be provided for the number of children present at any one time. The center shall develop procedures for maintaining all cribs or crib-like furniture and bedding in a clean and sanitary manner. There shall be no restraining devices of any type used in cribs.

g. Infant walkers cannot be used.

h. All items used for sleeping must be used in compliance with manufacturer standards for age and weight of the child.

[ARC 9021C, IAB 3/19/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

441—109.13(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.

109.13(1) *Nutritionally balanced meals or snacks.* The center shall serve each child a full, nutritionally balanced meal or snack as defined by the CACFP guidelines (August 1, 2024) 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.

109.13(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 (August 1, 2024). Menus shall be 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 should not be served per CACFP FNS-877 (August 1, 2024). 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.

109.13(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 (August 1, 2024). Foods shall be appropriate for the infant's nutritional requirements and eating abilities. Special formulas prescribed by a physician or health care provider shall be given to a child who has a feeding problem.

b. Bottles or containers of infant foods should be warmed under running, warm tap water or by placing them in a container of water that is no warmer than 120°F (49°C). Bottles and infant foods should never be warmed in a microwave oven.

c. 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 or cot with a bottle or any other food item or left sleeping with a bottle or food item. Spoon feeding shall be adapted to the developmental capabilities of the child.

d. 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.

e. Whole milk for children under two years of age who are not on formula or breast milk unless otherwise directed by a physician shall be used.

f. 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.

109.13(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 (August 1, 2024) 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 (August 1, 2024) may be provided by parents for special occasions such as birthdays or holidays.

109.13(5) *Food preparation, storage, and sanitation.* Centers shall ensure that food preparation and storage procedures are consistent with the recommendations of the CACFPs (August 1, 2024) 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.

109.13(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.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.14(237A) Extended evening care. A center providing extended evening care between the hours of 9 p.m. and 5 a.m. shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter, with the additional requirements set forth below.

109.14(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 that 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.

109.14(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.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.15(237A) School-based before- and after-school and summer programs. 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. Centers that operate in a school building shall comply with the licensing requirements for centers contained in Iowa Code chapter 237A and this chapter with the following considerations:

109.15(1) Infant-specific regulations outlined in paragraph 109.12(4) “e” and subrule 109.13(3) are not applicable.

109.15(2) Centers 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.

109.15(3) Centers shall ensure that the indoor and outdoor space occupied by the center is sanitary, safe, and hazard-free. Outdoor space used for recreation during the school day is sufficient for use by the child care program.

109.15(4) Centers that serve only school-age children and that operate in a school building are exempted from testing for lead and carbon monoxide.

109.15(5) Personnel. For director requirements set forth in subrule 109.6(1), for 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.

109.15(6) Child’s file. All requirements under subrule 109.9(2) must be followed. For a center serving school-age children that operates in the same school facility in which the child attends school, documentation, including certificates of immunization, certificates of immunization exemption, or provisional certificates of immunization, shall be submitted to both locations in accordance with 641—Chapter 7.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

441—109.16(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.

109.16(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 rule 655—6.3(152).

109.16(2) *Health policies.*

a. The center shall have a written health policy, consistent with the National Health and Safety Performance Standards (August 1, 2024), 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 department.

- 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.

109.16(3) Exceptions. The following exceptions to this chapter 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 two years of age.
- b. All staff who have contact with children shall have a minimum of ten clock hours of special training in caring for mildly ill children.
- c. There shall be 40 square feet of program space per child.
- d. 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.
- e. 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.

[ARC 9021C, IAB 3/19/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 232.69 and chapter 237A.

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CHAPTER 111
FAMILY-LIFE HOMES

[Prior to 7/1/83, Social Services[770] Ch 111]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/31

441—111.1(249) Definitions.

“Eligible adult” means a person 18 years of age or older who meets the eligibility requirements for services or is a recipient of protective services and who is considering or needs a living arrangement in a family-life home.

“Encouragement to share in the interests and activities of the household” means that the family welcomes and encourages the person to participate with the family in the family’s general family conversations and in the family’s social, recreational, educational, and religious activities; the family invites and encourages use of the general facilities of the family’s home; and the family expects the person to care for the person’s assigned living quarters and to participate within reason in the chores of the household.

“Essentially capable of physical self-care” means the person is ambulatory or can move from place to place; can manage the activities of daily living, including personal hygiene and grooming, toileting, dressing and undressing, feeding, and medicating; and can attend to the care of personal property adequately with minimal support or occasional assistance.

“Family” means a person or persons, either related or unrelated to the client, who constitute the members of the household and are related to one another by kinship of blood, marriage, or adoption.

“Family-life home” means a private household offering a protective social living arrangement for one or two eligible adults who are not able or willing to adequately maintain themselves in an independent living arrangement but who are essentially capable of physical self-care. In this living arrangement, the family provides the client room, board, laundry, encouragement to share in the interests and activities of the household, and opportunities for participation in the social, cultural, educational, religious, and other activities of the community.

“Not able or willing to adequately maintain themselves in an independent living arrangement” means that the person requires some assistance, encouragement, or social stimulation for adequate self-care or to maintain physical or mental health or personal safety.

“Private household” means a dwelling unit occupied exclusively by a family and furnished by and belonging to the family by reason of ownership, rental agreement, or by a contract for purchase of life estate.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.2(249) Application for certification.

111.2(1) The department will issue a certificate of approval for the operation of a family-life home upon the recommendation of a local office of the department.

111.2(2) Any person has the right to make application for a family-life home certificate.

111.2(3) Persons wishing to care for adults shall make application to the local office of the department.

111.2(4) When an applicant has reached a decision to operate a family-life home, the applicant shall complete an Application for Certification form.

111.2(5) Each applicant shall supply two references who may be contacted by the local office of the department.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.3(249) Provisions pertaining to the certificate.

111.3(1) No family-life home shall be certified to provide a living arrangement for more than two eligible adults.

111.3(2) At least one responsible adult member of the family shall be at the family dwelling or be reasonably available to the client during most of the daytime and nighttime hours, based on the service worker's assessment of the individual's need for supervision.

111.3(3) The certificate shall be effective for one year from the date issued subject to continued compliance with rules governing the program.

111.3(4) The certificate shall not be transferred to another person nor be valid for an address other than that shown on the certificate issued.

111.3(5) A current certificate shall be in the possession of the certified family-life home and be available for inspection.

111.3(6) There will be no fee nor charge for the certificate issued.

111.3(7) A certified family-life home shall not be concurrently licensed as a residential care facility, intermediate care facility, child care center or a foster family home. An exception may be made for a home to be concurrently licensed as a foster family home and certified as a family-life home in order to provide continued care for a person who was placed in the home as a foster child.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.4(249) Physical standards.

111.4(1) The family-life home shall be safe, clean, well-ventilated, and properly lighted and heated. The family's dwelling shall comply with all local health ordinances.

111.4(2) The family's dwelling shall not be a dwelling unit furnished by or belonging to a client.

111.4(3) Sleeping rooms shall be suitably and comfortably furnished.

111.4(4) Each resident shall have a single bedroom unless there is agreement among the family and the residents that a room may be shared.

111.4(5) The family shall provide nutritional food in sufficient quantity to meet the needs of the client.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.5(249) Personal characteristics of family-life home family.

111.5(1) The adult head of the private household shall be a mature, responsible individual who is physically able to maintain a private household and who shall exercise good judgment in caring for adults.

111.5(2) The family shall have an appreciation of and respect for the client's relationship with the client's own relatives, neighbors and friends.

111.5(3) The family shall respect the client's religious background and affiliation.

111.5(4) The family shall have sufficient income and resources to provide adequately for the family's own needs.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.6(249) Health of family.

111.6(1) Prior to certification, the family shall furnish the local office of the department with a medical report on each member of the household. The report shall be on a Provider Health Assessment form.

111.6(2) The medical report shall provide significant findings of a physician, such as the presence or absence of any communicable disease.

111.6(3) Medical reexaminations may be required at the discretion of a physician or the local office of the department.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.7(249) Planned activities and personal effects.

111.7(1) The daily routine shall be to promote and provide an opportunity for normal activity with time for rest and recreation compatible with the needs of the client.

111.7(2) Every client shall be encouraged to develop social relationships through participation in neighborhood and other community and group activities.

111.7(3) The family shall not require a client to do general housecleaning, cooking, or child care for the family. A client may voluntarily share in these responsibilities.

111.7(4) Space shall be provided where a client may keep personal belongings.
[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.8(249) Client eligibility.

111.8(1) The client shall be 18 years of age or older as proven by birth or school records, personal records, or by records of the department or another agency.

111.8(2) The client shall be willing to live in a certified family-life home by the client's own declaration or the declaration of a person legally responsible for such client.

111.8(3) The client shall be willing to accept the terms and requirements of the family-life home program.

111.8(4) The client shall be capable of personal physical self-care.
[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.9(249) Medical examinations, records, and care of a client.

111.9(1) A physician shall certify that the client is free from any communicable disease and does not require a higher level of care than that provided by a family-life home. The certification shall be given prior to placement and following an annual medical review thereafter. The certification shall be given on a Physician's Report Health Care Plan form.

111.9(2) The family shall have available, at all times, the name, address and telephone number of the client's physician.

111.9(3) The family shall keep the department informed of any health problems. The family shall immediately notify the department in case of an accident, illness, or emergency that may affect the placement.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.10(249) Placement agreement. The head of the family-life home and the resident shall enter into a placement agreement by signing a Family Life Home Placement Agreement form.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.11(249) Legal liabilities. The department will advise the family to seek counsel regarding the family's needs for insurance to cover personal injury, property damage, and other legal contingencies.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.12(249) Emergency care and release of client.

111.12(1) In case of an emergency, vacation, or overnight trip, requiring the family's temporary absence from the home, the local office of the department shall be notified and arrangements shall be made with a designated, responsible person for the care of a client during the period of absence.

111.12(2) The department shall be notified when the client leaves or the client or family expresses a desire for the client to leave the family-life home.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

441—111.13(249) Information about client to be confidential. Information concerning a client, the client's family, and the client's background shall be regarded and handled as confidential by all persons involved in the client's care.

[ARC 0348D, IAB 6/10/26, effective 8/1/26]

These rules are intended to implement Iowa Code sections 234.6(1) "e" and 249.3(2) "a"(1).

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CHAPTER 119
RECORD CHECK EVALUATIONS FOR
CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/31

441—119.1(135B,135C) Definitions.

“Deferred judgment” means the same as defined in Iowa Code section 907.1 and is considered an admission of committing an act. Under this chapter, the admission of committing an act must be considered a conviction for purposes of public protection.

“Requesting entity” means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can be employed by the entity or participate in a training or education program and includes the following:

1. Health care facilities as defined in Iowa Code section 135C.1.
2. Programs in which the provider is regulated by the state or receives any state or federal funding and the employee being evaluated provides direct services to consumers, including but not limited to programs that employ homemakers or home health aides, programs that provide adult day services, hospices, federal home- and community-based services waiver providers, elder group homes, and assisted living programs.
3. Substance abuse programs for juveniles as described in Iowa Code section 125.14A.
4. Hospitals as defined in Iowa Code section 135B.1.
5. Psychiatric medical institutions for children as defined in Iowa Code section 135H.1.
6. The department as described in Iowa Code sections 217.44 and 217.45.
7. Department institutions as described in Iowa Code section 218.13.
8. Child foster care facilities as described in Iowa Code section 237.1.
9. Medicaid home- and community-based services waiver providers as described in Iowa Code section 249A.29.
10. Certified nurse aide training programs as described in Iowa Code section 135C.33(9).
11. Nursing education programs as described in Iowa Code chapter 152.

“Start employment or attend the training program” means to begin to receive a salary or take classes.

“Training” means certified nurse aide training programs as described in Iowa Code section 135C.33(9) or nursing education programs as described in Iowa Code chapter 152.

[ARC 0349D, IAB 6/10/26, effective 8/1/26]

441—119.2(135B,135C) When record check evaluations are requested.

119.2(1) *Record check evaluations on prospective employees and students.* A requesting entity shall request a record check evaluation prior to employment or enrollment of a person whose background check indicates a criminal or dependent adult abuse or child abuse record. Any deferred judgments will be considered in criminal background checks. Criminal, child abuse and dependent adult abuse background checks are required on all prospective employees or students, including employees or students who have terminated employment or participation in a training program for any reason or any length of time and wish to return to the same employment or training program, unless an exemption is provided in these rules.

a. A hospital or licensee of a health care facility may employ a person for up to 60 calendar days pending completion of the evaluation if all the following criteria are met:

- (1) The employment does not involve operation of a motor vehicle; and
- (2) The person to be employed has been convicted of a simple misdemeanor offense under Iowa Code section 123.47 or chapter 321 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2(1); and

(3) The person to be employed does not have a record of founded child or dependent adult abuse; and

(4) The hospital or licensee has requested an evaluation.

b. A training program in a facility licensed under Iowa Code chapter 135C may allow a student who is applying for, enrolled in, or returning to a certified nurse aide training program to participate in the clinical education component of the training program for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

(1) The student's clinical education component of the training program involves children or dependent adults; and

(2) The program does not involve operation of a motor vehicle; and

(3) The student has been convicted of a simple misdemeanor offense under Iowa Code section 123.47 or chapter 321 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2(1); and

(4) The student does not have a record of founded child or dependent adult abuse; and

(5) The training program has requested an evaluation.

119.2(2) *Record check evaluations on current employees and students.* A requesting entity shall request a record check evaluation on current employees and students when a current employee or student background check indicates a criminal conviction other than an Iowa Code chapter 321 simple misdemeanor or equivalent simple misdemeanor offense from another jurisdiction or a dependent adult or child abuse record and the requesting entity intends to continue to employ the employee or to continue the student's enrollment in a training program. The requesting entity shall request a current criminal or dependent adult or child abuse record check when the entity receives credible information as determined by the entity that a current employee or student has a criminal or dependent adult or child abuse record that has not been previously considered by the requesting entity.

119.2(3) *Transfer of employee between facilities.* If a person owns or operates more than one facility, and an employee of one of the facilities is transferred to another facility without a lapse in employment, the facility is not required to request additional criminal or abuse record checks of the employee or obtain a new record check evaluation.

119.2(4) *Exceptions to record check evaluation requirements for employment under Iowa Code chapter 135B or 135C or participation in a training program in facilities licensed under Iowa Code chapter 135C.* If an evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment, the person who is or was employed by a hospital licensed under Iowa Code chapter 135B and is hired by another hospital or the person who is or was employed by a facility licensed under Iowa Code section 135C.33 and is hired by another facility licensed under Iowa Code section 135C.33 may commence employment without further action by the department subject to the following conditions:

a. The record check performed by the subsequent employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

b. 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.

c. Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

d. The person subject to the record checks has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a new record check evaluation shall be performed.

e. Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

f. The subsequent employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

119.2(5) *Exceptions to record check evaluation requirements for new employees under Iowa Code chapter 135B or 135C or participants in a training program in facilities licensed under Iowa Code chapter 135C.* If the person approved for employment or participation does not start employment or attend the training program within 30 days from the notice of decision approving the person, the requesting entity must perform a new record check.

a. If the evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment or participation in a training program, the person being considered for employment may commence employment without further action by the department subject to the following conditions:

(1) The record check performed by the employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

(2) The position with the employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

(3) Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

(4) The employer or person subject to the record checks has maintained a copy of the previous evaluation. If a physical copy of the previous evaluation is not maintained, a new record check evaluation shall be requested.

(5) Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

(6) The employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

b. If the record check indicates that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation, a new record check evaluation shall be performed.

c. Record check evaluations completed in accordance with paragraph 119.4(3) "*c*" are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply.

[ARC 0349D, IAB 6/10/26, effective 8/1/26]

441—119.3(135C) Request for evaluation.

119.3(1) *Required documentation.* The requesting entity and the prospective employee or student shall complete and submit a Record Check Evaluation Form (471-2310) to the department by regular mail, email, or fax to request an evaluation. The department will not process evaluations that are not signed by the prospective employee or student. The position sought or held must be clearly written on the first page of the record check evaluation form. The form shall be accompanied by the following documents:

a. A copy of the documentation of the person's status on the division of criminal investigation (DCI) criminal history database generated within 30 days of the date on which the request for evaluation is submitted to the department.

b. A copy of the Iowa criminal history data, if there is a history, as provided to the requesting entity by DCI.

c. A copy of the documentation of the person's status on the dependent adult abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

d. A copy of the documentation of the person's status on the child abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

119.3(2) Additional documentation.

a. The requesting entity may provide or the department may request from the prospective employee or student 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 applicant's prior residences.

b. Any person or agency that might have pertinent information regarding the criminal or abuse history and rehabilitation of a prospective employee or student may be contacted.

[ARC 0349D, IAB 6/10/26, effective 8/1/26]

441—119.4(135B,135C) Completion of evaluation.

119.4(1) Considerations. The department will consider the following when conducting a record check evaluation:

- a. The nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held.
- b. The time elapsed since the commission of the crime or founded child or dependent adult abuse.
- c. The circumstances under which the crime or founded child or dependent adult abuse was committed.
- d. The degree of rehabilitation.
- e. The likelihood that the person will commit a crime or founded child or dependent adult abuse again.
- f. The number of crimes or instances of founded child or dependent adult abuse committed by the person involved.

119.4(2) Evaluation conclusions.

- a. The department may determine the following:
 - (1) The person may be employed by the entity or enroll in the training program with no restrictions.
 - (2) The person may be employed by the entity or enroll in the training program with restrictions.
 - (3) The person may be employed by the entity or enroll in the training program with restrictions specific to a position within the program.
 - (4) The person may not be employed by the entity or enroll in the training program.
- b. Restrictions on a person's employment or enrollment status will be based upon what is necessary for the protection of the person or persons receiving care.
- c. Medicaid waiver attendant care evaluations will determine that either the person may work or the person may not work pursuant to Medicaid law.

119.4(3) Notice of decision. The department will issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee or student.

- a. The notice will be valid only for employment with the employer or enrollment in a training or education program that requested the record check evaluation.
- b. The notice shall not be valid for employment with any other prospective employer or enrollment in another training program.
- c. Record check evaluations are valid for 30 days from the date the notice of decision is issued pursuant to 441—Chapter 16. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply.

d. The notice of decision shall contain the notice of right to appeal pursuant to 441—Chapter 7.
[ARC 0349D, IAB 6/10/26, effective 8/1/26]

441—119.5(135B,135C) Appeal rights. Any person or the person's attorney may file a written statement with the department requesting an appeal of the record check evaluation decision within 30 days of the date of the notice of the results of the record check evaluation in accordance with 441—Chapter 7.

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CHAPTER 125
KINSHIP FOSTER CARE APPROVAL STANDARDS

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/1/31

441—125.1(237) Definitions.

“Approval” means the authorization granted to a kinship caregiver by the department through an expedited process to provide child foster care and allows the kinship caregiver to receive maximum financial support and to obtain the information and resources necessary to meet the needs of a child under a court-ordered placement with the kinship caregiver.

“Approved kinship caregiver” means a kinship caregiver granted approval for kinship foster care.

“Child,” for the purpose of this chapter, only means the child or children who are in foster care.

“Consanguinity” means relatives who share a common biological ancestor with the child.

“Corporal punishment” means the intentional physical punishment of children.

“Fictive kin” means an adult person who is not a relative of a child but who has an emotionally significant and positive relationship with a child or the child’s family.

“Kinship care” means the care of a child by a relative or fictive kin providing full-time nurturing and protection.

“Kinship foster care” means an expedited process to approve a kinship caregiver for foster care through providing the necessary information, resources, and maximum financial support to the caregiver to meet the needs of the child court ordered to placement in the caregiver’s care.

“Kinship foster caregiver” means a relative or fictive kin providing care for a child who is approved for kinship foster care.

“Reasonable and prudent parent standard” means the same as defined in Iowa Code section 237.1.

“Recruitment and retention contractor” means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents or any of its subcontractors.

“Relative” means an individual related to the child within the fourth degree of consanguinity or affinity, by marriage, or through adoption. This includes the parent of a sibling of the child if the sibling’s parent’s parental rights were not previously terminated in relation to the child.

“Service area manager” means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.2(237) Application for approval.

125.2(1) *Right to apply.* A relative or fictive kin of a child who has been court-ordered to placement in the relative or fictive kin’s care can apply for kinship foster care approval. All applicants must be at least 18 years of age.

125.2(2) *Referrals.* A relative or fictive kin caregiver wishing to apply for kinship foster care approval shall be referred by the department or the department’s contractor for kinship navigator services. The department’s recruitment and retention contractor in the applicable service area shall provide the application packet and assist in completing the approval process with the applicant.

125.2(3) *Decision to operate a kinship foster home.* When an applicant decides to operate a kinship foster family home, the applicant shall complete the Kinship Foster Care Approval Application.

125.2(4) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

125.2(5) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded child abuse report of a kinship foster parent applicant will be evaluated by the department to determine if the founded abuse merits prohibition of approval.

b. The department will evaluate founded child abuse reports on a case-by-case basis. Considerations the department will take include but are not limited to whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

125.2(6) Reports and information. The applicant shall furnish all requested reports and information relevant to the approval determination to the department.

125.2(7) Applications for reapproval. The department or its agent will send an application for reapproval 90 days before the approval expires. Applications for reapproval shall be made on the form specified in subrule 125.2(3).

a. Applications for reapproval shall be made no less than 30 days but no more than 90 days before the approval expires.

b. Applications for reapproval of a kinship foster family approval shall be submitted to the recruitment and retention contractor.

c. The department will approve or deny an application for reapproval as described in rules 441—125.3(237) and 441—125.4(237).

125.2(8) Notification. The department will notify an applicant of the approval or denial of an initial application within 60 days of the date that the applicant is referred to the recruitment and retention contractor. The department will notify an applicant regarding reapproval within 30 days of the expiration of the initial approval.

125.2(9) Approval. Approved kinship foster caregiver applicants will be approved for a term of two years.

a. Thereafter, the caregiver shall apply for reapproval every two years based on the requirements of subrule 125.2(7).

b. A new notice of approval is required any time the caregiver moves to a new home.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.3(237) Denial.

125.3(1) The department will deny the Kinship Foster Care Approval Application when:

a. The applicant, or any person residing in the home other than a foster child, has been convicted of a crime unless the department has evaluated the crime and concluded that the crime does not merit prohibition of approval.

b. The applicant, or any person residing in the home other than a foster child, has a record of founded child abuse unless the department has evaluated the founded abuse and concluded that the abuse does not merit prohibition of approval.

c. There is just cause due to a condition or combination of conditions that cannot be improved and prevents the kinship caregiver from caring for the child's physical, emotional, medical, or educational needs.

125.3(2) Reapplications shall be denied based on the same criteria as initial applications.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.4(237) Approval procedure.

125.4(1) Application. Applicants for an initial approval to become a kinship foster home shall submit the Kinship Foster Care Approval Application forms directed in rule 441—125.2(237).

125.4(2) Record checks. Prior to approval of an application for kinship foster care, applicants shall pass the record check procedures identified in rule 441—125.7(237).

125.4(3) Home study. The recruitment and retention contractor shall complete a kinship foster care home study.

a. Process. Information for the home study is gathered primarily through a face-to-face interview with the identified kinship caregiver(s) in the home. Tribal agencies may also be involved in conducting home studies for American Indian and Alaska Native children. 42 U.S.C. §671(a)(26)(B)

as amended to August 1, 2025, provides that any receiving state must treat any tribal home study report as meeting the requirements imposed by the state for the completion of a home study.

(1) The contractor shall hold at least one face-to-face interview with the applicant(s) with one of the interviews taking place in the applicant's home.

(2) A physical assessment of the home is required. The contractor shall use a Kinship Foster Care Home Study form to assess the physical structure of the home to verify it is safe for the child.

b. Caregiver assessment. The kinship caregiver shall be assessed to evaluate the caregiver's ability to meet the needs of the court-ordered placed child. The assessment will include the following criteria:

(1) The applicant's ability to provide for the child's physical, medical, and emotional needs; to respect the child's ethnic and religious identity; and to support the child's overall well-being.

(2) The safety of the child in relation to any animals that live on the applicant's property.

(3) Knowledge of the child's situation, the caregiver's relationship with the child, the child's family and knowledge of the child's situation and department involvement.

(4) Agreement to abstain from using physical forms of discipline.

(5) Understanding of the reasonable and prudent parenting standard and how to successfully apply the standard.

(6) The caregiver's willingness to access resources and additional supports needed for placement stability to meet the needs of their family and the child placed in their care.

(7) The caregiver's and other household members' current health status, including current prescription medications.

(8) The caregiver's previous or current challenges with mental health, substance use or both and the potential impact it may have on the caregiver's ability to care for the child.

(9) Assessment of whether previous violence was experienced in the caregiver's home and how it has been addressed.

(10) The caregiver's willingness and ability to ensure the child's attendance at school; appointments for medical, dental, and vision; activities; and to ensure family interactions with parents and siblings.

(11) Assessment of the caregiver's ability and willingness to commit to the child, to work with the department, and to be considered as a long-term permanency option.

(12) Understanding of household composition, who has access to the child, other adults and children in the household, relationship status of household members and family dynamics.

(13) Description of the caregiver's available formal and informal supports to ensure child safety and well-being.

c. Physical home assessment. The physical home assessment shall assess the following areas of the applicant's home and address necessary steps to mitigate concerns when identified:

(1) General description of the dwelling, including the number of bedrooms, bathrooms, and shared areas of the home.

(2) Determination of any signs of home infestation by rodents, insects, or other pests.

(3) Existence of external hazards, such as accessibility of pools/hot tubs, nearby bodies of water, railroad tracks, waste materials, or contaminated water.

(4) Existence of internal hazards that pose a risk of harm created by the physical structure of the home, such as broken or missing stairs, exposed wires, large holes in the floor, broken windows, or other physical hazards.

(5) Accessibility of hazardous materials or items in the home or on the property and the means to make them inaccessible to the child in an age-appropriate way or used with appropriate supervision.

(6) Evaluation of a child's access to the following:

1. Firearms and projectile weapons.

2. Medications.

3. Strong or toxic chemicals, such as detergents, bleach, and gasoline.

4. Tools, machinery, farm equipment, lawn mowers, and trampolines.

5. Potable water.
 - (7) Evaluation of the sleeping arrangements for children placed in the home, including:
 1. Planned sharing of sleeping spaces.
 2. Where children will have privacy to change clothes.
 3. If supports are needed to provide beds, bedding, or establish opportunities for privacy.
 4. Discussion of safe sleeping practices for children aged one and younger.
 - (8) Ability to ensure the child's access to age-appropriate personal hygiene (bathing, brushing teeth, wearing clean clothing).
 - (9) Ability to protect the child in an age-appropriate manner from pets or animals.
 - (10) Age-appropriate safe seat restraints (car seat, seatbelt, etc.) in personal vehicles used to transport the child.
 - (11) Ability to provide the child ongoing access to adequate, nutritious, age-appropriate food, including the ability to keep perishable items cold.
 - (12) Understanding of the child's dietary needs related to cultural/religious traditions, medical needs, and allergies.
 - (13) A plan for fire safety, including an escape plan and smoke detectors.
 - (14) Ability to create a safety plan that includes the ability to contact emergency services for assistance within a reasonable distance (neighbor's home, local business, etc.)
 - (15) Description of support mechanisms needed for the caregiver to address any barriers to meeting the physical needs of the home to ensure the safety and well-being of the child and steps taken to address the needs during the approval process.
- d. Written report.* The recruitment and retention contractor shall prepare a written report of the caregiver assessment. This assessment shall include a recommendation for approval or denial of the application and any other pertinent information in making the recommendation. The home study shall be maintained in the kinship caregiver's record maintained by the department.
- 125.4(4) Decision and notice of action.** The department will use the home study and the recommendation of the recruitment and retention contractor to approve or deny a caregiver for kinship foster care.
- a.* The department will notify the family of the decision in writing.
 - b.* If the department does not approve the home study, a notice will be issued according to the provisions of 441—Chapter 16 and state the reasons for that decision as listed in rule 441—125.3(237).
 - c.* A denial may be appealed pursuant to the provisions set forth in 441—Chapter 2506.

[ARC 0110D, IAB 3/4/26, effective 5/1/26; Editorial change: IAC Supplement 6/10/26]

441—125.5(237) Involvement of kin.

125.5(1) Support by kinship foster caregiver. Kinship foster caregivers shall support the involvement of biological or adoptive parents and other relatives of the child unless this involvement is evaluated and documented by the department to be detrimental to the child's well-being.

125.5(2) Nature of involvement. The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the kinship foster caregivers, biological or adoptive parents, and other members involved with the child and family.

125.5(3) Cultural connections. Throughout the provision of care, the kinship foster caregiver shall actively ensure that the child stays connected to the child's kin, culture, and community as required in the child's case permanency plan.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.6(237) Information on the child placed in the home.

125.6(1) Information about the child. Kinship foster caregivers shall maintain a separate file of information on the child placed in the home to include contact information for all medical, dental, vision, hearing and mental health professionals for the child; current medications for the child; school

reports and school pictures received; and the date, name, address and phone number of the person to whom the child was discharged at the end of placement. This file shall be provided to the department or the child's parent or guardian when the child leaves the placement.

125.6(2) Confidentiality. Kinship foster caregivers shall maintain confidentiality regarding the child in their placement, except as required to comply with rules on mandatory reporting of child abuse and with the child's case permanency plan. Kinship foster caregivers shall not without parent, guardian and department consent post pictures or information concerning the child on any internet website.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.7(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 18 years of age or older living in the home of the applicant. The purpose of the record checks is to determine whether any of these persons has any founded child abuse or dependent adult abuse reports or criminal convictions or has been placed on the sex offender registry.

125.7(1) Procedure. The department's contractor for recruitment and retention shall assist applicants in completing required record checks, including fingerprinting.

125.7(2) Iowa records. Each applicant and anyone who is 18 years of age or older living in the home of the applicant shall be checked for records with:

- a. The Iowa central abuse registry;
- b. The Iowa division of criminal investigation;
- c. The Iowa sex offender registry; and
- d. Iowa Courts Online.

125.7(3) Other records. Each applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years. Each adult age 18 years of age or older shall also be fingerprinted for a national criminal history check.

125.7(4) Evaluation of record. If the applicant or anyone living in the home has a record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department will not approve the applicant for kinship foster care unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

125.7(5) Exclusion. An evaluation will not be performed if the person has been convicted of:

- a. A felony offense as set forth in Iowa Code section 237.8(2) "a"(3); or
- b. A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2) "a"(3).

125.7(6) Scope. The evaluation will consider the nature and seriousness of the founded child or dependent adult abuse or crime in relation to:

- a. The position sought or held;
- b. The time elapsed since the abuse or crime was committed;
- c. The circumstances under which the crime or founded abuse was committed;
- d. The degree of rehabilitation;
- e. The likelihood that the person will commit the abuse or crime again; and
- f. The number of abuses or crimes committed by the person.

125.7(7) Evaluation form. The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return to the department the Record Check Evaluation Form, within ten calendar days of the date of receipt, to be used to assist in the evaluation. Failure of the person to complete and return the Record Check Evaluation Form to the department within the specified time frame shall result in denial of approval.

125.7(8) Evaluation decision. Centralized service area staff or designees will conduct the evaluation and make the decision. The department will inform the subject of the decision and describe the basis of the decision using the criteria specified in subrule 125.7(6). The department will send the form to the person on whom the evaluation was completed:

- a. Within 30 days of receipt of the completed form, or
- b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified.

125.7(9) *Reapproval.* Applicants approved for kinship foster care who apply for reapproval shall be subject to the same checks as new applicants, except for fingerprinting. The department will evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation will be conducted using the same process as described in rule 441—125.7(237).

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.8(237) Medical examinations and health care of the child.

125.8(1) *Medical and dental care.* Kinship foster caregivers shall keep the child's department case manager informed of any medical and dental appointments as well as any treatments prescribed for the child.

a. The department may delegate its authority, as custodian, to consent to routine and emergency medical care to a licensed foster parent or approved kinship foster caregiver.

b. Routine medical care includes but is not limited to the following areas:

(1) Preventive care, also known as wellness care, not including the administration of a vaccination. Parents or guardians of the child must provide consent for administration of a vaccination.

(2) Non-emergency medical care, including but not limited to a physical examination, a diagnostic laboratory test, or a medical visit for a minor illness.

(3) Routine dental and vision care, including cleanings and annual examinations.

(4) Use of necessary medication, including but not limited to antibiotics. This does not include psychotropic/mental health medications. Parents or guardians of the child must provide consent for the administration of new psychotropic/mental health medications.

c. When routine and emergency medical consent has not been delegated by the department to the approved kinship foster caregiver:

(1) Kinship foster caregivers shall contact the child's parents to engage them in the process of accessing routine medical and dental care for their child unless parental rights have been terminated.

(2) In case of an emergency or urgent situation requiring medical care and treatment of an acute illness, disease or condition of the child, when a delay or inability to access parental or department consent for medical care or treatment would endanger the health or physical well-being of the child, kinship foster caregivers can provide consent for medical care and treatment.

125.8(2) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization that is against medical treatment for disease.

a. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record.

b. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.9(237) Training and discipline of child.

125.9(1) *Methods of training and discipline.* The home study evaluation of each applicant shall include a discussion and a written assessment of the kinship foster caregivers' methods of training and discipline. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

125.9(2) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the department and the caseworker for the child will be investigated by the department promptly and referred to the proper authorities when necessary.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.10(237) Emergency care and release of child.

125.10(1) *Supervision and arrangements for emergency care.* Kinship foster caregivers shall provide supervision of the child in preadoptive placement as dictated by the individual child's specific needs.

a. In case of emergency requiring the kinship foster caregiver's temporary absence from the home, arrangements shall be made with designated, responsible persons for the care of the child during the period of absence.

b. The department shall be notified of all emergency absences of the kinship foster caregivers.

125.10(2) *Release of child.* The kinship foster caregivers shall release the child only to the agency, a parent or guardian from whom the child was received for care, or the person specifically designated by the agency, parent or guardian.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.11(237) Changes in kinship foster care home. Kinship foster caregivers shall notify the department and the recruitment and retention contractor within 30 working days of:

1. Any change in the persons living in the home (except for the child placed in the home);
2. A move to a new home; or
3. Any circumstances in the home that could negatively affect the health, safety or welfare of the child in the family's care.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

441—125.12(237) Liability. Kinship foster caregivers who apply the reasonable and prudent parent standard reasonably and in good faith in regard to the child(ren) placed in their home shall have immunity from civil or criminal liability that might otherwise be incurred or imposed. This rule shall not remove or limit any existing liability protection afforded under any other law.

[ARC 0110D, IAB 3/4/26, effective 5/1/26]

These rules are intended to implement Iowa Code chapter 237 and section 234.40.

[Filed ARC 0110D (Notice ARC 9846C, IAB 12/24/25), IAB 3/4/26, effective 5/1/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 152 FOSTER CARE CONTRACTING

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

PREAMBLE

This chapter sets forth the contracting process used for providers of foster group care, child welfare emergency services shelter, and supervised apartment living, including standards for rate-setting, payment mechanisms, and provider monitoring, audits, and sanctions. The terms of these contracts are limited to no more than six years pursuant to 11—Chapter 118. This chapter also establishes provider qualifications, service authorization procedures, documentation requirements, and service termination and appeal procedures associated with these foster care services. Refer to 441—Chapter 156 for additional program requirements.

441—152.1(234) Definitions.

“Affiliates” means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

“Authorized representative,” within the context of rule 441—152.3(234), means that person appointed to carry out audit procedures, including an assigned auditor, fiscal consultant, or agent contracted for a specific audit or audit procedure.

“Bureau of service contract support” means the division of fiscal management bureau that is responsible for administering performance-based contracts.

“Child” means a person under 18 years of age or a person 18, 19, or 20 years of age who meets the criteria in Iowa Code section 234.1.

“Claim” means each record the department receives that tells the amount of requested payment and the service rendered by a provider to a child and family.

“Client” means a child who has been found to be eligible for foster care services through the department of human services.

“Confidence level” means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

“Contract” means a formal written agreement between the department of human services and a provider of foster care services.

“Contract monitor” means a department employee who is assigned to assist in developing, monitoring, and evaluating a contract and to provide related technical assistance.

“Department” means the Iowa department of human services and includes the local offices of the department.

“Extrapolation” means using sample data meeting the confidence level requirement to estimate the total dollars of overpayment or underpayment.

“Family,” for purposes of child welfare service delivery, shall include the following:

1. The natural or adoptive parents, stepparents, domestic partner of the natural or adoptive parent, and children who reside in the same household.

2. A child who lives with an adult related to the child within the fourth degree of consanguinity and the adult relatives within the fourth degree of consanguinity in the child’s household who are responsible for the child’s supervision. Relatives within the fourth degree of consanguinity include: full or half siblings, aunts, uncles, great-aunts, great-uncles, nieces, great-nieces, nephews, great-nephews, grandparents, great-grandparents, great-great-grandparents, and first cousins.

3. A child who lives alone or who resides with a person or persons not legally responsible for the child’s support.

“Fiscal record” means a tangible and legible history that documents the criteria established for financial and statistical records as set forth in subrule 152.2(5).

“*Grant*” means an award of funds to develop specific programs or achieve specific outcomes.

“*Juvenile court officer*” means a person appointed as a juvenile court officer or chief juvenile court officer under Iowa Code chapter 602.

“*Non-prime programming time*” means any period of the day other than prime programming time and sleeping time.

“*Overpayment*” means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to foster care services and results in a payment greater than that to which the provider is entitled.

“*Prime programming time*” means any period of the day when special attention, supervision, or treatment is necessary (for example, upon awakening of the clients in the morning until their departure for school, during meals, after school, during transition between activities, evenings and bedtime, and on nonschool days such as weekends, holidays, and school vacations).

“*Probation*” means a specified period of conditional participation in the provision of foster care services.

“*Provider*” means the entity that has executed a contract with the department to provide services.

“*Random sample*” means a systematic (or every “nth” unit) sample for which each item in the universe has an equal probability of being selected.

“*Referral worker*” means the department worker or juvenile court officer who refers the case to a provider and who is responsible for carrying out the follow-up activities of determining client eligibility and ensuring that the service authorization is completed.

“*Service authorization*” means the process of determining service necessity and the level of care and number of units of service to be provided to a child.

“*Service record*” means an individual, tangible, and legible file that records service-related activities set forth in subrule 152.2(4).

“*Site*” means each licensed location of the foster care provider.

“*Sleeping time*” means any period of the day during which clients are normally sleeping.

“*Suspension of payments*” means the withholding of all payments due a provider until resolution of the matter in dispute between the provider and the department.

“*Underpayment*” means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the foster care services program and to which the provider is entitled.

“*Unit of service*” means one day for group care and child welfare emergency services shelter.

“*Universe*” means all items (claims) submitted by a specific provider for payment during a specific period, from which a random sample will be drawn.

“*Withholding of payments*” means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted claims for purposes of offsetting overpayments previously made to the provider.

[ARC 2885C, IAB 1/4/17, effective 3/1/17; ARC 3442C, IAB 11/8/17, effective 1/1/18; ARC 6857C, IAB 2/8/23, effective 4/1/23]

441—152.2(234) Conditions of participation.

152.2(1) *Provider licensure.* A provider facility shall obtain licensure prior to accepting placements from the department.

152.2(2) *Provider staffing.* At a minimum, all providers shall meet all licensure requirements for staff qualifications, training, and number of staff pursuant to 441—Chapter 105, Chapter 108, or Chapter 114.

152.2(3) *Provider charges.* A provider shall not charge departmental clients more than it receives for the same foster care services provided to nondepartmental clients. The provider shall agree not to require any fee from departmental clients unless a fee is required by the department and is consistent with federal regulation and state policy.

152.2(4) *Maintenance of service records.* A provider shall maintain complete and legible records as required in this subrule.

a. For foster group care and shelter care, the provider shall establish and maintain confidential, individual service records for each client receiving foster care services. The service records must adequately support the provision of child welfare services and group care maintenance as defined in rule 441—156.1(234). The service record shall include, at a minimum, those items identified in rule 441—114.11(237) and 441—Chapter 105 and shall also include all of the following:

- (1) Additional reports, if requested by the referral worker.
- (2) Form 470-3055.
- (3) Daily documentation of billed per diem services. The documentation shall include:
 1. The child's first and last name;
 2. The month, day, and year service was provided;
 3. The first and last names of the persons who provided the service;
 4. A clear description of the specific service rendered, including interventions, actions, and activities performed which support the provision of child welfare services.
- (4) Notes, which shall be entered no less than every seven calendar days, indicating the child's general progress in regard to the child's care plan.
- (5) Any problem areas or unusual behavior for the child.

b. For supervised apartment living, the provider shall establish and maintain confidential, individual service records for each client receiving supervised apartment living services. The service records must adequately support the provision of services consistent with rules 441—108.10(238) and 441—202.9(234).

c. Failure to maintain records or failure to make records available to the department or to its authorized representatives upon request may result in a notice of violation and recoupment of payments pursuant to rules 441—152.3(234) and 441—152.4(234).

152.2(5) *Maintenance of financial and statistical records.* The provider shall maintain sufficient financial and statistical records, including program and census data, to document the validity of the reports submitted to the department. The records shall be available for review at any time during normal business hours by department personnel, the department's fiscal consultant, and state or federal audit personnel.

a. At a minimum, financial and statistical records shall include all revenue and expenses supported by a provider's general ledger and documentation on file in the provider's office. These records include, but are not limited to:

- (1) Payroll information.
- (2) Capital asset schedules.
- (3) All canceled checks, deposit slips, and invoices (paid and unpaid).
- (4) Audit reports (if any).
- (5) The board of directors' minutes (if applicable).
- (6) Loan agreements and other contracts.
- (7) Reviewable, legible census reports and documentation of units of service provided to departmental clients that identify the individual client and are kept on a daily basis and summarized in a monthly report.

(8) For nondepartmental clients, sufficient documentation of utilization to establish a complete unit of service count.

b. The provider shall maintain a list of all staff and supervisors providing foster care services and their qualifications for each program.

c. Independent audits. When a provider has an audit conducted, a firm not related to the provider shall conduct the audit. The provider shall submit a copy of the independent audit report to the department within 30 days of receipt of the report. The bureau of service contract support shall maintain the report.

152.2(6) *Cost report.* Providers shall complete Form 470-5421 as required by contract. The instructions for the cost report are found in Comm. 502.

a. Due date. The cost report shall be submitted to the department no later than three months after the close of the provider's established fiscal year. The provider may request a one-month extension from the bureau of service contract support.

b. Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

c. County reimbursement for child welfare services shelter costs. If a shelter care provider's actual and allowable costs as set forth in 441—Chapter 156 for a child's shelter care placement exceed the amount the department is authorized to pay and the provider is reimbursed by the child's county of legal settlement for the difference between actual and allowable costs and the amount reimbursed by the department, the amount paid by the county shall not be included by the department in its reimbursement rate determination, as long as the amount paid is not greater than the provider's actual and allowable costs or the statewide average of actual and allowable costs as identified in annual appropriations, whichever is less.

[ARC 2885C, IAB 1/4/17, effective 3/1/17; ARC 6857C, IAB 2/8/23, effective 4/1/23]

441—152.3(234) Provider reviews. The department may, at its discretion, review any provider at any time. Records generated and maintained by the department or its fiscal agent may be used by reviewers and in all proceedings of the department.

152.3(1) Review of provider records. The department shall have the authority to conduct a scheduled or unannounced visit to evaluate the adequacy of service records in compliance with the policies and procedures for foster care services.

152.3(2) Purpose. Upon proper identification, authorized representatives of the department shall have the right to review the service and fiscal records of the provider to determine whether:

- a.* The department has accurately paid claims for services.
- b.* The provider has furnished the services.
- c.* The provider has retained service records and fiscal records that substantiate claims submitted for payment during the review period.
- d.* Expenses reported to the department have been handled as required under subrule 152.2(6).

152.3(3) Method. The department shall select the appropriate method of conducting a review and shall protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department. Review procedures may include, but are not limited to, the following:

- a.* Comparing service and fiscal records with each claim.
- b.* Interviewing clients and employees of providers.

152.3(4) Sampling. The department's procedures for reviewing a provider's service records may include the use of random sampling and extrapolation. When these procedures are used, all sampling will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level.

a. Findings. The review findings generated through the review procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. Extrapolation. Findings of the sample will be extrapolated to the universe for the review period. The total of the payments determined to be in error in the review sample shall be divided by the total payments in the reviewed sample to calculate the percentage of dollars paid in error. This percentage shall then be multiplied by the total payments in the review universe to determine the extrapolated overpayment.

c. Disagreement with findings. When the provider disagrees with the department's review findings and the findings have been generated through sampling and extrapolation, the provider may present evidence to show that the sample was invalid. The burden of proof of compliance rests with

the provider. The evidence may include a 100 percent review of the universe of provider records used by the department in the drawing of the department's sample. This review shall:

- (1) Be arranged and paid for by the provider.
- (2) Be conducted by a certified public accountant.
- (3) Demonstrate that bills and records not reviewed in the department's sample complied with program regulations and requirements.
- (4) Be submitted to the department with all supporting documentation.

152.3(5) *Actions based on review findings.*

a. The department shall report the results of a review of provider records to concerned parties consistent with the provisions of 441—Chapter 2505.

b. When an overpayment is found, the department may do one or more of the following:

- (1) Request repayment in writing.
- (2) Impose sanctions provided for in rule 441—152.4(234).
- (3) Investigate and refer the matter to an agency empowered to prosecute.

[ARC 2885C, IAB 1/4/17, effective 3/1/17; Editorial change: IAC Supplement 6/10/26]

441—152.4(234) Sanctions against providers. Failure to meet the requirements relevant to provider contracting, financial record keeping, billing and payment, and client record keeping may subject providers to sanctions.

152.4(1) *Grounds for sanction.* The department may impose sanctions against a provider for committing one or more of the following actions:

a. Failing to provide and maintain the quality of the services to children and families within established standards, including:

- (1) Failing to meet standards required by state or federal law for licensure.
- (2) Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.
- (3) Engaging in a course of conduct or performing an act that is in violation of state or federal regulations or continuing that conduct following notification that it should cease.
- (4) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions subject to this chapter.

(5) Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

(6) Being suspended or terminated from participation in another governmental program.

(7) Committing a negligent practice resulting in client death or injury.

b. Failing to disclose or make available to the department or its authorized agent records of services provided to a child and family and records of payments made for those services.

c. Failing to provide accurate and auditable cost report information or engaging in deceptive billing practices, such as, but not limited to:

(1) Presenting or causing to be presented for payment any false or deceptive claim for services.

(2) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

d. Submitting or causing to be submitted false information to meet service authorization requirements.

e. Inducing, furnishing or otherwise causing the child or family to receive foster care services that are not authorized (overutilization of services).

f. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

g. Failing to repay or arrange for the repayment of identified overpayments or other erroneous payments.

h. Failing to submit the cost report on time or failing to submit complete responses to follow-up questions from the department or its fiscal consultant within 14 days of request without written approval from the bureau of service contract support.

152.4(2) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted.

a. Notification shall set forth:

- (1) The nature of the discrepancies or violations.
- (2) The known dollar value of the discrepancies or violations.
- (3) The method of computing the dollar value.
- (4) Further actions to be taken or sanctions to be imposed by the department.
- (5) Any actions required of the provider.

b. The provider shall have 15 days after the date of the notice to appeal to the contract owner.

152.4(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 152.4(1):

- a.* A term of probation for provision of foster care services.
- b.* Termination from participation in the provision of foster care services.
- c.* Suspension from provision of foster care services.
- d.* Suspension or withholding of payments to the provider.
- e.* Review of 100 percent of the provider's claims before payment.
- f.* Referral to the appropriate state licensing board for investigation.
- g.* Referral of the matter to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.
- h.* Suspension of foster care services licensure.
- i.* Termination of foster care services licensure.
- j.* Reduction of payment to 75 percent of the current rate for failure to submit the cost report or cost report clarifications timely.
- k.* Termination of the provider's contract for failure to submit the report within six months of the end of the fiscal year.

152.4(4) *Imposition and extent of sanction.* The department shall determine the sanction to impose. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- a.* Seriousness of the offense.
- b.* Extent of violations.
- c.* History of prior violations.
- d.* Prior imposition of sanctions.
- e.* Prior provision of technical assistance.
- f.* Pattern of failure to follow program rules.
- g.* Whether a lesser sanction will be sufficient to remedy the problem.
- h.* Actions taken or recommended by peer review groups or licensing bodies.

152.4(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider. Each decision to include an affiliate shall be made on a case-by-case basis after giving due regard to all relevant factors and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated when the conduct was committed in the course of official duty or was effectuated with the knowledge or approval of that person.

b. When there are grounds for sanction pursuant to subrule 152.4(1) against a provider facility, campus, or site, the department may suspend or terminate the provision of foster care services by:

- (1) The provider; or
- (2) The specific facility, campus, or site; or
- (3) Any individual within the provider's organization who is responsible for the violation.

c. No provider shall submit claims for payments to the department for any services provided by any facility, campus, site, or person within the organization that has been suspended or terminated

from provision of foster care services, except for those services provided before the suspension or termination.

d. Suspension or termination from provision of foster care services shall preclude the submission of claims to the department for payment for any services provided after suspension or termination, whether submitted personally or through the provider.

152.4(6) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation pursuant to paragraph 152.3(5)“b” or subrule 152.4(2) and has demanded repayment of an identified overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payments pending a final determination. When the department intends to withhold or suspend payments, it shall notify the provider in writing.

152.4(7) *Notice of sanction.* When a provider has been sanctioned, the department shall notify, as appropriate, the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

[ARC 2885C, IAB 1/4/17, effective 3/1/17; ARC 6857C, IAB 2/8/23, effective 4/1/23]

441—152.5(234) Adverse actions. Notice of adverse actions shall be given in accordance with 441—Chapter 16. The right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7.

[ARC 2885C, IAB 1/4/17, effective 3/1/17; ARC 6857C, IAB 2/8/23, effective 4/1/23]

These rules are intended to implement Iowa Code section 234.6.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 164
MORE OPTIONS FOR MATERNAL SUPPORT (MOMS) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

441—164.1(217) Definitions.

“Client” means an individual receiving the services enumerated in Iowa Code section 217.41C through the program.

“Pregnancy support services” means the same as defined in Iowa Code section 217.41C.

“Program” means the more options for maternal support (MOMS) program outlined in Iowa Code section 217.41C.

“Program administrator” means the department or a nonprofit entity incorporated in this state with a tax-exempt status pursuant to Section 501(c)(3) of the Internal Revenue Code that is awarded a contract by the department to administer the program, including managing a statewide network of providers and other duties outlined in Iowa Code section 217.41C.

“Provider of pregnancy support services” or *“provider”* means the same as defined in Iowa Code section 217.41C.

[ARC 9105C, IAB 4/16/25, effective 6/1/25]

441—164.2(217) Pregnancy support services. Pregnancy support services do not include health care treatment or services for purposes of the Health Insurance Portability and Accountability Act of 1996.

[ARC 9105C, IAB 4/16/25, effective 6/1/25]

441—164.3(217) Program administrator responsibilities.

164.3(1) If a nonprofit entity is awarded a contract by the department through the request for proposals process to administer the program, that program administrator may assume ownership and oversight of any existing contracts providers have with the department. The program administrator will work with the department to facilitate and execute the contract reassignments.

164.3(2) A program administrator shall prepare and submit an annual program evaluation report in a format prescribed by the department at the end of each contracted year. The program administrator shall use the results of the evaluation report at a minimum to support and assist providers in the continuous quality improvement process.

164.3(3) A program administrator shall maintain a minimum number of providers, as specified by the department, to include any provider contracts reassigned by the department, if applicable.

164.3(4) A program administrator shall only be eligible to receive reimbursement for services described in its contract and shall not charge additional fees to the department or to providers.

[ARC 9105C, IAB 4/16/25, effective 6/1/25]

441—164.4(217) Client feedback. The department will create a process for clients to provide confidential feedback regarding their experience with providers.

[ARC 9105C, IAB 4/16/25, effective 6/1/25]

441—164.5(217) Appeals. An applicant for program administrator, provider, or client who disagrees with a decision of the department may submit an appeal in accordance with 441—Chapter 2506.

[ARC 9105C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 217.41C.

[Filed ARC 9105C (Notice ARC 8541C, IAB 12/11/24), IAB 4/16/25, effective 6/1/25]

[Editorial change: IAC Supplement 6/10/26]

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]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

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 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 child's own home, or a nonregistered family child care home.

[ARC 2169C, IAB 9/30/15, effective 1/1/16; ARC 6965C, IAB 4/5/23, effective 6/1/23]

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 in foster care or 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 as defined in rule 441—83.60(249A) to have a condition which impairs the child's intellectual and social functioning.

3. The child has been diagnosed by a mental health professional as defined in rule 441—24.1(225C) 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 work and 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 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 signed by the parent and the provider.

“*Recoupment*” means the repayment of an overpayment by a payment from the client or provider or both.

“*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; ARC 6965C, IAB 4/5/23, effective 6/1/23]

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.

(1) For initial eligibility, an applicant family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” cannot exceed the amounts in this subparagraph.

1. 160 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 numbered paragraph “1” or “2.”

(2) For ongoing eligibility, at the time of a family’s annual eligibility redetermination as described in subrule 170.3(5), if the family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” exceeds the amounts in subparagraph 170.2(1)“a”(1), the family may continue to be eligible as long as the family’s nonexempt gross monthly income does not exceed the amounts in this subparagraph.

1. 225 percent of the federal poverty level applicable to the family size for children needing basic care or special-needs care; or

2. 85 percent of Iowa’s median family income, if that figure is lower than the standard in numbered paragraph “1.”

(3) For ongoing eligibility, at the time of a family’s annual eligibility redetermination as described in subrule 170.3(5), if the family’s nonexempt gross monthly income as established in paragraph 170.2(1)“c” exceeds the amounts in subparagraphs 170.2(1)“a”(1) and 170.2(1)“a”(2), the family may continue to be eligible as long as the family’s nonexempt gross monthly income does not exceed the amounts in this subparagraph.

1. 250 percent of the federal poverty level applicable to the family size for children needing basic care; or

2. 275 percent of the federal poverty level applicable to the family size for children needing special-needs care.

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.

(5) Child care services for licensed foster parents who need child care for foster children are provided without regard to income.

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 Supplemental Nutrition Assistance Program (SNAP) 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 unless one parent is permanently disabled as described in subparagraph 170.2(2)“b”(4). 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 32 or more hours per week (28 hours per week if the family includes a special needs child) or an average of 32 or more hours per week (28 hours per week if the family

includes a special needs child) 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 temporarily medically incapacitated, or to instances of one parent in a two-parent household being permanently disabled, 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, 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 one parent is temporarily incapacitated, the units of service authorized shall be based on the need of the parent who is not incapacitated.

- For a two-parent family, if one of the parents has a permanent disability and is unable to care for the child or participate in work or training, the disabled parent does not need to meet another need for service requirement. The units of service authorized shall be based only on the need of the parent who is not disabled.

(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 subparagraphs 170.2(2) "b"(10) and (11).

(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 32 or more hours per week (28 hours per week if the family includes a special needs child) or an average of 32 or more hours per week (28 hours per week if the family includes a special needs child) 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) The parent is a licensed foster parent who needs child care for foster children.

(10) Family eligibility shall continue during an approved certification period when a temporary lapse in need for service for a parent established under this subparagraph occurs. A temporary lapse is defined as:

1. Any time-limited absence from work or a training or education program for a parent due to:
 - Need to care for a family member.
 - An illness.
 - Maternity leave.
 - Family Medical Leave Act (FMLA) situations for household members.
 - Participation in a treatment/rehabilitation program.
2. Any reduction in employment or education/training hours that fall below the minimum number required at 170.2(2)“b”(1), (2) or (8) as long as the parent continues to work or attend training or education.
3. Any student holiday or break for a parent participating in training or education.
4. Any interruption in work for a seasonal worker who is not working between regular industry work seasons.
5. Any other cessation of work or attendance at a training or education program that does not exceed three months.

(11) 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) or Form 470-0462 or 470-0462(S). 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 or licensed foster parents who need child care for foster children. 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 32 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 160 percent of the federal poverty guidelines whose members, for at least 32 hours per week in the aggregate, are employed or are participating at a satisfactory level in an approved training program or educational program.

(4) Families with an income at or below 200 percent of the federal poverty guidelines whose members are employed at least 28 hours per week with a special-needs child as a member of the family.

b. Exceptions to priority groups. The following are eligible for child care assistance notwithstanding waiting lists for child care services:

- (1) Families with protective child care needs.
- (2) Recipients of the family investment program or those whose earned income was taken into account in determining the needs of family investment program recipients.
- (3) Families that receive a state adoption subsidy for a child.
- (4) Families that are experiencing homelessness.
- (5) Licensed foster parents who need child care for foster children.

c. Effect on need for service. Families approved under a priority group are not required to meet the requirements in paragraph 170.2(2) “b” except at review or redetermination.

170.2(4) Reporting changes. The parent may report any changes in circumstances affecting these eligibility requirements and changes in the choice of provider to the department worker or the PROMISE JOBS worker within ten calendar days of the change.

a. If the change is timely reported within ten calendar days, the effective date of the change shall be the date when the change occurred.

b. If the change is not timely reported within ten calendar days, the effective date of the change shall be the date when the change is reported to the department office or the PROMISE JOBS office.

c. Exceptions. The following changes must be reported:

(1) Changes in income when the family’s gross monthly income exceeds 85 percent of Iowa’s median family income.

(2) A lapse in a parent’s need for service found in paragraph 170.2(2) “b” that is not temporary.

(3) A change in residency outside of the state of Iowa.

(4) No eligible child remains in the home.

d. The department worker shall disregard any reported changes that are not required to be reported unless the change would cause the authorized units to be increased or the family copay amount to be decreased.

[ARC 8506B, IAB 2/10/10, effective 3/1/10; ARC 9651B, IAB 8/10/11, effective 10/1/11; ARC 1525C, IAB 7/9/14, effective 7/1/14; ARC 1606C, IAB 9/3/14, effective 10/8/14; ARC 2555C, IAB 6/8/16, effective 7/1/16; ARC 3092C, IAB 6/7/17, effective 7/1/17; ARC 3791C, IAB 5/9/18, effective 7/1/18; ARC 4470C, IAB 6/5/19, effective 7/1/19; ARC 5035C, IAB 5/6/20, effective 7/1/20; ARC 6309C, IAB 5/4/22, effective 7/1/22; ARC 6565C, IAB 10/5/22, effective 10/1/22; ARC 6965C, IAB 4/5/23, effective 6/1/23; ARC 8741C, IAB 1/8/25, effective 2/12/25]

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), or
- (2) Form 470-4377 or 470-4377(S), 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.

f. Licensed foster parents who need child care for foster children.

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.

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).

(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) 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, licensed foster parents who need child care for foster children, 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 calendar 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; ARC 6965C, IAB 4/5/23, effective 6/1/23]

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. For families whose eligibility is established in subparagraphs 170.2(1) “a”(1) and 170.2(1) “a”(2), 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. For families whose eligibility is established in subparagraph 170.2(1) “a”(3), the fee is a percentage of the cost of child care for each child in the family who receives service.

a. Sliding fee schedule.

(1) For families whose eligibility is established in subparagraphs 170.2(1) “a”(1) and 170.2(1) “a”(2), the child care assistance (CCA) and CCA plus programs fee schedule, dated July 2024, found on the department’s website is effective for eligibility determinations made on or after July 1, 2024.

(2) For families whose eligibility is established in subparagraph 170.2(1) “a”(3), the CCA exit program fee schedule, dated July 2024, found on the department’s website is effective for eligibility determinations made on or after July 1, 2024.

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 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 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 provider selected by the parent to provide care in the child’s own home shall be sent Form 470-2890 or 470-2890(S). The provider shall complete and sign Form 470-2890 or 470-2890(S) and return the form to the department before payment may be made. An identifiable application is an application that contains a legible name and address and that has been signed. Signature on the form certifies the provider’s understanding of and compliance with the conditions and requirements for nonregistered in-home care providers that include:

(1) Professional development. The provider shall complete:

1. Prior to provider agreement and every five years thereafter, minimum health and safety trainings, approved by the department, in the following content areas:

- Prevention and control of infectious disease, including immunizations.
- Prevention of sudden infant death syndrome and use of safe sleep practices.
- Administration of medication, consistent with standards for parental consent.
- Prevention of and response to emergencies due to food and allergic reactions.
- Building and physical-premises safety, including identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
- Prevention of shaken baby syndrome and abusive head trauma.
- Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event.
- Handling and storage of hazardous materials and appropriate disposal of biocontaminants.
- Precautions in transporting children.

Minimum health and safety training may be required prior to the five-year period if content has significant changes which warrant that the training be renewed.

2. Prior to provider agreement, two hours of Iowa’s training for mandatory reporting of child abuse.

3. Prior to provider agreement, first-aid and cardiopulmonary resuscitation (CPR) training meeting the following requirements:

- Training shall be provided by a nationally recognized training organization, such as the American Red Cross, American Heart Association, National Safety Council, American Safety and Health Institute or MEDIC First Aid or by an equivalent trainer using curriculum approved by the department.

- First-aid training shall include certification in infant and child first aid.
- The provider shall maintain a valid certificate indicating the date of first-aid training and the expiration date.

- The provider shall maintain a valid certificate indicating the date of CPR training and the expiration date.

(2) Limits on the number of children for whom care may be provided.

(3) Unlimited parental access to the child or children during hours when care is provided, unless prohibited by court order.

(4) Conditions that warrant nonpayment.

f. Nonregistered family child care home. A nonregistered child care home shall meet the requirements set forth in 441—Chapter 120.

g. Iowa records checks for in-home care. If a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete and submit the required authorization form(s) to the department. The department shall use the form(s) to conduct Iowa criminal history record and child abuse record checks.

(1) The purpose of these checks is to determine whether the person has committed a transgression that prohibits or limits the person's involvement with child care.

(2) The department may also conduct criminal and child abuse record checks in other states and may conduct dependent adult abuse, sex offender registry, and other public or civil offense record checks in Iowa or in other states.

(3) Records checks shall be repeated every two years and when the department or provider becomes aware of any new transgressions.

h. National criminal history record checks for in-home care. If a person who provides in-home care applies to receive public funds as reimbursement for providing child care for eligible clients, the provider shall complete Form DCI-45 and Form FD-258.

(1) The provider subject to this check shall submit any other forms required by the department of public safety to authorize the release of records.

(2) The provider subject to this check is responsible for any costs associated with obtaining the fingerprints and for submitting the prints to the department.

(3) Fingerprints may be taken (rolled) by law enforcement agencies or by agencies or companies that specialize in taking fingerprints.

(4) The national criminal history record check shall be repeated for each person subject to the check every four years and when the department or provider becomes aware of any new transgressions committed by that person in another state.

(5) The department may rely on the results of previously conducted national criminal history record checks when a person subject to a record check in one child development home or child care home submits a request for involvement with child care in another child care home, so long as the person's national criminal history record check is within the allowable four-year time frame. All initial or new applications shall require a new national criminal history record check.

i. Transgressions. If any person subject to the record checks in paragraph 170.4(3)“g” or 170.4(3)“h” has a record of founded child abuse, dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall follow the process for prohibition or evaluation defined at 441—subrule 120.11(3).

(1) If any person would be prohibited from registration, employment, or residence, the person shall not provide child care and is not eligible to receive public funds to do so. The department's designee shall notify the applicant.

(2) A person who continues to provide child care in violation of this rule is subject to penalty and injunction under Iowa Code chapter 237A.

170.4(4) *Components of service program.* Every child eligible for child care services shall receive supervision, food services, and program and activities, and may receive transportation.

170.4(5) *Levels of service according to age.* Rescinded IAB 9/30/92, effective 10/1/92.

170.4(6) *Provider's individual program plan.* Rescinded IAB 2/10/10, effective 3/1/10.

170.4(7) *Payment.* The department shall make payment for child care provided to an eligible family when the family reports their choice of provider to the department and the provider has a completed Form 470-3871 or 470-3871(S) 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 paragraph 170.4(7) “d,” shall be the actual rate charged by the provider for a private individual, not to exceed the maximum rates shown below. When a provider does not have a half-day rate in effect, a rate is established by dividing the provider’s declared full-day rate by 2. When a provider has neither a half-day nor a full-day rate, a rate is established by multiplying the provider’s declared hourly rate by 4.5. Payment shall not exceed the rate applicable to the provider type and age group as shown in the tables below. To be eligible for the special-needs rate, the provider must submit documentation to the child’s service worker that the child needing services has been assessed by a qualified professional and meets the definition for “child with special needs,” and a description of the child’s special needs, including but not limited to adaptive equipment, more careful supervision, or special staff training.

Table 1 Half-Day Rate Ceilings for (Licensed Center)								
	No Quality Rating		Quality Rating 1 or 2		Quality Rating 3 or 4		Quality Rating 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	\$25.66	\$51.94	\$25.66	\$51.94	\$25.66	\$51.94	\$27.00	\$51.94
Preschool	\$19.50	\$30.43	\$20.25	\$30.43	\$21.50	\$30.43	\$22.97	\$30.43
School Age	\$16.50	\$30.34	\$17.10	\$30.34	\$17.50	\$30.34	\$18.50	\$30.34

Table 2 Half-Day Rate Ceilings for (Child Development Home A/B)								
	No Quality Rating		Quality Rating 1 or 2		Quality Rating 3 or 4		Quality Rating 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	\$16.63	\$24.95	\$16.63	\$24.95	\$16.63	\$24.95	\$17.50	\$26.25
Preschool	\$15.00	\$22.50	\$15.50	\$23.25	\$16.00	\$24.00	\$17.00	\$25.50
School Age	\$15.00	\$22.50	\$15.25	\$22.88	\$15.50	\$23.25	\$15.75	\$23.63

Table 3 Half-Day Rate Ceilings for (Child Development Home C)								
	No Quality Rating		Quality Rating 1 or 2		Quality Rating 3 or 4		Quality Rating 5	
Age Group	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs	Basic	Special Needs
Infant and Toddler	\$18.00	\$27.00	\$18.00	\$27.00	\$18.00	\$27.00	\$18.50	\$27.75
Preschool	\$16.28	\$24.42	\$17.00	\$25.50	\$17.50	\$26.25	\$18.50	\$27.75
School Age	\$15.00	\$22.50	\$15.75	\$23.63	\$16.44	\$24.66	\$17.50	\$26.25

Table 4 Half-Day Rate Ceilings for Child Care Home (Not Registered)		
Age Group	Basic	Special Needs
Infant and Toddler	\$16.63	\$24.95
Preschool	\$15.00	\$22.50
School Age	\$15.00	\$22.50

The following definitions apply in the use of the rate tables:

(1) “Licensed center” shall mean those providers as defined in 170.4(3) “a.” “Child development home A/B” or “child development home C” shall mean those providers as defined in 170.4(3) “b.” “Child care home (not registered)” shall mean those providers as defined in 441—Chapter 120.

(2) Under age group, “infant and toddler” shall mean age two weeks to three years; “preschool” shall mean three years to school age; “school age” shall mean a child in attendance in full-day or half-day classes.

(3) “No Quality Rating” shall mean a provider who does not have a current quality rating.

(4) A provider who is rated under the quality rating system shall be paid according to the corresponding quality rating payment level in the tables above only during the period the rating is valid as defined in 441—Chapter 118. If the provider’s quality rating expires, the provider shall be paid according to the “No Quality Rating” payment level. Programs whose quality rating has expired shall not receive backdated payments once a new rating is awarded.

(5) For a provider rated “Quality Rating 1” through “Quality Rating 4,” if the rating period expires before a new quality level is approved, the provider will be paid according to the “No Quality Rating” payment level until the new quality level is approved.

(6) For a provider rated “Quality Rating 5,” if a renewal application is received before the current rating period expires, the provider will continue to be paid according to the “Quality Rating 5” payment level until a decision is made on the provider’s application.

(7) “Quality Rating 1 or 2” shall mean a provider who has achieved a rating of Level 1 or Level 2 under the quality rating system.

(8) “Quality Rating 3 or 4” shall mean a provider who has achieved a rating of Level 3 or Level 4 under the quality rating system.

(9) “Quality Rating 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 bureau of child care services chief. 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; or
- (2) Using an electronic request for payment submitted through the KinderTrack system.

Providers using this method shall print Form 470-4535 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.

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441—170.5(237A) Adverse actions.

170.5(1) Provider agreement. The department may refuse to enter into or may revoke 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 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 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.

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441—170.6(237A) Appeals. Notice of adverse action shall be given in accordance with 441—Chapter 16. The right to appeal shall be given in accordance with 441—Chapter 7.

[ARC 6965C, IAB 4/5/23, effective 6/1/23]

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—Chapter 2506.

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.

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.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 174
STUDENT ABUSE REPORTS AND INVESTIGATIONS

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/1/31

441—174.1(232E) Application—not exclusive.

174.1(1) Iowa Code chapter 232E applies only to incidents of alleged student abuse that occur on or after July 1, 2025, and only if the report of the alleged student abuse is made within three years from the date of the occurrence of the incident alleged in the report.

174.1(2) Iowa Code chapter 232E does not provide an exclusive process or remedy for addressing alleged misconduct by a school employee involving a student and does not preclude or replace other available forms of reporting, investigation, or disciplinary action for complaints that do not meet the threshold of student abuse.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.2(232E) Definitions.

“Board of educational examiners” means the same as defined in Iowa Code chapter 232E.

“Credible report” means a report of alleged student abuse that is deemed by the department to be both investigable and complete and is an accepted report for the purposes of an investigation under Iowa Code chapter 232E.

“Department policies and procedures” means the written guidelines formulated by the department to be used by department personnel involved in the reporting and investigation of allegations of student abuse.

“Disposition data and information,” for the purposes of disclosure of such data and information to a school employee under paragraph 174.9(2)“b” and as specified under subrule 174.10(3), means materially relevant data and information pertaining to the department’s determination that the allegation of student abuse is substantiated.

“Identifiable,” relative to an allegedly abused student or to a school employee allegedly involved in an incident, means an individual who is not anonymous and who may be identified by specific factors, such as name, age, address, or birth date.

“Identifiable source,” with reference to the reporter of an allegation of student abuse, means an individual who is not anonymous; who may be identified by specific factors, such as name, age, address, or birth date; and who is available to sign the written report of alleged student abuse.

“Incident” means an occurrence of behavior that meets the definition of student abuse.

“Inconclusive,” with reference to a credible report of student abuse that has been referred to law enforcement, means that, because the joint investigation has not yet been concluded, there is not sufficient evidence to determine whether the incident occurred.

“Injury” means bodily injury for which evidence of the injury is still apparent at least 24 hours after an incident.

“Investigation” means the same as defined in Iowa Code chapter 232E.

“Investigation report data and information,” for the purposes of disclosure of such data and information to a school employee under paragraph 174.9(2)“b” and as specified under subrule 174.10(3), means materially relevant data and information pertaining to an investigation of an allegation of student abuse based upon which the department determines the alleged student abuse is substantiated.

“Investigator” means personnel of the department to whom a credible report is assigned for investigation.

“Model policy” means the policy and procedures formulated by the department of education in consultation with the department to be used in the reporting and investigating of an allegation of student abuse under Iowa Code chapter 232E.

“Nonpublic school” means the same as defined in Iowa Code chapter 232E.

“Preponderance of the evidence” means reliable, credible evidence that is of greater weight than evidence offered in opposition to it.

“Public school” means the same as defined in Iowa Code chapter 232E.

“Public school district” means the same as defined in Iowa Code chapter 232E.

“Receipt of a report” or *“receipt of a credible report”* occurs on the date of the business day on which a credible report is initially assigned to an investigator.

“School employee” means the same as defined in Iowa Code chapter 232E.

“School time” means the hours of a regular school day as specified by the board of directors of a public school district or by the authorities in charge of a nonpublic school.

“Student” means the same as defined in Iowa Code chapter 232E.

“Student abuse” means the same as defined in Iowa Code chapter 232E.

“Substantiated,” with reference to a credible report of student abuse, means that, based on the investigation, there is a preponderance of the evidence indicating the incident occurred.

“Unsubstantiated,” with reference to a credible report of student abuse, means that, based on the investigation, there is not a preponderance of the evidence indicating the incident occurred.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.3(232E) Abuse intake process—report of alleged student abuse.

174.3(1) If, during the abuse intake process under Iowa Code chapter 232, subchapter III, part 2, and Iowa Code chapter 235B, an identifiable source reports information that the department, in accordance with department policies and procedures, determines may constitute an allegation of student abuse, the identifiable source shall be referred to the student abuse intake process.

174.3(2) If, during the abuse intake process under Iowa Code chapter 232, subchapter III, part 2, and Iowa Code chapter 235B, the department determines the information reported by an identifiable source does not constitute an allegation of student abuse subject to investigation by the department, the department shall reject the report and may inform the identifiable source of all the following:

- a. The report is rejected and the basis for the rejection.
- b. Rejection of the report of alleged student abuse does not preclude other options for reporting, investigation, or disciplinary action for complaints that do not meet the threshold of student abuse, including:

- (1) Contacting law enforcement.
- (2) Contacting the county attorney.
- (3) Contacting private counsel for the purpose of filing a civil suit or complaint.
- (4) Filing a complaint with the superintendents of the public school district or the authorities in charge of the nonpublic school associated with the school employee allegedly involved in the alleged misconduct or contacting the board of educational examiners, as applicable.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.4(232E) Student abuse intake process—credible reports.

174.4(1) Following the referral of an identifiable source of a report of alleged student abuse to the student abuse intake process, the department will do all the following:

- a. Assist the identifiable source in making a report of alleged student abuse. Reports shall be made in a manner similar to that specified in Iowa Code section 232.70 as adapted for application to student abuse reports in department policies and procedures.

- b. Determine if the report of alleged student abuse is a credible report.

- c. If the report of alleged student abuse is determined to be a credible report, refer the credible report to an investigator for investigation.

174.4(2) Credible reports. To be a credible report, a report of alleged student abuse must be deemed to be both investigable and complete by the department.

174.4(3) Investigable reports.

- a. To be deemed investigable, a report of alleged student abuse must provide all the following details as specified in department policies and procedures:

(1) The person allegedly responsible for the act or omission is identifiable, was a school employee at the time of the alleged incident, and remains a school employee at the time the alleged abuse is reported.

(2) The alleged act or omission of the school employee is alleged to have occurred on school grounds during school time or on or at a school-related curricular or extracurricular activity.

(3) The alleged act or omission of the school employee resulted in injury or otherwise meets the definition of student abuse.

(4) The allegedly abused student is identifiable and is a student or was a student at the time of the alleged incident.

b. If the report of alleged student abuse is deemed not to be investigable, the report will be dismissed for lack of jurisdiction.

c. Not physical abuse.

(1) For the purposes of determining whether the alleged act or omission of a school employee constitutes physical abuse that meets the definition of student abuse under subparagraph 174.4(3)“a”(3), reasonable contact under circumstances described in Iowa Code section 280.21(2) does not constitute physical abuse.

(2) In determining the reasonableness of the contact or force used under subparagraph 174.4(3)“c”(1), the following factors will be considered:

1. The nature of the misconduct of the student, if any, precipitating the physical contact by the school employee.

2. The size and physical condition of the student.

3. The instrumentality used in making the physical contact.

4. The motivation of the school employee in initiating the physical contact.

5. The extent of injury to the student resulting from the physical contact.

174.4(4) Complete reports.

a. To be deemed complete, a report of alleged student abuse must meet all the following conditions as specified in department policies and procedures. The report must:

(1) Contain information regarding the identifiable source making the allegation of student abuse; the student allegedly abused; the school employee allegedly involved in the alleged incident; any witnesses to the alleged incident; and any person who examined, counseled, or treated the student for the alleged abuse.

(2) Include a concise statement of the facts surrounding the alleged incident, including the date, time, and place of occurrence, if known.

(3) Be reduced to writing, signed by the identifiable source, and witnessed by a person of majority age.

b. If a report of alleged student abuse is deemed incomplete by the department, the report will not be rejected unless either of the following conditions applies:

(1) The reporter of the alleged student abuse is not an identifiable source and does not sign the written report, and the report is not witnessed by a person of majority age.

(2) A reasonable person would conclude that the absence of the information missing from the report of alleged student abuse would render an investigation of the report futile or impossible.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.5(232E) Options if report dismissed or rejected during student abuse intake. If the report of alleged student abuse is dismissed as not being investigable for lack of jurisdiction or rejected as incomplete, the department may inform the identifiable source of all the following:

174.5(1) The report is being dismissed or rejected and the basis for the dismissal or rejection.

174.5(2) Dismissal or rejection of the report of alleged student abuse does not preclude other options for reporting, investigation, or disciplinary action for complaints that do not meet the threshold of student abuse, including:

a. Contacting law enforcement.

- b.* Contacting the county attorney.
- c.* Contacting private counsel for the purpose of filing a civil suit or complaint.
- d.* Filing a complaint with the superintendent of the public school district or the authorities in charge of the nonpublic school associated with the school employee allegedly involved in the alleged misconduct or contacting the board of educational examiners, as applicable.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.6(232E) Notification of school authorities and identifiable source regarding credible reports. The department, in accordance with department policies and procedures, will notify all the following when a report of alleged student abuse is determined to be a credible report:

174.6(1) The board of directors of the public school district or the authorities in charge of the nonpublic school associated with the school employee allegedly involved in the incident, as applicable, and the board of educational examiners, if applicable. The department of education shall cooperate with the department in completing the required notifications under this paragraph and shall provide the department with access to school contact information in a manner that ensures the accuracy of the notifications.

174.6(2) The identifiable source.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.7(232E) Investigation—duties of an investigator and school authorities.

174.7(1) *Duties of an investigator.* An investigator will do all the following:

- a.* Commence an investigation within 24 hours of the receipt of a credible report.
- b.* Based on a credible report received, if an investigator determines the alleged student abuse constitutes a criminal act:

(1) Refer the matter to law enforcement, defer the department's investigation, and work jointly with law enforcement in law enforcement's investigation. The investigator may share with law enforcement information collected by the department during the joint investigation.

(2) If the investigation is deferred under this paragraph, resume the deferred investigation following completion of the joint investigation if the investigator determines information collected during the joint investigation warrants further investigation. The investigator will complete the resumed investigation within 30 business days of its commencement and will submit a written investigation report to the entities as specified under this rule upon the completion of the resumed investigation.

c. During the investigation:

(1) Interview the allegedly abused student, any witnesses or persons who may have knowledge of the circumstances contained in the credible report, and the school employee allegedly involved in the incident identified in the credible report.

(2) Conduct the interview of the allegedly abused student and any other student in a manner similar to that specified in Iowa Code section 232.71B(7), relating to child abuse assessment interviews conducted in facilities or schools as adapted for application to student abuse interviews in department policies and procedures.

(3) Provide notification to the parent or guardian of the allegedly abused student in a manner similar to that specified in Iowa Code section 232.71B(2), relating to the notification of parents regarding a child abuse assessment as adapted for application to student abuse investigations in department policies and procedures.

(4) Provide notification to the school employee allegedly involved in the incident in a manner similar to that specified in Iowa Code section 232.71B(4), relating to the notification of a person alleged to have committed child abuse as adapted for application to student abuse investigations in department policies and procedures.

d. Complete the investigation within 30 business days of the date of receipt of the credible report unless the investigation is deferred.

e. Include in the written investigation report the information specified in department policies and procedures. At a minimum, the written investigation report will include all of the following:

- (1) A general overview of the investigation.
- (2) If the matter was not referred to law enforcement and the department's investigation was not deferred, a statement that, in the investigator's opinion, the allegations in the credible report are either substantiated or unsubstantiated.
- (3) If the matter was referred to law enforcement, the department's investigation was deferred, and the joint investigation has not been completed, a statement that the allegations in the credible report are inconclusive pending the results of the joint investigation.
- (4) Any alternative status or disposition of the investigation.
- (5) Any other information relevant to the investigation and the department's determination relating to the allegation of student abuse.

174.7(2) *Duties of school authorities.*

a. Granting access and immunity.

(1) The board of directors of a public school district or the authorities in charge of a nonpublic school shall cooperate with the investigator by providing confidential access to the allegedly abused student named in the credible report for the purpose of interviewing the student and shall allow the investigator confidential access to other students for the purpose of conducting interviews to obtain relevant information.

(2) The immunity granted by Iowa Code sections 232.73 and 235B.3(11) applies to participation in good faith by boards of directors of a public school district and the authorities in charge of nonpublic schools, the facilities of a public school or nonpublic school, and public school districts in an investigation and when providing confidential access to a student.

b. The board of directors of a public school district or the authorities in charge of a nonpublic school shall provide an investigator access to an allegedly abused student's education records pursuant to 34 CFR §99.31 as amended to August 1, 2025.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.8(232E) School employee resignation during pendency of investigation. Following a determination by the department that a report of alleged student abuse is a credible report, the department will complete the investigation of the credible report in accordance with rule 441—174.7(232E), whether the school employee allegedly involved in the incident resigns any time prior to or at the time of the submission of the written investigation report.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.9(232E) Substantiated report—right of school employee to contested case proceedings and further review.

174.9(1) At the time the written investigation report is submitted to the board of directors of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable, under paragraph 174.7(1) "*e.*" the department will provide notice of the department's determination regarding the allegation of student abuse to the school employee who is the subject of the investigation pursuant to 441—Chapter 16.

174.9(2) If the notice of determination includes a statement that the allegation of student abuse is substantiated, the notice of determination will also inform the school employee who is the subject of the investigation of:

a. The school employee's right to contested case proceedings and further review pursuant to 441—Chapter 2506; and

b. The right and process to request additional investigation report data and information and disposition data and information as specified in department policies and procedures.

174.9(3) The appellant must appeal on or before the thirtieth day following the date of notice of the determination.

174.9(4) The department will notify the board of directors of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable, of the following:

- a. If the school employee requests contested case proceedings under 441—Chapter 2506.
- b. The proposed decision of the contested case.
- c. If any party requests director's review pursuant to rule 441—subrule 2506.27(1).
- d. The final decision of the contested case.

174.9(5) Any disciplinary, employment, or other action that may be taken in response to an investigation report by the directors of a public school district or the authorities in charge of a nonpublic school, and the board of educational examiners, if applicable, is stayed during the pendency of the proceedings under subrule 174.9(2).

[ARC 9953C, IAB 1/7/26, effective 3/1/26; Editorial change: IAC Supplement 6/10/26]

441—174.10(232E) Case record retention—protection of identifiable source—disclosure limitations.

174.10(1) The department will retain the case record, including the intake report, the written investigation report, and all related supporting documentation, for three years from the date the written investigation report is submitted pursuant to paragraph 174.7(1) “e” to the director of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable.

174.10(2) The name and identity of the identifiable source of a report of alleged student abuse will not be disclosed with the following exceptions:

- a. To department personnel and law enforcement involved in, and as necessary to perform official duties related to, the reporting and investigation of a specific allegation of student abuse.
- b. To the board of educational examiners if the allegation of student abuse involves a school employee who is licensed, certified, or authorized by the board of educational examiners, or who holds an active statement of recognition issued by the board of educational examiners, as necessary to perform official duties related to the specific allegation of student abuse.
- c. To other persons for good cause as determined by the department based on criteria specified in department policies and procedures.

174.10(3) Student abuse information.

a. Student abuse information is confidential and shall not be a public record under Iowa Code chapter 22. The confidentiality of all student abuse information will be maintained, except as specifically provided in these rules and department policies and procedures.

b. Student abuse information may be shared with department personnel as necessary to perform official duties.

c. With the exception of the name and identity of the identifiable source, the disclosure of which is subject to subrule 174.10(2), any investigation report data and information and disposition data and information, as specified by department policies and procedures, may be disclosed, upon request, only to the following:

- (1) The student named in the report of student abuse as the victim or the student's attorney or guardian ad litem.
- (2) The parent or guardian or the attorney for the parent or guardian of the student named in the report of student abuse as the victim.
- (3) A person or the attorney for the person named in a report as having abused the student.
- (4) Law enforcement involved in the investigation of the report of student abuse.
- (5) The board of directors of the public school district or the authorities in charge of the nonpublic school, as applicable, and the board of educational examiners, if applicable, that received the written investigation report.
- (6) The county attorney.

(7) The administrative law judge or court involved in a contested case proceeding or further review upon a finding that the information is necessary for the resolution of an issue arising in any phase of a case involving a determination of a substantiated allegation of student abuse.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

441—174.11(232E) Substantial compliance. Because investigative procedures seldom allow for rigid observance of the protocol, substantial compliance with these rules is required with the overriding goal of reaching a fair and unbiased resolution of a report of alleged student abuse.

[ARC 9953C, IAB 1/7/26, effective 3/1/26]

These rules are intended to implement Iowa Code chapter 232E.

[Filed ARC 9953C (Notice ARC 9641C, IAB 10/29/25), IAB 1/7/26, effective 3/1/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 175 ABUSE OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 135]
[Previously appeared as Ch 135—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

DIVISION I CHILD ABUSE

[Rescinded IAB 5/6/98, effective 9/1/98]

441—175.1 to 175.20 Reserved.

DIVISION II CHILD ABUSE ASSESSMENT

PREAMBLE

The purpose of this division is to implement requirements established in the Iowa Code which charge the department of human services with accepting reports of child abuse, assessing those reports and taking necessary steps to ensure a reported child's safety. Protection is provided through encouraging the reporting of suspected cases of abuse, conducting a thorough and prompt assessment of the reports, and providing rehabilitative services to abused children and their families. This response to reports of child abuse emphasizes child safety and engagement of a family in services, where necessary. The assessment-based approach recognizes that child protection and strong families are the responsibility not only of the family itself, but also of the larger community (including formal and informal service networks). It is the department's legal mandate to respond to reports of child abuse. The assessment approach shall allow the department to develop divergent strategies when responding to reports of child abuse, adjusting its response according to the severity of abuse, to the functioning of the family, and to the resources available within the child and family's community.

441—175.21(232,235A) Definitions.

"Adequate food, shelter, clothing, medical or mental health treatment, supervision or other care" means that food, shelter, clothing, medical or mental health treatment, supervision or other care which, if not provided, would constitute a denial of critical care.

"Allegation" means a statement setting forth a condition or circumstance yet to be proven.

"Assessment" means the process by which the department responds to all accepted reports of alleged child abuse. An "assessment" addresses child safety, family functioning, culturally competent practice, and identifies the family strengths and needs, and engages the family in services if needed. The department's assessment process occurs either through a child abuse assessment or a family assessment.

"Assessment intake" means the process by which the department receives and records a report of suspected child abuse.

"Caretaker" means a person responsible for the care of a child as defined in Iowa Code section 232.68.

"Case" means a report of suspected child abuse that has been accepted for assessment services.

"Child abuse assessment" means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2) "a"(1) through (3) and (5) through (11) as amended by 2016 Iowa Acts, Senate File 2258; or which allege child abuse as defined in Iowa Code section 232.68(2) "a"(4) that also allege imminent danger, death, or injury to a child. A "child abuse assessment" results in a disposition and a determination

of whether a case meets the definition of child abuse and a determination of whether criteria for placement on the registry are met.

“Denial of critical care” means the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing, medical or mental health treatment, supervision or other care necessary for the child’s health and welfare when financially able to do so, or when offered financial or other reasonable means to do so, and shall mean any of the following:

1. Failure to provide adequate food and nutrition to the extent that there is danger of the child suffering injury or death.

2. Failure to provide adequate shelter to the extent that there is danger of the child suffering injury or death.

3. Failure to provide adequate clothing to the extent that there is danger of the child suffering injury or death.

4. Failure to provide adequate health care to the extent that there is danger of the child suffering injury or death. A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child and shall not be placed on the child abuse registry. However, a court may order that medical service be provided where the child’s health requires it.

5. Failure to provide the mental health care necessary to adequately treat an observable and substantial impairment in the child’s ability to function.

6. Gross failure to meet the emotional needs of the child necessary for normal development.

7. Failure to provide for the adequate supervision of the child that a reasonable and prudent person would provide under similar facts and circumstances when the failure results in direct harm or creates a risk of harm to the child.

8. Failure to respond to the infant’s life-threatening conditions (also known as withholding medically indicated treatment) by providing treatment (including appropriate nutrition, hydration and medication) which in the treating physician’s reasonable medical judgment will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician’s reasonable medical judgment any of the following circumstances apply: the infant is chronically and irreversibly comatose; the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant’s life-threatening conditions, or otherwise be futile in terms of the survival of the infant; the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.

“Department” means the Iowa department of human services and includes the local offices of the department.

“Differential response” means an assessment system in which there are two discrete pathways to respond to accepted reports of child abuse, a child abuse assessment and a family assessment. The child abuse assessment pathway shall require a determination of abuse and a determination of whether criteria for placement on the central abuse registry are met.

“Facility providing care to a child” means any public or private facility, including an institution, hospital, health care facility, intermediate care facility for persons with an intellectual disability, residential care facility for persons with an intellectual disability, or skilled nursing facility, group home, mental health facility, residential treatment facility, shelter care facility, detention facility, or child care facility which includes licensed day care centers, all registered family and group day care homes and licensed family foster homes. A public or private school is not a facility providing care to a child, unless it provides overnight care. Public facilities which are operated by the department of human services are assessed by the department of inspections and appeals.

“Family assessment” means an assessment process by which the department responds to all accepted reports of child abuse which allege child abuse as defined in Iowa Code section 232.68(2) “a”(4), but do not allege imminent danger, death, or injury to a child. A “family assessment” does not

include a determination of whether a case meets the definition of child abuse and does not include a determination of whether criteria for placement on the central abuse registry are met.

“Home” means a permanent or temporary structure where one resides, including a licensed foster family home. For the purpose of this chapter, “home” shall not be construed to include any public or private facility, such as an institution, hospital, health care facility, intermediate care facility for persons with an intellectual disability, residential care facility for persons with an intellectual disability, skilled nursing facility, group care, mental health facility, residential treatment facility, shelter care facility, detention facility, licensed day care center, or child foster care provided by an agency.

“Illegal drug” means cocaine, heroin, amphetamine, methamphetamine or other illegal drugs, including marijuana, or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

“Immediate threat” or *“imminent danger”* means conditions which, if no response were made, would be more likely than not to result in sexual abuse, injury or death to a child.

“Infant,” as used in the definition of “denial of critical care,” numbered paragraph “8,” means an infant less than one year of age or an infant older than one year of age who has been hospitalized continuously since birth, who was born extremely prematurely, or who has a long-term disability.

“Nonaccidental physical injury” means an injury which was the natural and probable result of a caretaker’s actions which the caretaker could have reasonably foreseen, or which a reasonable person could have foreseen in similar circumstances, or which resulted from an act administered for the specific purpose of causing an injury.

“Physical injury” means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition or damage to any bodily tissue which results in the death of the person who has sustained the damage.

“Preponderance of evidence” means evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it.

“Proper supervision” means that supervision which a reasonable and prudent person would exercise under similar facts and circumstances, but in no event shall the person place a child in a situation that may endanger the child’s life or health, or cruelly or unduly confine the child. Dangerous operation of a motor vehicle is a failure to provide proper supervision when the person responsible for the care of a child is driving recklessly, or driving while intoxicated with the child in the motor vehicle. The failure to restrain a child in a motor vehicle does not, by itself, constitute a cause to assess a child abuse report.

“Rejected intake” means a report of suspected child abuse that has not been accepted for assessment.

“Reporter” means the person making a verbal or written statement to the department, alleging child abuse.

“Report of suspected child abuse” means a verbal or written statement made to the department by a person who suspects that child abuse has occurred.

“Reside” or *“resides”* means to habitually sleep or live. A person’s subjective intent as to where the person resides is not relevant.

“Sex trafficking” means the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of commercial sexual activity as defined in Iowa Code section 710A.1.

“Sex trafficking victim” means a victim of sex trafficking.

“Subject of a report of child abuse” means any of the following:

1. A child named in a report as having been abused, or the child’s attorney or guardian ad litem.
2. A parent or the attorney for the parent of a child named in a child abuse assessment summary as having been abused.
3. A guardian or legal custodian, or that person’s attorney, of a child named in a child abuse assessment summary as having been abused.

4. A person or the attorney for the person named in a child abuse assessment summary as having abused a child.

“*Unduly*” shall mean improper or unjust, or excessive.

[ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 1156C, IAB 10/30/13, effective 1/1/14; ARC 2069C, IAB 8/5/15, effective 10/1/15; ARC 2742C, IAB 10/12/16, effective 12/1/16; ARC 5248C, IAB 11/4/20, effective 1/1/21]

441—175.22(232) Receipt of a report of suspected child abuse. Reports of suspected child abuse shall be received by local department offices, the central abuse registry, or the Child Abuse Hotline.

175.22(1) Any report made to the department which alleges child abuse, as defined in Iowa Code section 232.68, or constitutes a complaint that a child is a child in need of assistance, as defined in Iowa Code section 232.2(6), shall be accepted for assessment.

175.22(2) Reports of suspected child abuse which do not meet the legal definition of child abuse shall become rejected intakes.

a. If a report of suspected child abuse does not meet the legal definition of child abuse or is accepted as a family assessment, but a criminal act harming a child is alleged, the department shall immediately refer the matter to the appropriate law enforcement agency.

b. If a report constitutes an allegation of child sexual abuse as defined under Iowa Code section 232.68(2)“*a*”(3) as amended by 2016 Iowa Acts, Senate File 2258, except that the suspected abuse resulted from the acts or omissions of a person who was not a caretaker or was not a person who resides in a home with the child, the department shall refer the report to law enforcement orally as soon as practicable and follow up in writing within 72 hours of receiving the report.

[ARC 1156C, IAB 10/30/13, effective 1/1/14; ARC 2069C, IAB 8/5/15, effective 10/1/15; ARC 2742C, IAB 10/12/16, effective 12/1/16]

441—175.23(232) Sources of report of suspected child abuse.

175.23(1) *Mandatory reporters.* Any person meeting the criteria of a mandatory reporter is required to make an oral report of the suspected child abuse to the department within 24 hours of becoming aware of the abusive incident and make a written report to the department within 48 hours following the oral report. If the person making the report has reason to believe that immediate protection for the child is advisable, that person shall also make an oral report to an appropriate law enforcement agency.

175.23(2) *Others required to report.* In addition to mandatory reporters which are so designated by the Iowa Code, there are other classifications of persons who are required, either by administrative rule or department policy, to report suspected child abuse when this is a duty identified through the person’s employment. Others required to report include:

a. Income maintenance workers.

b. Certified adoption investigators.

175.23(3) *Permissive reporters.* Any person who suspects child abuse may make an oral or written report, or both, to the department. Mandatory reporters may report as permissive reporters when they suspect abuse of a child outside the scope of their professions. A permissive reporter may remain anonymous and is not required by law to report abuse.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.24(232) Assessment intake process. The primary purpose of intake is to obtain available and pertinent information regarding an allegation of child abuse and determine whether a report of suspected child abuse becomes accepted for assessment or a rejected intake.

175.24(1) To result in an assessment, the report of suspected child abuse must include some information to indicate all of the following.

a. The alleged victim of child abuse is a child.

b. The alleged perpetrator of child abuse is:

(1) A caretaker; or

(2) A person who resides in a home with the child, if the allegation is sexual abuse as defined in Iowa Code section 232.68(2) “a”(3) as amended by 2016 Iowa Acts, Senate File 2258; or

(3) A person who engages in or allows child sex trafficking as defined in Iowa Code section 232.68(2) “a”(11) as amended by 2016 Iowa Acts, Senate File 2258.

c. The alleged incident falls within the definition of child abuse.

175.24(2) If the report constitutes a child abuse allegation, a determination is made as to whether the assessment will be assigned as a child abuse assessment, to be commenced within 24 hours of receiving the report, or a family assessment, to be commenced within 72 hours of receiving the report.

a. A child abuse assessment is required for all accepted reports which allege child abuse as defined in Iowa Code section 232.68(2) “a”(1) through (3) and (5) through (11) as amended by 2016 Iowa Acts, Senate File 2258; or which allege child abuse as defined in Iowa Code section 232.68(2) “a”(4) that also allege imminent danger, death, or injury to a child. If one or more of the following factors are met, a child abuse assessment shall be required:

(1) The alleged abuse type includes a category other than denial of critical care.

(2) The allegation requires a one-hour response or alleges imminent danger, death, or injury to a child.

(3) The child has been taken into protective custody as a result of the allegation.

(4) There is an open service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the noncustodial parent if the noncustodial parent is the alleged person responsible.

(5) The alleged person responsible is not a birth or adoptive parent, a legal guardian, or a member of the child’s household.

(6) There has been a termination of parental rights in juvenile court on the alleged person responsible or on any caretaker who resides in the home.

(7) There has been prior confirmed or founded abuse within the past six months which lists any caretaker who resides in the home as the person responsible.

(8) It is alleged that illegal drugs are being manufactured or sold from the family home.

(9) The allegation is failure to thrive or that the caretaker has failed to respond to an infant’s life-threatening condition.

(10) The allegation involves an incident for which the caretaker has been charged with a felony under Iowa Code chapter 726.

b. A family assessment is required for all accepted reports which allege child abuse as defined in Iowa Code section 232.68(2) “a”(4) but do not allege imminent danger, death, or injury to a child. If all of the following factors are met, a family assessment shall be required:

(1) The alleged abuse type is denial of critical care only.

(2) The allegation does not require a one-hour response or allege imminent danger, death, or injury to a child.

(3) The child has not been taken into protective custody as a result of the allegation.

(4) There is no current open service case on the alleged child victim or any sibling or any other child who resides in the home or in the home of the noncustodial parent if the noncustodial parent is the alleged person responsible.

(5) The alleged person responsible is a birth or adoptive parent, a legal guardian, or a member of the child’s household.

(6) There has not been a termination of parental rights in juvenile court on the alleged person responsible or on any caretaker who resides in the home.

(7) There has been no prior confirmed or founded abuse within the past six months which lists any caretaker who resides in the home as the person responsible.

(8) It is not alleged that illegal drugs are being manufactured or sold from the family home.

(9) The allegation is not failure to thrive or that the caretaker has failed to respond to an infant’s life-threatening condition.

(10) The allegation does not involve an incident for which the caretaker has been charged with a felony under Iowa Code chapter 726.

175.24(3) Only the person making a report of suspected abuse may be contacted during the intake process to expand upon or to clarify information in the report. Any contact with subjects of the report or with anyone outside the department of human services, other than the original reporter(s), automatically causes the report of suspected child abuse to be accepted for assessment.

175.24(4) If the report of suspected child abuse fails to constitute a child abuse allegation.

a. When it is determined that the report of suspected child abuse fails to constitute a child abuse allegation, the report of suspected child abuse shall become a rejected intake and shall be evaluated to determine whether the information reported constitutes a complaint that a child is a child in need of assistance.

b. When it is determined that a report of a child needing the assistance of the court fails to meet the definition of a child in need of assistance, the report shall become a rejected intake.

c. Rejected intake information shall be maintained by the department for three years from the date the report was rejected and shall then be destroyed.

175.24(5) Intake information shall be provided as follows:

a. The county attorney shall be notified of all reports of suspected child abuse.

b. When a report of suspected child abuse is received which does not meet the requirements for an assessment or is accepted as a family assessment and there is information about a criminal act harming a child, the department shall notify law enforcement of the report.

c. If the department has reasonable cause to believe that a child or youth for whom the department has responsibility for placement, care, or supervision is or is at risk of being a victim of sex trafficking or a severe form of trafficking in persons, the department must identify that child or youth as such, document it in agency records, and refer the information as necessary to determine appropriate services, in accordance with 42 U.S.C. Section 671(a)(9)(C). Additionally, the department shall report the child or youth immediately, and in no case later than 24 hours, to law enforcement authorities, in accordance with 42 U.S.C. Section 671(a)(34).

[ARC 8453B, IAB 1/13/10, effective 3/1/10; ARC 1156C, IAB 10/30/13, effective 1/1/14; ARC 2069C, IAB 8/5/15, effective 10/1/15; ARC 2742C, IAB 10/12/16, effective 12/1/16]

441—175.25(232) Assessment process. A child abuse assessment shall be initiated within 24 hours following the report of suspected child abuse. A family assessment shall be initiated within 72 hours following the report of suspected child abuse. The primary purpose in conducting an assessment is to protect the safety of the child named in the report. The secondary purpose of the assessment is to engage the child's family in services in a culturally competent way, to enhance family strengths and to address needs, where this is necessary and desired.

175.25(1) *Observing and evaluating the child's safety.* A safety assessment and risk assessment will be completed during the course of a child abuse assessment or family assessment.

a. During a child abuse assessment, when there is an immediate threat to the child's safety, reasonable efforts shall be made to observe the alleged child victim and evaluate the safety of the child named in the report within one hour of receipt of the report of suspected child abuse. Otherwise, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 24 hours of receipt of the report of suspected child abuse.

(1) When the alleged perpetrator clearly does not have access to the alleged child victim, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 96 hours of receipt of the report of suspected child abuse.

(2) When reasonable efforts have been made to observe the alleged child victim within the specified time frames and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be delayed or waived with supervisory approval.

b. During a family assessment, reasonable efforts shall be made to observe the alleged child victim and evaluate the child's safety within 72 hours of receipt of the report of suspected child abuse.

(1) When reasonable efforts have been made to observe the alleged child victim within the specified time frame and the worker has established that there is no risk to the alleged child victim, the observation of the alleged child victim may be delayed or waived with supervisory approval.

(2) If at any time during a family assessment a child is determined unsafe or in imminent danger, it appears that the immediate safety or well-being of a child is endangered, it appears that the family may flee or the child may disappear, or that the facts otherwise warrant, the department shall immediately commence a child abuse assessment as defined in Iowa Code section 232.71B as amended by 2013 Iowa Acts, House File 590.

(3) If the department determines that safety issues continue to require a child to reside outside of the child's home at the conclusion of a family assessment, the department shall transfer the assessment to the child abuse assessment pathway for a disposition.

c. If the department has reasonable cause to believe that a child or youth for whom the department has responsibility for placement, care, or supervision is or is at risk of being a victim of sex trafficking or a severe form of trafficking in persons, the department must identify that child or youth as such, document it in agency records, and determine appropriate services, in accordance with 42 U.S.C. Section 671(a)(9)(C). Additionally, the department shall report the child or youth immediately, and in no case later than 24 hours, to law enforcement authorities, in accordance with 42 U.S.C. Section 671(a)(34).

175.25(2) *Interviewing the alleged child victim.* The primary purpose of an interview with the child, during the course of a child abuse assessment or family assessment, is to gather information regarding the abuse allegation, the child's immediate safety, and risk of abuse. During a child abuse assessment, the child protection worker shall also identify the person or persons responsible for the alleged abuse as well as the nature, extent, and cause of injuries, if any, to the child named in the report of suspected child abuse.

175.25(3) *Interviewing subjects of the report and other sources.*

a. During a child abuse assessment, attempts shall be made to conduct interviews with subjects of the report and persons who have relevant information to share regarding the allegations. This may include contact with physicians to assess the child's condition. The child's custodial parents or guardians and the alleged perpetrator (if different) shall be interviewed or offered the opportunity to be interviewed. The court may waive the requirement of the interview for good cause.

b. During a family assessment, the child's custodial parents or guardians shall be interviewed or offered the opportunity to be interviewed. The child protection worker may request information from any person believed to have knowledge regarding a child named in an assessment. A family assessment requires the cooperation of the family; should a family choose not to participate, the department is required to transfer the assessment to the child abuse assessment pathway for a disposition.

175.25(4) *Gathering of physical and documentary evidence.* During a child abuse assessment, evidence shall be gathered from, but not be limited to, interviews, observations, photographs, medical and psychological reports and records, reports from child protection centers, written reports, audiotapes and their transcripts or summaries, videotapes and their transcripts or summaries, or other electronic forms.

175.25(5) *Evaluating the home environment and relationships of household members.* An evaluation of the home environment shall be conducted during the course of an assessment with the consent of the parent or guardian. If permission is refused, the juvenile court may authorize the worker to enter the home to observe or interview the child.

a. If protective concerns are identified, the child protection worker shall evaluate the child named in the report and any other children in the same home as the parents or other persons responsible for their care.

(1) Each assessment shall include a full description of observations and information gathered during the assessment process. This description shall provide information which evaluates the safety of the child named in the report.

(2) If the child protection worker has concerns about a child's safety or a family's functioning, the worker shall conduct a more intensive assessment until those concerns are addressed.

b. When an assessment is conducted at an out-of-home setting, an evaluation of the environment and relationships where the abuse allegedly occurred shall be conducted.

c. The child abuse assessment shall include a description of the name, age, and condition of other children in the same home as the child named in the report.

175.25(6) *Evaluating the information.* During a child abuse assessment, evaluation of information shall include an analysis, which considers the credibility of the physical evidence, observations, and interviews, and shall result in a conclusion of whether or not to confirm the report of suspected child abuse.

175.25(7) *Determining placement on central abuse registry.* During a child abuse assessment, a determination of whether the report data and disposition data of a confirmed case of child abuse is subject to placement on the central abuse registry pursuant to Iowa Code section 232.71D shall be made on each assessment. Determining placement on the central abuse registry is not applicable in a family assessment.

175.25(8) *Service recommendations and referrals.* During or at the conclusion of a child abuse assessment or a family assessment, the department shall consult with the child's family to offer services to the child and the child's family which address strengths and needs identified in the assessment. The department may recommend information, information and referral, community care referral, or services provided by the department. If it is believed that services are necessary for the protection of the abused child or other children in the home, juvenile court intervention shall be sought.

a. *Information or information and referral.*

(1) Either information or information and referral shall be offered when:

1. A family assessment has identified the child to be at low risk of future abuse or neglect; or
2. A child abuse assessment has identified the abuse is not confirmed and the child is believed to be at low risk of future abuse or neglect; or
3. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at low risk of future abuse or neglect.

(2) Recommendation options for information and information and referral.

1. When no service needs are identified, the worker may recommend no service; or
2. When service needs are identified, the worker may recommend new or continuing services to the family to be provided through informal supports; or
3. When service needs are identified, the worker may recommend new or continuing services to the family to be provided through community organizations.

b. *Referral to community care.*

(1) A referral to community care shall be offered when:

1. A family assessment has identified the child to be at moderate or high risk of future abuse or neglect; or
2. A child abuse assessment has identified the abuse is not confirmed and the child is believed to be at moderate or high risk of future abuse or neglect; or
3. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at moderate risk of future abuse or neglect.

(2) Referral to community care not offered. A referral to community care shall not be offered when any child in the family has an open child welfare service case with the department, a child in need of assistance petition was filed or is pending, or if the abuse occurred in an out-of-home setting.

(3) Responsibilities for community care referral.

1. At the conclusion of a family assessment, the department shall transfer the case, if appropriate, to a contracted provider to review the service plan for the child and family.

2. The contracted provider shall make a referral to the department abuse hotline if a family's noncompliance with a service plan places a child at risk.

- If any of the criteria for child abuse as defined in Iowa Code section 232.68 are met, the department shall commence a child abuse assessment.
- If criteria for a child in need of assistance as defined in Iowa Code section 232.2(6) are met, the department shall determine whether to request a child in need of assistance petition.

c. Referral for department services.

(1) The department shall provide or arrange for and monitor services for abused children and their families on a voluntary basis or under a final or intermediate order of the juvenile court when:

1. A child abuse assessment has identified the abuse is confirmed and not placed on the registry and the child is believed to be at high risk of future abuse or neglect; or
2. A child abuse assessment has identified the abuse is founded.

(2) The worker shall recommend new or continuing services to the family to be provided by the department, either directly or through contracted agencies.

(3) Families that refuse voluntary services shall be referred for a child in need of assistance petition through juvenile court.

175.25(9) *Court action following assessment.* If, upon completion of an assessment performed under Iowa Code section 232.71B as amended by 2013 Iowa Acts, House File 590, the department determines that the best interests of the child require juvenile court action, the department shall act appropriately to initiate the action.

a. If at any time during the assessment process the department believes court action is necessary to safeguard a child, the department shall act appropriately to initiate the action.

b. The department shall assist the juvenile court or district court during all stages of court proceedings involving an alleged child abuse case in accordance with Iowa Code section 232.71C as amended by 2013 Iowa Acts, House File 590.

[ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 1156C, IAB 10/30/13, effective 1/1/14; ARC 2069C, IAB 8/5/15, effective 10/1/15]

441—175.26(232) Completion of a written assessment report. The child protection worker shall complete a written assessment report as follows:

175.26(1) *Completion of a child abuse assessment report.* A child abuse assessment report shall be completed within 20 business days of the receipt of the child abuse report. In most instances, a child abuse assessment report shall be developed in conjunction with the child and family being assessed. A child abuse assessment report shall consist of two parts as follows:

a. Report and disposition data. A child abuse assessment report shall include report and disposition data as follows:

(1) Allegations: the report of suspected child abuse which caused the assessment to be initiated and additional allegations raised after the report of suspected child abuse becomes a case that have not been previously investigated or assessed. If the report of suspected child abuse was initially accepted as a family assessment, the reason why it was transferred to a child abuse assessment shall be identified.

(2) Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person alleged responsible, current services or supports, access of the person alleged responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not alleged responsible for the abuse.

(3) Findings and contacts: a description of the child's condition including identification of the nature, extent, and cause of the injuries, if any, to the child named in the report; identification of the injury or risk to which the child was exposed; the circumstances which led to the injury or risk to the child; the identity of the person alleged to be responsible for the injury or risk to the child; an evaluation of the home environment; the name and condition of other children in the same home as

the child named in the report if protective concerns are identified; a list of collateral contacts; and a history of confirmed or founded abuse.

(4) Determination regarding the allegations of child abuse: a statement of determination of whether the allegation of child abuse was founded, confirmed but not placed on the central abuse registry, or not confirmed. The statement shall include a rationale for placing or not placing the report on the central abuse registry.

(5) Recommendation for services as specified in 175.25(8) and a statement describing whether services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

1. The statement shall include the type of services recommended, if any, and whether these services are to be provided by the department, a child welfare service contractor, another community organization, other informal supports, or another source.

2. If services are already being provided, the statement shall include a recommendation whether these services should continue.

(6) Juvenile court recommendation: a statement describing whether juvenile court action is necessary to ensure the safety of the child; the type of action needed, if any; and the rationale for the recommendation.

(7) Criminal court recommendation: a statement describing whether criminal court action is necessary and the rationale for the recommendation.

(8) Addendum: An addendum to a child abuse assessment report shall be completed within 20 business days when any of the following occur:

1. New information becomes available that would alter the finding, conclusion, or recommendation of the report.

2. Substantive information that supports the finding becomes available.

3. A subject who was not previously interviewed requests an interview to address the allegations of the report.

4. A review or a final appeal decision modifies the report.

b. Use of assessment data. A safety assessment, family risk assessment, and safety plan, if applicable, may be used as part of the child's initial case plan, referenced at 441—subrule 130.7(3), for cases in which the department will provide services.

175.26(2) *Completion of a family assessment report.* A family assessment report shall be completed within ten business days of the receipt of the report of suspected child abuse. A family assessment report shall consist of assessment data only.

a. Assessment data. A family assessment report shall include information pertaining to the department's evaluation of a family, which includes:

(1) Allegations: the report of suspected child abuse which caused the assessment to be initiated and additional allegations raised after the report of suspected child abuse becomes a case that have not been previously assessed.

(2) Evaluation of the child's safety: evaluation of the child's safety and the risk for occurrence or reoccurrence of abuse. Criteria to be used in the evaluation of the child's safety include, but are not limited to, the severity of the incident or condition, chronicity of the incident or condition, age of the child, attitude of the person alleged responsible, current services or supports, access of the person alleged responsible for the abuse to the child, and protectiveness of the parent or caretaker who is not alleged responsible for the abuse.

(3) Contacts: description of the circumstances that led to the allegations of abuse; strengths and needs of the child, and of the child's parent, home, and family; any information obtained from others during the assessment; a history of confirmed or founded abuse; and an evaluation of the home environment and evaluation of any other children in the same home as the parents or other persons responsible for the children's care.

(4) Recommendation for services as specified in 175.25(8) and a statement describing whether services are necessary to ensure the safety of the child or to prevent or remedy other identified problems.

1. The statement shall include the type of services recommended, if any, and whether these services are to be provided by the department, a child welfare service contractor, another community organization, other informal supports, or another source.

2. If services are already being provided, the statement shall include a recommendation whether these services should continue.

b. Use of assessment data. A safety assessment, family risk assessment, and safety plan may be used as part of the information referred for any services in which the family voluntarily agrees to participate.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.27(232) Contact with juvenile court or the county attorney. The child protection worker may orally contact juvenile court or the county attorney, or both, as circumstances warrant.

175.27(1) Report of intake. When a report of suspected child abuse is accepted or rejected for assessment, the county attorney shall be provided a child protective service intake form, with information about the allegation of child abuse and with identifying information about the subjects of the report.

175.27(2) Report of disposition. The child protection worker shall provide the juvenile court and the county attorney with a copy of the child abuse assessment report, which pertains to the findings, determinations, and recommendations regarding the child abuse assessment.

175.27(3) Report of assessment. The child protection worker shall provide the county attorney and the juvenile court with a copy of the family risk assessment, safety assessment, safety plan, and family assessment report when any of the following occur:

a. County attorney's or juvenile court's assistance necessary. The worker requires the court's or the county attorney's assistance to complete the assessment process.

b. Court's protection needed. The worker believes that the child requires the court's protection.

c. Child adjudicated. The child is currently adjudicated or pending adjudication under a child in need of assistance petition or a delinquency petition.

d. County attorney or juvenile court requests copy. The county attorney or juvenile court requests a copy of the child abuse assessment data. The child protection worker shall document when the assessment data is provided to the county attorney or juvenile court and the rationale provided for the request.

[ARC 8453B, IAB 1/13/10, effective 3/1/10; ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.28(232) Consultation with health practitioners or mental health professionals. The child protection worker may contact a health practitioner or a mental health professional as circumstances warrant and shall contact a health practitioner or a mental health professional when the worker requires the assistance of the health practitioner or mental health professional in order to complete the assessment process or when the worker requires the opinion or advice of the health practitioner or mental health professional in order to determine if the child requires or should have required medical, health or mental health care as a result of suspected abuse.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.29(232) Consultation with law enforcement.

175.29(1) During the course of a child abuse assessment, the child protection worker may contact law enforcement as warranted and shall contact law enforcement when the worker believes that:

a. The abuse reported may require a criminal investigation and subsequent prosecution.

b. The child must be separated from the person responsible for the abuse.

c. Contact by the child protection worker with the family will result in a volatile and dangerous response by the child or family members.

175.29(2) During the course of a family assessment, the child protection worker shall not involve law enforcement for the purposes of a joint investigation, but shall immediately refer any information regarding a criminal act harming a child to the appropriate law enforcement agency.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.30(232) Information shared with law enforcement. When the department is jointly conducting a child abuse assessment with law enforcement personnel, the department may share information gathered during the child abuse assessment process when an assessment is conducted in conjunction with a criminal investigation. When the department has rejected an intake or an intake is accepted for a family assessment, only the information collected at intake (excluding reporter information) may be shared with law enforcement.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.31(232) Completion of required correspondence.

175.31(1) *Notification to parents that an assessment is being conducted.* Written notice shall be provided to the parents of a child who is the subject of an assessment within five working days of commencing an assessment. Both custodial and noncustodial parents shall be notified, if their whereabouts are known. If it is believed that notification will result in danger to the child or others, an emergency order to prohibit parental notification shall be sought from juvenile court.

175.31(2) *Notification of completion of assessment and right to request correction.* Written notice which indicates that the child abuse assessment is completed shall be provided to all subjects of a child abuse assessment and to the mandatory reporter who made the report of child abuse. Both custodial and noncustodial parents shall be notified if their whereabouts are known.

a. The notice shall contain the following information pursuant to Iowa Code section 235A.19:

(1) A subject may request correction of the information contained within the child abuse assessment report if the subject disagrees with the information.

(2) A person named responsible for the abuse has the right to appeal if the department does not correct the data or findings as requested.

(3) A subject, other than the person named responsible for the abuse, has the opportunity to file a motion to intervene in an appeal hearing.

b. If the child abuse assessment results in a determination that abuse is confirmed, the notice shall indicate the type of abuse, name of the child and name of the person responsible for the abuse and whether the report has been placed on the central abuse registry.

c. The department shall provide written notice to the parent or guardian of each child listed in the family assessment report of the completion of the assessment and review any service recommendations. Because no determination concerning child abuse or neglect is made and nothing is reported to the central abuse registry, a subject of a family assessment shall not be afforded the opportunity for a contested case hearing pursuant to Iowa Code chapter 17A.

[ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.32(232,235A) Case records. The assessment case record shall contain the assessment report as described in rule 441—175.26(232) and any related correspondence or information which pertains to the assessment or to the child and family. The name of the person who made the report of child abuse shall not be disclosed.

175.32(1) *Child abuse assessment report.* A child abuse assessment report has two parts.

a. Report and disposition data as described in 175.26(1) “a.” Subjects of the report have access to report and disposition data, including, where applicable, confirmation of placement on the central abuse registry for abuse reports meeting the criteria pursuant to Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590. A child abuse assessment report shall be submitted to

the central abuse registry only if the abuse is confirmed and determined to meet the criteria pursuant to Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590.

b. Assessment data as described in 175.26(1)“*b*” shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian approves the release as provided in Iowa Code section 217.30 or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(2) *Family assessment report.* A family assessment report includes assessment data only as described in 175.26(2)“*b*.” Assessment data shall be available to subjects. Release of assessment data shall be accomplished only when the parent or guardian of a child named in a family assessment report approves the release as provided in Iowa Code section 217.30 or as specified in Iowa Code section 235A.15. Assessment data shall not be submitted to the central abuse registry.

175.32(3) *Child abuse assessments where abuse was confirmed but not placed on the central abuse registry.* The following conditions apply to case records for assessments in which abuse was confirmed but not placed on the central registry.

a. Access to the report data and disposition data is authorized only to the subjects of the report, the child protection worker, the law enforcement officer responsible for assisting in the assessment or for the temporary emergency removal of a child from the child’s home, the multidisciplinary team assisting the department in the assessment of the abuse, the county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department or contract personnel necessary for official duties, the department of justice, and the attorney for the department.

b. The child abuse assessment is retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child abuse assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 9. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(4) *Child abuse assessments not placed on the central abuse registry where abuse was not confirmed.* The following conditions apply to case records for assessments in which abuse was not confirmed and not placed on the central registry:

a. Access to the assessment data on a child abuse assessment summary where abuse was not determined to have occurred and, therefore, the assessment was not placed on the central abuse registry is authorized only to the subjects of the assessment, the child protection worker, the county attorney, juvenile court, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The child abuse assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 2505. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

175.32(5) *Family assessment.* The following conditions apply to case records for all family assessments:

a. Access to the assessment data on a family assessment report is authorized only to the subjects of the assessment, the child protection worker, a person or agency responsible for the care of the child if the department or juvenile court determines that access is necessary, the department of justice, and department or contract personnel necessary for official duties.

b. Records are retained for five years from the date of intake or five years from the date of closure of the service record, whichever occurs later.

c. The family assessment report is subject to the confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 2505. No confidential information shall be released without consent except where there is otherwise authorized access to information as specified in the provisions of Iowa Code section 235A.15.

[ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 1156C, IAB 10/30/13, effective 1/1/14; Editorial change: IAC Supplement 6/10/26]

441—175.33(232,235A) Child protection centers. The department may contract with designated child protection centers for assistance in conducting child abuse assessments. When a child who is the subject of an assessment is interviewed by staff at a child protection center, that interview may be used in conjunction with an interview conducted by the child protection worker. Written reports developed by the child protection center shall be provided to the child protection worker and may be included in the assessment case record. Video or audio records are considered to be part of the assessment process and shall be maintained by the child protection center under the same confidentiality provisions of Iowa Code section 217.30 and 441—Chapter 2505. Services or assistance from a child protection center will not be available through a family assessment. Law enforcement may refer families as appropriate.

[ARC 1156C, IAB 10/30/13, effective 1/1/14; Editorial change: IAC Supplement 6/10/26]

441—175.34(232) Department-operated facilities. When an allegation of child abuse occurs at a department-operated facility, the allegation shall be referred to the department of inspections and appeals for investigation or assessment.

441—175.35(232,235A) Jurisdiction of assessments. Child protection workers serving the county in which the child's home is located have primary responsibility for completing the assessment except when the suspected abuse occurs in an out-of-home placement. Circumstances in which the department shall conduct an assessment when another state is involved include the following:

175.35(1) *Child resides in Iowa but incident occurred in another state.* When the child who is the subject of a report of suspected abuse physically resides in Iowa but has allegedly been abused in another state, the worker shall do all of the following:

- a. Obtain available information from the reporter.
- b. Make an oral report to the office of the other state's protective services agency and request assistance from the other state in completing the assessment.
- c. Complete the assessment with assistance, as available, of the other state.

175.35(2) *Child resides in another state, but is present within Iowa.* When the child who is the subject of a report of abuse is a legal resident of another state, but is present within Iowa, the worker receiving the report shall do all of the following:

- a. Act to ensure the safety of the child.
- b. Contact the child's state of legal residency to coordinate the assessment of the report.
- c. Commence an assessment if the state of legal residency declines to conduct an investigation.

175.35(3) *Child resides in another state and perpetrator resides in Iowa.* When the child who is the subject of a report of abuse resides in another state and the perpetrator resides in Iowa, the worker receiving the report shall do all of the following:

- a. Contact the state where the child resides and offer assistance to that state in its completion of a child abuse assessment. This assistance shall include an offer to interview the person allegedly responsible for the abuse and any other relevant source of information.
- b. Commence an assessment if the child's state of legal residency declines to conduct an investigation.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.36(235A) Multidisciplinary teams. Multidisciplinary teams shall be developed in county or multicounty areas in which more than 50 child abuse cases are received annually. These teams

may be used as an advisory group to assist the department in conducting child abuse assessments. Multidisciplinary teams consist of professionals practicing in the disciplines of medicine, public health, mental health, social work, child development, education, law, juvenile probation, law enforcement, nursing, and substance abuse counseling. Members of multidisciplinary teams shall maintain confidentiality of cases in which they provide consultation. Rejected intakes shall not be shared with multidisciplinary teams since the rejected intakes are not considered to be child abuse information. During the course of a child abuse assessment, information regarding the initial report of child abuse and information related to the child and family functioning may be shared with the multidisciplinary team. After a conclusion is made, only report data and disposition data on confirmed cases of child abuse may be shared with the team members. When the multidisciplinary team is created, all team members shall execute an agreement, filed with the central abuse registry, which specifies:

175.36(1) Consultation. The team shall be consulted solely for the purpose of assisting the department in the child abuse assessment and diagnosis of child abuse cases.

175.36(2) Redissemination. No team member shall redisseminate child abuse information obtained through the multidisciplinary team. This shall not preclude redissemination of information as authorized by Iowa Code section 235A.17 when an individual team member has received information as a result of another authorized access provision of the Iowa Code.

175.36(3) Department not bound. The department shall consider the recommendation of the team in a specific child abuse case but shall not, in any way, be bound by the recommendation.

175.36(4) Confidentiality provisions. Any written report or document produced by the team pertaining to an assessment case shall be made a part of the file for the case and shall be subject to all confidentiality provisions of 441—Chapter 2505, unless the child abuse assessment results in placement on the central abuse registry in which case the written report or document shall be subject to all confidentiality provisions of Iowa Code chapter 235A.

175.36(5) Written records. Any written records maintained by the team which identify an individual child abuse assessment case shall be destroyed when the agreement lapses.

175.36(6) Compensation. Consultation team members shall serve without compensation.

175.36(7) Withdrawal from contract. Any party to the agreement may withdraw with or without cause upon the giving of 30 days' notice.

175.36(8) Expiration date. The date on which the agreement will expire shall be included.

[ARC 1156C, IAB 10/30/13, effective 1/1/14; Editorial change: IAC Supplement 6/10/26]

441—175.37(232) Community education. The department shall conduct a continuing publicity and educational program for the personnel of the department, mandatory reporters, and the general public to encourage recognition and reporting of child abuse, to improve the quality of reports of child abuse made to the department, and to inform the community about the assessment-based approach to child abuse cases.

441—175.38(235) Written authorizations. Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on the authorization for release of child abuse information form to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.39(232) Founded child abuse. Reports of child abuse where abuse has been confirmed shall be placed on the central abuse registry as founded child abuse for either five or ten years under any of the circumstances specified by Iowa Code section 232.71D as amended by 2013 Iowa Acts, House File 590. When none of the placement criteria listed in Iowa Code section 232.71D(3)“b” as amended by 2013 Iowa Acts, House File 590, are applicable, reports of denial of critical care by

failure to provide adequate clothing or failure to provide adequate supervision and physical abuse where abuse has been confirmed and determined to be minor, isolated, and unlikely to reoccur shall not be placed on the central abuse registry as a case of founded child abuse. The confirmed abuse shall be placed on the registry unless all three conditions are met.

175.39(1) *Confidentiality of founded child abuse report and data.* The confidentiality of report and disposition data pertaining to founded child abuse shall be maintained as provided in Iowa Code chapter 235A. Access to the report and disposition data on founded child abuse is authorized only as provided in Iowa Code section 235A.15.

175.39(2) *Sealing and expungement of founded child abuse report and data.* Report and disposition data pertaining to founded child abuse shall be sealed and expunged as provided in Iowa Code section 235A.18.

[ARC 9698B, IAB 9/7/11, effective 8/15/11; ARC 0487C, IAB 12/12/12, effective 2/1/13; ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.40(235A) Retroactive reviews. Rescinded IAB 9/7/11, effective 8/15/11.

441—175.41(235A) Access to child abuse information. Requests for child abuse information shall include sufficient information to demonstrate that the requesting party has authorized access to the information.

175.41(1) *Written requests.* Requests for child abuse information shall be submitted on a Request for Child Abuse Information form to the county office of the department, except requests made for the purpose of determining employability of a person in a department-operated facility shall be submitted to the central abuse registry. Subjects of a report may submit a request for child abuse information to the county office of the department on a request for child abuse information form, a notice of child abuse assessment: founded form, a notice of child abuse assessment: confirmed not registered form, a notice of child abuse assessment: not confirmed form, or a family assessment report form. The county office is granted permission to release child abuse information to the subject of a report immediately upon verification of the identity and subject status.

175.41(2) *Oral requests.* Oral requests for child abuse information may be made when a person making the request believes that the information is needed immediately and if the person is authorized to access the information. When an oral request to obtain child abuse information is granted, the person approving the request shall document the approval to the central abuse registry through use of a request for child abuse information form or a notice of child abuse assessment: founded form.

Upon approval of any request for child abuse information authorized by this rule, the department shall withhold the name of the person who made the report of child abuse unless ordered by a juvenile court or district court after a finding that the person's name is needed to resolve an issue in any phase of a case involving child abuse. Written requests and oral requests do not apply to child abuse information that is disseminated to an employee of the department, to a juvenile court, or to the attorney representing the department as authorized by Iowa Code section 235A.15.

175.41(3) *Written authorizations.* Requests for information from members of the general public as to whether a person is named on the central abuse registry as having abused a child shall be submitted on an Authorization for release of child abuse information form to the county office of the department or the central abuse registry. The form shall be completed and signed by the person requesting the information and the person authorizing the check for the release of child abuse information. The department shall not provide requested information when the authorization form is incomplete. Incomplete authorization forms shall be returned to the requester.

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

441—175.42(235A) Person conducting research. The supervisor of the central abuse registry shall be responsible for determining whether a person requesting child abuse information is conducting bona fide research, whether the research will further the official duties and functions of the central abuse registry, and whether identified information is essential to the research design. A bona fide

research design is one which shows evidence of a good-faith, academically objective and sincere intent to add to the body of knowledge about child abuse. To make this determination, the central abuse registry shall require the person to submit credentials and the research design. Additional criteria for approval of a research project may include whether the research involves contact with subjects of child abuse information, and whether contact with department personnel is required to complete the research design. If it is determined that the research will involve use of identified information, the central abuse registry shall also determine under what circumstances and in what format the information is to be used and shall execute an agreement with the researcher which will enable the researcher to obtain access to identified information on subjects of child abuse investigations, as an agent of the central abuse registry. The department will require the researcher to assume costs incurred by the department in obtaining or providing information for research purposes. The department shall keep a public record of persons conducting this research.

175.42(1) *Child abuse factors.* For purposes of conducting research pursuant to Iowa Code sections 235A.15 and 235A.23, official duties and functions of the central abuse registry shall include analysis or identification of child abuse factors in at least one of the following areas:

- a. Causes of abuse—victim, parent and perpetrator characteristics, types of abuse, and correlations to family and environmental factors.
- b. Effects of abuse—immediate and long-term effects of abuse on the individual child victim, the child's family and the perpetrator, in areas such as family functioning, foster placement, emotional and medical problems, and criminal activity; and effects of abuse on the community and society in general.
- c. Prevention of abuse—intervention, prevention and treatment strategies.
- d. Treatment of abuse—impact of service delivery upon recidivism and maintenance of the family unit.
- e. Reporting of abuse—mandatory and permissive reporter characteristics, training needs, and perception of the department's protective services to children and families.
- f. Identification of strengths and weaknesses in statute, policy or practice concerning child abuse services.

175.42(2) *Guidelines.* To be accepted by the central abuse registry, a research proposal originating outside the department shall meet the following guidelines:

- a. The proposal shall meet the criteria listed above as "official duties and functions" of the central abuse registry.
- b. The research shall be conducted by a competent researcher, evidenced by affiliation with a recognized human services agency, government body, or academic, social work or medical facility. The researcher shall demonstrate an ability to conduct nonbiased research and present findings in a professional and responsible manner which will benefit the department in providing protective services to children and families.
- c. The proposed research shall not unduly interfere with the ongoing duties and responsibilities of department staff.
- d. When the proposed research includes contact with subjects of child abuse information, the research design shall reflect a plan for initial subject contact by the department, which includes the following:
 - (1) Subjects shall be informed in writing of their right to refuse to participate in the research.
 - (2) Subjects shall receive written assurance that their participation in the research will not affect eligibility for services.
 - (3) Department staff shall be advised of research goals and procedures prior to contact with subjects, in order to answer questions which may arise.
 - (4) Subjects shall receive written assurance that when identifying information is released by the central abuse registry to research staff, the information will remain confidential and that all child abuse information will be deidentified prior to publication of the research findings.

175.42(3) *Approval procedures.* Procedures for approval of a research proposal are conducted as follows:

a. The supervisor of the central abuse registry shall designate a person to be the single point of contact (SPOC) for all research proposals requesting child abuse information or involving department staff who provide child protective services. All proposals shall be routed to the SPOC at the Division of Adult, Children and Family Services, Department of Human Services, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Having received a research proposal, the SPOC shall log the date the proposal was received and other identifying information about the researcher and the research design and shall convene a research advisory committee to review the proposal. This committee may consist of:

(1) The unit supervisor of the child and dependent adult abuse registry, when applicable.

(2) The unit managers for the programs addressed by the research proposal.

(3) The research specialist.

(4) Representatives from the field, including a service area manager or designee and one representative from a service area, appointed by the service area manager, if a specific service area is involved.

(5) A representative from the department's division of data management, when the proposal involves use of one of the department's computerized data systems.

(6) A representative of the attorney general's office, when the proposal involves legal questions or issues.

(7) Other persons whom the SPOC may designate to assist in the review.

c. The SPOC is responsible for ensuring that advisory committee members receive copies of the research proposal.

d. The advisory committee may meet in person or by teleconference.

e. The researcher may, at the discretion of the SPOC, be provided an opportunity to address the advisory committee concerning the research proposal and answer questions about the research design.

f. The committee shall determine the value of the proposed research and formulate recommendations for acceptance of the proposal (with conditions as necessary) or rejection of the proposal (with rationale for the rejection). These recommendations shall be submitted to the SPOC.

g. The SPOC shall transmit the committee's recommendations, with additional comments and recommendations, as needed, to the division administrators for the divisions involved.

h. The division administrators shall review committee recommendations and submit the research proposal to the director or designee for final approval.

i. After review by the director, the proposal shall be returned to the SPOC, who shall notify the researcher of the director's decision, which decision shall be final.

j. If the research proposal is approved, the SPOC shall prepare a written research agreement with the researcher which provides:

(1) The purpose of the research.

(2) The research design or methodology.

(3) The control of research findings and publication rights of all parties, including the deidentification of child abuse information prior to publication.

(4) The duties of all parties in conducting the research.

(5) The transfer of funds, if applicable.

k. The SPOC shall be responsible for securing written approval of the research agreement from the attorney general's office, applicable division administrators, and the researcher.

l. The SPOC shall be responsible for maintaining the research agreement throughout the research project and renewing or modifying the agreement when necessary.

441—175.43(235A) Child protection services citizen review panels. The purposes of the child protection services citizen review panels established in this rule are to comply with requirements set forth by the Child Abuse Prevention and Treatment Act and to take advantage of this process

to identify strengths and weaknesses of the child protective service system as a whole, including community-based services and agencies. The specific objectives are to clarify expectations for child protective services with current policy; to review consistency of practice with current policy; to analyze trends and recommend policy to address them; and to provide feedback on what is or is not working, and why, and to suggest corrective action if needed.

175.43(1) *Establishment of panels.* The department shall establish at least three panels, with at least one panel each at the state level, multicounty level, and county level. The department may designate as panels one or more existing entities established under state or federal law, such as multidisciplinary teams, if the entities have the capacity to satisfy the requirements of the function of a citizen review panel set forth in the Child Abuse Prevention and Treatment Act and the department ensures that the entities will satisfy the requirements. The department shall establish procedures to be used for selecting the panels.

175.43(2) *Membership of panels.* Each panel established shall be composed of a multidisciplinary team of volunteer members who are broadly representative of the community in which the panel is established, including members who possess knowledge and skills related to the diagnosis, assessments, and disposition of child abuse cases, and who have expertise in the prevention and treatment of child abuse. The membership of each panel shall include professionals practicing in the disciplines of medicine, nursing, public health, substance abuse, domestic violence, mental health, social work, child development, education, law, juvenile probation, law enforcement; or representatives from organizations that advocate for the protection of children. The panel shall function under the leadership of a chairperson and vice-chairperson who are elected annually by the membership. Members shall enter into a contract with the department.

175.43(3) *Meetings.* Each panel established pursuant to this rule shall meet not less than once every three months.

175.43(4) *Functions.* Each panel established pursuant to this rule shall:

a. Evaluate the extent to which the department effectively discharges the child protection responsibilities in accordance with: the state plan and the child protection standards under subsection (b) of the Child Abuse Prevention and Treatment Act of 1996; the child protection duties of the department set forth in Iowa Code chapters 232 and 235A; and any other criteria that the panel considers important to ensure the protection of children, including:

(1) A review of the extent to which the child protective services system is coordinated with the foster care and adoption programs established under Part E of Title IV of the Social Security Act (42 U.S.C.S. 670 et seq.); and

(2) A review of child fatalities and near fatalities.

b. Provide for public outreach and comment in order to:

(1) Assess the impact of current procedures and practices upon children and families in the community; and

(2) Make recommendations to the state and the public on improving the child protective services system at the state and local levels.

175.43(5) *Redissemination.* No panel member shall disseminate child abuse information obtained through the citizen review panel. This shall not preclude dissemination of information as authorized by Iowa Code section 235A.17 when an individual panel member has received information as a result of another authorized access provision of the Iowa Code.

175.43(6) *Department not bound.* The department shall consider the recommendations of the panel but shall not, in any way, be bound by the recommendations.

175.43(7) *Confidentiality.* Members and staff of a panel may not disclose child abuse information about any specific child abuse case to any person or government official and may not make public any information unless authorized by the Iowa Code to do so.

175.43(8) *Reports.* Each panel established under this rule shall prepare and make available to the public, on an annual basis, a report containing a summary of the activities of the panel.

175.43(9) *Staff assistance.* The department shall provide staff assistance to citizen review panels for the performance of their duties, upon request of the panel.

175.43(10) *Access to child abuse information.* Citizen review panels shall be under contract to carry out official duties and functions of the department and have access to child abuse information according to Iowa Code section 235A.15 [2 “e”(2)].

[ARC 1156C, IAB 10/30/13, effective 1/1/14]

These rules are intended to implement Iowa Code sections 232.68, 232.71D, 232.67, 232.69, 232.70, 232.71B, 232.71C, and 232.72 to 232.77 and Iowa Code chapter 235A.

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[Editorial change: IAC Supplement 6/10/26]

- ¹ Effective date of amendments to subrule 175.8(4), paragraph “a,” subparagraphs (7), (9), and (10); subrule 175.8(5); rules 175.9 and 175.15 delayed 70 days by the Administrative Rules Review Committee.
- ² Effective date of 175.25(4) “d” delayed 70 days by the Administrative Rules Review Committee at its meeting held January 3, 1996; delay lifted by the Committee at its meeting held February 5, 1996, effective February 6, 1996.
- ³ Effective date of amendments adopted in ARC 7975A delayed 70 days by the Administrative Rules Review Committee at its meeting held June 9, 1998.

CHAPTER 201 SUBSIDIZED ADOPTIONS

[Prior to 7/1/83, Social Services(770), Ch 138]
[Previously appeared as Ch 138—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services(498)]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/30

441—201.1(600) Administration. The department shall administer the subsidized adoption program, in conformance with the legal requirements for adoption.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.2(600) Definitions.

“Child” means a person who has not attained age 18 or a person with a physical or mental disability who has not attained age 21.

“Escrow account” means an interest-bearing account in a bank or savings and loan association that is maintained by the department in the name of a particular child.

“Maintenance subsidy” means a monthly payment to assist the family in meeting the living expenses and expenses related to the care of a child with special needs in covering the cost of room, board, clothing, and spending money. The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

“Nonrecurring expenses” means reasonable and necessary adoption fees, court costs, attorney fees and other expenses that are directly related to the legal adoption of a child with special needs. These shall be limited to attorney fees, court filing fees and other court costs.

“Physician” means a licensed medical or osteopathic doctor as defined in rule 441—77.1(249A).

“Presubsidy” means payment for maintenance or special services for a child with special needs who is placed in an adoptive home and who meets all eligibility criteria for maintenance subsidy but whose adoption is not finalized.

“Qualified intellectual disability professional” means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. A person who holds at least a bachelor’s degree in a human services field, including but not limited to social work, sociology, special education, rehabilitation counseling, or psychology.

“Qualified mental health professional” means a person who meets all the following conditions:

1. Holds a master’s degree in a mental health field, including but not limited to psychology, counseling and guidance, psychiatric nursing, or social work; or is a doctor of medicine or osteopathic medicine; and
2. Holds a current Iowa license when required by the Iowa professional licensure laws for persons practicing as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker; and
3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and services needs and in providing mental health services.

“Special services subsidy” means payment to a provider or reimbursement to the parent for medical, dental, therapeutic, or other services, equipment or appliances required by a child to meet the child’s identified special needs.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.3(600) Conditions of eligibility or ineligibility.

201.3(1) The child is eligible for subsidy when the department or a private agency has documented that it has been unable to place the child in an appropriate adoptive home without a

subsidy and the child is determined to be a child with special needs based on one or more of the following reasons:

- a.* The child has a medically diagnosed disability, as determined by a physician, an advanced registered nurse practitioner or a physician associate, that substantially limits one or more major life activities, requires ongoing professional treatment, impacts the child's ability to perform daily living skills, and is expected to last 12 months or longer.
- b.* The child has been determined by a qualified intellectual disability professional to be intellectually disabled.
- c.* The child has been determined by a qualified professional to be at high risk of developing a qualifying medical, mental, or emotional condition as defined in this subrule. A child in this group is eligible for subsidy of nonrecurring expenses only.
- d.* The child has been diagnosed by a qualified mental health professional to have a psychiatric condition that impairs the child's mental, intellectual, or social functioning and for which the child requires ongoing professional services.
- e.* The child has been diagnosed by a qualified mental health professional to have a behavioral or emotional disorder characterized by situationally inappropriate behavior that deviates substantially from behavior appropriate to the child's age or significantly interferes with the child's intellectual, social and personal adjustment and that requires ongoing treatment.
- f.* The child is aged five or older.
- g.* The child is a member of a sibling group of three or more children who are placed in the same adoptive home.

201.3(2) A child who enters the United States from another country on the basis of a visa classifying the child as an orphan, in accordance with the Immigration and Naturalization Act as amended to December 31, 2023, for the purpose of adoption by a specific United States family is not eligible for subsidized adoption maintenance payments, medical assistance, or special services, except for nonrecurring expenses.

201.3(3) Adverse eligibility determinations by the department may be appealed according to rules in 441—Chapter 2506.

201.3(4) The department shall review the subsidy agreement when the child reaches the age of 17½ to determine whether the child is eligible to receive subsidy to the age of 21 due to the child's physical, intellectual, or mental health disability.

- a.* The disability shall be diagnosed by a physician, a qualified mental health professional, or a qualified intellectual disability professional.
- b.* The diagnosis shall be current within one year prior to the child's eighteenth birthday.
- c.* The child's parents shall provide documentation of the child's disability.

[ARC 8415C, IAB 11/27/24, effective 1/1/25; Editorial change: IAC Supplement 6/10/26]

441—201.4(600) Application. Application for presubsidy or subsidy for a child with special needs in the guardianship of the department shall be made at the time of the adoptive placement of the child, or at any time in the adoptive process before finalization of the adoption.

201.4(1) The prospective adoptive family residing in Iowa who has been studied and approved for adoptive placement, or a family residing outside of the state of Iowa studied and approved by a governmental child-placing agency or a licensed child-placing agency in that state, may apply for subsidy for an eligible Iowa child.

201.4(2) Withdrawal of the subsidy application shall be reported to the department immediately.

201.4(3) The effective date for the Adoption Subsidy Agreement will be the date the agreement is signed by the adoptive parents and the department, which may be the date the child is placed in the adoptive home or any date up to and including the date the adoption is finalized. The agreement shall state the amount of the presubsidy or subsidy, the frequency and duration of payments and the conditions under which the agreement may be terminated.

201.4(4) An application for subsidy cannot be taken after the child is adopted except when there are facts relevant to a child's eligibility that were not presented before the finalizing of the adoption.

a. Upon receiving verification that the child was eligible before the child's adoption, the department may conduct an administrative review of the facts and may determine that the child is an eligible child with special needs. Eligibility will be effective after the Application for Subsidy is completed and the Adoption Subsidy Agreement form is signed by all parties.

b. Requests for determination after the adoption is finalized shall be forwarded with verification of eligibility to the department. The department shall conduct an administrative review of eligibility factors and render a written decision within 30 days of receipt of request and verification materials unless additional verification is requested. If additional verification is requested, a decision shall be reached within 30 days of receipt of additional verification materials.

201.4(5) A child in the guardianship of a licensed child-placing agency may be eligible for adoption subsidy when one of the following conditions is met:

a. The child receives or is eligible to receive SSI based on a diagnosed disability, or

b. The child received federally funded adoption subsidy in a prior adoption.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.5(600) Negotiation of amount of presubsidy or subsidy.

201.5(1) The amount of presubsidy or subsidy shall be negotiated between the department and the adoptive parents and shall be based upon the needs of the child and the circumstances of the family.

a. Each time negotiations are completed, the Adoption Subsidy Agreement shall be completed.

b. The Adoption Subsidy Agreement shall be completed and retained in an inactive case record for future reference when:

(1) A child is eligible for subsidy but the child or family does not currently need assistance; or

(2) The child is at risk of being determined a child with special needs according to paragraph 201.3(1) "a," "b," "d," or "e" in the future.

201.5(2) Other services available to the family free of charge to meet the needs of the child, such as other federal, state, and local governmental and private assistance programs, shall be explored and used before the expenditure of subsidy funds.

Unearned income of the child shall be verified by documentation provided to the department worker by the family from the source of the income.

201.5(3) A maintenance subsidy may be no less than \$10 per month.

201.5(4) An adoptive family may request a review of the subsidy agreement when there is a change in the family's circumstances or the needs of the child.

201.5(5) Maintenance subsidy shall continue under the same rules if the adoptive family moves outside of the state of Iowa.

201.5(6) The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found at rule 441—156.6(234).

a. The maximum monthly maintenance payment for a child in subsidized adoption shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found in 441—subrule 156.6(1) and 441—paragraph 156.6(4) "f" for eligible adoptions that take place on or after July 1, 2025. Eligible subsidized and future subsidized adoptions that took place on June 30, 2025, or before will remain on the basic rate in effect on June 30, 2025.

b. Basic rate effective July 1, 2025:

<u>Age of child</u>	<u>Daily rate</u>
0 through 5	\$18.50
6 through 11	\$19.24
12 through 15	\$21.06

16 or older

\$21.34

[ARC 8415C, IAB 11/27/24, effective 1/1/25; ARC 9860C, IAB 12/24/25, effective 2/1/26]

441—201.6(600) Types of subsidy.**201.6(1) *Special services only.***

a. Reimbursement to the family or direct payment to a provider may be made for the following special services needed to meet the needs of the child:

(1) Outpatient counseling or therapy services. Reimbursement for outpatient individual or family services may be provided from a non-Medicaid provider only with approval from the department and when one of the following applies:

1. The services are not available from a Medicaid provider within a reasonable distance from the family.

2. The child and the family were already receiving therapy or counseling from a non-Medicaid provider and it would not be in the child's best interest to disrupt the services.

3. Available Medicaid providers lack experience in working with foster, adoptive, or blended families.

Reimbursement to non-Medicaid providers shall be limited to the Medicaid rate.

(2) Expenses for transportation, lodging, or per diem related to preplacement visits, not to exceed \$2,000 per family.

(3) Medical services not covered by the Medicaid program when the child, either alone or with the family, resides outside the state of Iowa and that state's Medicaid does not cover a needed service, or a provider enrolled with Iowa Medicaid cannot be secured. An adoption subsidy payment shall not supplement the Medicaid payment rate to a Medicaid provider or a non-Medicaid provider.

(4) An additional premium amount as a result of adding the child to the family's health insurance group.

(5) Medical transportation, food and lodging not covered by Medicaid when the child is receiving specialized care in a facility 50 miles or farther from the family home, when the family is participating in services and to facilitate reunification with the child.

(6) Supplies and equipment as required by the child's special needs and unavailable through other resources.

1. When the siblings in a sibling group of three or more are placed together, a one-time-only payment can be made, not to exceed \$500 per child, to reimburse the family for expenses related to accommodating the needs of the sibling group.

2. When home modifications have been authorized to accommodate a child's special needs and the family later sells the house, the family shall repay the department an amount equal to the increase in the equity value of the home attributable to the modifications.

(7) Nonrecurring expenses. Payment for nonrecurring expenses is generally limited to a total of \$1,000 per child for attorney fees, court costs and other related legal expenses. Nonrecurring expenses may be paid when the adoptive family has negotiated an Adoption Subsidy Agreement or an Agreement to Future Adoption Subsidy.

(8) Funeral benefits at the amount allowed for a foster child in accordance with 441—Chapter 156.

b. The need for special services shall be documented in the Adoption Subsidy Agreement. The family shall provide documentation of expenses to the department.

c. Any single special service and any special service delivered over a 12-month period costing \$500 or more shall have prior approval from the central office adoption program manager prior to expending program funds.

d. For all Medicaid covered services, the department shall reimburse at the same rate and duration as Medicaid as set forth in rule 441—79.1(249A).

201.6(2) *Maintenance only.* A monthly payment to assist with room, board, clothing and spending money may be provided, as determined under this chapter. The child will also be eligible for medical assistance pursuant to 441—Chapter 75.

201.6(3) *Maintenance and special services.* For children with special needs, a special services subsidy may also be included when a maintenance subsidy is provided.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.7(600) Determination of ongoing subsidy eligibility and suspension of subsidy payments.

201.7(1) Eligibility for continuation of adoption subsidy shall be evaluated when the department has reasonable cause to suspect the adoptive parent is not providing financial support or is no longer legally responsible for the child. This includes but is not limited to the following circumstances:

- a. The child is placed in out-of-home care.
- b. A person alleges the parents are not providing financial support to the child.
- c. A person other than the parent is awarded legal custody of the child.
- d. A person other than the parent is appointed as the guardian of the child.
- e. The child has applied for food assistance or other benefits.
- f. The child has not resided with the parent for the past 30 consecutive days.
- g. The parent is incarcerated.
- h. The parent is awaiting trial for criminal charges related to harm caused to a child in the home.

201.7(2) The department will contact the child's parents via letter, telephone, or electronic or other means and document such efforts.

201.7(3) The child's parents shall provide documentation of support, including receipts, to the department upon request.

201.7(4) Upon completion of the department's evaluation of the child's continued eligibility for adoption subsidy, the department will issue a written notice to the parents documenting required ongoing actions by the parents, including an expectation of continued cooperation by the parents to provide documentation of ongoing support to the child at the request of the department.

201.7(5) The department shall suspend adoption subsidy payments if the parents refuse to cooperate or if the department is unable to determine whether the parents are providing financial support or are legally responsible for the child.

201.7(6) Through a Notice of Decision, the department shall terminate the Adoption Subsidy Agreement upon a finding that the child is not being financially supported.

201.7(7) When the child has resided out of the parental home for 30 consecutive days, the department will request a renegotiation of the Adoption Subsidy Agreement with the parents to reduce or suspend payments as agreed to by the parents.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.8(600) Termination of subsidy. Subsidy will terminate when any of the following occur:

201.8(1) The adoptive child no longer meets the definition of child in rule 441—201.1(600).

201.8(2) The child marries.

201.8(3) The adoptive parents are no longer using the maintenance payments to support the child.

201.8(4) Death of the child or death of the parents of the child (one in a single-parent family and both in a two-parent family).

201.8(5) Upon conclusion of the terms of the agreement.

201.8(6) Upon request of the adoptive parents.

201.8(7) The adoptive parents are no longer legally responsible for the child.

201.8(8) The child enlists in the military.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.9(600) Reinstatement of subsidy. Reinstatement of subsidy will be made when the subsidy was terminated because of reasons in subrule 201.8(3), 201.8(6), or 201.8(7) and the reason for termination no longer exists.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.10(600) New application. New applications will be taken at any time, but processed only so long as funds are available. Maintenance and special services already approved will continue.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.11(600) Medical assistance based on residency. Children with special needs eligible for any type of subsidy are entitled to medical assistance as defined in 441—Chapter 75. The funding source for medical assistance is based on the following criteria:

201.11(1) IV-E-eligible children:

a. IV-E-eligible children residing in Iowa from Iowa and from other states shall receive medical assistance from Iowa.

b. IV-E-eligible children from Iowa residing in another state shall receive medical assistance from the family's state of residence, even though medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

201.11(2) Non-IV-E-eligible children:

a. Non-IV-E-eligible children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Non-IV-E-eligible children from Iowa residing in another state shall be covered by Iowa's medical assistance unless eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act as amended to December 31, 2023.

c. Non-IV-E-eligible children from another state residing in Iowa shall be covered by Iowa's medical assistance if all the following conditions are met:

(1) The child is under the age of 21.

(2) The child is residing in Iowa in a private home with the child's adoptive parent or parents.

(3) Another state is currently paying an adoption subsidy for the child pursuant to an adoption assistance agreement in effect for the child with that state.

(4) The state paying the adoption subsidy is a member of the interstate compact on adoption and medical assistance (ICAMA).

(5) The state paying the adoption subsidy 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 as amended to December 31, 2023, 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.

201.11(3) When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the family. An exception shall be made when the initial Iowa subsidy agreement provides for services not covered by the other states.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

441—201.12(600) Presubsidy recovery. The department will recover the cost of presubsidy maintenance and special services provided by the department as follows:

201.12(1) Funds will be applied to the cost of presubsidy maintenance and special services from the unearned income of the child.

201.12(2) The department will serve as payee to receive the child's unearned income. The income will be placed in an account and be applied toward the cost of the child's current care with the remainder placed in an escrow account.

201.12(3) When a child has funds in escrow, these funds may be used by the department to meet the current needs of the child not covered by the presubsidy payments and not prohibited by the source of the funds.

201.12(4) When the child leaves presubsidy care, funds in the escrow shall be paid to the adoptive parents or to the child if the child has attained the age of majority.

[ARC 8415C, IAB 11/27/24, effective 1/1/25]

These rules are intended to implement Iowa Code sections 600.17 to 600.23.

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CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/14/29

441—204.1(234) Definitions.

“*Child*” means either a person less than 18 years of age or a person 18, 19, or 20 years of age who meets one or more of the following conditions:

1. Is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma.
2. Is attending an instructional program leading to a high school equivalency diploma.
3. Has been identified by the director of special education of the area education agency as a child requiring special education as defined in Iowa Code section 256B.2(1).

“*Guardianship subsidy*” means a monthly payment to assist in covering the cost of room, board, clothing, and spending money for the child.

“*Nonrecurring expenses*” means reasonable and necessary guardianship fees, court costs, attorney fees, and other expenses that are directly related to finalizing the legal guardianship of a child. These expenses shall be limited to attorney fees, court filing fees and other court costs.

“*Relative*” means a person to whom a child is related by blood, marriage, or adoption, or a person who has a significant, committed, positive relationship with the child.

“*Sibling group*” means at least two children who are whole or half-siblings. A sibling group may include adopted children who have a common parent.

[ARC 811IC, IAB 7/10/24, effective 8/14/24]

441—204.2(234) Eligibility.

204.2(1) *General conditions of eligibility.* The guardian named in a permanency order under Iowa Code section 232.104(2)“d”(1) or chapter 232D for a child who was previously in the custody of the department is eligible for subsidy when all of the following conditions exist:

- a. The child has a documented permanency goal of:
 - (1) Guardianship; or
 - (2) Another planned permanent living arrangement.
- b. The child is either:
 - (1) Ten years of age or older and consents to the guardianship; or
 - (2) Part of a sibling group with a child aged ten or older.
- c. The child has lived in continuous foster family care with the prospective guardian for the six months before initiation of the guardianship subsidy.
- d. The prospective guardian is a licensed relative foster parent who has a significant relationship with the child and demonstrates a willingness to make a long-term commitment to the child’s care.
 - (1) The guardian shall be a relative as defined in this chapter.
 - (2) Placement with that guardian must be in the best interest of the child. The best-interest determination must be documented in the case file.
- e. A child who is part of a sibling group with a child ten years of age or older may be eligible for subsidy if all criteria are met. The following conditions for the younger sibling shall also be met:
 - (1) The sibling is placed as a foster child in the same prospective guardian home.
 - (2) The guardian and the department agree it is appropriate for guardianship to be granted for the sibling.

204.2(2) *Residency.* The subsidized guardianship applicant or recipient need not reside in Iowa.

204.2(3) *Unearned income.* The family or the guardian shall provide to the department documentation from the source of the child’s unearned income.

204.2(4) Other services. Other services available to meet the needs of the child that are free of charge, such as federal, state, and local governmental programs, or private assistance programs, shall be explored and used prior to the expenditure of subsidized guardianship funds.

[ARC 8111C, IAB 7/10/24, effective 8/14/24]

441—204.3(234) Application. Applications for the subsidized guardianship program may be made at any county office of the department.

204.3(1) Application forms. Application for a subsidized guardianship shall be made on the approved department form.

204.3(2) Eligibility determination. The determination of whether a child meets the eligibility requirements is made by the department. The proposed guardian shall be notified in writing of the decision of the department regarding the child's eligibility for the program and the amount of subsidy to be provided.

204.3(3) Effective date. The effective date of the guardianship subsidy payment shall be the date the guardianship order is signed if all other conditions of eligibility are met.

204.3(4) Redetermination. The department shall review the child's eligibility, the needs of the child and the child's unearned income every 12 months. Reviews may be done more often if needed due to the child's need for special services, revision of the subsidy amount because of the child's age, or a request for review by the guardian.

204.3(5) Determination of eligibility after age 18. The department shall review the subsidy agreement when the child reaches the age of 17½ to determine whether the child is eligible to receive a subsidy to the age of 21 to complete high school or equivalency or due to the child's physical, intellectual, or mental health disability.

a. A disability shall be diagnosed by a physician, a qualified mental health professional or a qualified intellectual disability professional.

b. The diagnosed disability shall be current within one year prior to the child's eighteenth birthday.

c. Documentation of the child's diagnosed disability shall be provided by the child's guardian to the department.

d. Upon the child's reaching the age of 18, the subsidy may continue until the child completes courses leading to a high school diploma or equivalency or reaches the age of 21. Documentation of school enrollment and completion shall be provided by the child's guardian.

[ARC 8111C, IAB 7/10/24, effective 8/14/24]

441—204.4(234) Negotiation of amount of subsidy.

204.4(1) Subsidy agreement. The amount of subsidy shall be negotiated between the department and the guardian and shall be based upon the needs of the child and the circumstances of the family.

204.4(2) Amount of subsidy. Each time negotiations are completed, the department and the guardian shall complete and sign a new Guardianship Subsidy Agreement.

a. The maximum monthly maintenance payment for a child in subsidized guardianship shall be made pursuant to the foster family care maintenance rates according to the age and special needs of the child as found in 441—subrule 156.6(4).

(1) The rate for the guardianship subsidy shall not exceed the state's current daily basic foster care rate plus any daily special needs allowance or sibling allowance for which the child is eligible, as found in 441—subrule 156.6(4).

(2) Reserved.

b. If the subsidized guardianship payment is less than the maximum amount allowed, the guardian may request an increase if there is a substantial change in the child's needs and circumstances that requires additional resources.

c. Guardianship payments shall continue if the guardian dies or becomes incapacitated and has named a successor guardian in the Guardianship Subsidy Agreement or in any amendments to the agreement.

204.4(3) *Placement outside of home.* If a child needs to be placed out of the guardian's home and the plan is for the child to return to the guardian within six months, a partial subsidy amount may be negotiated.

204.4(4) *Nonrecurring expenses.* The nonrecurring expenses necessary to finalize a guardianship shall not exceed \$2,000.

204.4(5) *Special services.*

a. Reimbursement to the guardian family or direct payment made to a provider is limited to the following services:

(1) Outpatient individual or family services provided from a non-Medicaid provider only with approval from the department and when one of the following applies:

1. The services are not available from a Medicaid provider within a reasonable distance from the family.

2. The child and the family were receiving therapy or counseling from a non-Medicaid provider and it would not be in the child's best interest to disrupt the services.

3. Available Medicaid providers lack experience in working with foster, adopted, or blended families.

(2) Travel-related expenses including transportation, meals and lodging not covered by Medicaid for visitation or family therapy when the child is receiving Medicaid-paid services out of the home.

(3) Supplies and equipment as required by the child's special needs and unavailable through other resources.

(4) Funeral benefits at the amount allowed for a foster child in accordance with rule 441—156.8(234).

b. Any single special service and any special service delivered over a 12-month period costing \$500 or more shall have prior approval from the department prior to expending program funds.

c. For all Medicaid-covered services, the department shall reimburse at the same rate and duration as Medicaid as set forth in rule 441—79.1(249A).

[ARC 8111C, IAB 7/10/24, effective 8/14/24]

441—204.5(234) *Parental liability.* These subsidy payments are considered foster care payments for purposes of child support recovery and as such create a support debt for the legally responsible parent or parents.

[ARC 8111C, IAB 7/10/24, effective 8/14/24]

441—204.6(234) *Determination of ongoing subsidy eligibility and suspension of subsidy payments.*

204.6(1) Eligibility for continuation of guardianship subsidy shall be evaluated when the department has good cause to suspect the guardian is not providing financial support or is no longer legally responsible for the child. Good cause includes, but is not limited to, the following circumstances:

a. The child is placed in out-of-home care under Iowa Code chapter 232.

b. A person alleges the guardian is not providing financial support to the child.

c. A person other than the guardian is awarded legal custody of the child.

d. A person other than the guardian is appointed as the guardian of the child.

e. The child has applied for food assistance or other benefits.

f. The child has not resided with the guardian for the past 30 consecutive days.

g. The guardian is incarcerated.

h. The guardian is awaiting trial for criminal charges related to harm caused to a child in the home.

204.6(2) The department will contact the child's guardian via letter, telephone, or electronic or other means and document such efforts if an evaluation is determined to be necessary.

204.6(3) If such an evaluation occurs, the child's guardian shall provide documentation of support, including receipts, to the department upon request.

204.6(4) Upon completion of the department's evaluation of the child's continued eligibility for guardianship subsidy, the department will issue a written notice to the guardian documenting required ongoing actions by the guardian, including an expectation of continued cooperation by the guardian to provide documentation of ongoing support to the child at the request of the department.

204.6(5) The department shall suspend guardianship subsidy payments if the guardian refuses to cooperate with any department evaluation designed to determine legal responsibility for the child or to determine whether the guardian is providing financial support for the child.

204.6(6) Through a Notice of Decision, the department will notify the guardian that the guardianship subsidy payment will be suspended, modified, or terminated.

204.6(7) When the child has resided out of the guardian's home for 30 consecutive days, the department shall request a renegotiation of the Guardianship Subsidy Agreement with the guardian to reduce or suspend payments as agreed to by the guardian.

[ARC 811IC, IAB 7/10/24, effective 8/14/24]

441—204.7(234) Termination of subsidy. A Guardianship Subsidy Agreement remains in effect until the subsidy is terminated. The subsidy shall terminate when any of the following occur, and a notice shall be sent that states the reason for the termination:

1. The child reaches the age of 18, unless the department determines that the subsidy may continue until the child reaches the age of 21 as specified by subrule 204.3(5).
2. The child marries or enlists in the military.
3. The child no longer lives with the guardian, except for placement outside the home as limited by subrule 204.4(3).
4. The relationship ends due to the death of the child.
5. The terms of the Guardianship Subsidy Agreement are concluded.
6. The guardian requests that the guardianship payment cease.
7. The department has determined the guardian is not providing financial support to the child.
8. The guardian fails to abide by the terms of the Guardianship Subsidy Agreement.
9. The guardianship case is terminated by court order.
10. The department funds for subsidized guardianship are no longer available.
11. Due to incapacity, the guardian can no longer discharge the responsibilities necessary to protect and care for the child, the guardianship has been or will be vacated, and a successor guardian was not named in the Guardianship Subsidy Agreement.
12. The death of the guardian when a successor guardian is not named in the Guardianship Subsidy Agreement (one in a single-parent family or both in a two-parent family).

[ARC 811IC, IAB 7/10/24, effective 8/14/24]

441—204.8(234) Reinstatement of subsidy. Reinstatement of the subsidy shall be made when the subsidy was terminated at the guardian's request and the guardian has requested reinstatement.

[ARC 811IC, IAB 7/10/24, effective 8/14/24]

441—204.9(234) Appeals. The guardian may appeal adverse determinations pursuant to 441—Chapter 2506.

[ARC 811IC, IAB 7/10/24, effective 8/14/24; Editorial change: IAC Supplement 6/10/26]

441—204.10(234) Medical assistance.

204.10(1) Children eligible for subsidy are entitled to medical assistance as defined in 441—Chapter 75. When an Iowa child receives medical assistance from another state, Iowa shall discontinue paying any medical costs the month following the move unless additional time is necessary for a timely notice of decision to be provided to the guardian.

204.10(2) The funding source for medical assistance is based on the following criteria:

- a. Children from Iowa residing in Iowa shall be covered by Iowa's medical assistance.

b. Children from Iowa residing in another state shall receive medical assistance from the state of residence if eligible. Iowa shall provide medical assistance for children not eligible in their state of residence. Medical assistance available in the family's state of residence may vary from Iowa's medical assistance.

c. Children from another state residing in Iowa shall continue to be covered by the other state's medical assistance unless the state has adopted the adoption assistance interstate compact and a contract between Iowa and the other state exists.

[ARC 8111C, IAB 7/10/24, effective 8/14/24]

These rules are intended to implement Iowa Code section 234.6 and 2006 Iowa Acts, House File 2734, section 17, subsection 11.

[Filed emergency 8/12/99 after Notice 6/16/99—published 9/8/99, effective 9/1/99]

[Filed emergency 9/15/06 after Notice 7/19/06—published 10/11/06, effective 11/1/06]

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[Filed ARC 8111C (Notice ARC 7359C, IAB 1/24/24), IAB 7/10/24, effective 8/14/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 223
DISABILITY SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—223.1(231) Eligibility for LTSS disability services. To be eligible for disability services system funding, an individual will meet the following financial and needs-based eligibility criteria.

223.1(1) Financial eligibility.

- a. An adult with disabilities will have an income equal to or less than 200 percent of the federal poverty level.
- b. A family of a child with disabilities will have an income equal to or less than 200 percent of the federal poverty level.
- c. A person who is eligible for federally funded services and other support will apply for such services and support.
- d. Income will be verified using the best information available.
- e. Financial eligibility will be reviewed on an annual basis and may be reviewed more often in response to increases or decreases in income.
- f. An individual who is eligible for medical assistance must apply for and exhaust such funding for services and support prior to utilization of disability service system funding.

223.1(2) Resource requirements. There are no resource limits for the family of a child seeking children's disability services. An adult seeking disability services must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multiperson household or follow the most recent federal supplemental security income guidelines.

- a. The countable value of all countable resources, both liquid and nonliquid, shall be included in the eligibility determination, except as exempted in this subrule.
- b. A transfer of property or other assets within five years of the time of application with the result of qualifying, or with the intent to qualify, for assistance may result in denial or discontinuation of funding.

c. The following resources are exempt:

- (1) A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead shall include all land that is contiguous to the home and the buildings located on the land.
- (2) One automobile used for transportation.
- (3) Tools of an actively pursued trade.
- (4) General household furnishings and personal items.
- (5) Burial account or trust limited in value as to that allowed in the medical assistance program.
- (6) Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources are also exempt from consideration in eligibility determination:

- (1) A retirement account that is in the accumulation stage.
- (2) A medical savings account.
- (3) An assistive technology account.
- (4) A burial account or trust limited in value as to that allowed in the medical assistance program.

223.1(3) Needs-based eligibility.

- a. An individual must be a resident of Iowa, or, if the individual is a minor, the custodial parent must be a resident of Iowa.

b. An individual must have a disability and reside in or be at risk of residing in institutional settings due to the individual's disability.

c. The results of a standardized functional assessment must support the type and frequency of disability services identified in the individual's case plan. A functional assessment must be completed within 60 days of application for services. The standardized functional assessment methodology will be developed by the department.

[ARC 9282C, IAB 5/14/25, effective 7/1/25]

441—223.2(231) Option for waiting lists for disability services. The department will maintain a waiting list of individuals denied access to the program due to lack of available funds. Waiting list information will include the date on which the individual was placed on the waiting list. If additional funds become available, the department will contact individuals on the list.

[ARC 9282C, IAB 5/14/25, effective 7/1/25]

441—223.3(231) Access standards. DAPs shall meet the following access standards.

223.3(1) Support for community living. The first appointment shall occur within 30 days of the completion of the functional assessment determining need for a home health aide, home and vehicle modification, respite, or supportive community living.

223.3(2) Support for employment. The initial referral shall take place within seven days of the completion of the functional assessment determining need for day habilitation, job development, supported employment, or prevocational services.

223.3(3) Service coordination. An individual shall receive service coordination within ten days of the initial request for such service.

223.3(4) Service limitations. The following limitations apply for an individual receiving disability services:

a. A service limit equal to that established for the home- and community-based services waiver for individuals with disabilities in the medical assistance program created in Iowa Code chapter 249A.

b. A provider reimbursement payment will not be less than that provided through the home- and community-based services waiver for individuals with disabilities in the medical assistance program created in Iowa Code chapter 249A.

223.3(5) Additional access standards. Additional minimum access standards for STSS and LTSS will be defined in the DAP's district plan and approved by the department.

[ARC 9282C, IAB 5/14/25, effective 7/1/25]

441—223.4(231) Appeal rights.

223.4(1) Definitions. For the purposes of this rule, the following definitions apply.

"Agency action" includes the whole or part of an agency rule or other statement of law or policy, order, decision, license, proceeding, investigation, sanction, relief, or the equivalent or a denial thereof, or a failure to act, or any other exercise of agency discretion or failure to do so, or the performance of any agency duty or the failure to do so.

"Appellant" means any person bringing an appeal under this chapter, including any person's authorized representative as defined in subrule 223.4(14).

"Person" means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

"Reviewer" means the individual assigned by the department to review an appeal record and issue a written decision on behalf of the department. The department's reviewer will be screened from the underlying case and will not have prior knowledge of the facts that precipitated the appeal.

223.4(2) Appeal. A person that disagrees with the department's agency action related to an eligibility determination or denial of disability services may request an appeal within 120 calendar days of the date of the determination or denial.

a. The following actions may be appealed:

(1) The determination that eligibility criteria have not been met.

(2) The denial or limited authorization of a requested service, including the type or level of service.

(3) The decision to reduce, suspend, or terminate previously authorized services.

(4) The denial, in whole or in part, of payment for a service that was provided.

(5) The failure of the department to act within the required time frames.

b. Appeal requests submitted by regular mail are considered filed on the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the department. Appeal requests sent electronically are considered filed on the date on which the electronic submission was completed.

c. In computing any time period specified in this rule, the period:

(1) Excludes the day of the event that triggers the period;

(2) Includes every day of the time period (including Saturdays, Sundays, and holidays on which the department is closed); and

(3) Includes the last day of the period, but if the last day is a Saturday, Sunday, or legal holiday, the period continues until the end of the next day that is not a Saturday, Sunday, or legal holiday.

223.4(3) *Request.* The person may request an appeal using a form prescribed by the department and in a manner prescribed by the department.

223.4(4) *Acknowledgment of appeal.* The department will send an acknowledgment of receipt of the appeal to the parties-in-interest to the appeal.

223.4(5) *Acceptance or denial of appeal.* The department will determine with reasonable promptness whether the person is entitled to an appeal. If a request for an appeal is denied, the department will provide written notice of and the reasons for the denial. On or before the thirtieth calendar day following the denial of appeal, the party requesting the appeal may provide additional information related to the appeal and request reconsideration of the denial of the appeal.

223.4(6) *Documentation.* If an appeal request is granted, the appellant may submit a written statement, supported by relevant documentation, to establish all pertinent facts and circumstances. Documents shall be submitted to the department within 14 calendar days of the date the appeal is acknowledged. The department's reviewer may request additional documents or information from the appellant as needed to assist the department's evaluation of the appeal.

223.4(7) *Ex parte communication.* The department's reviewer, the director, and all parties to the appeal are bound by the rules against ex parte communication set forth in Iowa Code section 17A.17 and rule 441—7.9(17A).

223.4(8) *Withdrawal.* An appellant may withdraw a request for appeal at any time. Requests to withdraw an appeal will be granted.

223.4(9) *Department review.* The department's reviewer will review the appeal record and issue a written proposed decision to all parties within 30 calendar days. The written proposed decision will include the reviewer's findings of fact and rationale for the decision.

223.4(10) *Director's review.*

a. Time. Parties may appeal the proposed decision to the director. A request for director's review shall be in writing and postmarked or received within 14 calendar days of the date on which the proposed decision was issued. A request for director's review may be accompanied by a brief written summary of the arguments in favor of granting a director's review.

b. Granting or denial of review. The department has full discretion to grant or deny a request for director's review. In addition, the director may initiate review of a proposed decision on the director's own motion at any time on or before the thirtieth calendar day following the issuance of the proposed decision. When the department grants a request for director's review, the parties will be notified of the decision, and a copy of the request will be included with the notification.

c. Limited record. A director's review will be limited to the issues and information contained in the record reviewed by the reviewer who issued the proposed decision.

d. Oral arguments. Upon specific request, the director may, at the director's discretion, permit parties to present oral arguments with the parties' requests for director's review.

e. Decision issued. The director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the director will issue a final decision on or before the ninetieth day from the date the director grants review.

223.4(11) Final decisions.

a. No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the proposed decision will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

b. Director decision issued. Any decision issued by the director after granting a director's review will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

c. Written notice of final decision. The parties-in-interest will be provided written notice of the department's final decision. The department will also notify the appellant of the right to seek judicial review, where applicable.

223.4(12) Interpreters. The department will provide translation and interpretation services to parties-in-interest, if requested. When a party-in-interest is illiterate or semiliterate, the reviewer will advise the party-in-interest of the party-in-interest's rights.

223.4(13) Persons living with disabilities. Persons living with disabilities will 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 (as amended, effective December 31, 2023) and Section 504 of the Rehabilitation Act (as amended, effective October 1, 2016).

223.4(14) Authorized representatives.

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

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

c. Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this rule shall enter an appropriate written appearance.

223.4(15) Not contested cases. Appeals brought under this chapter are not contested cases, appellants will not be granted a contested case hearing, and the provisions in 441—Chapter 2506 do not apply.

[ARC 9282C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 231.23.

[Filed ARC 9282C (Notice ARC 9018C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 225 AGING SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—225.1(231) Applicability. The rules set forth in the chapters under the jurisdiction of the department apply to all grants awarded to any recipient through the department and to any entities regulated by the department. Compliance with these rules is mandatory unless a waiver is granted in accordance with the procedures in 441—Chapter 2504.

[ARC 9495C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—225.2(231) Definitions. The following definitions apply to 441—Chapters 225 through 229 unless otherwise specified.

225.2(1) Definitions.

“Administration on Aging” means the federal agency established to administer the provisions of the federal Act.

“Dietitian” or *“licensed dietitian”* means a person who maintains a license granted by the Iowa board of dietetics.

“Federal Act” means the Older Americans Act, 42 U.S.C. §3001 et seq., as amended to October 1, 2025, and all references herein are as amended to October 1, 2025.

“Plan of correction” means a plan developed by an area agency on aging and approved by the department that describes the actions the area agency on aging shall take to correct deficiencies arising from the agency’s failure to perform and specifies the date by which those deficiencies shall be corrected.

“Title” means a specific title of the federal Act.

225.2(2) Definitions adopted by reference. The following terms have the same meaning as defined in the federal Act and 45 CFR 1321 as amended to October 1, 2025:

“Abuse”

“Access” or *“access services”*

“Area agency on aging”

“Area plan on aging”

“Elder abuse”

“Family caregiver”

“Greatest economic need”

“Greatest social need”

“In-home services”

“Legal assistance”

“Multipurpose senior center”

“Neglect”

“Planning and service area (PSA)”

“Service provider”

“State plan on aging”

“Tribal organization”

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—225.3(231) Aging network. Aging services are delivered through the aging network, which consists of:

1. The state unit on aging, 441—Chapter 226;
2. Area agencies on aging, 441—Chapter 227;
3. Service providers;
4. Office of the state long-term care ombudsman, 441—Chapter 230; and
5. Aging and disability resource centers, 441—Chapter 224.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—225.4(231) Conflict of interest.

225.4(1) Conflict of interest includes any action or failure to act made by the state unit on aging, an area agency on aging, a service provider, a contractor, or a legal representative that may be an actual or perceived conflict between official duties and personal interest. Conflict of interest exists when any action made for program purposes by any entity or individual holding an official position or performing duties:

- a.* Results in a situation that interferes with a program's or program employee's or representative's ability to provide objective information or act in the best interests of the individual.
- b.* Uses an official position for private gain (other than salary).
- c.* Gives preferential treatment to any entity, contractor, or individual or fails to act impartially in the conduct of official duties.
- d.* Impedes or adversely affects governmental efficiency or economy.
- e.* Engages in conduct that could adversely affect the confidence of the public in the integrity of the program initiatives.
- f.* Creates circumstances where it might reasonably be perceived that an entity's or individual's judgment could be influenced by the nature of the circumstances.
- g.* Uses any property of the individual giving care or the individual receiving care for personal use.
- h.* Leads to decisions that are or have the appearance of being contrary to duties of the aging network, the state plan, or 45 CFR 1321 as amended to October 1, 2025.

225.4(2) The state unit on aging will have policies and procedures in effect to avoid conflicts of interest in accordance with 45 CFR 1321 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 226
STATE UNIT ON AGING RESPONSIBILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—226.1(231) Designated state unit on aging. The department is designated as the sole state unit on aging in Iowa. The department will perform all state unit on aging duties in accordance with the federal Act; 45 CFR 1321 through 1324 as amended to October 1, 2025; and Iowa Code chapter 231.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.2(231) Policies and procedures. The department will develop and maintain policies and procedures in accordance with the federal Act; 45 CFR 1321 and 1324 as amended to October 1, 2025; and Iowa Code chapter 231.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.3(231) Public input. The state unit on aging will establish mechanisms and varied methods to obtain the views of older individuals, family caregivers, service providers, and the public on a periodic basis, with a focus on those in greatest economic need and greatest social need according to 45 CFR 1321 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.4(231) State plan on aging.

226.4(1) Authority. As the state unit on aging, the department will develop and administer a state plan on aging or state plan amendment pursuant to the federal Act.

226.4(2) Multiyear state plan on aging. The department will develop and submit for approval a two-, three-, or four-year state plan on aging in compliance with the federal Act; 45 CFR 1321 and 1324 as amended to October 1, 2025; Iowa Code chapter 231; and the procedures and associated instructions, guidance, and direction specified by the federal Administration on Aging.

226.4(3) State plan amendment. The department may, in its discretion, develop and submit to the federal Administration on Aging for consideration an amendment to the state plan on aging at any time.

226.4(4) State plan on aging and state plan amendment review process. Once the department develops the state plan on aging or state plan amendment, the department will comply with the following chronological review and comment process:

a. The department will hold at least one public hearing on the proposed state plan or state plan amendment; and

b. The department will submit the state plan or state plan amendment to the council on health and human services for consideration. The council will make recommendations on the state plan or state plan amendment after reviewing the plan and public comments; and

c. The department will submit a state plan or state plan amendment to the governor or governor's designee for approval and signature; and

d. The department will submit a state plan or state plan amendment approved by the governor to the federal Administration on Aging for approval at least 45 days before the effective date of the state plan or state plan amendment.

226.4(5) State plan on aging or state plan amendment not approved. If a state plan or state plan amendment is not approved by the governor or governor's designee or the federal Administration on Aging, the department may, in its discretion, table or revise the proposed state plan or state plan amendment. If the department revises the proposed state plan or state plan amendment, the department will follow the comment and approval process outlined in subrule 226.4(4).

226.4(6) Technical changes to state plan on aging. The department or the governor may, at either party's discretion, make technical corrections to a submitted state plan or state plan amendment prior to approving it.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.5(231) Designation of and changes to PSAs. The department will divide the state into distinct PSAs in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and Iowa Code chapter 231.

226.5(1) Notice of changes to PSAs will be provided in accordance with 441—Chapter 16.

226.5(2) Appeals to designation of and changes to PSAs.

a. Appeals to the department's designation of PSAs may be brought forth by applicants seeking to change existing PSA designation.

b. Appeals will be provided in accordance with 441—Chapter 2506. Iowa Code section 17A.19 does not apply to these appeals. Applicants whose appeal rights have been exhausted may appeal that decision to the federal Departmental Appeals Board (DAB) in accordance with the federal Act and with the procedures set forth in 45 CFR Part 16 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—226.6(231) Designating area agencies on aging. The department will designate an area agency on aging for each PSA in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and Iowa Code chapter 231. Upon designation, an area agency on aging is considered an instrumentality of the state and will adhere to all state and federal mandates applicable to an instrumentality of the state.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.7(231) Withdrawal of designation of area agency on aging. The department will withdraw an area agency on aging's designation as an area agency when the department determines that the area agency on aging does not meet the requirements of the federal Act, regulations, Iowa Code, Iowa Administrative Code, terms and conditions of grant awards, or department policies and procedures. Notice of withdrawal will be provided in accordance with 441—Chapter 16.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.8(231) Appeals to withdrawal of area agency on aging designation.

226.8(1) An area agency on aging may appeal the department's action or proceeding to withdraw the designation of an area agency on aging. Appeals will be provided in accordance with 441—Chapter 2506. Iowa Code section 17A.19 does not apply to these appeals.

226.8(2) An area agency on aging may appeal the department's decision to the federal DAB in accordance with the federal Act and with the procedures set forth in 45 CFR Part 16 as amended to October 1, 2025. The DAB may refer an appeal to its Alternative Dispute Resolution Division for mediation prior to making a decision on the appeal.

[ARC 9495C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—226.9(231) Area plan on aging reviews and approvals. The department will review new, revised, or amended area plans on aging and may approve once any plan has been reviewed in accordance with the process in 441—Chapter 227.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.10(231) Intrastate funding formula. The department will develop an intrastate funding formula for distribution of funds received under the federal Act and state funds to organizations serving as designated area agencies on aging that complies with 45 CFR 1321.49 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.11(231) Evaluation and compliance. The department will monitor area agencies on aging to ensure quality performance and compliance as set forth in 45 CFR 1321 as amended to October 1, 2025.

226.11(1) *Correction of deficiencies.*

a. Remedies. The purpose of remedies is to ensure prompt action is taken by an area agency on aging to correct deficiencies arising from failure to perform as identified by this rule. The department will determine the remedies to be applied to the area agency on aging for failure to perform.

b. Number of remedies. The department may apply one or more remedies for each deficiency constituting failure to perform or for all deficiencies constituting failure to perform.

c. Notification requirements. The department will give the area agency on aging written notice of the remedy in accordance with 441—Chapter 16. The written notice of remedy will include the following:

- (1) The nature of the failure to perform.
- (2) The remedy imposed.
- (3) The effective date of the remedy.
- (4) The right to appeal the determination leading to the remedy.

d. Factors to be considered in selecting remedies. In order to select the appropriate remedy, the department will determine the seriousness of the failure to perform by considering whether the area agency on aging's failure to perform:

- (1) Is isolated.
- (2) Constitutes a pattern.
- (3) Is broad in scope.
- (4) Creates a financial burden for the department, other area agencies on aging, or the aging network.
- (5) Creates an administrative burden for the department, other area agencies on aging, or the aging network.

226.11(2) *Available remedies.* The department may select one or more of the following remedies with reference to a cited failure to perform. In selecting an appropriate remedy, the department may also consider the area agency on aging's prior history of failure to perform in general and specifically with reference to the cited failure to perform.

a. Directed in-service training. The department may require the staff of an area agency on aging to attend an in-service training program. The area agency on aging is responsible for the payment for the directed in-service training.

b. Department monitoring. The department may require an area agency on aging to receive increased monitoring by the department. The frequency and duration of the monitoring is within the discretion of the department.

c. Directed plan of correction. The department may develop a plan of correction and require an area agency on aging to take action within specified time frames.

d. Mandatory plan of correction. The department may require an area agency on aging to develop a mandatory plan of correction for approval by the department within specified time frames pursuant to subrule 226.11(2).

e. Reduction of funding. The department may reduce the amount of funding distributed.

f. Investigative audit. The department may require an area agency on aging to receive an investigative audit. The area agency on aging is responsible for the payment for this investigative audit.

g. Conditional approval. The department may conditionally approve area plans and amendments with required corrections to be made by the area agency on aging within no more than 90 days. If the plan is not approved, the department may withdraw designation as specified in rule 441—226.7(231).

h. Other remedies. The department may also impose other remedies, as appropriate.

i. Withdrawal of designation. The department may withdraw a designation of an area agency on aging pursuant to rule 441—226.7(231).

226.11(3) *Duration of remedies.* Remedies will continue until the area agency on aging has achieved substantial compliance as determined by the department or the designation as an area agency on aging is withdrawn.

226.11(4) *Appeal of a determination of failure to perform.*

a. An area agency on aging may appeal the department's determination of a failure to perform that leads to a remedy citation. Appeals will be provided in accordance with 441—Chapter 2506. Iowa Code section 17A.19 does not apply to these appeals.

b. An area agency on aging may not appeal the choice of remedy, including the factors considered by the department in choosing the remedy.

[ARC 9495C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—226.12(231) Data management. The director is the principal officer of the state to administer data reporting. The department will maintain data on all individuals served. The department will develop policy and procedures for data management and confidentiality in accordance with 45 CFR 1321 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.13(231) State agency Title III and Title VI coordination responsibilities. The department will coordinate efforts with Title III and Title VI programs, including area agencies on aging and service providers, to ensure outreach is provided to tribal elders and family caregivers regarding services for which they may be eligible under Title III or Title VI or both in accordance with 45 CFR 1321.53 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.14(231) Emergency and disaster requirements.

226.14(1) *Emergency planning.* The department will:

a. Establish emergency plans as set forth in Section 307(a)(28) of the federal Act.
b. Coordinate with area agencies on aging, service providers, and local emergency management.
c. Coordinate efforts among area agencies on aging and Title VI programs in emergency and disaster preparedness planning, response, and recovery. The department will communicate with the relevant Title VI program director(s) as set forth in 45 CFR 1322 as amended to October 1, 2025, to specify how the department and the area agencies on aging will communicate and coordinate with Title VI programs regarding emergency and disaster preparedness planning, response, and recovery.

226.14(2) *Use of Title III funds to address disasters.*

a. The department in its discretion may use Title III funds without regard to its approved intrastate funding formation or funds distribution plan during presidential declared major disaster declarations under the Stafford Act (42 U.S.C. 5121 through 5207 as amended to October 1, 2025) when Title III services as defined in 441—Chapter 228 are impacted by the declaration.

b. When implementing this authority, the department may set aside funds, up to 5 percent of the department's total Title III allocations, if specified as being allowed to be withheld for the purpose in the department's approved intrastate funding formula or funds distribution plan, or with prior approval from the Assistant Secretary for Aging.

c. Set-aside funds that are awarded under this provision must comply with the requirements in 45 CFR 1321.101 as amended to October 1, 2025.

d. If the state or an Indian tribe requests and receives a major disaster declaration under the Stafford Act (42 U.S.C. 5121 through 5207 as amended to October 1, 2025), the department may use disaster relief flexibilities under Title III as set forth in 45 CFR 1321.101 as amended to October 1, 2025, to provide disaster relief services for areas of the state where the specific major disaster declaration is authorized and where older adults and family caregivers are affected.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.15(231) Prevention of elder abuse, neglect, and exploitation. In accordance with Title VII, Chapter 3, of the federal Act, the department will develop, strengthen, and carry out programs for the prevention of, detection of, assessment of, treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation. All programs using Title VII, Chapter 3, funds will meet requirements as set forth in the federal Act and guidance as set forth by the Assistant Secretary for Aging.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—226.16(231) State legal assistance development program. The department will designate a state legal assistance developer to ensure the provision and monitoring of legal assistance, advice, and technical assistance delivery to older individuals and other service providers. The legal assistance developer activities will be contained in the state plan in accordance with the federal Act; 45 CFR 1324 as amended to October 1, 2025; and department policies and procedures. The state legal assistance developer may provide technical assistance to individuals when other legal assistance is not available.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 227
AREA AGENCY ON AGING RESPONSIBILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—227.1(231) Area agency on aging responsibilities. Each area agency on aging will be the lead on all aging issues on behalf of all older individuals and caregivers in each PSA in accordance with the federal Act; 45 CFR 1321 through 1324 as amended to October 1, 2025; Iowa Code chapter 231; and policies and procedures defined by the department. Each area agency on aging is designated by the department as an aging and disability resource center as defined in rule 441—224.1(225A) and subject to the requirements therein.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.2(231) Board of directors. Each area agency on aging will have a board of directors in accordance with 45 CFR 1321 as amended to October 1, 2025; articles of incorporation; and bylaws. Pursuant to Iowa Code section 231.23, the area agency on aging will use the procedures defined by the department for selecting members of the area agency on aging's board of directors. The selection procedure will be incorporated into the bylaws of the board of directors.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.3(231) Staffing. Each area agency on aging will ensure adequate staffing levels to meet the needs of the PSA and the approved area plan. Each area agency on aging must notify the department of changes in management-level staff within seven calendar days. Staff performing area agency on aging functions and services will demonstrate competency and knowledge pertinent to the staff's areas of responsibility and include the following.

227.3(1) Director. Each area agency on aging's board of directors will name a qualified director and may employ other staff as necessary to manage and monitor the area plan.

227.3(2) Fiscal. Each area agency on aging will have adequate staff or contractors to perform duties to manage and monitor the fiscal responsibilities of an area agency on aging.

227.3(3) Elder abuse prevention and awareness. Staff and contractors completing elder abuse prevention and awareness activities must complete dependent adult mandatory reporter training requirements and any mandatory trainings from the department.

227.3(4) Case management. Staff and contractors completing case management activities must complete dependent adult mandatory reporter training requirements and any mandatory trainings from the department.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.4(231) Conflicts of interest. Each area agency on aging will have policies and procedures regarding conflicts of interest at organizational and individual levels in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and department policies and procedures.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.5(231) Policies and procedures. Each area agency on aging will develop and maintain policies and procedures in accordance with the federal Act; 45 CFR 1321 as amended to October 1, 2025; and requirements set forth by the department. All manuals, guidelines, and standards referred to by these rules will be maintained by the area agency on aging and available for public inspection and departmental monitoring.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.6(231) Public participation.

227.6(1) Advisory council. Each area agency on aging will establish an advisory council. The council shall carry out advisory functions that further the area agency on aging's mission of

developing and coordinating community-based systems of services for all older individuals and family and older relative caregivers specific to each PSA.

a. Composition of council. The council shall include individuals and representatives of community organizations from or serving the PSA who will help to enhance the leadership role of the area agency on aging in developing community-based systems of services prioritizing those in greatest economic need and greatest social need. The advisory council shall be made up of:

(1) More than 50 percent older individuals, including minority individuals who are participants or who are eligible to participate in programs under this rule, with efforts to include individuals identified as in greatest economic need and individuals identified as in greatest social need in 45 CFR 1321.65(b)(2) as amended to October 1, 2025;

(2) Representatives of older individuals;

(3) Family caregivers, which may include older relative caregivers;

(4) Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);

(5) Representatives of service providers, which may include legal assistance, nutrition, evidence-based disease prevention and health promotion, caregiver, long-term care ombudsman, and other service providers;

(6) Persons with leadership experience in the private and voluntary sectors;

(7) Local elected officials;

(8) The general public; and

(9) As available:

1. Representatives from Indian tribes, pueblos, or tribal aging programs; and

2. Older relative caregivers, including kin and grandparent caregivers of children or adults aged 18 to 59 with a disability.

b. Conflicts of interest. Pursuant to 45 CFR 1321 as amended to October 1, 2025, the advisory council shall not operate as a board of directors for the area agency on aging. Individuals may not serve on both the advisory council and the board of directors for the same entity.

227.6(2) Public input. Each area agency will have mechanisms and varied methods to obtain periodic views of older individuals, caregivers, service providers, and the public with a focus on those in greatest economic need and greatest social need. Additionally, the views of participants will be obtained about the services participants receive, which will be used to improve services.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.7(231) Advocacy. Each area agency on aging will serve as the public advocate for the development and enhancement of comprehensive and coordinated community-based systems of services in each community throughout and specific to each PSA. Each area agency on aging will carry out this responsibility in accordance with 45 CFR 1321 as amended to October 1, 2025. Advocacy requirements shall not supersede a prohibition contained in the federal appropriation on the use of federal funds to lobby the Congress or the lobbying provision applicable to private nonprofit agencies and organizations contained in OMB Circular A-122 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.8(231) Area plan on aging. Each area agency on aging will operate under an area plan on aging approved by the department.

227.8(1) Multiyear area plan on aging. Each area agency on aging will develop and administer a two-, three-, or four-year area plan on aging specific to each PSA. Each area agency on aging will develop and submit the area plan on aging to the department for approval following the form, format, policies, and procedures specified by the department and in accordance with 45 CFR 1321.9 and 1321.65 as amended to October 1, 2025.

a. Area plan on aging annual update. Each area agency on aging will provide an annual update to its multiyear area plan on aging according to department policies, procedures, and instructions.

b. Area plan on aging amendments. Each area agency on aging will amend the approved area plan on aging and submit it to the department for approval when requested by the department or when necessary, according to 45 CFR 1321 as amended to October 1, 2025.

227.8(2) Advisory council review and comment. Each area agency on aging will submit any new area plan on aging, annual updates, or amendments for review and comment to the advisory council before the new plan, annual update, or amendment is sent to the department for approval.

227.8(3) Public input. Each area agency on aging will obtain public input in accordance with 45 CFR 1321.65 as amended to October 1, 2025. Each area agency on aging will:

a. Provide a minimum time period of at least 30 calendar days, unless a waiver is provided by the department during an emergency or when a time-sensitive action is otherwise necessary, for public review and comment on a new multiyear area plan on aging and area plan aging amendments;

b. Hold at least one public hearing on the area plan on aging and area plan amendments.

(1) The public hearing(s) will be held prior to submission of the area plan on aging or amendment(s) at a time that permits older individuals, public officials, and other interested parties reasonable opportunity to participate.

(2) The hearing(s) will be conducted in a barrier-free, fully accessible manner virtually or in person or both.

(3) The public hearing agenda and associated documents will be accessible and available to the public prior to the hearing.

1. Direct service waiver requests will be listed as a separate agenda item.

2. Priority services will be listed as a separate agenda item.

(4) Each area agency on aging will provide notice of the hearing in accordance with Iowa Code section 21.4(1) and by sending notice to all known groups of older individuals, PSA public officials, and other interested parties. The notice will be issued 30 days prior to the public hearing and include the time, date, and location of the public hearing. Each area agency on aging will comply with any applicable state or federal laws and regulations governing public hearing processes and procedures.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.9(231) Title III and Title VI coordination. For an area agency on aging where Title VI programs exist within the area agency on aging's PSA, the area agency on aging's policies and procedures, developed in coordination with the relevant Title VI program director(s), as set forth in 45 CFR 1322.13(a) as amended to October 1, 2025, must explain how the area agency on aging's network, including service providers, will coordinate with Title VI programs to ensure compliance with Section 306(a)(11)(B) of the federal Act (42 U.S.C. 3026(a)(11)(B) as amended to October 1, 2025).

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.10(231) Fiscal responsibilities.

227.10(1) Expenditure of state and federal funds. Each area agency on aging will adhere to the policies and procedures related to expenditure of state and federal funds developed in accordance with the federal Act; 45 CFR 1321 through 1324, 45 CFR 75, and 2 CFR 200, all as amended to October 1, 2025; Iowa Code chapter 231; and department policies and procedures.

227.10(2) Contracts and commercial relationships. A contract or agreement between an area agency on aging and an outside entity will not restrict the area agency on aging from contracting with other entities that provide similar services. All contracts and commercial relationships must avoid conflicts of interest as detailed in rule 441—225.3(231).

a. Each area agency on aging will maintain a file of all current contracts and contracts up to three years. These files will be made available for monitoring and assessment by the department.

b. Each area agency on aging must request prior approval from the department 30 days prior to signing the contract for any proposed service contracts with for-profit organizations.

227.10(3) Program income. Funds collected and qualifying as program income must be handled in accordance with 45 CFR 1321.9(c)(2) as amended to October 1, 2025.

227.10(4) Cost sharing. Area agencies on aging may apply for a waiver using the department's processes to implement cost sharing for allowable services as part of the area plan on aging approval process consistent with 45 CFR 1321 as amended to October 1, 2025. Final approval of a cost sharing plan for each area agency on aging will be at the discretion of the department. If an area agency on aging has been approved by the department to implement cost sharing with consumers, each area agency on aging will follow the regulations of 45 CFR 1321 as amended to October 1, 2025. No eligible individual or family caregiver shall be denied service because the individual or family caregiver will not or cannot contribute to the cost of the service.

227.10(5) Private pay. Each area agency on aging or service provider may implement private pay programs in accordance with 45 CFR 1321 as amended to October 1, 2025, and department processes.

227.10(6) Sectarian use. Sectarian instruction or religious worship shall not be provided using funds received under the federal Act.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.11(231) Compliance monitoring. Each area agency on aging will develop and implement procedures to monitor the programmatic and fiscal requirements of all programs, service providers and activities. Each area agency on aging will implement procedures to correct deficiencies in programmatic and fiscal performance of all programs, service providers and activities. Each area agency on aging will implement appropriate processes to monitor contracted entities determined to be subrecipients of the area agency on aging's federal funds.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.12(231) Quality performance. Each area agency on aging will develop and implement procedures in accordance with 45 CFR 1321 as amended to October 1, 2025, to evaluate and, when necessary, improve the quality and effectiveness of services provided directly by agency staff or contracted service providers.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.13(231) Data collection, sharing, and confidentiality.

227.13(1) Data collection. All data collected as a result of an organization's designation as an area agency on aging is owned and governed by the department's policies and procedures.

227.13(2) Data protection. Each area agency on aging will use appropriate administrative, technical and physical safeguards to protect the confidentiality, integrity and availability of data collected. Each area agency on aging will ensure that staff take appropriate confidentiality trainings and will provide documentation of completed trainings when requested by the department.

227.13(3) Confidentiality. Each area agency on aging will implement procedures to ensure confidentiality in compliance with 45 CFR 1321 as amended to October 1, 2025, and 441—Chapter 2505.

[ARC 9495C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—227.14(231) Reporting. Each area agency on aging will submit consumer, service, program, and financial reports in accordance with department policies and procedures and with federal and state reporting requirements. Each area agency on aging will:

227.14(1) Complete client assessment and data collection, at a minimum, once each fiscal year per 45 CFR 1321 as amended to October 1, 2025.

227.14(2) Be solely responsible for obtaining and reporting necessary information from subgrantees, contractors and subcontractors.

227.14(3) Complete accurate program or financial reports by the established due dates, even if waiver is granted. Failure to do so may subject an area agency on aging to remedies provided in rule 441—226.5(231).

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.15(231) Emergency and disaster requirements.

227.15(1) *Emergency and disaster plans.* Each area agency on aging will establish emergency plans in accordance with 45 CFR 1321.97 as amended to October 1, 2025.

227.15(2) *Service coordination.* For continuity of services to individuals, each area agency on aging will coordinate with federal, local, and state emergency response agencies; service providers; relief organizations; local and state governments; and any other entities that have responsibility for disaster relief service delivery, as well as with tribal emergency management, as appropriate, to plan, respond, and recover from an emergency.

227.15(3) *Coordination with Title VI programs.* Area agencies on aging that have Title VI programs in operation within their PSA will have policies and procedures, developed in communication with the relevant Title VI program director(s) as set forth in 45 CFR 1322 as amended to October 1, 2025, in place for communication and coordination methods with Title VI programs regarding emergency and disaster preparedness planning, response, and recovery.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.16(231) Direct service provisions.

227.16(1) An area agency on aging will not provide a direct service as defined in 45 CFR 1321 as amended to October 1, 2025, except as allowed by the department pursuant to the requirements identified in the federal Act and 45 CFR 1321 as amended to October 1, 2025. The department in its judgment may allow an area agency on aging to provide any service directly when the area agency on aging demonstrates in its direct service request that:

- a.* Direct provision of service is necessary to ensure an adequate supply of the service and no potential provider was identified during the public hearing process; or
- b.* The proposed service will be of comparable quality in the view of the area agency on aging advisory council and will meet or exceed service standards developed by the area agency on aging; or
- c.* Each area agency on aging can provide a service of equal quality at lower cost than another provider.

227.16(2) The department may waive the conditions for direct service provision for case management, information and assistance services, and outreach services per 45 CFR 1321 as amended to October 1, 2025.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

441—227.17(231) Grievance. Each area agency on aging will implement grievance procedures in compliance with 45 CFR 1321 as amended to October 1, 2025. Those grievance procedures shall contain at least the following procedures for resolution:

1. Acknowledgment of grievance.
2. Process for attempting to informally resolve dispute.
3. Notification of the outcome of the grievance.
4. Opportunity to submit the grievance to the department.

[ARC 9495C, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapter 231.

[Filed ARC 9495C (Notice ARC 9375C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 230
LONG-TERM CARE OMBUDSMAN

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—230.1(231) Definitions.

“Certified volunteer” means a certified volunteer long-term care ombudsman as authorized under Iowa Code section 231.45. A certified volunteer is considered a representative of the office.

“Federal Act” means the federal Older Americans Act, 42 U.S.C. §3001 et seq., as amended to October 1, 2025.

“Office” means the office of the state long-term care ombudsman established pursuant to the federal Act and Iowa Code section 231.42.

“Ombudsman” means the state long-term care ombudsman appointed by the director.

“Representative of the office” means the same as defined in 45 CFR §1324.1 as amended to October 1, 2025.

[ARC 9496C, IAB 8/20/25, effective 10/1/25]

441—230.2(231) Interference. A representative of the office who is denied access to a resident or tenant in a long-term care facility, assisted living program, or elder group home or to medical and social records while in the course of conducting official duties pursuant to Iowa Code section 231.42 or whose work is interfered with during the course of an investigation shall report such denial or interference to the office, which will report the interference to the director.

[ARC 9496C, IAB 8/20/25, effective 10/1/25]

441—230.3(231) Monetary civil penalties—basis. The director, in consultation with the ombudsman, may impose a monetary civil penalty of not more than \$1,500 on an officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home who intentionally prevents, interferes with, or attempts to impede the duties of the state, ombudsman, or representative of the office pursuant to Iowa Code section 231.42(8).

[ARC 9496C, IAB 8/20/25, effective 10/1/25]

441—230.4(231) Monetary civil penalties—notice of penalty. The office will notify the officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home in writing by certified mail of the intent to impose a civil penalty pursuant to 441—Chapter 16. The notice will include, at a minimum, the following information:

1. The nature of the interference and the date the action occurred.
2. The statutory basis for the penalty.
3. The amount of the penalty.
4. The date the penalty is due.
5. Instructions for responding to the notice, including information on the individual’s right to appeal.

[ARC 9496C, IAB 8/20/25, effective 10/1/25]

441—230.5(231) Monetary civil penalties—appeals. An officer, owner, director, or employee of a long-term care facility, assisted living program, or elder group home who is assessed a monetary civil penalty for interference with the official duties of a long-term care ombudsman may appeal the penalty as set forth in 441—Chapter 2506.

[ARC 9496C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—230.6(231) Certified volunteer long-term care ombudsman program.

230.6(1) Application. Any individual may apply to the office to become a certified volunteer.

a. *Application forms.* Application forms may be accessed on the department’s website.

b. Submission of forms. Each applicant shall complete an application and submit it to the office at the address listed on the form.

230.6(2) Applicants shall not be accepted into the program if:

- a.* It is determined that the applicant has a conflict of interest as defined in the federal Act; or
- b.* The applicant has unfavorable references, which will include a criminal background check and abuse check.

230.6(3) Training. Prior to certification, applicants must successfully complete the required training as approved by the office. Successful completion means completion of all assignments and tasks during training, demonstration of proper techniques and skills, and an understanding of the role of the certified volunteer in the long-term care setting.

230.6(4) Approval for certification. Final approval for certification as a certified volunteer will be made by the office and will be subject to the applicant's successful completion of the required training. The office has the right to require that the applicant receive additional personal training prior to certification and has the right to deny certification to applicants not meeting the training criteria.

230.6(5) Certification.

a. Notification. A certified volunteer will be notified in writing within 14 days following the conclusion of the training program if certification has been continued or revoked.

b. Certification will initially be for one year, with recertification available following the certified volunteer's completion of a minimum of 18 hours of approved continuing education in the first year and completion of a progress review by the office.

230.6(6) Continuing education.

a. All certified volunteers shall complete a minimum of 18 hours of approved continuing education annually.

b. Certified volunteers are responsible for reporting continuing education hours to the office or designee within 30 days following the completion of the continuing education event.

230.6(7) Decertification.

a. Reasons for decertification. A certified volunteer may be decertified by the office for any of the following reasons:

- (1) Falsification of information on the application;
- (2) Breach of confidentiality;
- (3) Acting as a certified volunteer without proper certification;
- (4) Attending less than the required continuing education training;
- (5) Voluntary termination;
- (6) Unprofessional conduct;
- (7) Failure to carry out the duties as assigned; or
- (8) Actions that are found by the office to violate the rules or intent of the program.

b. Notice of decertification. The office will notify the certified volunteer and the facility in writing of a decertification pursuant to 441—Chapter 16.

c. Request for reconsideration. A request for reconsideration or reinstatement of certification may be made in writing to the office. The request must be filed within 14 days after receipt of the notice of revocation.

d. Response time. The office will investigate and consider the request and notify the requesting party and the facility of the decision within 30 days of receipt of the written request.

230.6(8) Duties. The certified volunteer shall assist the office or designee in carrying out the duties described in the federal Act.

[ARC 9496C, IAB 8/20/25, effective 10/1/25]

441—230.7(231) Managed care ombudsman services.

230.7(1) The office may provide advocacy and assistance to eligible recipients, or the families or legal representatives of such eligible recipients, of long-term services and supports provided through

the Medicaid program who are receiving services in a long-term care facility or under one of the home- and community-based services waivers.

230.7(2) Representatives of the office providing an individual with assistance and advocacy services authorized under Iowa Code section 231.44 shall be provided access to the individual and to the individual's medical, social, and administrative records related to the provision of the long-term services and supports to the individual, as authorized by the individual or the individual's legal representative, as necessary to carry out the duties specified by Iowa Code section 231.44.

230.7(3) The office and representatives of the office, when providing assistance and advocacy services under Iowa Code section 231.44, will be considered a health oversight agency as defined in 45 CFR §164.501 as amended to October 1, 2025, for the purposes of health oversight activities described in 45 CFR §164.512(d) as amended to October 1, 2025. Recipient information available to the office and representatives of the office under this subrule shall be limited to the recipient's protected health information as defined in 45 CFR §160.103 as amended to October 1, 2025, for the purpose of recipient case resolution.

[ARC 9496C, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code sections 231.41, 231.42, 231.44, and 231.45.

[Filed ARC 9496C (Notice ARC 9385C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 231
OFFICE OF PUBLIC GUARDIAN

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—231.1(231E,633) Purpose. This chapter implements the office of public guardian as created in Iowa Code chapter 231E and establishes standards and procedures for the state office of public guardian and local offices of public guardian. It also establishes the qualifications of consumers eligible for services.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.2(231E,633) Definitions. Words and phrases used in this chapter are as defined in Iowa Code chapter 231E or 633 unless the context indicates otherwise. The following definitions also apply to this chapter:

“Evaluation” means a comprehensive, in-depth evaluation to identify an individual’s current situation, ability to function, strengths, problems, and care needs in the following major functional areas: physical health, medical care utilization, activities of daily living, instrumental activities of daily living, mental and social functioning, financial resources, physical environment, and utilization of services and support.

“Fee” or *“fees”* means any costs assessed by the state office or a local office against a protected person or a client for public guardianship services.

“Guardian case manager” means an employee of the state office or a local office, or a contractor of a local office, who provides public guardianship services to protected persons or clients or who supervises employees, contractors, or volunteers who provide public guardianship services to protected persons or clients. “Guardian case manager” does not include employees or contractors whose responsibilities are strictly administrative in nature.

“Program” means the activities and services offered by the office of public guardian pursuant to Iowa Code chapter 231E.

“Record” means any information obtained by the state or local office in the performance of its duties.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.3(231E,633) Public guardian qualifications. All public guardians shall have graduated from an accredited four-year college or university or shall have an equivalent combination of education and full-time equivalent work experience working with older adults, people with disabilities, or people overcoming social, economic, psychological or health problems. All guardian case managers shall be certified by the Center for Guardianship Certification within 12 months of assuming duties as a guardian case manager. This certification shall be kept current while the person is serving as a guardian case manager.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.4(231E,633) Ethics and standards of practice. The state office adopts the National Guardianship Association Standards of Practice adopted in 2000, and revised in 2022, and as amended to October 1, 2025, as a statement of the best practices and the highest quality of practice for persons serving as guardians or conservators. The adoption of standards of practice in this document is not intended to amend or diminish the statutory scheme but rather to supplement and enhance the understanding of the statutory obligations to be met by public guardians when serving as a public guardian. Upon appointment to serve a protected person or client, the public guardian shall perform all duties imposed by the court or other entity having jurisdiction and imposed by applicable law and, as appropriate, shall utilize standards found in the National Guardianship Association Standards of Practice as amended to October 1, 2025. Representative payees will adhere to the standards of

the Social Security Administration, as well as any service contracts or grants established by the department.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.5(231E,633) Staffing ratio. The state office or a local office will be responsible for no more than 40 protected persons per full-time equivalent guardian case manager at any one time. In the state office's sole discretion, the state office or a local office may exceed staffing ratios only under the following circumstances:

1. A priority situation exists as defined in subrule 231.7(2), and
2. Acceptance of case(s) will not adversely affect services to current protected persons or clients.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.6(231E,633) Conflict of interest. A conflict of interest arises when the state office or a local office serving a protected person or client has any personal or departmental interest that is or may be perceived as self-serving or adverse to the position or best interest of the protected person or client. When assigning the state office or a local office, all reasonable efforts shall be made to avoid a conflict of interest or the appearance of a conflict of interest.

231.6(1) The assigned state office or local office shall not:

- a. Provide direct services to the protected person or client receiving public guardianship services;
- b. Enter into any transaction, take any action, or make any decision related to the protected person's or client's finances that would benefit the state office or a local office; any of the state office's or a local office's employees, volunteers, or contractors; or any relatives of any of the state office's or a local office's employees, volunteers, or contractors;
- c. Employ friends or family to provide services to the protected person or client for a fee; or
- d. Solicit or accept incentives from service providers.

231.6(2) The state office or a local office shall be independent from all service providers, thus ensuring that the public guardian remains free to challenge inappropriate or poorly delivered services and to advocate on behalf of the protected person or client.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.7(231E,633) Individuals eligible for services. The office of public guardian will seek to restrict appointments to only those necessary. The state office or a local office will not accept an appointment based upon a voluntary petition unless that appointment is as a successor guardian or conservator and the court has, after notice and hearing, found by clear and convincing evidence that the protected person meets the legal standard for appointment of a guardian in Iowa Code section 633.552, the legal standard for appointment of a conservator in Iowa Code section 633.553, or both.

231.7(1) In order to qualify for services, an individual shall meet all of the following criteria:

- a. Is a resident of the state of Iowa;
- b. Is aged 18 or older or is at least 17 years and six months of age for appointment of a guardian or conservator on a standby basis for a minor approaching majority pursuant to Iowa Code section 633.567;
- c. Does not have a suitable individual or appropriate entity willing and able to serve as guardian, conservator, or representative payee;
- d. Is "incompetent" as defined in Iowa Code section 633.3(25) (for appointment of a guardian or conservator) or is incapable of managing social security or supplemental security income (SSI) payments as determined by the Social Security Administration (for representative payee);
- e. Is an individual for whom guardianship, conservatorship, or representative payee services are the least restrictive means of meeting the individual's needs; and
- f. A viable plan for improving the care and safety of the individual is possible.

231.7(2) The following cases shall be given priority:

- a. Those involving abuse, neglect or exploitation that public guardianship services can address;

- b.* Those in which a critical medical decision must be made; or
- c.* Any situation that may cause serious or irreparable harm to the individual's mental or physical health or finances.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.8(231E,633) Application and intake process—guardianship, conservatorship, and representative payee.

231.8(1) Any person may submit an application for services on behalf of an individual believed to be in need of public guardianship services. Applications are available on the department's website. Incomplete applications will not be considered. Communication with the state office or a local office or the submission of an application does not guarantee eligibility for public guardianship services and does not create any type of fiduciary relationship between the state office and the individual on whose behalf the application is submitted.

231.8(2) The state office will make a determination regarding eligibility of the individual and acceptance or denial of the case based on a review of the completed application.

231.8(3) The state office will grant or deny an application for services as soon as practicable but, in any event, within 60 days of receipt of the application.

231.8(4) Failure of the state office to grant or deny an application within the specified time period may be deemed a denial of the application by the state office.

231.8(5) In the event that the state office or a local office does not have sufficient resources to accept new cases, the state office will place applications that are eligible for public guardianship services on a waiting list.

a. Cases will be taken off the waiting list in the order in which they were received.

b. Cases that meet the priority criteria outlined in subrule 231.7(2) will be moved to the top of the waiting list and will be taken off the waiting list in the order in which they were received.

231.8(6) The state office or a local office will only file a petition to be appointed as guardian or conservator of an eligible individual if there is no person or entity that has an interest in the welfare of the adult who could file the petition pursuant to Iowa Code section 633.556(1).

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.9(231E,633) Case records.

231.9(1) The state office or a local office will establish a case record for each protected person or client the state office or a local office is appointed to serve. At a minimum, the case record must contain demographic information, including:

a. Copies of the evaluations, medical records, and updates, if any;

b. A separate financial management folder containing an inventory, an individual financial management plan, a record of all financial transactions made on behalf of the protected person or client by the public guardian, copies of receipts for all expenditures made by the public guardian on behalf of the protected person or client, and copies of all other documents pertaining to the protected person or client's financial situation as required by the state office;

c. Itemized statements of costs incurred in the provision of services for which the public guardian received court-authorized reimbursement directly from the protected person or client's estate; and

d. Other information as required by the state office.

231.9(2) All case records maintained by the public guardian shall be confidential as provided in Iowa Code section 231E.4(6) "g."

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.10(231E,633) Confidentiality. Notwithstanding Iowa Code chapter 22, the following provisions shall apply to records obtained by public guardians in the course of their duties.

231.10(1) Unless otherwise provided by rule or law, records and information of the state office of public guardian are governed by 441—Chapter 2505.

231.10(2) Records and information obtained as part of an application for public guardianship services are confidential.

a. If more than one application for public guardianship services is submitted on behalf of the same individual, the state office may disclose the following information to the applicants:

- (1) The date of any other application submitted on behalf of the individual;
- (2) The name and contact information of the other applicant or applicants;
- (3) The status of the other application or applications, including copies of any notices sent to the other applicant or applicants.

b. The state office or a local office may disclose the existence of an application and information contained in an application to family members, service providers, case managers, or others named in an application for public guardianship services in order to gather supplemental information necessary to determine eligibility for public guardianship services or to attempt to locate an individual for whom an application was submitted.

c. The state office may release records and information obtained as part of an application for public guardianship services to a local office of public guardian in anticipation of the local office providing public guardianship services to the individual.

231.10(3) Records and information about a protected person or client obtained or maintained for use by the state office or a local office of public guardian are confidential. Once appointed as an individual's guardian, conservator, or representative payee, the state office or a local office may, at the state office's or a local office's sole discretion, exercise the authority granted by the court or federal agency to obtain, disclose, or consent to the release of confidential records or information about the protected person or client if doing so is necessary and in the best interest of the protected person or client. The state office or a local office will obtain the written consent of the protected person or client or the person's or client's legal representative prior to obtaining or disclosing confidential records or information outside the scope of the state office's or a local office's authority. Disclosure of a record or information under this rule does not affect the confidential nature of the record.

231.10(4) Records and information may be redacted so that personally identifiable information is kept confidential.

231.10(5) The state office or a local office may enter into contracts or agreements with public or private entities in order to carry out the state office's or a local office's official duties. Information necessary to carry out these duties may be shared with these entities.

[ARC 9497C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—231.11(231E,633) Termination or limitation. Either a local office or the state office may seek the termination or limitation of a local office's duties under circumstances including:

1. Public guardianship services are no longer needed or do not benefit the protected person or client;
2. The protected person's or client's assets allow for hiring a paid guardianship or conservatorship service provider;
3. A conflict of interest or the appearance of a conflict of interest arises;
4. The state or a local office lacks adequate staff or financial resources;
5. The protected person or client moves outside the state or outside the local office's service area;
6. Public guardianship is no longer the last resort for assistance;
7. The contract between the state office and a local office is terminated by either party and there is no other local office that can be appointed as a successor;
8. Termination of the program by law; or
9. Other circumstances that indicate a need for termination or limitation.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.12(231E,633) Service fees.

231.12(1) The state office and a local office shall be entitled to reasonable compensation for their public guardianship services as determined by using the following criteria:

- a.* Such compensation shall not exceed actual costs.
- b.* Collection of fees may be adjusted or waived based upon the ability of the protected person or client to pay, upon whether financial hardship to the protected person or client would result, or upon a finding that collection of such fees is not economically feasible.
- c.* The state office may collect a fee from the estate of a deceased consumer.

231.12(2) Fees for guardianship and conservatorship services provided by the state office will be assessed according to the following fee schedule:

Action or Responsibility	Fee
One-time case opening:	
Guardianship	\$200
Conservatorship	\$300
Guardian and conservatorship	\$500
Monthly guardianship and/or conservatorship services.	
Total value of liquid assets:	
\$1,500 - \$9,999	\$100
\$10,000 - \$19,999	\$125
\$20,000 - \$29,999	\$150
\$30,000 - \$39,999	\$175
\$40,000 - \$49,999	\$200
\$50,000 - \$59,999	\$225
\$60,000 - \$69,999	\$250
\$70,000 - \$79,999	\$275
\$80,000 - \$89,999	\$300
\$90,000 - \$99,999	\$325
\$100,000 or above	\$350

231.12(3) Fees for guardianship and conservatorship services provided by a local office will be assessed at the rates established by contract between the state office and a local office. Contracts between the state office and local offices are public records.

231.12(4) Fees for representative payee services will be as established by the federal governmental agency that appoints the representative payee.

231.12(5) Notwithstanding the foregoing, the state office or a local office may collect fees pursuant to court order for other actual, necessary and extraordinary services or expenses, including legal fees. Necessary and extraordinary services or expenses may include but are not limited to services or expenses related to:

- a.* Recovering real or personal property or funds belonging to the protected person,
- b.* Bringing or defending against a suit or claim on behalf of the protected person,
- c.* Challenging the actions or accounting of a prior fiduciary, or
- d.* Establishing a trust for the benefit of the protected person.

231.12(6) The state office or a local office may collect fees even when claims of creditors of the consumer may be compromised.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

441—231.13(231E,633) Denial of services—appeal.

231.13(1) An application for services will be denied when it is determined by the state office that:

- a.* The application is incomplete;
- b.* The individual is not a resident of Iowa;
- c.* The individual is not aged 18 or older (or at least 17 and 6 months of age for appointment of a guardian or conservator on a standby basis for a minor approaching majority pursuant to Iowa Code section 633.567);
- d.* The individual has a suitable individual or appropriate entity willing and able to serve as guardian, conservator, or representative payee;
- e.* The individual has adequate financial resources available to compensate a professional guardian, conservator, or representative payee;
- f.* The individual is not incompetent as defined in Iowa Code section 633.3(25) (for appointment of a guardian or conservator);
- g.* The individual is not incapable of managing the individual's social security or SSI payments as determined by the Social Security Administration (for representative payee);
- h.* The individual is not an individual for whom guardianship, conservatorship, or representative payee services are the least restrictive means of meeting the individual's needs; or
- i.* A viable plan for improving the care and safety of the individual is not possible.

231.13(2) Notice of denial will be provided in accordance with 441—Chapter 16.

231.13(3) Applicants wishing to challenge a denial based on paragraph 231.13(1) “*f*” may file a petition pursuant to Iowa Code section 633.556 within 30 days of the date of the denial and give notice of the filing of the petition to the state office of public guardian.

231.13(4) Applicants wishing to challenge a denial for any other reason listed in subrule 231.13(1) may appeal in accordance with 441—Chapter 2506.

231.13(5) If the state office or a local office petitions to terminate services, a protected person or client may challenge that decision in the appropriate court or federal agency.

[ARC 9497C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

441—231.14(231E,633) Contesting the actions of a guardian, conservator, or representative payee.

231.14(1) Each local office shall develop a complaint procedure for the internal investigation and resolution of complaints. The complaint procedure shall be made available on the local office's website. The local office will provide a copy of the complaint procedure to each protected person and client.

231.14(2) If a complaint is not resolved by the local office to the satisfaction of the complainant, the complainant may express the complainant's concerns to the state office in writing or verbally.

231.14(3) The state office will advise the complainant that the complainant may also raise any concerns with the court or with the federal governmental agency with oversight of the representative payee.

[ARC 9497C, IAB 8/20/25, effective 10/1/25]

These rules are intended to implement Iowa Code chapters 231E and 633.

[Filed ARC 9497C (Notice ARC 9380C, IAB 6/25/25), IAB 8/20/25, effective 10/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 301
BEHAVIORAL HEALTH SERVICE SYSTEM ELIGIBILITY AND SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

441—301.1(225A) Individual eligibility for behavioral health service system funding. To be eligible for behavioral health service system funding, an individual must meet the following financial and needs-based eligibility criteria.

301.1(1) *Financial eligibility.* Income requirements for adults and household income for children are as follows:

- a. Income equal to or less than 200 percent of the federal poverty level.
- b. Income will be verified using the best information available.
- c. Financial eligibility will be reviewed on an annual basis and may be reviewed more often in response to increases or decreases in income.
- d. An individual who is eligible for medical assistance must apply for and exhaust such funding for services and supports prior to utilization of behavioral health service system funding.

301.1(2) *Resource requirements.* Individuals seeking behavioral services must have resources that are equal to or less than \$2,000 in countable value for a single-person household or \$3,000 in countable value for a multiperson household.

a. The countable value of all countable resources, both liquid and nonliquid, will be included in the eligibility determination, except as exempted in this subrule.

b. A transfer of property or other assets within five years of the time of application with the result of, or intent to, qualify for assistance may result in denial or discontinuation of funding.

c. The following resources will be exempt:

(1) A homestead, including equity in a family home or farm that is used as the individual household's principal place of residence. The homestead will include all land that is contiguous to the home and the buildings located on the land.

(2) One automobile used for transportation.

(3) Tools of an actively pursued trade.

(4) General household furnishings and personal items.

(5) Burial account or trust limited in value as to that allowed in the medical assistance program.

(6) Cash surrender value of life insurance with a face value of less than \$1,500 on any one person.

(7) Any resource determined excludable by the Social Security Administration as a result of an approved Social Security Administration work incentive.

d. If an individual does not qualify for federally funded or state-funded services or other support but meets all income, resource, and functional eligibility requirements of this chapter, the following types of resources will additionally be considered exempt from consideration in eligibility determination:

(1) A retirement account that is in the accumulation stage.

(2) A medical savings account.

(3) An assistive technology account.

(4) A burial account or trust limited in value as to that allowed in the medical assistance program.

301.1(3) *Needs-based eligibility.* An individual must:

a. Be a resident of Iowa or, if a minor, the custodial parent or legal guardian is a resident of Iowa.

b. Currently have, or at any time during the preceding 12-month period have had, a behavioral health condition.

301.1(4) *Service-specific eligibility.* Notwithstanding the financial and needs-based eligibility requirements in subrule 301.1(1), 301.1(2), or 301.1(3), individuals may be subject to additional diagnostic, level of care, or admission requirements for services. Individuals receiving:

- a.* Twenty-three-hour observation and holding services must meet admission criteria set forth in 441—subrule 24.37(1).
- b.* Crisis stabilization community-based services must meet service eligibility requirements set forth in 441—subrule 24.38(1).
- c.* Crisis stabilization residential services must meet service eligibility requirements set forth in 441—subrule 24.39(1).
- d.* Covered substance use disorder treatment services must meet the applicable levels of the third edition of the American Society of Addiction Medicine (ASAM) Criteria as published by the ASAM and as amended to July 1, 2025.
- e.* Assertive community treatment (ACT) services must meet service eligibility requirements set forth in 441—subrule 78.45(1).
- f.* Subacute services must meet admission requirements set forth in 481—subrule 71.13(2).
- g.* Outpatient competency restoration must have a court order to receive the service pursuant to Iowa Code section 812.6.
- h.* Psychiatric medical institutions for children (PMIC) services must meet certification of need requirements set forth in rule 481—41.9(135H).

301.1(5) *Exceptions.* Receipt of the following behavioral health services is as defined and is not subject to individual eligibility criteria in subrule 301.1(1), 301.1(2), or 301.1(3):

- a.* Prevention.
- b.* Early intervention services.
- c.* Crisis services.
- d.* Outpatient competency restoration.
- e.* Jail-based behavioral health services.
- f.* System navigation.

[ARC 9274C, IAB 5/14/25, effective 7/1/25]

441—301.2(225A) The behavioral health care continuum.

301.2(1) *Behavioral health services.* Behavioral health services overseen by a BH-ASO will include ensuring access to the full continuum of behavioral health care, including:

- a.* Prevention services, including indicated prevention, primary substance use prevention and universal prevention, and selective prevention.
- b.* Early identification.
- c.* Early intervention services.
- d.* Crisis services, including immediate access to crisis assessment and evaluation; access centers; sobering centers; mobile crisis response; crisis-stabilization, community-based services; and crisis-stabilization, residential services.
- e.* Mental health outpatient treatment services, including screening, assessment, diagnosis, risk assessment, and crisis planning.
- f.* Mental health, high-intensity outpatient treatment services, including ACT, intensive outpatient programs (IOP), intensive psychiatric rehabilitation (IPR), partial hospitalization, and day treatment.
- g.* PMIC.
- h.* Mental health inpatient treatment.
- i.* Hospital alternatives, including subacute services, 23-hour observation and holding, and crisis respite services.
- j.* Substance use disorder outpatient treatment services, including assessment and evaluation services.
- k.* Substance use disorder intensive outpatient treatment services.
- l.* Substance use disorder partial hospitalization services.
- m.* Substance use disorder clinically managed residential treatment services.
- n.* Recovery supports.

- o.* Peer support and peer recovery coaching.
- p.* Peer wellness and recovery community centers.
- q.* Transitional living and recovery housing programs.
- r.* Jail-based behavioral health services, including provision of behavioral health treatment and medications in jails.
- s.* Commitment-related services, including prescreening, secure transportation, legal representation, and mental health advocates.
- t.* Outpatient competency restoration.
- u.* Outreach, education, and engagement services.
- v.* Additional services deemed necessary for a district or statewide as determined by the district behavioral health service system plan and approved by the department.

301.2(2) *Additional requirements.* Additional requirements related to behavioral health services include crisis system navigation that must be available 24 hours per day, 7 days per week, 365 days per year.

301.2(3) *Option for waiting lists.* The department will maintain a waiting list of individuals denied access to the program due to lack of available funds. Waiting list information will include the date on which the individual was placed on the waiting list. If additional funds become available, the department will contact individuals on the list.

[ARC 9274C, IAB 5/14/25, effective 7/1/25]

441—301.3(225A) Provider qualifications.

301.3(1) *Behavioral health safety net service providers.* Behavioral health safety net service providers, which are defined in rule 441—300.1(225A), are required to:

- a.* Adhere to minimum access standards as set forth in 441—subrule 302.2(1).
- b.* Accept behavioral health service system funds as payment in full for individuals served through behavioral health service system funding. The safety net provider may not bill individuals for missed appointments, or for copayments or other cost-sharing arrangements, except as described in individual eligibility standards in rule 441—301.1(225A).
- c.* Work with BH-ASOs to coordinate care for the individuals the safety net provider serves, including making referrals to secure services and supports appropriate for the individual, coordinating warm handoffs to ensure continuity of care, coordinating transportation, and performing post-discharge follow-up.
- d.* Notify the BH-ASO within seven days when a safety net provider is at or above 90 percent capacity to admit individuals in need of behavioral health services.

301.3(2) *Behavioral health service system provider eligibility.* The following persons or organizations are eligible to participate as behavioral health service system providers to the extent allowed under the scope of their licensure, certification, or accreditation:

- a.* Hospitals providing inpatient psychiatric treatment or emergency department services licensed pursuant to Iowa Code chapter 135B.
- b.* Providers of outpatient mental health services licensed to practice in the state of Iowa or accredited under 441—Chapter 24.
- c.* Providers of crisis services accredited under 441—Chapter 24.
- d.* Community mental health centers (CMHCs) accredited under 441—Chapter 24.
- e.* Certified community behavioral health clinics (CCBHCs) certified by the department.
- f.* Federally qualified health centers (FQHCs) certified by the Centers for Medicare and Medicaid Services (CMS).
- g.* Providers of substance use disorder treatment programs and problem gambling treatment programs licensed pursuant to 641—Chapter 155.
- h.* Local tobacco control programs designated by the department.
- i.* Recovery community centers (RCCs) designated by the department.
- j.* Providers of recovery support services (RSSs) designated by the department.

- k. Subacute mental health facilities licensed pursuant to 481—Chapter 71.
- l. PMICs licensed pursuant to 481—Chapter 41.
- m. Providers of prevention services designated by the department.
- n. Providers of early intervention services designated by the department.
- o. Recovery and peer support providers trained or certified through approved programs designated by the department.

[ARC 9274C, IAB 5/14/25, effective 7/1/25]

441—301.4(225A) Appeal rights.

301.4(1) Definitions. For the purposes of this rule, the following definitions apply.

“Agency action” includes the whole or part of an agency rule or other statement of law or policy, order, decision, license, proceeding, investigation, sanction, relief, or the equivalent or a denial thereof, or a failure to act, or any other exercise of agency discretion or failure to do so, or the performance of any agency duty or the failure to do so.

“Appellant” means any person bringing an appeal under this chapter, including any person’s authorized representative as defined in subrule 301.4(14).

“Person” means any individual, partnership, corporation, association, governmental subdivision, or public or private organization of any character other than an agency.

“Reviewer” means the individual assigned by the department to review an appeal record and issue a written decision on behalf of the department. The department’s reviewer will be screened from the underlying case and will not have prior knowledge of the facts that precipitated the appeal.

301.4(2) Appeal. A person that disagrees with the department’s agency action related to an eligibility determination or denial of behavioral health services may request an appeal within 120 calendar days of the date of the determination or denial.

a. The following actions may be appealed:

- (1) The determination that eligibility criteria have not been met.
- (2) The denial or limited authorization of a requested service, including the type or level of service.
- (3) The decision to reduce, suspend, or terminate previously authorized services.
- (4) The denial, in whole or in part, of payment for a service that was provided.
- (5) The failure of the department to act within the required time frames.

b. Appeal requests submitted by regular mail are considered filed on the date postmarked on the envelope sent to the department or, when a postmarked envelope is not available, on the date the appeal is stamped received by the department. Appeal requests sent electronically are considered filed on the date on which the electronic submission was completed.

c. In computing any time period specified in this rule, the period:

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

301.4(3) Request. The person may request an appeal using a form prescribed by the department and in a manner prescribed by the department.

301.4(4) Acknowledgment of appeal. The department will send an acknowledgment of receipt of the appeal to the parties-in-interest to the appeal.

301.4(5) Acceptance or denial of appeal. The department will determine with reasonable promptness whether the person is entitled to an appeal. If a request for an appeal is denied, the department will provide written notice of and the reasons for the denial. On or before the thirtieth calendar day following the denial of appeal, the party requesting the appeal may provide additional information related to the appeal and request reconsideration of the denial of the appeal.

301.4(6) Documentation. If an appeal request is granted, the appellant may submit a written statement, supported by relevant documentation, to establish all pertinent facts and circumstances. Documents shall be submitted to the department within 14 calendar days of the date the appeal is acknowledged. The department's reviewer may request additional documents or information from the appellant as needed to assist the department's evaluation of the appeal.

301.4(7) Ex parte communication. The department's reviewer, the director, and all parties to the appeal are bound by the rules against ex parte communication set forth in Iowa Code section 17A.17 and rule 441—7.9(17A).

301.4(8) Withdrawal. An appellant may withdraw a request for appeal at any time. Requests to withdraw an appeal will be granted.

301.4(9) Department review. The department's reviewer will review the appeal record and issue a written proposed decision to all parties within 30 calendar days. The written proposed decision will include the reviewer's findings of fact and rationale for the decision.

301.4(10) Director's review.

a. Time. Parties may appeal the proposed decision to the director. A request for director's review shall be in writing and postmarked or received within 14 calendar days of the date on which the proposed decision was issued. A request for director's review may be accompanied by a brief written summary of the arguments in favor of granting a director's review.

b. Granting or denial of review. The department has full discretion to grant or deny a request for director's review. In addition, the director may initiate review of a proposed decision on the director's own motion at any time on or before the thirtieth calendar day following the issuance of the proposed decision. When the department grants a request for director's review, the parties will be notified of the decision, and a copy of the request will be included with the notification.

c. Limited record. A director's review will be limited to the issues and information contained in the record reviewed by the reviewer who issued the proposed decision.

d. Oral arguments. Upon specific request, the director may, at the director's discretion, permit parties to present oral arguments with the parties' requests for director's review.

e. Decision issued. The director will issue a final decision within the timelines prescribed by federal or state law. For all appeals for which there is no federal or state timeliness standard, the director will issue a final decision on or before the ninetieth day from the date the director grants review.

301.4(11) Final decisions.

a. No appeal or denial of director review. If there is no timely appeal from or review of the proposed decision, the proposed decision will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

b. Director decision issued. Any decision issued by the director after granting a director's review will be considered the final agency action and is subject to judicial review in accordance with Iowa Code section 17A.19.

c. Written notice of final decision. The parties-in-interest will be provided written notice of the department's final decision. The department will also notify the appellant of the right to seek judicial review, where applicable.

301.4(12) Interpreters. The department will provide translation and interpretation services to parties-in-interest, if requested. When a party-in-interest is illiterate or semiliterate, the reviewer will advise the party-in-interest of the party-in-interest's rights.

301.4(13) Persons living with disabilities. Persons living with disabilities will 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 (as amended, effective December 31, 2023) and Section 504 of the Rehabilitation Act (as amended, effective October 1, 2016).

301.4(14) Authorized representatives.

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

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

c. Appearance by attorney. Legal counsel appearing on behalf of any person in a proceeding under this rule shall enter an appropriate written appearance.

301.4(15) *Not contested cases.* Appeals brought under this chapter are not contested cases, appellants will not be granted a contested case hearing, and the provisions in 441—Chapter 2506 do not apply.

[ARC 9274C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 225A.

[Filed ARC 9274C (Notice ARC 9016C, IAB 3/19/25), IAB 5/14/25, effective 7/1/25]

[Editorial change: IAC Supplement 6/10/26]

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CHAPTER 41
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—41.1(135H) Definitions. The definitions set forth in Iowa Code section 135H.1 are incorporated herein. As used in this chapter:

“*Nurse practitioner*” means a registered professional nurse who is currently licensed to practice in the state, who meets state requirements and is currently licensed to practice nursing under the nursing board[655] rules in the Iowa Administrative Code.

“*Physician associate*” means a person licensed to practice under Iowa Code chapter 148C.

[ARC 6973C, IAB 4/5/23, effective 5/10/23; Editorial change: IAC Supplement 6/10/26]

481—41.2(135H) Application for license. In order to obtain an initial license for a PMIC, the applicant must comply with Iowa Code chapter 135H and the rules in this chapter. Each applicant must submit the following documents to the department:

1. A completed Psychiatric Medical Institutions for Children application;
2. A copy of a department of human services license as a comprehensive residential care facility issued pursuant to Iowa Code section 237.3(2) “a,” or a copy of a license granted by the department of public health pursuant to Iowa Code section 125.13, as a facility which provides substance abuse treatment;
3. A floor plan of each floor of the facility on 8½” by 11” paper showing:
 - Room areas in proportion;
 - Room dimensions;
 - Numbers for all rooms including bathrooms;
 - A designation of use for each room; and
 - Window and door locations;
4. A photograph of the front and side elevation of the facility;
5. The fee set forth in Iowa Code section 135H.5; and
6. Evidence of:
 - Accreditation in accordance with Iowa Code section 135H.6(1) “b”;
 - Department of public health certificate of need;
 - Approval of the department of human services in accordance with Iowa Code section 135H.6(1) “e”; and
 - Compliance with the requirements of Iowa Code section 135H.6(1) “f.”

This rule is intended to implement Iowa Code sections 135H.4, 135H.5, and 135H.6.

[ARC 6973C, IAB 4/5/23, effective 5/10/23]

481—41.3(135H) Renewal application or change of ownership. In order to renew a license or change ownership of the psychiatric medical institution for children, the applicant must submit to the department:

1. A completed application form 30 days before the renewal date or before the date of the ownership change; and
2. The PMIC license fee.

41.3(1) Denial, suspension or revocation of a license. The department may deny, suspend or revoke a PMIC license for any of the reasons set forth in Iowa Code section 135H.8.

The department will issue notice of denial, suspension or revocation by certified mail or by personal service.

41.3(2) Appeal process. When a license is denied, revoked or suspended, a hearing may be requested pursuant to 481—subrule 50.5(2) and shall be conducted pursuant to rule 481—50.6(10A). During the appeal process, the status of a license shall remain as it was on the date the hearing was requested. The status shall not change until a final decision is rendered by the department.

This rule is intended to implement Iowa Code sections 135H.8 and 135H.9.
[ARC 6973C, IAB 4/5/23, effective 5/10/23]

481—41.4(135H) Licenses for distinct parts. 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. The following requirements shall be met for licensing a distinct part:

41.4(1) The distinct part shall serve only children who require the category of care and services immediately available within that part.

41.4(2) The distinct part shall meet all the standards, rules and regulations which pertain to the category for which a license is sought.

41.4(3) The distinct part must be operationally and financially feasible.

41.4(4) A separate personal care staff with qualifications appropriate to the care and services offered must be regularly assigned and working in the distinct part under responsible management.

41.4(5) Separately licensed distinct parts may have some services such as management, building maintenance, laundry and dietary in common with each other.

[ARC 6973C, IAB 4/5/23, effective 5/10/23]

481—41.5(135H) Waivers. Waivers from these rules may be granted by the director of the department:

1. When the need for a waiver has been established; and
2. When there is no danger to the health, safety, welfare or rights of any child.

The waiver will apply only to a specific PMIC.

Waivers shall be reviewed at the time of each licensure survey by the department to determine continuing need.

41.5(1) To request a waiver, the licensee must:

- a. Apply in writing on a form provided by the department;
- b. Cite the rule or rules from which a waiver is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain how the waiver is consistent with the individual program plans; and
- e. Demonstrate that the requested waiver will not endanger the health, safety, welfare or rights of any child.

41.5(2) Upon receipt of a request for waiver, the director shall:

- a. Examine the rule from which the waiver is requested;
- b. Evaluate the requested waiver against the requirement of the rule to determine whether the request is necessary to meet the needs of the children; and
- c. Examine the effect of the requested waiver on the health, safety or welfare of the children.

[ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—41.6(135H) Notice to the department.

41.6(1) The department shall be notified at the times stated when the following events are expected to occur:

- a. Thirty days before addition, alteration or new construction is begun in the PMIC or on the premises;
- b. Thirty days in advance of closure of the PMIC or change in the category of license sought; and
- c. Within two weeks of any change of administrator.

41.6(2) Prior to the purchase, transfer, assignment or lease of a PMIC, the licensee shall:

- a. Inform the department in writing of the pending sale, transfer, assignment or lease of the facility; and
- b. Inform the department in writing 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 complete.

[ARC 6973C, IAB 4/5/23, effective 5/10/23]

481—41.7(135H) Inspection of complaints. The department shall conduct a preliminary review of all complaints filed against a PMIC. Unless a complaint is determined to be intended as harassment or to be without reasonable basis, the department shall inspect the PMIC within 20 working days of receipt of the complaint.

This rule is intended to implement Iowa Code section 135H.12.

481—41.8(135H) General requirement. Inpatient psychiatric services for recipients under age 21 must be provided under the direction of a physician.

When a resident has received services immediately before reaching age 21, services must be complete before the earlier of the following:

1. The date the recipient no longer requires services; or
2. The date the recipient reaches age 22.

481—41.9(135H) Certification of need for services. All recipients of services shall have written certification which ensures the following:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so services will no longer be needed.

Certification of need shall be completed in accordance with 42 CFR Sections 441.152 and 441.153.

[ARC 6973C, IAB 4/5/23, effective 5/10/23]

481—41.10(135H) Active treatment. Inpatient psychiatric services must involve "active treatment," which means implementation of a professionally developed and supervised individual plan of care as described in rule 481—41.12(135H). The plan of care shall be:

1. Developed and implemented no later than 14 days after admission; and
2. Designed to achieve discharge from inpatient status at the earliest possible time.

481—41.11(135H) Individual plan of care. "Individual plan of care" means a written plan developed for each child. The plan of care shall be designed to improve the condition of each child to the extent that inpatient care is no longer necessary.

41.11(1) The plan of care must be based on a diagnostic evaluation that includes examination of the:

- a. Medical,
- b. Psychological,
- c. Social,
- d. Behavioral, and
- e. Developmental aspects of the child's situation.

The plan of care shall reflect the need for inpatient psychiatric care.

41.11(2) The plan of care shall be developed by the team of professionals specified in rule 481—41.13(135H) in consultation with the recipient, the parents, legal guardian or other person into whose care the child will be released after discharge. The plan of care shall include:

- a. Diagnoses, symptoms, complaints and complications indicating the need for admission;
- b. Treatment objectives;
- c. An integrated program of therapies, activities and experiences designed to meet the objectives;
- d. A description of the functional level of the individual;

e. Any orders for:

- (1) Medications,
- (2) Treatments,
- (3) Restorative and rehabilitative services,
- (4) Activities,
- (5) Therapies,
- (6) Social services,
- (7) Diet, and
- (8) Special procedures recommended for the health and safety of the patient; and

f. At an appropriate time, postdischarge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the recipient's family, school and community upon discharge.

41.11(3) The plan of care shall be reviewed every 30 days by the team referred to in rule 481—41.13(135H) to:

a. Determine that services being provided are or were required on an inpatient basis; and

b. Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

This rule is intended to implement Iowa Code section 135H.3.

481—41.12(135H) Individual written plan of care. Before admission to a PMIC and before authorization for payment, the attending physician or staff physician must establish written plans for continuing care including review and modification of the plan of care.

481—41.13(135H) Plan of care team. The individual plan of care shall be developed by an interdisciplinary team of physicians and other personnel who are employed by the facility or provide services to patients.

41.13(1) Based on education and experience, the team must be capable of:

a. Assessing the recipient's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;

b. Assessing the potential resources of the recipient's family;

c. Setting treatment objectives; and

d. Prescribing therapeutic modalities to achieve the plan's objectives.

41.13(2) The team shall include at least one member who is experienced in child psychiatry or child psychology and must include, as a minimum, either:

a. A board-eligible or board-certified psychiatrist; or

b. A clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy; or

c. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnoses and treatment of mental diseases, and a psychologist who has a master's degree in clinical psychology or who has been certified by the state psychological association.

41.13(3) The team must also include one of the following:

a. A psychiatric social worker;

b. A registered nurse with specialized training or one year of experience in treating mentally ill individuals;

c. A licensed occupational therapist who has specialized training in treating mentally ill individuals; or

d. A psychologist who has a master's degree in clinical psychology or who has been certified by the state psychological association.

This rule is intended to implement Iowa Code section 135H.3.

481—41.14(135H) Required discharge. The licensee shall not refuse to discharge a child when directed by the physician, parent or legal guardian unless so directed by the court.

481—41.15(135H) Criminal behavior involving children. A person who has a record of a criminal conviction or a founded child abuse or dependent adult abuse shall not be licensed to operate, be employed by, or reside in a PMIC unless an evaluation of the crime or founded child or dependent adult abuse has been made by the department of human services which concludes that the crime or founded child or dependent adult abuse does not merit prohibition of employment.

41.15(1) A PMIC shall request that the department of human services (DHS) conduct a criminal and child abuse record check, when a person is being considered for licensure or for employment if the person will:

- a. Have direct responsibility for a child;
- b. Have access to a child when the child is alone; or
- c. Reside in the facility.

41.15(2) A PMIC shall inform all new applicants for employment of the requirement for the criminal and child abuse record checks and the possibility of a dependent adult abuse record check. The PMIC shall obtain, from the applicant, a signed acknowledgment of the receipt of this information.

41.15(3) A PMIC shall include the following inquiry in an application for employment: “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?”

41.15(4) DHS will inform the PMIC of the results of the criminal, child abuse, and dependent adult abuse record checks. If a record of a criminal conviction or founded child or dependent adult abuse exists, the PMIC will be informed on Form 470-2310, “Record Check Evaluation.” The subject of the report shall complete that form and it shall be returned to DHS to request evaluation of the record to determine whether prohibition of the person’s licensure, employment, or residence is warranted.

41.15(5) If the evaluation is not requested or if the DHS determines that the person has committed a crime or has a record of founded child abuse or dependent adult abuse which warrants prohibition of licensure, employment, or residence, the person shall not be licensed to operate, be employed by, or reside in a PMIC.

This rule is intended to implement Iowa Code section 135H.7.

481—41.16(22,135H) Confidential or open information. The department maintains files for psychiatric medical institutions for children. These files are organized by facility name and contain both open and confidential information.

41.16(1) Open information includes:

- a. License application and status;
- b. Waiver requests and responses;
- c. Final findings of state license survey investigations;
- d. Records of complaints;
- e. Plans of correction submitted by the facility;
- f. Medicaid status; and
- g. Official notices of license sanctions.

41.16(2) Confidential information includes:

- a. Inspection or investigation information which does not comprise a final finding. This information may be made public in a proceeding concerning the denial, suspension or revocation of a license, under Iowa Code section 135H.8;
- b. Names and identities of all complainants; and
- c. Names of children in all facilities, identifying information and the address of anyone other than an owner.

This rule is intended to implement Iowa Code sections 22.11, 135H.11 and 135H.13.
 [ARC 5719C, IAB 6/16/21, effective 7/21/21; ARC 6973C, IAB 4/5/23, effective 5/10/23]

481—41.17(135H) Additional provisions concerning physical restraint. If a PMIC uses a physical restraint, the following provisions shall apply:

41.17(1) No employee shall use any prone restraints. For the purposes of this rule, “prone restraints” means those in which an individual is held face down on the floor. Employees who find themselves involved in the use of a prone restraint as the result of responding to an emergency must take immediate steps to end the prone restraint.

41.17(2) No employee shall use any restraint that obstructs the airway of any resident.

41.17(3) If an employee physically restrains a resident who uses sign language or an augmentative mode of communication as the resident’s primary mode of communication, the resident shall be permitted to have the resident’s hands free of restraint for brief periods, unless an employee determines that such freedom appears likely to result in harm to self or others.

This rule is intended to implement Iowa Code sections 135H.4 and 135H.5.

[ARC 8857B, IAB 6/16/10, effective 7/21/10]

This chapter is intended to implement Iowa Code chapters 17A, 22 and 135H.

[Filed emergency 7/7/89—published 7/26/89, effective 7/7/89]

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[Editorial change: IAC Supplement 6/10/26]

¹ Incorporated 11/28/90

CHAPTER 53 HOSPICE LICENSE STANDARDS

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—53.1(135J) Definitions. The use of the word “shall” indicates mandatory standards. The definitions set out in Iowa Code section 135J.1 shall be considered to be incorporated verbatim in the rules. As used in this chapter:

“*Bereavement service*” is emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

“*Care setting*” means the place in which care is being given, for example, patient’s home, a hospital, a care facility or another place of residence.

“*Family*” means the immediate kin of the patient, including a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, child, or stepchild. Additional relatives or individuals with significant personal ties to the hospice patient may be included in the hospice patient’s family.

“*Home care provider*” means a care agency that contracts with the hospice to provide services in the home of the hospice patient. The providers may include, but are not limited to, hospice aides, homemakers, nurses, occupational therapists or physical therapists.

“*Primary caregiver*” means the person with major responsibility for providing care to a hospice patient.

“*Protocols*” are defined as written sets of directions to be followed in performing procedures. These may be routine or may describe specific actions staff must follow when particular events occur.

“*Psychosocial needs*” involve a person’s mental and emotional life related to behavior to other people.

“*Social services*” are services provided by someone who has a bachelor’s or higher degree in social work.

“*Spiritual counselor*” may be clergy, a hospice employee, a volunteer or someone chosen by the patient.

“*Utilization review*” means a program to assess the kind of care delivered and to identify needs which may not have been met.

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.2(135J) License. Application for an initial or renewal license may be obtained from the Department of Inspections and Appeals, Division of Health Facilities, Lucas State Office Building, Des Moines, Iowa 50319.

53.2(1) Prior to the issuance of a license each hospice must meet all the requirements set forth in this chapter.

53.2(2) The applicant shall submit a nonrefundable biennial license fee of \$500. If a license lapses for failure to make timely application for renewal, an additional 25 percent is required.

53.2(3) Each hospice seeking licensure is surveyed before the initial license is issued and at least every 36 months thereafter.

53.2(4) Home care provider and inpatient facilities used by the hospice shall be inspected by the department to determine whether hospice regulations are met.

53.2(5) Hospices certified as Medicare providers by the department or accredited by an organization approved by the Centers for Medicare and Medicaid Services for federal certification will be licensed without inspection.

53.2(6) The department may not prohibit any entity from establishing or maintaining a hospice without a license.

53.2(7) The department may deny, suspend or revoke a license if the department finds that a hospice does not comply with these rules.

53.2(8) A license is issued only for the premises, person, hospital or facility named on the application. The license may not be transferred or assigned to another person or entity.

53.2(9) A license expires two years after the date issued unless it is suspended or revoked before that date.

This rule is intended to implement Iowa Code sections 135J.2 and 135J.4 to 135J.6.

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.3(135J) Patient rights. Each hospice program shall have written policies and procedures that support, enhance and protect the human, civil, constitutional and statutory rights of all patients.

53.3(1) Patient rights include, but are not limited to, the right to:

- a. Be treated with dignity and respect;
- b. Be informed of the type of care and the services provided by the hospice program;
- c. Information regarding diagnosis and prognosis and any change in either;
- d. Review and participate in their plan of care; and
- e. Privacy.

53.3(2) A copy of these rights shall be provided to all individuals admitted to a hospice.

This rule is intended to implement Iowa Code section 135J.3(3).

481—53.4(135J) Governing body. The hospice shall have a local governing body which consists of people who represent the geographic area for which the hospice intends to provide service.

53.4(1) The governing body shall:

- a. Develop a written mission statement, goals and objectives for the hospice and meet with sufficient regularity to ensure accomplishment of those goals and objectives;
- b. Develop, amend and implement bylaws;
- c. Assume responsibility for the total operation of the hospice;
- d. Appoint an administrator whose qualifications and duties are defined in writing and who has authority to manage the business affairs and to direct all programs of the hospice;
- e. Provide for medical direction by a licensed physician, including naming a qualified physician to be available in the medical director's absence;
- f. Provide appropriate, qualified personnel in sufficient quantity to ensure availability of hospice services listed below. Physician and nursing services and the provision of appropriate drugs shall be available 24 hours a day, seven days a week;
- g. Develop and implement written policies and procedures relating to:
 - (1) Admission and discharge criteria,
 - (2) Response to referrals,
 - (3) Medical direction,
 - (4) Physician services,
 - (5) Nursing services,
 - (6) Nutritional services,
 - (7) Pharmacy services,
 - (8) Social services,
 - (9) Volunteer services,
 - (10) Spiritual services,
 - (11) Patient and family education,
 - (12) Bereavement services,
 - (13) Staff response to death at home and in institutions,
 - (14) Coordination and communication between all agencies serving the patient and family,
 - (15) Communication with community agencies, and
 - (16) Community education efforts;
- h. Develop and implement written personnel policies; and
- i. Develop and implement a written plan for review of the services delivered.

53.4(2) The governing body shall ensure that someone is responsible to:

- a. Organize and direct the ongoing functions of the hospice program;
- b. Meet the requirements of the written job descriptions;
- c. Maintain liaison with the governing body and staff to ensure administrative control and professional supervision over all patient and family services furnished;
- d. Provide orientation and in-service training for all staff which covers the physical, emotional, spiritual and social needs of hospice patients and their families during the final stages of illness, at death and during grief;
- e. Plan, organize, implement, guide and evaluate the program;
- f. Formulate and conduct a review of policies and procedures, including quality assurance; and
- g. Ensure that all required reports and records are completed, submitted and maintained. This includes personnel, administrative and clinical records.

This rule is intended to implement Iowa Code section 135J.3.

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.5(135J) Quality assurance and utilization review. The hospice must have a written procedure for individual assessment of care provided, a process for identifying problems and a system to report findings and recommendations for improving the quality of care delivered to the governing body.

53.5(1) The medical director, patient coordinator and social worker used by the hospice program shall review a minimum of a 10 percent sample of combined active and inactive clinical records of care delivered to hospice patients on a periodic and ongoing basis. A written summary shall be prepared for each individual assessment, commenting on the amount and kind of care delivered and including statements addressing any unmet needs.

53.5(2) All summaries of individual assessments shall be reviewed by the people responsible for coordinating quality assurance on a periodic and ongoing basis. A written report will be prepared addressing any identified problems with care, treatment services, availability of services and methods of care delivery.

53.5(3) The quality assurance reports shall be made available to the hospice administrator and governing body. The reports shall be reviewed by the governing body at least annually, and the review recorded in the governing body's meeting minutes.

This rule is intended to implement Iowa Code section 135J.3(8).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.6(135J) Attending physician services. The patient or family shall designate an attending physician or physician associate who is responsible for managing necessary medical care. The attending physician shall:

1. Have an active Iowa license pursuant to Iowa Code chapter 148 or 148C;
2. Certify in conjunction with the medical director that each person requesting admittance is eligible as required by Iowa Code section 135J.1(3) for hospice care;
3. Be responsible for the medical component of the plan of care;
4. Participate in developing and revising the plan of care;
5. Arrange for continuity of the medical management in the attending physician's absence; and
6. Monitor the condition of the patient and family by direct contact, or communication with the interdisciplinary team (IDT) and others.

This rule is intended to implement Iowa Code section 135J.3(4).

[ARC 6975C, IAB 4/5/23, effective 5/10/23; Editorial change: IAC Supplement 6/10/26]

481—53.7(135J) Medical director. Each hospice shall have a medical director who is a physician licensed to practice medicine pursuant to Iowa Code chapter 148. The medical director shall:

1. Be a member of the interdisciplinary team;
2. Monitor the quality of care provided;

3. Assist in providing assurance of the quality of care provided to the patient and family;
 4. Maintain liaison with the attending physician;
 5. Review clinical material from the patient's attending physician to certify the prognosis as anticipated by that physician;
 6. Participate in providing direction for the medical component of care;
 7. Participate in resolving conflicts regarding care to be provided; and
 8. Participate in the development and review of patient care policies, procedures and protocols.
- This rule is intended to implement Iowa Code section 135J.3(1).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.8(135J) Interdisciplinary team (IDT). The IDT shall establish a plan of care for each patient based on assessments performed by team members.

53.8(1) The interdisciplinary team shall include, but is not limited to, the:

- a. Patient, to the extent the patient is able and willing to participate;
- b. Hospice patient's family, to the extent the family is able and willing to participate;
- c. A doctor of medicine or osteopathy who is an employee of or under contract with the hospice;
- d. Patient care coordinator;
- e. Registered nurse;
- f. Social worker; and may include
- g. A pastoral or other counselor and others deemed appropriate by the hospice.

53.8(2) Within 48 hours of admission, the attending physician or registered nurse and at least one IDT team member shall develop an initial plan based on a preliminary assessment of the patient needs.

53.8(3) Within five calendar days of admission, the interdisciplinary team shall assess the needs of the patient and family. A care plan shall be based on these findings.

53.8(4) Within five calendar days of admission, the interdisciplinary team shall meet to develop a comprehensive written plan of care. The plan of care shall:

- a. Identify the primary caregiver or an alternate arrangement for care;
- b. List the needs of the patient and family;
- c. List any intervention planned to meet the needs of the patient and family and the results expected from each intervention;
- d. Indicate which team member(s) is responsible for each intervention;
- e. Indicate the anticipated frequency of each intervention; and
- f. Indicate the prognosis and expected disease process.

53.8(5) The IDT shall monitor and revise the plan of care on a regular basis. The team shall meet at least every 15 days and exchange information regarding the needs of the patient and family. Changes in the care plan shall be made when the needs of the patient or family change or when interventions do not result in the expected or intended response.

This rule is intended to implement Iowa Code section 135J.3(5).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.9(135J) Nursing services. Nursing services shall be planned and provided or supervised by a registered nurse who has a current Iowa license to practice nursing. The service shall be available 24 hours a day, seven days a week.

53.9(1) A registered nurse shall assess patient and family nursing needs and develop a nursing plan of care to meet these needs.

53.9(2) The nursing service staff shall:

- a. Participate in IDT meetings to develop and amend the plan of care;
- b. Provide nursing service in accordance with the overall plan of care developed by the IDT;
- c. Consult with the patient and family regarding how to meet nursing and nursing-related needs of the patient;

- d.* Document nursing care given and observations made regarding patient, family reactions and status;
- e.* Consult with other care providers and the family to enhance continuity of care;
- f.* Develop and implement nursing service objectives, policies and procedures; and
- g.* Assign duties to nurses and hospice aides consistent with their education and experience.

53.9(3) Persons who are employed by, volunteer with or work under contract to a licensed hospice organization may administer medications only if they are also a licensed nurse, a licensed physician or a certified medication aide.

This rule is intended to implement Iowa Code section 135J.3(2).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.10 Reserved.

481—53.11(135J) Coordinator of patient care.

53.11(1) A registered nurse, social worker or health care administrator shall be designated to coordinate implementation of the plan of care for each patient.

53.11(2) The coordinator of patient care shall at least:

- a.* Coordinate all aspects of patient care to ensure continuity, including care by all service disciplines in all care settings;
- b.* Facilitate exchange of information among all personnel who provide services to ensure complementary efforts and support for objectives outlined in the plan of care;
- c.* Facilitate communication between caregivers, patient and family;
- d.* Maintain a roster of patients;
- e.* Maintain a schedule for IDT review of care plans;
- f.* Chair IDT conferences;
- g.* Develop job descriptions for all nursing personnel;
- h.* Establish staff schedules to meet patient needs and ensure 24-hour service;
- i.* Develop and implement orientation and training programs;
- j.* Develop and implement performance evaluation for the nursing staff; and
- k.* Facilitate periodic meetings of the professional nursing staff to evaluate the nursing care provided by hospice personnel.

This rule is intended to implement Iowa Code section 135J.3(2).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.12(135J) Social services. Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.

53.12(1) Education and experience. A qualified social worker is a person who:

- a.* Has a master of social work (MSW) degree from a school of social work accredited by the Council on Social Work Education; or
- b.* Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or
- c.* Has a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW as described in paragraph 53.12(1) "a"; and
- d.* Has one year of social work experience in a health care setting; or
- e.* Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, was employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.

53.12(2) The social worker shall at least:

- a.* Consider the emotions and social support system of the patient;
- b.* Identify patient social service needs;
- c.* Participate on the IDT to develop and amend the plan of care;

- d.* Provide services in accordance with the plans of care developed by the IDT;
- e.* Document services provided and observations made regarding patient and family response and status; and
- f.* Cooperate and communicate with other providers and the family to enhance the continuity of care.

This rule is intended to implement Iowa Code section 135J.3(2).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.13(135J) Counseling services. Counseling is the process of helping people adjust to the grief of illness, dying and loss. Counseling shall be provided in accordance with the plan of care. When the interdisciplinary team identifies the need for additional counseling services, a team member shall be designated to make an appropriate referral. No referrals may be made without the agreement of the patient and the family.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.14(135J) Volunteer services. Each hospice shall provide volunteer services to meet patient and family needs. A coordinator of volunteer services shall be designated to implement written policies and procedures. Volunteers must be used in defined roles and under the supervision of a designated hospice employee. The hospice must maintain, document and provide volunteer orientation and training that is consistent with hospice industry standards.

This rule is intended to implement Iowa Code section 135J.3(2).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.15(135J) Spiritual counseling. Spiritual counseling shall be available to all patients and their families.

53.15(1) Spiritual counseling shall:

- a.* Be based on the beliefs and values of the patient and family; and
- b.* Be provided in accordance with the interdisciplinary plan of care.

53.15(2) If spiritual counseling is provided through a working relationship with clergy or other spiritual counselors in the community, there shall be ongoing communication between that counselor and the interdisciplinary care team.

53.15(3) There shall be written and implemented policies and procedures regarding spiritual counseling.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.16(135J) Optional services. Optional services are services provided by the hospice which are not required. Examples are hospice aide, therapy and respite. The following apply to the provision of all optional services provided by a hospice:

53.16(1) All service providers shall be oriented to the hospice concept and philosophy.

53.16(2) All services shall be provided in accordance with the interdisciplinary plan of care.

53.16(3) Written and implemented policies and procedures shall:

- a.* Identify service providers;
- b.* Identify the person who will supervise the provision of services;
- c.* Require documentation of services provided and patient and family response; and
- d.* Describe a mechanism for evaluating quality of care provided.

This rule is intended to implement Iowa Code section 135J.1(7).

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

481—53.17(135J) Contracted services. A hospice may contract with other health care providers for the provision of all services.

53.17(1) Contracts shall be written and clearly delineate the authority and responsibility of each party to the contract.

53.17(2) The hospice shall maintain responsibility for coordinating and administering the hospice program.

53.17(3) Contracting for a service does not absolve the hospice of legal responsibility for provision of that service.

53.17(4) The hospice shall inform the patient whether the hospice is paying for the contracted services.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.18(135J) Short-term hospital services. Each hospice shall have a written agreement with a local or area hospital which promotes continuation of the hospice plan of care and training for hospital staff who care for hospice patients.

This rule is intended to implement Iowa Code section 135J.3(2).

481—53.19(135J) Bereavement services. Bereavement services shall be available to each family after the death of a patient and shall be provided in accordance with family needs.

53.19(1) Bereavement services shall include:

- a.* Exchange of information between people who provide bereavement services and team members who provided care before death;
- b.* Consideration of the family's situation, including risk factors, used to develop a plan for services;
- c.* Identification of types of help or intervention to be available and provided;
- d.* Contact with the family after the death as required by their needs as documented in the plan of care; and
- e.* A process to assess family reactions and hospice referrals for intervention deemed appropriate by the IDT.

53.19(2) There shall be written and implemented policies and procedures governing the delivery of bereavement services.

This rule is intended to implement Iowa Code section 135J.3(6).

481—53.20(135J) Records. In accordance with accepted principles of medical record practice, each hospice shall maintain a centralized complete record on every individual receiving services. This record shall be preserved for at least six years following termination of services.

53.20(1) Each entry shall be dated and signed, including the name and title of the person who makes the entry.

53.20(2) The record shall include documentation of all services provided, whether furnished by the hospice or by contractual agreement. Each record shall include, but not be limited to:

- a.* Patient identification and demographic data;
- b.* Initial and subsequent assessments;
- c.* The plan of care;
- d.* Medical history;
- e.* Documentation of all services provided;
- f.* Consent and authorization forms;
- g.* Physicians' orders;
- h.* Medication records;
- i.* Discharge summary; and
- j.* Discharge and transfer records.

53.20(3) The hospice shall have written and implemented policies to safeguard destruction or unauthorized use of patient records. Written procedures shall govern use and removal of records, conditions for release of information and identification by title of the person who may release records.

[ARC 6975C, IAB 4/5/23, effective 5/10/23]

These rules are intended to implement Iowa Code sections 135J.1 to 135J.6.

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CHAPTER 57
RESIDENTIAL CARE FACILITIES
[Prior to 7/15/87, Health Department[470] Ch 57]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—57.1(135C) Definitions. The following definitions apply to this chapter and to 481—Chapter 62. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in these rules.

“Accommodation” means the provision of lodging, including sleeping, dining, and living areas.

“Activities of daily living” means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting and ambulation.

“Administrator” means a person approved by the department who administers, manages, supervises, and is in general administrative charge of a residential care facility, whether or not such person has an ownership interest in the facility, and whether or not the functions and duties are shared with one or more other persons.

“Ambulatory” means the condition of a person who immediately and without the aid of another person is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“Basement” means that part of a building where the finish floor is more than 30 inches below the finish grade of the building.

“Board” means the regular provision of meals.

“Change of ownership” means the purchase, transfer, assignment, or lease of a licensed residential care facility.

“Communicable disease” means a disease caused by the presence within a person’s body of a virus or microbial agent which may be transmitted either directly or indirectly to other persons.

“Department” means the department of inspections and appeals.

“Distinct part” means a clearly identifiable area or section containing contiguous rooms within a health care facility.

“Interdisciplinary team” means the group of persons who develop a single, integrated, individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian if applicable, the resident’s advocate if desired by the resident, a referral agency representative, other appropriate staff members, other providers of services, and other persons relevant to the resident’s needs.

“Legal representative” means the resident’s guardian or conservator if one has been appointed or the resident’s power of attorney.

“Mechanical restraint” means restriction by the use of a mechanical device of a resident’s mobility or ability to use the hands, arms or legs.

“Medication” means any drug, including over-the-counter substances, ordered and administered under the direction of the primary care provider.

“Nonambulatory” means the condition of a person who immediately and without the aid of another person is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“Personal care” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and eating, and supervision over medications which can be self-administered.

“Physical restraint” means direct physical contact on the part of a staff person to control a resident’s physical activity for the resident’s own protection or for the protection of others.

“Primary care provider” means any of the following who provide primary care and meet licensure standards:

1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician associate.

"Program of care" means all services being provided for a resident in a health care facility.

"Prone restraint" means a restraint in which a resident is in a face-down position against the floor or another surface.

"Rate" means the daily fee that is charged for all residents equally and that includes the cost of all minimum services required in these rules and regulations.

"Records" includes electronic records.

"Responsible party" means the person who signs or cosigns the residency agreement required in rule 481—57.15(135C) or the resident's legal representative. In the event that a resident has neither a legal representative nor a person who signed or cosigned the resident's residency agreement, the term "responsible party" shall include the resident's sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, a religious group, fraternal organization, or foundation that assumes responsibility and advocates for its client patients and pays for their health care.

"Restrictions" means the measures taken to control a resident's physical activity for the resident's own protection or for the protection of others.

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 3737C, IAB 4/11/18, effective 5/16/18; ARC 3738C, IAB 4/11/18, effective 5/16/18; Editorial change: IAC Supplement 6/10/26]

481—57.2(135C,17A) Waiver. A waiver from these rules may be granted by the director of the department in accordance with 481—Chapter 6. A request for waiver will be granted or denied by the director within 120 calendar days of receipt.

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—57.3(135C) Application for licensure.

57.3(1) Application and licensing—new facility or change of ownership. In order to obtain an initial residential care facility license for a facility not currently licensed as a residential care facility or for a residential care facility when a change of ownership is contemplated, the applicant must:

- a. Make application at least 30 days prior to the proposed opening date of the facility. Application shall be made on forms provided by the department.
- b. Meet all of the rules, regulations, and standards contained in 481—Chapters 50, 57 and 60. Exceptions noted in 481—subrule 60.3(2) shall not apply.
- c. Submit a letter of intent and a written résumé of care. The résumé of care shall meet the requirements of subrule 57.3(2).
- d. Submit a floor plan of each floor of the residential care facility. The floor plan of each floor shall be drawn on 8½" × 11" paper, show room areas in proportion, room dimensions, window and door locations, designation of the use of each room, and the room numbers for all rooms, including bathrooms.
- e. Submit a photograph of the front and side of the residential care facility.
- f. Submit the statutory fee for a residential care facility license.
- g. Comply with all other local statutes and ordinances in existence at the time of licensure.
- h. Submit a certificate signed by the state or local fire inspection authority as to compliance with fire safety rules and regulations.

57.3(2) Résumé of care. The résumé of care shall describe the following:

- a. Purpose of the facility;
- b. Criteria for admission to the facility;
- c. Ownership of the facility;
- d. Composition and responsibilities of the governing board;
- e. Qualifications and responsibilities of the administrator;

f. Medical services provided to residents, to include the availability of emergency medical services in the area and the designation of a primary care provider to be responsible for residents in an emergency;

g. Dental services provided to residents and available in the area;

h. Nursing services provided to residents, if applicable;

i. Personal services provided to residents, including supervision of or assistance with activities of daily living;

j. Activity program;

k. Dietary services, including qualifications of the person in charge, consultation service (if applicable) and meal service;

l. Other services available as applicable, including social services, physical therapy, occupational therapy, and recreational therapy;

m. Housekeeping;

n. Laundry;

o. Physical plant; and

p. Staffing provided to meet residents' needs.

57.3(3) *Renewal application.* In order to obtain a renewal of the residential care facility license, the applicant must submit the following:

a. The completed application form 30 days prior to the annual license renewal date of the residential care facility license;

b. The statutory license fee for a residential care facility;

c. An approved current certificate signed by the state or local fire inspection authority as to compliance with fire safety rules and regulations;

d. Changes to the résumé of care, if any; and

e. Changes to the current residency agreement, if any.

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.4(135C) Issuance of license. Licenses are issued to the person, entity or governmental unit with responsibility for the operation of the facility and for compliance with all applicable statutes, rules and regulations.

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.5(135C) Licenses for distinct parts.

57.5(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, contain contiguous rooms, and provide separate categories of care and services.

57.5(2) The following requirements shall be met for 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. Personal care 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.

This rule is intended to implement Iowa Code sections 135C.6(2) and 135C.14.

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.6(135C) Special classifications.

57.6(1) *Memory care.*

a. Designation and application. A residential care facility may choose to care for residents who require memory care in a distinct part of the facility or designate the entire residential care facility as

one that provides memory care. Residents in the memory care unit or facility shall meet the level of care requirements for a residential care facility. "Memory care" in a residential care facility means the care of persons with early Alzheimer's-type dementia or other disorders causing dementia. (I, II, III)

(1) Application for approval to provide this category of care shall be submitted by the licensee on a form provided by the department. (III)

(2) Plans to modify the physical environment shall be submitted to the department for review based on the requirements of 481—Chapter 60. (III)

(3) If the unit or facility is to be a locked unit or facility, all locking devices shall meet the Life Safety Code and any requirements of the state fire marshal. If the unit or facility is to be unlocked, a system of security monitoring is required. (I, II, III)

b. Résumé of care. A résumé of care shall be submitted to the department for approval at least 30 days before a separate memory care unit or facility is opened. For facilities with a memory care unit, this résumé of care is in addition to the résumé of care required by subrule 57.3(2). A new résumé of care shall be submitted when services are substantially changed. The résumé of care shall:

- (1) Describe the population to be served;
- (2) State the philosophy and objectives;
- (3) List criteria for transfer to and from the memory care unit or facility;
- (4) Include a copy of the floor plan;
- (5) List the titles of policies and procedures developed for the unit or facility;
- (6) Propose a staffing pattern;
- (7) Set out a plan for specialized staff training;
- (8) State visitor, volunteer, and safety policies;
- (9) Describe programs for activities, social services and families; and
- (10) Describe the interdisciplinary team and the role of each team member.

c. Policies and procedures. Separate written policies and procedures shall be implemented in the memory care unit or facility and shall address the following:

(1) Criteria for admission and the preadmission evaluation process. The policy shall require a statement from the primary care provider approving the placement before a resident may be moved into a memory care unit or facility. (II, III)

(2) Safety, including a description of the actions required of staff in the event of a fire, natural disaster, emergency medical event or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility and explain the manner in which the effectiveness of the security system will be monitored. (II, III)

(3) Staffing requirements, including the minimum number, types and qualifications of staff in the unit or facility in accordance with resident needs. (II, III)

(4) Visitation policies, including suggested times for visitation and ensuring the residents' rights to free access to visitors unless visits are contraindicated by the interdisciplinary team. (II, III)

(5) The process and criteria which will be used to monitor and to respond to risks specific to the residents, including but not limited to drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

d. Assessment prior to transfer or admission. Prior to the transfer or admission of a resident applicant to the memory care unit or facility, a complete assessment of the resident applicant's physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by facility staff and shall become part of the resident's permanent record upon admission. (II, III)

e. Staff training. All staff working in a memory care unit or facility shall have training appropriate to the needs of the residents. (I, II, III)

(1) Upon assignment to the unit or facility, all staff working in the unit or facility shall be oriented to the needs of residents requiring memory care. Staff members shall have at least six hours

of special training appropriate to their job descriptions within 30 days of assignment to the unit or facility. (I, II, III)

(2) Training shall include the following topics: (II, III)

1. An explanation of Alzheimer's disease and related disorders, including symptoms, behavior and disease progression;
2. Skills for communicating with persons with dementia;
3. Skills for communicating with family and friends of persons with dementia;
4. An explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the caregiving role, and family dynamics;
5. The importance of planned and spontaneous activities;
6. Skills in providing assistance with activities of daily living;
7. Skills in working with challenging residents;
8. Techniques for cueing, simplifying, and redirecting;
9. Staff support and stress reduction;
10. Medication management and nonpharmacological interventions.

(3) Nursing staff, certified medication aides, medication managers, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of memory care residents. The six-hour initial training required in subparagraph 57.6(1) "e"(1) shall count toward the required annual in-service training. (II, III)

f. Staffing. There shall be at least one staff person on a memory care unit at all times. (I, II, III)

g. Others living in the memory care unit. A resident not requiring memory care services may live in the memory care unit if the resident's spouse requiring memory care services lives in the unit or if no other beds are available in the facility and the resident or the resident's legal representative consents in writing to the placement. (II, III)

h. Revocation, suspension or denial. The memory care unit license or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and 481—Chapter 50.

57.6(2) *Residential care facility for persons with an intellectual disability (RCF/ID).*

a. Definition. For purposes of this rule, the following term shall have the meaning indicated.

"Qualified intellectual disability professional" means a psychologist, physician, physician associate, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and has one year's experience working with persons with an intellectual disability.

b. Designation and application. A residential care facility may choose to care for persons with an intellectual disability in a distinct part of the facility or designate the entire residential care facility as a residential care facility for persons with an intellectual disability. Residents shall meet the level of care requirements for a residential care facility. (I, II, III)

(1) Application for approval to provide this category of care shall be submitted by the licensee on a form provided by the department. (III)

(2) Plans to modify the physical environment shall be submitted to the department for review based on the requirements of 481—Chapter 60. (III)

c. Résumé of care. A résumé of care shall be submitted to the department for approval at least 30 days before a residential care facility for persons with an intellectual disability is opened. A new résumé of care shall be submitted when services are substantially changed. The résumé of care shall:

- (1) Describe the population to be served;
- (2) Include a copy of the floor plan;
- (3) List the titles of policies and procedures developed for the unit or facility;
- (4) Set out a plan for specialized staff training;
- (5) State visitor, volunteer, and safety policies;
- (6) Describe programs for activities, social services and families; and
- (7) Describe the interdisciplinary team and the role of each team member.

d. Policies and procedures. Separate written policies and procedures shall be implemented in the residential care facility for persons with an intellectual disability and shall address the following:

(1) Criteria for admission and the preadmission evaluation process. The policy shall require a statement from the primary care provider approving the placement before a resident may be moved into a residential care facility for persons with an intellectual disability. The policy shall require a primary diagnosis of an intellectual disability for admission. (II, III)

(2) Safety, including a description of the actions required of staff in the event of a fire, natural disaster, emergency medical event or catastrophic event. (II, III)

(3) Staffing requirements, including the minimum number, types and qualifications of staff in the facility in accordance with resident needs. (II, III)

(4) Visitation policies, including suggested times for visitation and ensuring the residents' rights to free access to visitors unless visits are contraindicated by the interdisciplinary team. (II, III)

(5) The process and criteria which will be used to monitor and to respond to risks specific to the residents, including but not limited to drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

e. Assessment prior to transfer or admission. Prior to the transfer or admission of a resident applicant to the facility, a complete assessment of the resident applicant's physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by facility staff and shall become part of the resident's permanent record upon admission. (II, III)

f. Administrator qualifications. In addition to meeting the requirements of subrule 57.10(1), the administrator of a residential care facility for persons with an intellectual disability shall have at least one year's documented experience in direct care or supervision of persons with an intellectual disability. An individual employed as an administrator on May 16, 2018, will be deemed to meet the requirements of this subrule.

g. In-service educational programming. The in-service educational programming required by paragraph 57.10(2)"c" shall include educational programming specific to serving persons with an intellectual disability.

h. Revocation, suspension or denial. The facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and 481—Chapter 50.

This rule is intended to implement Iowa Code sections 135C.2(3)"b" and 135C.14.

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 3737C, IAB 4/11/18, effective 5/16/18; ARC 6974C, IAB 4/5/23, effective 5/10/23; Editorial change: IAC Supplement 6/10/26]

481—57.7(135C) General requirements.

57.7(1) The license shall be displayed in the facility in a conspicuous place which is accessible to the public. (III)

57.7(2) The license shall be valid only in the possession of the licensee to whom it is issued.

57.7(3) The posted license shall accurately reflect the current status of the residential care facility. (III)

57.7(4) The license shall expire one year after the date of issuance or as indicated on the license.

57.7(5) The licensee shall:

a. Assume the responsibility for the overall operation of the residential care facility. (I, II, III)

b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III)

c. Provide an organized continuous 24-hour program of care commensurate with the needs of the residents. (I, II, III)

57.7(6) 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. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.8(135C) Certified volunteer long-term care ombudsman program. A certified volunteer long-term care ombudsman appointed in accordance with Iowa Code section 231.45 shall operate within the scope of the rules for volunteer ombudsmen promulgated by the office of the long-term care ombudsman and the Iowa department on aging.

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.9(135C) Required notifications to the department. The department shall be notified:

57.9(1) Thirty days before any proposed change in the residential care facility's functional operation or addition or deletion of required services; (III)

57.9(2) Thirty days before the beginning of the renovation, addition, functional alteration, change of space utilization, or conversion in the residential care facility or on the premises; (III)

57.9(3) Thirty days before closure of the residential care facility; (III)

57.9(4) Within two weeks of any change in administrator; (III)

57.9(5) Ninety days before a change in the category of license; (III)

57.9(6) Thirty days before a change of ownership, the licensee shall:

a. Inform the department of the pending change of ownership; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee; (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 residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.10(135C) Administrator. Each residential care facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these rules. (III)

57.10(1) *Qualifications of an administrator.*

a. The administrator shall be at least 21 years of age and shall have a high school diploma or equivalent. (III) In addition, this person shall meet at least one of the following conditions:

(1) Have a two-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of two years' experience in the field; or (III)

(2) Have a four-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year experience in the field; or (III)

(3) Have a master's degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year experience in the field; or (III)

(4) Be a licensed nursing home administrator; or (III)

(5) Have completed a one-year educational training program approved by the department for residential care facility administrators; or (III)

(6) Have passed the National Association of Long Term Care Administrator Boards (NAB) RC/AL administrator licensure examination; or

(7) Have two years of direct care experience and at least six months of administrative experience in a residential care facility. (III)

b. An individual employed as an administrator on January 14, 2015, will be deemed to meet the requirements of this subrule.

57.10(2) *Duties of an administrator.* The administrator shall:

a. Select and direct competent personnel who provide services for the residential care program. (III)

b. Arrange for the heads of nursing, social services, dietary and activities to attend a minimum of ten contact hours of educational programs per year to increase skills and knowledge needed for

their positions. The ten hours is in addition to the in-service requirements in paragraph 57.10(2)“c.” (III)

c. Provide in-service educational programming for all employees with direct resident contact and maintain records of programs and participants. (III) In-service educational programming offered during each calendar year shall include, at minimum, the following topics: (I, II, III)

- (1) Infection control.
- (2) Emergency preparedness (fire, tornado, flood, 911, etc.).
- (3) Meal time procedures/dietary.
- (4) Resident activities.
- (5) Mental illness/behavior modification/crisis intervention.
- (6) Resident safety/supervision.
- (7) Resident rights.
- (8) Medication education, to include administration, storage and drug interactions.
- (9) Resident service plans/programming/goals.

57.10(3) *Administrator serving at more than one residential care facility.* The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

a. An administrator of more than one facility shall designate in writing an administrative staff person in each facility who shall be responsible for directing programs in the facility.

b. The administrative staff person designated by the administrator shall:

(1) Have at least one year of experience in a supervisory or direct care position in a residential care facility or in a facility for the intellectually disabled, mentally ill or developmentally disabled; (II, III)

(2) Be knowledgeable of the operation of the facility; (II, III)

(3) Have access to records concerned with the operation of the facility; (II, III)

(4) Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)

(5) Be at least 21 years of age; (III)

(6) Be empowered to act on behalf of the licensee concerning the health, safety and welfare of the residents; and (II, III)

(7) Have training in emergency response, including how to respond to residents' sudden illnesses. (II, III)

c. If an administrator serves more than one facility, the administrator must designate in writing regular and specific times during which the administrator will be available to consult with staff and residents to provide direction and supervision of resident care and services. (II, III)

57.10(4) *Provisional administrator.* A provisional administrator may be appointed on a temporary basis by the residential care facility licensee to assume the administrative responsibilities for a residential care facility for a period not to exceed one year when the facility has lost its administrator and has not been able to replace the administrator, provided that the department has been notified and approved the provisional administrator prior to the date of the provisional administrator's appointment. (III) The provisional administrator must meet the requirements of paragraph 57.10(3)“b.”

57.10(5) *Temporary absence of administrator.*

a. In the temporary absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

(1) Be knowledgeable of the operation of the facility; (III)

(2) Have access to records concerned with the operation of the facility; (III)

(3) Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

(4) Be at least 21 years of age; (III)

(5) Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

(6) Have training in emergency response, including how to respond to residents' sudden illnesses. (II, III)

b. If the administrator is absent for more than six weeks, a provisional administrator must be appointed pursuant to subrule 57.10(4).

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.11(135C) Personnel.

57.11(1) *Alcohol and drug use prohibited.* No person under the influence of intoxicating drugs or alcoholic beverages shall be permitted to provide services in a residential care facility. (I, II)

57.11(2) *Job description.* There shall be a written job description developed for each category of worker. The job description shall include the job title, responsibilities and qualifications. (III)

57.11(3) *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 2014 Iowa Acts, chapter 1040, 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)

57.11(4) *Personnel record.* A personnel record shall be kept for each employee and shall include but not be limited to the following information about the employee: name and address, social security number, date of birth, date of employment, position, experience and education, references, results of criminal record checks, child abuse checks and dependent adult abuse checks, and date of discharge or resignation. (III)

57.11(5) *Supervision and staffing.*

a. The facility shall provide sufficient staff to meet the needs of the residents served. (I, II, III)

b. Personnel in a residential care facility shall provide 24-hour coverage for residential care services. Personnel shall be awake at all times while on duty. (I, II, III)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (I, II, III)

d. Staff shall be aware of and provide supervision levels based on the present needs of the residents in the staff's care. The facility shall document the supervision of residents who require more than general supervision, as defined by facility policy. (I, II, III)

e. The facility shall maintain an accurate record of actual hours worked by employees. (III)

57.11(6) *Physical examination and screening.* Employees shall have a physical examination no longer than 12 months prior to beginning employment and every four years thereafter. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

57.11(7) *Orders for medications and treatments.* Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 2273C, IAB 12/9/15, effective 1/13/16]

481—57.12(135C) General policies. The licensee shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures shall be available for review by the department, other agencies designated by Iowa Code section 135C.16(3), staff, residents, residents' families or legal representatives, and the public and shall be reviewed by the licensee annually. (II)

57.12(1) *Facility operation.* The licensee shall establish written policies for the operation of the facility, including, but not limited to the following: (III)

a. Personnel; (III)

b. Admission; (III)

c. Evaluation services; (II, III)

d. Programming and individual program plans; (II, III)

e. Registered sex offender management; (II, III)

- f.* Crisis intervention; (II, III)
- g.* Discharge or transfer; (III)
- h.* Medication management, including self-administration of medications and chemical restraints; (III)
- i.* Resident property; (II, III)
- j.* Resident finances; (II, III)
- k.* Records; (III)
- l.* Health and safety; (II, III)
- m.* Nutrition; (III)
- n.* Physical facilities and maintenance; (III)
- o.* Resident rights; (II, III)
- p.* Investigation and reporting of alleged dependent adult abuse; (II, III)
- q.* Investigation and reporting of accidents or incidents; (II, III)
- r.* Transportation of residents; (II, III)
- s.* Resident supervision; (II, III)
- t.* Smoking; (III)
- u.* Visitors; (III)
- v.* Disaster/emergency planning; (III) and
- w.* Infection control. (III)

57.12(2) *Personnel policies.* Written personnel policies shall include the hours of work and attendance at educational programs. (III)

57.12(3) *Infection control.* The facility shall have a written and implemented infection control program, which shall include policies and procedures based on guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. The infection control program shall address the following:

- a.* Techniques for hand washing; (I, II, III)
- b.* Techniques for handling of blood, body fluids, and body wastes; (I, II, III)
- c.* Dressings, soaks or packs; (I, II, III)
- d.* Infection identification; (I, II, III)
- e.* Resident care procedures to be used when there is an infection present; (I, II, III)
- f.* Sanitation techniques for resident care equipment; (I, II, III)
- g.* Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III) and
- h.* Techniques for use and disposal of needles, syringes, and other sharp instruments. (I, II, III)

57.12(4) *Resident care techniques.* The facility shall have written and implemented procedures to be followed if a resident needs any of the following treatment or devices:

- a.* Intravenous or central line catheter; (I, II, III)
- b.* Urinary catheter; (I, II, III)
- c.* Respiratory suction, oxygen or humidification; (I, II, III)
- d.* Decubitus care; (I, II, III)
- e.* Tracheostomy; (I, II, III)
- f.* Nasogastric or gastrostomy tubes; (I, II, III)
- g.* Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

57.12(5) *Emergency care.* The facility shall establish written policies for the provision of emergency medical care to residents and employees in case of sudden illness or accident. The policies shall include a list of those individuals to be contacted in case of an emergency. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.13(135C) Admission, transfer and discharge.

57.13(1) *General admission policies.*

- a.* Residents shall be admitted to a residential care facility only on a written order signed by a primary care provider, specifying the level of care, and certifying that the individual being admitted requires no more than personal care and supervision and does not require routine nursing care. (II, III)
- b.* No residential care facility shall admit or retain a resident who is in need of greater services than the facility can provide. (I, II, III)
- c.* No residential care facility shall admit more residents than the number of beds for which the facility is licensed. (II, III)
- d.* A residential care facility is not required to admit an individual through court order, referral or other means without the express prior approval of the administrator. (III)
- e.* The admission of a resident shall not grant the residential care facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and the safe and orderly management of the residential care facility as required by these rules. (III)
- f.* Individuals under the age of 18 shall not be admitted to a residential care facility without prior written approval by the department. A distinct part of a residential care facility, segregated from the adult section, may be established based on a résumé of care that is submitted by the licensee or applicant and is commensurate with the needs of the residents of the residential care facility and that has received the department's review and approval. (III)
- g.* No health care facility and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property unless such resident is related within the third degree of consanguinity to the person acting as guardian. (III)

57.13(2) Discharge or transfer.

- a.* Notification shall be made to the legal representative, primary care provider, and sponsoring agency, if any, prior to the transfer or discharge of any resident. (III)
- b.* The licensee shall not refuse to discharge or transfer a resident when the primary care provider, family, resident, or legal representative requests such transfer or discharge. (II, III)
- c.* Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)
- d.* When a resident is transferred or discharged, the appropriate record will accompany the resident to ensure continuity of care. "Appropriate record" includes the resident's face sheet, service plan, most recent orders of the primary care provider and any notifications of upcoming scheduled appointments. (II, III)
- e.* When a resident is transferred or discharged, the resident's unused prescriptions shall be sent with the resident or with a legal representative only upon the written order of a primary care provider. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.14(135C) Involuntary discharge or transfer.

57.14(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.* Repeated refusal by the resident to participate in the resident's service plan;
- d.* Due to action pursuant to Iowa Code chapter 229; or
- e.* Nonpayment for the resident's stay, as described in the residency agreement for the resident's stay.

57.14(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)

57.14(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)

57.14(4) *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 seven 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 receipt of your request by the department and you will not be transferred prior to a final decision. In emergency circumstances, extension of the 14-day requirement may be permitted upon request to the department's designee. If you lose the hearing, you will not be transferred before the expiration of (1) 30 days following receipt of the original notice of the discharge or transfer, or (2) 5 days following final decision of such hearing, including 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 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; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's long-term care ombudsman. The notice shall indicate that a copy has been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent. (II)

c. The notice required by paragraph 57.14(4) "*a*" shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs: (II)

(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.

d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 57.14(6).

57.14(5) *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 transfer or discharge. (II, III)

a. A copy of this notice must be placed in the resident's file. The notice must 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:

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 within 7 days after receiving this notice. You have the 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 receipt of your request by the department. 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 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; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's long-term care ombudsman. The notice shall indicate that a copy has been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent. (II)

c. A hearing requested pursuant to this subrule shall be held in accordance with subrule 57.14(6).

57.14(6) Hearing.

a. Request for hearing.

- (1) The resident must request a hearing within 7 days of receiving the 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 receipt of the request by the department unless the resident 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 9. The hearing shall be public unless the resident or the resident's legal 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 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, the responsible party, and the office of the long-term care ombudsman not later than 5 full business days after 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. A representative of the office of the long-term care ombudsman shall have the right to appear at the hearing.

f. The administrative law judge's written decision shall be mailed by certified mail to the licensee, resident, responsible party, and the office of the long-term care ombudsman within 10 working days after the hearing has been concluded.

57.14(7) *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)

57.14(8) *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 57.14(5) and emergency notice is provided within 48 hours.

57.14(9) *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 57.14(9) "b" does not apply if the discharge has already occurred pursuant to subrule 57.14(5) 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).

e. The receiving health care facility of a resident involuntarily transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

57.14(10) *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.

57.14(11) *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) Incompatibility with or disturbing to other roommates.

(2) For the welfare of the resident or other residents of the facility.

(3) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.

(4) 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.

(5) 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 57.14(11) "a"(4). (II)

(2) As punishment or behavior modification, except as specified in subparagraph 57.14(11) "a"(1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph 57.14(11)“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, III)

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, III)

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 1753C, IAB 12/10/14, effective 1/14/15; ARC 3523C, IAB 12/20/17, effective 1/24/18]

481—57.15(135C) Residency agreement.

57.15(1) Each residency agreement shall:

a. State the base rate or scale per day or per month, the services included, and the method of payment. (III)

b. Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the agreement shall:

(1) Stipulate that no further additional fees shall be charged for items not contained in the complete schedule of services; (III)

(2) State the method of payment for additional charges; (III)

(3) 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)

(4) State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services provided by a barber, beautician, and such. (III)

c. Contain an itemized list of services to be provided to the resident based on an assessment at the time of the resident’s admission and in consultation with the administrator and including the specific fee the resident will be charged for each service and the method of payment. (III)

d. Include the total fee to be charged initially to the resident. (III)

e. State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (II, III) Furthermore, the agreement shall provide that the facility shall give:

(1) Written notification to the resident, or the responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of such changes; (II, III)

(2) Notification to the resident, or the responsible party when appropriate, of changes in additional charges, based on a change in the resident’s condition. Notification must occur prior to the date such revised additional 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. (II, III)

f. State the terms of agreement in regard to a refund of all advance payments in the event of the transfer, death, or voluntary or involuntary discharge of the resident. (II, III)

g. State the terms of agreement concerning the holding of and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident’s responsible party. (II, III)

(1) The facility shall ask the resident or responsible party whether the resident's bed should be held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II, III)

(2) The facility shall inform the resident or responsible party that, when requested, the bed may be held beyond the number of days designated by the funding source, as long as payments are made in accordance with the agreement. (II, III)

h. State the conditions under which the involuntary discharge or transfer of a resident would be effected. (II, III)

i. Set forth any other matters deemed appropriate by the parties to the agreement. No agreement or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (II, III)

57.15(2) Each party to the residency agreement shall receive a copy of the signed agreement. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.16(135C) Medical examinations.

57.16(1) Each resident in a residential care facility shall have a designated primary care provider who may be contacted when needed. (II, III)

57.16(2) Each resident admitted to a residential care facility shall have a physical examination prior to admission. (II, III)

a. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the primary care provider, shall be a part of the resident's record. (II, III)

b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of medical concerns, diet, and results of any diagnostic procedures. (II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

57.16(3) The person in charge shall immediately notify the primary care provider of any accident, injury or adverse change in the resident's condition that has the potential for requiring physician intervention. (I, II, III)

57.16(4) Each resident shall be visited by or shall visit the resident's primary care provider at least once each year. The one-year period shall be measured from the date of admission and does not include the resident's preadmission physical. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.17(135C) Records.

57.17(1) *Resident record.* The licensee shall keep a permanent record on every resident admitted to the residential care facility, and all entries in the permanent record shall be current, dated, and signed. (III) 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, if designated; (III)
- d.* Primary care provider's name, telephone number, and address; (III)
- e.* Dentist's name, telephone number, and address; (III)
- f.* Name, address, and telephone number of next of kin or legal representative; (III)
- g.* Name, address, and telephone number of person to be notified in case of emergency; (III)
- h.* Pharmacy name, telephone number, and address; (III)
- i.* Mortuary name, telephone number, and address, if designated; (III)

- j.* Physical examination and medical history; (III)
- k.* Primary care provider's orders for the resident's level of care, medication, treatments, and diet. The orders shall be in writing and signed by the primary care provider quarterly; (III)
- l.* A notation of visits to primary care provider and other professional services; (III)
- m.* Documentation regarding services provided by other providers, including but not limited to home health agencies, hospice, day treatment and those providing medical, mental health and Medicaid waiver services; (III)
- n.* Documentation of any adverse change in the resident's condition; (II, III)
- o.* A notation describing the resident's condition on admission, transfer and discharge; (III)
- p.* A copy of instructions given to the resident, legal representative or facility in the event of discharge or transfer; (III)
- q.* In the event of a resident's death, notations of 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 the resident's family and primary care provider were notified of the resident's death; and (III)
- r.* A notation of disposition of personal property and medications upon the resident's transfer, discharge or death. (III)

57.17(2) Confidentiality of resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive the information. (II)

- a.* The facility shall limit access to any medical records to staff and professionals providing services to the resident. (II)
- b.* The facility shall limit access to the resident's personal records, e.g., financial records and social services records, to staff and professionals providing the service to the resident. Only those personnel concerned with the financial affairs of the resident may have access to the financial records. (II)
- c.* The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the primary care provider determines that the disclosure of the record or section thereof is contraindicated, in which case this information will be deleted prior to making the record available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)
- d.* This subrule is not meant to preclude access to resident records by representatives of state and federal regulatory agencies.

57.17(3) Incident record.

- a.* Each residential care facility shall maintain an incident record report and shall have available incident report forms. (II, III)
- b.* Report of incidents shall be in detail on an incident report form. (III)
- c.* The person in charge at the time of the incident shall oversee the preparation of and sign the incident report. The administrator or designee shall review, sign and date the incident report within 72 hours of the accident, incident or unusual occurrence. (II, III)
- d.* An incident report shall be completed for every accident or incident where there is apparent injury or where an injury of unknown origin may have occurred. (II)
- e.* An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III)
- f.* A copy of the incident report shall be kept on file in the facility. (II, III)

57.17(4) Retention of records.

- a.* Records shall be retained in the facility for five years following the termination of services to a resident. (III)
- b.* Records shall be retained within the facility upon change of ownership. (III)

c. When the facility ceases to operate, a copy of the resident's record shall be released to the facility to which the resident is transferred. (III)

d. When the facility ceases to operate, records shall be maintained for five years in a clean, dry secured storage area. (III)

57.17(5) *Electronic records.* In addition to the access provided in 481—subrule 50.10(2), an authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the residents of the facility. (II, III)

a. If access to an electronic record is requested by the authorized representative of the department, the facility may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion. (II, III)

b. The facility shall provide a terminal where the authorized representative may access records. (II, III)

c. If the facility is unable to provide direct print capability to the authorized representative, the facility shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.18(135C) Resident care and personal services.

57.18(1) A complete change of bed linen shall be provided at least once a week and more often if necessary. (III)

57.18(2) Residents shall receive sufficient supervision to promote personal cleanliness. (II, III)

57.18(3) Residents shall have clean clothing as needed. Clothing shall be appropriate to residents' activities and to the weather. (III)

57.18(4) Residents shall be encouraged to bathe at least twice a week. (II, III)

57.18(5) All nonambulatory residents shall be housed on the grade level floor unless the facility has a suitably sized elevator. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.19(135C) Drugs.

57.19(1) *Drug storage.*

a. Residents who have been certified in writing by their primary care provider as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided, with staff and the resident having access. Monitoring of the storage, administration and documentation by the resident shall be carried out by a person who meets the requirements of subrule 57.19(3) and is responsible for administering medications. (II, III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) Locked storage for drugs, solutions, and prescriptions shall be provided. (III)

(2) A bathroom shall not be used for drug storage. (III)

(3) The drug storage shall be kept locked when not in use. (III)

(4) The drug storage key shall be secured and available only to those employees charged with the responsibility of administering medications. (II, III)

(5) Schedule II drugs, as defined by Iowa Code chapter 124, shall be kept in a locked box within the locked drug storage. (II, III)

(6) Medications requiring refrigeration shall be kept locked in a refrigerator and separated from food and other items. (II, III)

(7) Drugs for external use shall be stored separately from drugs for internal use. (II, III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs, shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom, and shall be made accessible only to authorized persons. (I, II)

(9) Inspection of drug storage shall be made by the administrator or designee and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certification of the absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current primary care provider's order, and drugs improperly stored. (III)

(10) Bulk supplies of prescription drugs for multiresident use shall not be kept in a residential care facility. (III)

57.19(2) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, primary care provider's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or primary care provider issuing the drug. Where unit dose is used, prescribed medications shall, at a minimum, indicate the resident's full name, primary care provider's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. (III)

b. Sample medications provided by the resident's primary care provider shall clearly identify to whom the medications belong. (III)

c. Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or primary care provider for relabeling or disposal. (III)

d. The medication for each resident shall be kept or stored in the original containers unless the resident is participating in an individualized medication program. (II, III)

e. Unused prescription drugs shall be destroyed by the person in charge, in the presence of a witness, and with a notation made on the resident's record or shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the resident's primary care provider. (II, III)

g. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (I, II)

h. Instructions shall be requested from the Iowa board of pharmacy concerning disposal of unused Schedule II drugs prescribed for a resident who has died or for whom the Schedule II drug was discontinued. (III)

i. Discontinued medications shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the Iowa board of pharmacy. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic-stop order may vary for different types of drugs. The resident's primary care provider, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to possess any medications unless the primary care provider has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the primary care provider. (II)

m. The facility shall establish a policy to govern the distribution of prescribed medications to residents who are on leave from the facility. (II, III)

(1) Medications may be issued to residents who will be on leave from a facility for less than 24 hours. Only those medications needed for the time period the resident will be on leave from the facility may be issued. Non-child-resistant containers may be used. Instructions shall be provided and

include the date, the resident's name, the name of the facility, and the name of the medication, its strength, dose and time of administration. (II, III)

(2) Medication for residents on leave from a facility for longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy. (II, III)

(3) Medication for residents on leave from a facility may be issued only by facility personnel responsible for administering medication. (II, III)

57.19(3) *Drug administration—authorized personnel.*

a. A properly trained person shall be charged with the responsibility of administering medications as ordered by a primary care provider. (II, III)

b. The person shall have knowledge of the purpose of the drugs and their dangers and contraindications. (II, III)

c. The person shall be a licensed nurse or primary care provider or shall have successfully completed a department-approved medication aide course and passed a department-approved medication aide challenge examination administered by an area community college. (II, III)

d. Prior to taking a department-approved medication aide course, the person shall have a letter of recommendation for admission to the medication aide course from the employing facility. (III)

e. A person who is a nursing student or a graduate nurse may take the challenge examination in place of taking a medication aide course. The person 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; (III)

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination; (III)

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating that the person is competent in medication administration. (III)

f. 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. The requirements of paragraph 57.19(3) "d" do not apply to this person. (III)

g. In a freestanding residential care facility licensed for 15 or fewer beds, a person who has successfully completed a state-approved medication manager course may administer medications.

57.19(4) *Drug administration.*

a. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. In facilities where the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by observing the actual act of swallowing the oral medication and by charting the medication. Medications shall be prepared on the same shift of the same day that they are administered unless the unit dose system is used. (II)

b. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, primary care provider or pharmacist. For purposes of this subrule, "injectable medications" does not include an epinephrine autoinjector, e.g., an EpiPen. (II, III)

c. A resident certified by the resident's primary care provider as capable of injecting the resident's own insulin may do so. Insulin may be administered pursuant to paragraph 57.19(4) "b" or as otherwise authorized by the resident's primary care provider. (II, III) Authorization shall:

(1) Be in writing,

(2) Be maintained in the resident's record,

(3) Be renewed quarterly,

(4) Include the name of the person authorized to administer the insulin,

(5) Include documentation by the primary care provider that the authorized person is qualified to administer insulin to that resident. (II, III)

d. A resident may participate in the administration of the resident's own medication if the primary care provider has certified in writing in the resident's medical record that the resident is mentally and physically capable of participating and has explained in writing in the resident's medical record what the resident's participation may include.

e. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident, with an accurate count and authorized signatures at every shift. (II)

f. The facility may use a unit dose system.

g. Medication aides and medication managers may administer PRN medications without contacting a licensed nurse or primary care provider if all of the following apply: (I, II, III)

(1) A written order from the resident's primary care provider specifies the purpose of the PRN medication and the frequency, dosage and strength of the PRN medication.

(2) The resident's primary care provider provides in writing specific criteria for administering PRN medications.

(3) The pharmacist assesses the resident's use of PRN medications when conducting the inspection of drug storage as required by subparagraph 57.19(1)"b"(9).

h. The pharmacist shall assess the use of PRN medications when conducting the inspection of drug storage as required by subparagraph 57.19(1)"b"(9). (II, III)

i. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 2643C, IAB 8/3/16, effective 9/7/16; see Delay note at end of chapter]

481—57.20(135C) Dental services.

57.20(1) The residential care facility personnel shall assist residents in obtaining annual and emergency dental services and shall arrange transportation for such services. (III)

57.20(2) Dental services shall be performed only on the request of the resident, responsible party, legal representative, or primary care provider. The resident's primary care provider shall be advised of the resident's dental problems. (III)

57.20(3) All dental reports or progress notes shall be included in the resident record as available. The facility shall make reasonable efforts to obtain the records following the provision of services. (III)

57.20(4) Personal care staff shall assist the resident in carrying out the dentist's recommendations. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.21(135C) Dietary.

57.21(1) *Dietary staffing.*

a. A minimum of one person directly responsible for food preparation shall successfully complete a course meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another course may be substituted if the course's curriculum includes substantially similar competencies to a course that meets the requirements of the Food Code and the provider of the course files with the department a statement indicating that the course provides substantially similar instruction as it relates to sanitation and safe food handling. (III)

b. If the person is in the process of completing the food protection program in paragraph 57.21(1)"a," the requirement relating to the completion of a state-approved food protection program shall be considered to have been met.

c. In addition to the requirement of paragraph 57.21(1)"a," personnel who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (III)

57.21(2) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider's orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II, III)

b. Menus shall be planned and served to include foods and amounts necessary to meet federal dietary guidelines. (II, III)

c. At least three meals or their equivalent shall be served daily, at regular hours. (II, III)

(1) There shall be no more than a 14-hour span between offering a substantial evening meal and breakfast. (II, III)

(2) Unless contraindicated, evening snacks shall be offered routinely to all residents. Special nourishments shall be available when ordered by the primary care provider. (II, III)

d. Menus shall include a variety of foods prepared in various ways. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place for easy use by persons purchasing, preparing, and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary or requested, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

g. The facility shall provide an alternative choice at scheduled meal times. (III)

57.21(3) Dietary storage, food preparation, and service.

a. All food shall be handled, prepared, served and stored in compliance with the Food Code adopted pursuant to Iowa Code section 137F.2. (I, II, III)

b. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the bureau of nutrition and health promotion of the department of public health. (II, III)

c. Dishes shall be free of cracks, chips, and stains. (III)

d. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

57.21(4) Sanitation in food preparation area.

a. In facilities licensed for more than 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)

b. There shall be written procedures established for cleaning all work and serving areas in facilities with more than 15 beds. (III)

c. A schedule for duties to be performed daily shall be posted in each food area. (III)

d. All cooking equipment in facilities of 15 or more beds shall be provided with a properly sized exhaust system and hood to eliminate excess heat, moisture, and odors from the kitchen. (II, III)

e. The food service area shall be located so it will not be used as a passageway by residents, guests, or non-food service staff. (III)

f. There shall be no washing, ironing, sorting or folding of laundry in the food service area. Dirty linen shall not be carried through the food service area unless the linen is in sealed, leakproof containers. (III)

g. In facilities with more than 15 beds, a mechanical dishwasher is required. (III)

h. A three-compartment pot and pan sink with 110°F (43°C) to 115°F (46°C) water for washing, a compartment for rinsing with water at 170°F (76°C) to 180°F (82°C) for sanitizing with space for air drying, or a two-compartment sink with access to a mechanical dishwasher for sanitizing all utensils shall be provided. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.22(135C) Orientation and service plan.

57.22(1) Orientation. Within 24 hours of admission, each resident shall receive orientation to the facility. The orientation program shall be documented in the resident's file and shall include, but shall

not be limited to, a review of the resident's rights, the daily schedule, house rules and the facility's evacuation plan. (II, III)

57.22(2) *Initial service plan.* Within 48 hours of admission, the administrator or the administrator's designee shall develop an initial service plan to address any immediate health and safety needs. The plan shall be based on information gathered from the resident, family, referring party, primary care provider, and other significant persons. The plan shall be followed until the service plan required in subrule 57.22(3) is complete. (I, II, III)

57.22(3) *Service plan.* Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)

a. The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III)

b. The service plan shall include the documentation procedure for each goal and objective. (II, III)

c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III)

d. The service plan shall be reviewed at least quarterly by relevant staff, the resident and appropriate others, such as the resident's family, case manager and responsible party. The review shall include a written report which addresses a summary of the resident's progress toward goals and objectives and the need for continued services. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.23(135C) Resident activities program.

57.23(1) *Activities program.* Each residential care facility shall provide an organized resident activities program for the group and for the individual resident which shall include suitable activities. The facility shall offer at least two organized evening group activities per week and two organized weekend group activities per month. (III)

a. The activities program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's primary care provider. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The activities program shall include measureable goals for each resident. (III)

c. The activities program shall include both group and individual activities. (III)

d. Residents shall be encouraged, but not required, to participate in activities. (III)

57.23(2) *Coordination of activities program.*

a. Each residential care facility with 15 or fewer beds shall designate a person to oversee the activities program, develop goals and monitor progress. (III)

b. Each residential care facility with more than 15 beds shall employ a person to direct the activities program. (III)

c. Staffing for the activities program shall be provided on the minimum basis of 45 minutes per resident per week. (II, III)

d. The activities coordinator shall have completed the activities coordinator orientation course approved by the department within six months of employment or have comparable training and experience as approved by the department. (III)

e. There shall be a written plan for personnel coverage when the activities coordinator is absent during scheduled working hours. (III)

57.23(3) Duties of activities coordinator. The activities coordinator shall:

a. Have access to all residents' records. (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services. (III)

c. Keep all necessary records including:

(1) Attendance records; (III)

(2) Individual resident progress notes, recorded at least every three months; (III)

(3) Monthly calendars, prepared in advance, updated as necessary and maintained for one year. (III)

d. Coordinate the activities program with all other services in the facility. (III)

57.23(4) Supplies, equipment, and storage.

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III)

b. Storage shall be provided for recreational equipment and supplies. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.24(135C) Residents' rights.

57.24(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, the provisions of this rule and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, residents' families or legal representatives and the public and shall be reviewed annually. (II, III)

57.24(2) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible parties and for ensuring a response and disposition by the facility. (II, III) The written procedures shall:

a. Ensure the provision of assistance to residents as necessary to complete and submit complaints and recommendations; (II, III)

b. Ensure protection of the resident from any form of reprisal or intimidation; (II, III)

c. Include designation of an employee responsible for handling grievances and recommendations; (II, III)

d. Include a method of investigating and assessing the validity of a grievance or recommendation; (II, III) and

e. Include methods of recording grievances and actions taken. (II, III)

57.24(3) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II, III)

57.24(4) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon the resident's admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II, III)

a. The facility shall communicate to residents prior to or within five days after admission what residents may expect from the facility and its staff, and what is expected from residents. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following the resident's admission. (II, III)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf or hard of hearing, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II, III)

c. A statement shall be signed by the resident, or the resident's responsible party, if applicable, indicating an understanding of these rights and responsibilities and shall be maintained in the resident's record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. (II, III)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II, III)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English-speaking, deaf or hard-of-hearing, or blind residents of changes. (II, III)

57.24(5) Choice of primary care provider. Each resident shall be permitted free choice of a primary care provider, and pharmacy, if accessible. The facility may require the selected pharmacy to utilize a drug distribution system compatible with the system currently used by the facility. (II)

57.24(6) Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and treatment, which may include, but shall not be limited to, medical care, nutritional needs, activities, and social work services. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a resident with impaired decision-making skills, the responsible party shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment and to be informed of the resident's medical condition. (II, III)

57.24(7) Each resident shall be encouraged and assisted throughout the resident's period of stay to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

57.24(8) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of changes in policies and services that are more restrictive, and their views shall be solicited prior to action. (II)

57.24(9) The facility shall post in a prominent area the text of Iowa Code section 135C.46 (Retaliation Prohibited) and the name, telephone number, and address of the long-term care ombudsman, the department, and the local law enforcement agency to provide residents a further course of redress. (II)

57.24(10) All rights and responsibilities of the resident devolve to the resident's responsible party or any legal surrogate designated in accordance with state law, to the extent permitted by state law. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 5711C, IAB 6/16/21, effective 7/21/21]

481—57.25(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (I, II)

57.25(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (I, II)

57.25(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

57.25(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

57.25(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

57.25(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.26(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

57.26(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

57.26(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a. The resident refuses to see the visitor(s). (II)
- b. The resident's primary care provider documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c. The visitor's behavior is unreasonably disruptive to the functioning of the facility. This judgment must be made by the administrator, and the reasons shall be documented and kept on file. (II)

57.26(3) Decisions to restrict a visitor are reviewed and reevaluated:

- a. Each time the medical orders are reviewed by the primary care provider;
- b. At least quarterly by the facility's staff; or
- c. At the resident's request. (II)

57.26(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

57.26(5) Telephones shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

57.26(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

57.26(7) Residents, including residents court-ordered to the facility, shall be permitted to leave the facility at reasonable times unless there are justifiable reasons established in writing by court order, the primary care provider, the interdisciplinary team, or facility administrator for refusing permission. (II)

57.26(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.27(135C) Resident activities.

57.27(1) Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the primary care provider or interdisciplinary team as appropriate in the resident's record. (II)

57.27(2) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.28(135C) Resident property.

57.28(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The facility shall offer the resident the opportunity to

have personal property itemized and documented on an inventory sheet upon the resident's admission. The inventory sheet shall be kept in a safe location which is convenient to the resident and shall be updated at least annually. At discharge, residents may sign off on a list of the personal property they are taking with them. (II, III)

57.28(2) The facility shall provide for the safekeeping of personal effects, funds and other property of its residents. The facility may require that items of exceptional value or that would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

57.28(3) Funds or properties received by the facility, belonging or due a resident, expendable for the resident's account, shall be trust funds. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.29(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs. To the extent the facility assists in management, under written authorization by the resident, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

57.29(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

57.29(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

57.29(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24. Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a resident with impaired decision-making skills, the resident's legal representative shall designate a method of disbursing the resident's funds. (II)

57.29(4) If the facility makes financial transactions on a resident's behalf, the facility must document that it has prepared and sent an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

57.29(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's legal representative. (I, II)

57.29(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's legal representative. The department may report findings that resident funds have been used without written consent to the department's investigations division or the local law enforcement agency, as appropriate. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.30(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code section 347B.5. (II)

57.30(1) Residents may not be used to provide a source of labor for the facility against their will. Approval by the primary care provider is required for all work programs. (I, II)

57.30(2) Residents who perform work for the facility must receive compensation unless the work is part of their approved training program. Persons on the resident census who perform work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.31(135C) Family—shared rooms. Family members or spouses shall be permitted to share a room, if available, if requested by both parties, unless the primary care provider of one of the parties documents in the medical record specific reasons why such an agreement would have an adverse effect on the health of the resident. (II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.32(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. (I, II)

57.32(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (I, II)

57.32(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (I, II)

57.32(3) Drugs such as tranquilizers shall only be used in accordance with orders of the primary care provider. (I, II)

57.32(4) 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)

57.32(5) Staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 3737C, IAB 4/11/18, effective 5/16/18]

481—57.33(135C) Crisis intervention. If a facility utilizes physical restraints, the facility shall have written policies that define the uses of physical restraints, designate the administrator or designee as the person who may authorize their use, establish a mechanism for monitoring and controlling their use, and provide staff with proper training. (I, II, III)

57.33(1) Temporary physical restraint of residents shall be used only under the following conditions: (I, II)

a. An emergency to prevent injury to the resident or to others; or (I, II)

b. For crisis intervention, but shall not be used for punishment, for the convenience of staff or as a substitution for supervision or programming; (I, II) and

c. No staff person shall use any restraint that obstructs the airway of the resident. (I, II)

57.33(2) Authorization for the use of physical restraints must be prior to or immediately after application of the restraint. (I, II)

57.33(3) Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint. (I, II)

57.33(4) The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the resident's rights and to ensure safety shall be clearly set forth in the resident's record by the responsible staff persons. (I, II)

57.33(5) The primary care provider, the interdisciplinary team and the resident's responsible party shall be notified of any restraints administered. (I, II, III)

57.33(6) The facility shall provide to the staff a department-approved training program by qualified professionals on physical restraint techniques. (I, II)

a. The facility shall keep a record of training for review by the department and shall include attendance. (II, III)

b. Only staff with documented training in physical restraint and techniques shall be authorized to assist with physical restraint of a resident. (I, II)

c. Under no circumstances shall a resident be allowed to actively or passively assist in the restraint of another resident. (I, II)

57.33(7) Residents shall not be kept behind locked doors. (I, II)

57.33(8) Mechanical restraint is prohibited. Staff persons who find themselves involved in the use of a mechanical restraint when responding to an emergency must take immediate steps to end the mechanical restraint. (I, II)

[ARC 1753C, IAB 12/10/14, effective 1/14/15; ARC 3738C, IAB 4/11/18, effective 5/16/18]

481—57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III)

57.34(1) *Fire safety.*

a. All residential care facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

57.34(2) *Safety duties of administrator.* The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be prominently posted in a common area of the building. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (II, III)

57.34(3) *Resident safety.*

a. Smoking shall be prohibited, except as allowed by Iowa Code chapter 142D, the smokefree air Act. (II, III)

b. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III)

d. Storage areas for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall be locked. Residents permitted to access these materials shall be supervised by staff as identified in the resident's service plan. (I, II, III)

e. Sufficient numbers of noncombustible trash containers with covers shall be available. (III)

f. Residents' personal possessions that may constitute a hazard to residents or others shall be removed and stored. (III)

57.34(4) *First-aid kit.* A first-aid emergency kit shall be available on each floor in every facility. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.35(135C) Housekeeping.

57.35(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

57.35(2) Each resident room shall be cleaned on a routine schedule. (III)

57.35(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (II, III)

57.35(4) A hallway or corridor shall not be used for storage of equipment. (II, III)

57.35(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

57.35(6) Clothing worn by personnel shall be clean and washable. (III)

57.35(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

57.35(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (II, III)

57.35(9) Polishes used on floors shall provide a nonslip finish. (II, III)

57.35(10) Throw or scatter rugs shall have nonskid backing. (II, III)

57.35(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.36(135C) Maintenance.

57.36(1) Each facility shall establish a maintenance program to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. In facilities with more than 15 beds, the maintenance program shall be established in writing and available for review by the department. (II, III)

57.36(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (II, III)

57.36(3) Window treatments and furniture shall be clean and in good repair. (II, III)

57.36(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (II, III)

57.36(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the National Electric Code. (II, III)

57.36(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (II, III)

57.36(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (II, III)

57.36(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (II, III)

57.36(9) The facility shall be kept free of flies, other insects, and rodents. (II, III)

57.36(10) Janitor's closet.

a. Facilities shall be provided with storage for cleaning equipment and supplies. (III)

b. Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

c. In facilities licensed for more than 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.37(135C) Laundry.

57.37(1) All soiled linens shall be collected and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

57.37(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

57.37(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

57.37(4) Residents' personal laundry shall be marked with an identification if comingled with other residents' personal laundry. (III)

57.37(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

57.37(6) If laundry is done in the facility, the following shall be provided:

a. A clean, dry, well-lit area to accommodate a washer and dryer of adequate size to serve the needs of the facility. (III)

b. In facilities with more than 15 beds, the laundry room shall be divided into separate areas, one for sorting soiled linen and one for sorting and folding clean linen. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.38(135C) Garbage and waste disposal.

57.38(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

57.38(2) All containers for refuse shall be watertight and rodent-proof and have tight-fitting covers. (III)

57.38(3) All unlined containers shall be thoroughly cleaned each time the containers are emptied. (III)

57.38(4) All waste shall be properly disposed of in compliance with local ordinances and state codes. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.39(135C) Supplies.

57.39(1) *Linen supplies.*

- a.* There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)
 - b.* A complete change of bed linens shall be available in the linen storage area for each bed. (III)
 - c.* Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)
 - d.* Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)
 - e.* Adequate storage shall be provided for linens, pillows, and bedding. (III)
- 57.39(2) *Supplies, equipment and storage.***
- a.* All equipment shall be properly cleaned and sanitized before use by another resident. (III)
 - b.* Clean and sanitary storage shall be provided for equipment and supplies. (III)
 - c.* Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III)
 - d.* Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.40(135C) Buildings, furnishings, and equipment.

57.40(1) *Buildings—general requirements.*

- a.* All windows shall be supplied with window treatments that are kept clean and in good repair. (III)
- b.* Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)
- c.* The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

57.40(2) *Furnishings and equipment.*

- a.* All furnishings and equipment shall be durable, cleanable, and appropriate to their function. (III)
- b.* All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere. (III)
- c.* Upholstery materials shall be moisture- and soil-resistant as needed, except on furniture provided by the resident and the property of the resident. (III)

57.40(3) *Dining and living rooms.*

- a.* Every facility shall have a dining room and a living room easily accessible to all residents. (III)
- b.* Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. Living rooms shall be suitably furnished. (III)
- c.* Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. Dining rooms and furnishings shall be kept clean and sanitary. (III)

57.40(4) *Bedrooms.*

- a.* Each resident shall be provided with a standard, single, or twin bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)
- b.* Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)
- c.* Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)
- d.* There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)
- e.* There shall be drawer space for each resident's clothing. In a bedroom in which more than one resident resides, drawer space shall be assigned to each resident. (III)

f. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)
g. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless the radiator is covered so as to protect the resident from contact with it or from excessive heat. (III)

h. There shall be no more than four residents per room. (III)

57.40(5) Bath and toilet facilities.

a. All sinks shall have paper towel dispensers and an available supply of soap. (III)

b. Toilet paper shall be readily available to residents. (III)

57.40(6) Heating. A centralized heating system shall be maintained in good working order and capable of maintaining a comfortable temperature for residents of the facility. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (II, III)

57.40(7) Water supply.

a. Private sources of water supply shall be tested annually and the report made available for review by the department upon request. (III)

b. A bacterially unsafe source of water supply shall be grounds for denial, suspension, or revocation of license. (III)

c. The department may require testing of private sources of water supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

d. Hot and cold running water under pressure shall be available in the facility. (II, III)

e. Prior to construction of a new facility or new water source, private sources of water supply shall be surveyed and shall comply with the requirements of the department. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.41(135C) Family and employee accommodations.

57.41(1) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for the residents. (III)

57.41(2) In all facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for the residents. (III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.42(135C) Animals. No animals shall be allowed to reside in the facility except with written approval of the department and under controlled conditions. (II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.43(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. (I, II, III)

57.43(1) 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 57.43(2) “a” through “j.” (I, II, III)

57.43(2) 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.

57.43(3) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

57.43(4) 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 and 481—Chapter 60. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

481—57.44(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. “Respite care services” does not include crisis stabilization services provided pursuant to 2014 Iowa Acts, chapter 1044 (to be codified at Iowa Code section 225C.19A). “Respite care individual” means a person receiving respite care services. A residential care facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a residential care facility. (II, III)

57.44(1) *Length of stay.* Respite care may be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period. The 12-month period begins on the first day of the respite care individual's stay at the facility. (II, III)

57.44(2) *No separate license.* A residential care facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

57.44(3) *Involuntary termination of respite services.* The facility may terminate the respite services for a respite care individual. Rule 481—57.14(135C) shall not apply. The facility shall make proper arrangements for the welfare of the respite care individual prior to involuntary termination of respite services, including notification of the respite care individual's family or legal representative. (II, III)

57.44(4) *Contract.* Pursuant to rule 481—57.15(135C), the facility shall have a contract with each resident in the facility. When an individual is there for respite care services, the contract shall specify the time period during which the individual 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 that respite care services may be involuntarily terminated. The contract shall meet other requirements under rule 481—57.15(135C), except the requirements under subrule 57.15(7). (II, III)

57.44(5) *Admission as a resident.*

a. An individual being cared for under a respite care contract shall not be considered an admission to the facility.

b. A respite care individual shall be included in the facility's census.

c. The facility shall not enter into multiple 30-day contracts with an individual being cared for under a respite care contract in order to lengthen the individual's stay at the facility. (II, III)

d. If an individual being cared for under a respite care contract remains in the facility beyond 30 consecutive days and is eligible for admission, the department shall consider the individual a resident in the facility. The facility shall follow all requirements for the individual's admission to the facility. (II, III)

57.44(6) *Level of care.* Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide. (I, II, III)

57.44(7) *Reporting requirements.* The reporting requirements of rule 481—50.7(135C) shall apply to residents being cared for under a respite care contract. (I, II, III)

[ARC 1753C, IAB 12/10/14, effective 1/14/15]

These rules are intended to implement Iowa Code section 135C.14.

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[Editorial change: IAC Supplement 6/10/26]

◇ Two or more ARCs

¹ Effective date of 470—57.15(2)“a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 6/4/86.

² See IAB, Inspections and Appeals Department.

³ Effective date of 481—57.12(2)“a,” last paragraph, delayed 70 days by the Administrative Rules Review Committee at its meeting held July 8, 1993.

⁴ September 7, 2016, effective date of 57.19(3)“d,” 62.15(2)“d,” and 63.18(3)“d” [ARC 2643C] delayed 70 days by the Administrative Rules Review Committee at its meeting held August 5, 2016.

CHAPTER 58 NURSING FACILITIES

[Prior to 7/15/87, Health Department[470] Ch 58]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—58.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules. The use of the words “shall” and “must” indicates those standards are mandatory. The use of the words “should” and “could” indicates those standards are recommended.

“*Accommodation*” means the provision of lodging, including sleeping, dining, and living areas.

“*Administrator*” means a person licensed pursuant to Iowa Code chapter 147 who administers, manages, supervises, and is in general administrative charge of a nursing facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“*Ambulatory*” means the condition of a person who immediately and without aid of another is physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs if applicable to the facility.

“*Basement*” means that part of a building where the finish floor is more than 30 inches below the finish grade.

“*Board*” means the regular provision of meals.

“*Communicable disease*” means a disease caused by the presence of viruses or microbial agents within a person’s body, which agents may be transmitted either directly or indirectly to other persons.

“*Department*” means the state department of inspections and appeals.

“*Distinct part*” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

“*Medication*” means any drug including over-the-counter substances ordered and administered under the direction of the physician.

“*Nonambulatory*” means the condition of a person who immediately and without aid of another is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“*Nourishing snack*” is defined as a verbal offering of items, single or in combination, from the basic food groups. Adequacy of the “nourishing snack” will be determined both by resident interviews and by evaluation of the overall nutritional status of residents in the facility.

“*Person directed care environment*” means the provision of care and services provided in a facility that promotes decision making and choices by the resident, enhances the primary caregiver’s capacity to respond to each resident’s needs, and promotes a homelike environment. Examples of a person directed care environment include, but are not limited to, the Green House concept, the Eden alternative, service houses and neighborhoods.

“*Personal care*” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are assistance in getting in and out of bed, assistance with personal hygiene and bathing, assistance with dressing, meal assistance, and supervision over medications which can be self-administered.

“*Potentially hazardous food*” means a food that is natural or synthetic and that requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious or toxigenic microorganisms, the growth and toxin production of clostridium botulinum, or in raw shell eggs, the growth of salmonella enteritidis. Potentially hazardous food includes an animal food (a food of animal origin) that is raw or heat-treated; a food of plant origin that is heat-treated or consists of raw seed sprouts; cut melons; and garlic and oil mixtures that are not acidified or otherwise

modified at a food processing plant in a way that results in mixtures that do not support growth of bacteria.

“Primary care provider” means any of the following who provide primary care and meet certification standards:

1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician associate.

“Program of care” means all services being provided for a resident in a health care facility.

“Qualified intellectual disabilities professional” means a psychologist, physician, physician associate, registered nurse, educator, social worker, physical or occupational therapist, speech therapist or audiologist who meets the educational requirements for the profession, as required in the state of Iowa, and having one year’s experience working with persons with an intellectual disability.

“Qualified nurse” means a registered nurse or a licensed practical nurse, as defined in Iowa Code chapter 152.

“Rate” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules and regulations.

“Responsible party” means the person who signs or cosigns the admission agreement required in 481—58.13(135C) or the resident’s guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, religious groups, fraternal organizations, or foundations that assume responsibility and advocate for their client patients and pay for their health care.

“Restraints” means any chemical, manual method or physical or mechanical device, material, or equipment attached to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

“Substantial evening meal” is defined as an offering of three or more menu items at one time, one of which includes a high protein such as meat, fish, eggs or cheese. The meal would represent no less than 20 percent of the day’s total nutritional requirements.

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 1752C, IAB 12/10/14, effective 1/14/15; ARC 7033C, IAB 5/31/23, effective 7/5/23; Editorial change: IAC Supplement 6/10/26]

481—58.2(135C) Waivers. Waivers 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 a waiver 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 waiver will apply only to an individual nursing facility. Waivers will be reviewed at the discretion of the director of the department of inspections and appeals.

58.2(1) To request a waiver, the licensee must:

- a. Apply for a waiver in writing on a form provided by the department;
- b. Cite the rule or rules from which a waiver is desired;
- c. State why compliance with the rule or rules cannot be accomplished;
- d. Explain alternate arrangements or compensating circumstances which justify the waiver;
- e. Demonstrate that the requested waiver will not endanger the health, safety, or welfare of any resident.

58.2(2) Upon receipt of a request for a waiver, the director of inspections and appeals will:

- a. Examine the rule from which a waiver 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 waiver on the health, safety, or welfare of the residents;

d. Consult with the applicant if additional information is required.

58.2(3) Based upon these studies, approval of the waiver will be either granted or denied within 120 days of receipt.

[ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—58.3(135C) Application for licensure.

58.3(1) Initial application and licensing. In order to obtain an initial nursing facility license, for a nursing facility which is currently licensed, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Applicable exceptions found in rule 481—61.2(135C) shall apply based on the construction date of the facility.

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 60 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing 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;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Meet the requirements of a nursing facility for which licensure application is made;

h. Comply with all other local statutes and ordinances in existence at the time of licensure;

i. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(2) In order to obtain an initial nursing facility license for a facility not currently licensed as a nursing facility, the applicant must:

a. Meet all of the rules, regulations, and standards contained in 481—Chapters 58 and 61. Exceptions noted in 481—subrule 61.1(2) shall not apply;

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 60 days prior to the change of ownership of the facility on forms provided by the department;

d. Submit a floor plan of each floor of the nursing 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 locations;

e. Submit a photograph of the front and side elevation of the nursing facility;

f. Submit the statutory fee for a nursing facility license;

g. Comply with all other local statutes and ordinances in existence at the time of licensure;

h. Have a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules and regulations.

58.3(3) *Renewal application.* In order to obtain a renewal of the nursing facility license, the applicant must:

a. Submit the completed application form 30 days prior to annual license renewal date of nursing facility license;

b. Submit the statutory license fee for a nursing facility 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.

58.3(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 7033C, IAB 5/31/23, effective 7/5/23]

481—58.4(135C) General requirements.

58.4(1) The license shall be displayed in a conspicuous place in the facility which is viewed by the public. (III)

58.4(2) The license shall be valid only in the possession of the licensee to whom it is issued.

58.4(3) The posted license shall accurately reflect the current status of the nursing facility. (III)

58.4(4) Licenses expire one year after the date of issuance or as indicated on the license.

58.4(5) A nursing facility shall not be licensed for more beds than have been approved by the health facilities council pursuant to Iowa Code chapter 135 or than the facility can accommodate pursuant to the minimum physical standards for nursing facilities as set forth in 481—Chapter 61.

58.4(6) The facility shall post in a place readily accessible to residents, visitors, and persons inquiring about placement in the facility the results of the most recent survey of the facility. The facility shall maintain any surveys, certifications, and complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request. (III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.5(135C) Notifications required by the department. The department shall be notified:

58.5(1) Within 48 hours of any reduction or loss of nursing or dietary staff lasting more than seven days which places the staffing requirements below those required for licensing. No additional residents shall be admitted until the minimum staffing requirements are achieved; (III)

58.5(2) Thirty days before any proposed change in the nursing facility's functional operation or addition or deletion of required services; (III)

58.5(3) Thirty days before addition, alteration, or new construction is begun in the nursing facility or on the premises; (III)

58.5(4) Thirty days in advance of closure of the nursing facility; (III)

58.5(5) Within two weeks of any change in administrator; (III)

58.5(6) When any change in the category of license is sought; (III)

58.5(7) Prior to the purchase, transfer, assignment, or lease of a nursing facility, 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 60 days before the sale, transfer, assignment, or lease is completed. (III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.6(135C) Witness fees. Rescinded IAB 3/30/94, effective 5/4/94. See 481—subrule 50.6(4).

481—58.7(135C) Licenses for distinct parts.

58.7(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.

58.7(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. A 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—58.8(135C) Administrator.

58.8(1) Each nursing facility shall have one person in charge, duly licensed as a nursing home administrator or acting in a provisional capacity. (III)

58.8(2) A licensed administrator may act as an administrator for not more than two nursing facilities.

a. The distance between the two facilities shall be no greater than 75 miles. (II)

b. The administrator shall spend the equivalent of three full eight-hour days per week in each facility. (II)

c. The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

58.8(3) The licensee may be the licensed nursing home administrator providing the licensee meets the requirements as set forth in these regulations and devotes the required time to administrative duties. Residency in the facility does not in itself meet the requirement. (III)

58.8(4) A provisional administrator may be appointed on a temporary basis by the nursing facility licensee to assume the administrative duties when the facility, through no fault of its own, has lost its administrator and has been unable to replace the administrator.

a. No facility licensed under Iowa Code chapter 135C shall be permitted to have a provisional administrator for more than 12 consecutive months.

b. The facility shall notify the department in writing within 14 days of the administrator's appointment. The written notice shall include the estimated time frame for the appointment of the provisional administrator and the reason for the appointment of a provisional administrator. (III)

c. The provisional administrator's appointment must be approved by the board of examiners for nursing home administrators. The approval shall be confirmed in writing to the department. (III)

58.8(5) In the absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. The administrator shall not be absent from the facility for more than 3 months without approval of the department. (III)

The person designated shall:

a. Be knowledgeable of the operation of the facility; (III)

b. Have access to records concerned with the operation of the facility; (III)

c. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

d. Be at least 21 years of age; (III)

e. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

f. Have had training to carry out assignments and take care of emergencies and sudden illness of residents. (III)

58.8(6) A licensed administrator in charge of two facilities shall employ an individual designated as a full-time assistant administrator for each facility. (III)

58.8(7) An administrator of only one facility shall be considered as a full-time employee. Full-time employment is defined as 40 hours per week. (III)

[ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2020C, IAB 6/10/15, effective 7/15/15; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.9(135C) Administration.

58.9(1) The licensee shall:

a. Assume the responsibility for the overall operation of the nursing facility; (III)

b. Be responsible for compliance with all applicable laws and with the rules of the department; (III)

c. Establish written policies, which shall be available for review, for the operation of the nursing facility. (III)

58.9(2) The administrator shall:

a. Be responsible for the selection and direction of competent personnel to provide services for the resident care program; (III)

b. Be responsible for the arrangement for all department heads to annually attend a minimum of ten contact hours of educational programs to increase skills and knowledge needed for the position; (III)

c. Be responsible for a monthly in-service educational program for all employees and to maintain records of programs and participants; (III)

d. Make available the nursing facility payroll records for departmental review as needed; (III)

e. Be required to maintain a staffing pattern of all departments. These records must be maintained for six months and are to be made available for departmental review. (III)

481—58.10(135C) General policies.

58.10(1) There shall be written personnel policies in facilities of more than 15 beds to include hours of work, and attendance at educational programs. (III)

58.10(2) There shall be a written job description developed for each category of worker. The job description shall include title of job, job summary, qualifications (formal education and experience), skills needed, physical requirements, and responsibilities. (III)

58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

a. Employees shall have a physical examination before employment. (I, II, III)

b. Employees shall have a physical examination at least every four years. (I, II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

58.10(4) Health certificates for all employees shall be available for review. (III)

58.10(5) Rescinded IAB 10/19/88, effective 11/23/88.

58.10(6) There shall be written policies for emergency medical care for employees and residents in case of sudden illness or accident which includes the individual to be contacted in case of emergency. (III)

58.10(7) The facility shall have a written agreement with a hospital for the timely admission of a resident who, in the opinion of the attending physician, requires hospitalization. (III)

58.10(8) Infection control program. Each facility shall have a written and implemented infection control and exposure control program with policies and procedures based on the guidelines issued by the Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services. (I, II, III) CDC guidelines are available at www.cdc.gov.

58.10(9) Infection control committee. Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. The infection control committee may be part of or the same as another quality assurance committee as long as the following standards are met: (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

58.10(10) There shall be written policies for resident care programs and services as outlined in these rules. (III)

58.10(11) Prior to the removal of a deceased resident/patient from a facility, the funeral director or person responsible for transporting the body shall be notified by the facility staff of any special

precautions that were followed by the facility having to do with the mode of transmission of a known or suspected communicable disease. (III)

[ARC 0663C, IAB 4/3/13, effective 5/8/13; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.11(135C) Personnel.

58.11(1) *General qualifications.*

a. No person with a current record of habitual alcohol intoxication or addiction to the use of drugs shall serve in a managerial role of a nursing facility. (II)

b. No person under the influence of alcohol or intoxicating drugs shall be permitted to provide services in a nursing facility. (II)

c. No person shall be allowed to provide services in a facility if the person has a disease:

(1) Which is transmissible through required workplace contact, (I, II, III)

(2) Which presents a significant risk of infecting others, (I, II, III)

(3) Which presents a substantial possibility of harming others, and (I, II, III)

(4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, to determine (1), (2), (3) and (4).

d. Individuals with either physical or mental disabilities may be employed for specific duties, but only if that disability is unrelated to that individual's ability to perform the duties of the job. (III)

e. Persons employed in all departments, except the nursing department of a nursing facility, shall be qualified through formal training or through prior experience to perform the type of work for which they have been employed. Prior experience means at least 240 hours of full-time employment in a field related to their duties. Persons may be hired in laundry, housekeeping, activities and dietary without experience or training if the facility institutes a formal in-service training program to fit the job description in question and documents such as having taken place within 30 days after the initial hiring of such untrained employees. (III)

f. The health services supervisor shall be a qualified nurse as defined in these regulations. (II)

g. There shall be an organized ongoing in-service educational and training program planned in advance for all personnel in all departments. (II, III)

h. Nurse aides may be utilized in accordance with the requirements in 441—subrule 81.13(19) and rule 441—81.16(249A). Nurse aides who have received training other than the Iowa state-approved program must pass a competency evaluation approved by the department of inspections and appeals in accordance with 441—subrule 81.13(19) and rule 441—81.16(249A). Evidence of prior formal training must be presented to the facility or institution conducting the challenge examination before the examination is given. The approved facility or institution, following department of inspections and appeals guidelines, shall make the determination of who is qualified to take the examination. Documentation of the challenge examinations administered shall be maintained.

58.11(2) *Nursing supervision and staffing.*

a. Where only part-time nurses are employed, one nurse shall be designated health service supervisor. (III)

b. A qualified nurse shall be employed to relieve the supervising nurses, including charge nurses, on holidays, vacation, sick leave, days off, absences or emergencies. Pertinent information for contacting such relief person shall be readily available to nurses. (III)

c. When the health service supervisor serves as the administrator of a facility 50 beds and over, a qualified nurse must be employed to relieve the health service supervisor of nursing responsibilities. (III)

d. The department may establish on an individual facility basis the numbers and qualifications of the staff required in the facility using as its criteria the services being offered and the needs of the residents. (III)

e. A nursing facility of 75 beds or more shall have a qualified nurse on duty 24 hours per day, seven days a week. (II, III)

f. In facilities under 75 beds, if the health service supervisor is a licensed practical nurse, the facility shall employ a registered nurse, for at least four hours each week for consultation, who must be on duty at the same time as the health service supervisor. (II, III)

(1) This shall be an on-site consultation and documentation shall be made of the visit. (III)

(2) The registered nurse-consultant shall have responsibilities clearly outlined in a written agreement with the facility. (III)

(3) Consultation shall include but not be limited to the following: counseling the health service supervisor in the management of the health services; (III) reviewing and evaluating the health services in determining that the needs of the residents are met; (II, III) conducting a review of medications at least monthly if the facility does not employ a registered nurse part-time. (II, III)

g. Facilities with 75 or more beds must employ a health service supervisor who is a registered nurse. (II)

h. There shall be at least two people who shall be capable of rendering nursing service, awake, dressed, and on duty at all times. (II)

i. Physician's and other qualified health care practitioner's orders shall be implemented by qualified personnel. (II, III)

58.11(3) *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 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; ARC 5421C, IAB 2/10/21, effective 3/17/21; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.12(135C) Admission, transfer, and discharge.

58.12(1) *General admission policies.*

a. No resident shall be admitted or retained in a nursing facility who is in need of greater services than the facility can provide. (II, III)

b. No nursing facility shall admit more residents than the number of beds for which it is licensed, except guest rooms for visitors. (II, III)

c. There shall be no more beds erected than is stipulated on the license. (II, III)

d. There shall be no more beds erected in a room than its size and other characteristics will permit. (II, III)

e. The admission of a resident to a nursing facility shall not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal representative. (III)

f. The admission of a resident shall not grant the nursing facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and safe and orderly management of the facility as required by these rules. (III)

g. Residents have a right to retain and use personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (III)

h. Rescinded, effective 7/14/82.

i. Funds or properties received by the nursing facility belonging to or due a resident, expendable for the resident's account, shall be trust funds. (III)

j. Infants and children under the age of 16 shall not be admitted to health care facilities for adults unless given prior written approval by the department. A distinct part of a health care facility, segregated from the adult section, may be established based on a program of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)

k. No health care facility, and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property, unless such resident is related to the person acting as guardian within the third degree of consanguinity.

l. 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.

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.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care or to the admission of an individual to the Iowa Veterans Home. (II, III)

58.12(2) *Discharge or transfer.*

a. Prior notification shall be made to the resident, as well as the resident's next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)

b. Proper arrangements shall be made by the nursing facility for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)

c. The licensee shall not refuse to discharge or transfer a resident when the physician, family, resident, or legal representative requests such a discharge or transfer. (II, III)

d. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

e. When a resident is transferred or discharged, the appropriate record as set forth in 58.15(2) "k" of these rules will accompany the resident. (II, III)

f. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.13(135C) Contracts. Each contract shall:

58.13(1) State the base rate or scale per day or per month, the services included, and the method of payment; (III)

58.13(2) Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. Furthermore, the contract shall: (III)

a. Stipulate that no further additional fees shall be charged for items not contained in complete schedule of services as set forth in 58.13(3); (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)

58.13(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 the nursing assessment at the time of admission, which is determined in consultation with the administrator; (III)

58.13(4) Include the total fee to be charged initially to the specific resident; (III)

58.13(5) State the conditions whereby the facility may make adjustments to the facility's 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 additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional 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)

58.13(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)

58.13(7) State the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party.

a. The facility shall ask the resident or responsible party if the resident wants the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

58.13(8) State the conditions under which the involuntary discharge or transfer of a resident would be effected; (III)

58.13(9) State the conditions of voluntary discharge or transfer; (III)

58.13(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 health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter; (III)

58.13(11) Each party shall receive a copy of the signed contract. (III)

481—58.14(135C) Medical services.

58.14(1) Each resident in a nursing facility shall designate a licensed physician who may be called when needed. Professional management of a resident's care shall be the responsibility of the hospice program when:

a. The resident is terminally ill, and

b. The resident has elected to receive hospice services under the federal Medicare program from a Medicare-certified hospice program, and

c. The facility and the hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of hospice care.

58.14(2) Each resident admitted to a nursing facility shall have had a physical examination prior to admission. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be made part of the record in lieu of an additional physical examination. A record of the examination, signed by the physician or other qualifying health care practitioner, shall be a part of the resident's record. (III)

58.14(3) Arrangements shall be made to have a physician available to furnish medical care in case of emergency. (II, III)

58.14(4) Rescinded, effective 7/14/82.

58.14(5) The person in charge shall immediately notify the physician of any accident, injury, or adverse change in the resident's condition. (I, II, III)

58.14(6) A schedule listing the names and telephone numbers of the physicians shall be readily available to nursing staff. (III)

58.14(7) Residents shall be admitted to a nursing facility only on a written order signed by a physician certifying that the individual being admitted requires no greater degree of nursing care than the facility is licensed to provide. (III)

58.14(8) Physician delegation of tasks. Each resident, including private pay residents, shall be visited by or shall visit the resident's physician at least twice a year. The year period shall be measured from the date of admission and is not to include preadmission physicals.

a. For a skilled nursing patient, the resident must be seen by a physician for the initial comprehensive visit. Additional visits are required at least once every 30 days for 90 days after admission and at least once every 60 days thereafter. After the initial comprehensive visit, alternate required visits may be performed by an advanced registered nurse practitioner, clinical nurse specialist or physician associate who is working in collaboration with a physician, as outlined in Table 1. (III)

b. Notwithstanding the provisions of 42 CFR 483.40, any required physician task or visit in a nursing facility may also be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician associate who is working in collaboration with a physician, as outlined in Table 1. (III)

c. In dually certified skilled nursing/nursing facilities, the advanced registered nurse practitioner, clinical nurse specialist, and physician associate must follow the skilled nursing facility requirements for services for skilled nursing facility stays. For nursing facility stays in skilled nursing/nursing facilities, any required physician task or visit may be performed by an advanced registered nurse practitioner, clinical nurse specialist, or physician associate working in collaboration with the physician. (III)

d. Nurse practitioners, clinical nurse specialists, and physician associates may perform other tasks that are not reserved to the physician such as visits outside the normal schedule needed to address new symptoms or other changes in medical status. (III)

Table 1: Authority for non-physician practitioners to perform visits, sign orders, and sign certifications/recertifications when permitted by state law*

	Initial Comprehensive Visit/Orders	Other Required Visits ¹	Other Medically Necessary Visits and Orders ²	Certification/Recertification
Skilled Nursing Facilities				
Physician associate, nurse practitioner and clinical nurse specialist employed by the facility	May not perform/May not sign	May perform alternate visits	May perform and sign	May not sign
Physician associate, nurse practitioner and clinical nurse specialist not a facility employee	May not perform/May not sign	May perform alternate visits	May perform and sign	May sign subject to state requirements
Nursing Facilities				
Nurse practitioner, clinical nurse specialist, and physician associate employed by the facility	May not perform/May not sign	May not perform	May perform and sign	Not applicable+
Nurse practitioner, clinical nurse specialist, and physician associate not a facility employee	May perform/May sign	May perform	May perform and sign	Not applicable+

*As permitted by state law governing the scope and practice of nurse practitioners, clinical nurse specialists, and physician associates.

1 Other required visits include the skilled nursing resident monthly visits that may be alternated between physician and advanced registered nurse practitioners, clinical nurse specialists, or physician associates after the initial comprehensive visit is completed.

2 Medically necessary visits may be performed prior to the initial comprehensive visit.

+ This requirement relates specifically to coverage of Part A Medicare stays, which can take place only in a Medicare-certified skilled nursing facility.

[ARC 1048C, IAB 10/2/13, effective 11/6/13; ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 7033C, IAB 5/31/23, effective 7/5/23; Editorial change: IAC Supplement 6/10/26]

481—58.15(135C) Records.

58.15(1) *Resident admission record.* The licensee shall keep a permanent record on all residents admitted to a nursing facility with all entries current, dated, and signed. This shall be a part of the resident clinical record. (III) The admission record form shall include:

- a. Name and previous address of resident; (III)
- b. Birth date, sex, and marital status of resident; (III)
- c. Church affiliation; (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 next of kin or legal representative; (III)
- g. Name, address, and telephone number of person to be notified in case of emergency; (III)
- h. Mortician's name, telephone number, and address; (III)
- i. Pharmacist's name, telephone number, and address. (III)

58.15(2) *Resident clinical record.* There shall be a separate clinical record for each resident admitted to a nursing facility with all entries current, dated, and signed. (III) The resident clinical record shall include:

- a. Admission record; (III)
- b. Admission diagnosis; (III)
- c. The record of the admission physical examination described in subrule 58.14(2). It shall include the resident's name, sex, age, pertinent medical history, current medical status, tuberculosis status, and any other information required to adequately assess the resident and whether the facility is able to meet the resident's needs; (III)
- d. Physician's certification that the resident requires no greater degree of nursing care than the facility is licensed to provide; (III)
- e. Orders for medication, treatment, and diet in writing and signed by an appropriate qualifying health care practitioner quarterly; (III)
- f. Progress notes.
 - (1) Physician shall enter a progress note at the time of each visit; (III)
 - (2) Other professionals, i.e., dentists, social workers, physical therapists, pharmacists, and others shall enter a progress note at the time of each visit; (III)
- g. All laboratory, X-ray, and other diagnostic reports; (III)
- h. Nurse's record including:
 - (1) Admitting notes including time and mode of transportation; room assignment; disposition of valuables; symptoms and complaints; general condition; vital signs; and weight; (II, III)
 - (2) Routine notes including physician's visits; telephone calls to and from the physician; unusual incidents and accidents; change of condition; social interaction; and P.R.N. medications administered including time and reason administered, and resident's reaction; (II, III)
 - (3) Discharge or transfer notes including time and mode of transportation; resident's general condition; instructions given to resident or legal representative; list of medications and disposition; and completion of transfer form for continuity of care; (II, III)
 - (4) Death notes including notification of physician and family to include time, disposition of body, resident's personal possessions and medications; and complete and accurate notes of resident's vital signs and symptoms preceding death; (III)

- i. Medication record.*
- (1) An accurate record of all medications administered shall be maintained for each resident. (II, III)
- (2) Schedule II drug records shall be kept in accordance with state and federal laws; (II, III)
- j. Death record.* 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)
- k. Transfer form.*
- (1) The transfer form shall include identification data from the admission record, name of transferring institution, name of receiving institution, and date of transfer; (III)
- (2) The nurse's report shall include resident attitudes, behavior, interests, functional abilities (activities of daily living), unusual treatments, nursing care, problems, likes and dislikes, nutrition, current medications (when last given), and condition on transfer; (III)
- (3) The physician's report shall include reason for transfer, medications, treatment, diet, activities, significant laboratory and X-ray findings, and diagnosis and prognosis; (III)
- l. Consultation reports* shall indicate services rendered by allied health professionals in the facility or in health-centered agencies such as dentists, physical therapists, podiatrists, oculists, and others. (III)
- 58.15(3) Resident personal record.** Personal records may be kept as a separate file by the facility.
- a.* Personal records may include factual information regarding personal statistics, family and responsible relative resources, financial status, and other confidential information.
- b.* Personal records shall be accessible to professional staff involved in planning for services to meet the needs of the resident. (III)
- c.* When the resident's records are closed, the information shall become a part of the final record. (III)
- d.* Personal records shall include a duplicate copy of the contract(s). (III)
- 58.15(4) Incident record.**
- a.* Each nursing facility shall maintain an incident record report and shall have available incident report forms. (III)
- b.* Report of incidents shall be in detail on a printed incident report form or electronic form. (III)
- c.* The person in charge at the time of the incident shall prepare and sign the report. (III)
- d.* The report shall cover all accidents where there is apparent injury or where hidden injury may have occurred. (III)
- e.* The report shall cover all accidents or unusual occurrences within the facility or on the premises affecting residents, visitors, or employees. (III)
- f.* A copy of the incident report shall be kept on file in the facility. (III)
- 58.15(5) Retention of records.**
- a.* Records shall be retained in the facility for five years following termination of services. (III)
- b.* Records shall be retained within the facility upon change of ownership. (III)
- c.* Rescinded, effective 7/14/82.
- d.* When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)
- 58.15(6) Reports to the department.** The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)
- 58.15(7) Personnel record.**
- a.* An employment record shall be kept for each employee, consisting of the following information: name and address of employee, social security number of employee, date of birth of employee, date of employment, experience and education, references, position in the home,

criminal history and dependent adult abuse background checks, and date and reason for discharge or resignation. (III)

b. The personnel records shall be made available for review upon request by the department. (III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.16(135C) Resident care and personal services.

58.16(1) Beds shall be made daily and adjusted as necessary. A complete change of linen shall be made at least once a week and more often if necessary. (III)

58.16(2) Residents shall receive sufficient supervision so that their personal cleanliness is maintained. (II, III)

58.16(3) Residents shall have clean clothing as needed to present a neat appearance, to be free of odors, and to be comfortable. Clothing shall be based on resident choice and shall be appropriate to residents' activities and to the weather. (III)

58.16(4) Rescinded, effective 7/14/82.

58.16(5) Residents shall be encouraged to leave their rooms and make use of the recreational room or living room of the facility. (III)

58.16(6) Residents shall not be required to pass through another's bedroom to reach a bathroom, living room, dining room, corridor, or other common areas of the facility. (III)

58.16(7) Rescinded, effective 7/14/82.

58.16(8) Uncontrollable residents shall be transferred or discharged from the facility in accordance with contract arrangements and requirements of Iowa Code chapter 135C. (II, III)

58.16(9) Except for those who request differently, residents who are not bedfast shall be fully dressed each day to maintain self-esteem and promote the residents' normal lifestyles. (III)

58.16(10) Residents shall receive a bath of their choice, based on the facility's accommodations, as needed to maintain proper hygiene. (II, III)

481—58.17 Rescinded, effective 7/14/82.

481—58.18(135C) Nursing care.

58.18(1) Individual health care plans shall be based on resident treatment decisions, the nature of the illness or disability, treatment, and care prescribed. Goals shall be developed by each discipline providing service, treatment, and care. These plans shall be in writing, revised as necessary, and kept current. They shall be made available to all those rendering the services and for review by the department. (III)

58.18(2) Rescinded IAB 4/2/14, effective 5/7/14.

58.18(3) The facility shall provide resident and family education as an integral part of restorative and supportive care. (III)

58.18(4) The facility shall provide prompt response from qualified staff for the resident's use of the nurse call system. (II, III) (Prompt response being considered as no longer than 15 minutes.)

[ARC 1398C, IAB 4/2/14, effective 5/7/14]

481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:

58.19(1) *Activities of daily living.*

- a. Bathing; (II, III)
- b. Daily oral hygiene (denture care); (II, III)
- c. Routine shampoo; (II, III)
- d. Nail care; (III)
- e. Shaving; (III)

- f.* Daily care and application of prostheses (glasses, hearing aids, glass eyes, limb prosthetics, braces, or other assistive devices); (II, III)
- g.* Ambulation with equipment if applicable, or transferring, or positioning; (I, II, III)
- h.* Daily routine range of motion; (II, III)
- i.* Mobility (assistance with wheelchair, mechanical lift, or other means of locomotion); (I, II, III)
- j.* Elimination.
 - (1) Assistance to and from the bathroom and perineal care; (II, III)
 - (2) Bedpan assistance; (II, III)
 - (3) Care for incontinent residents; (II, III)
 - (4) Bowel and bladder training programs including in-dwelling catheter care (i.e., insertion and irrigation), enema and suppository administration, and monitoring and recording of intake and output, including solid waste; (I, II, III)
- k.* Colostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
- l.* Ileostomy care (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II, III)
- m.* All linens necessary; (III)
- n.* Nutrition and meal service.
 - (1) Regular, therapeutic, modified diets, and snacks; (I, II, III)
 - (2) Mealtime preparation of resident; (II, III)
 - (3) Assistance to and from meals; (II, III)
 - (4) In-room meal service or tray service; (II, III)
 - (5) Assistance with food preparation and meal assistance including total assistance if needed; (II, III)
 - (6) Assistance with adaptive devices; (II, III)
 - (7) Enteral nutrition (to be performed by a registered nurse or licensed practical nurse only); (I, II, III)
 - (8) Sufficient fluid intake to maintain proper hydration and health; (I, II, III)
- o.* Promote initiation of self-care for elements of resident care; (II, III)
- p.* Oral suctioning (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse). (I, II)

58.19(2) Medication and treatment.

- a.* Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I, II)
- b.* Provision of the appropriate care and treatment of wounds, including pressure sores, to promote healing, prevent infection, and prevent new sores from developing; (I, II)
- c.* Blood glucose monitoring; (I, II)
- d.* Vital signs, blood pressure, and weights; (I, II)
- e.* Ambulation and transfer; (II, III)
- f.* Provision of restraints; (I, II)
- g.* Administration of oxygen (to be performed only by a registered nurse or licensed practical nurse or by a qualified aide under the direction of a registered nurse or licensed practical nurse); (I, II)
- h.* Provision of all treatments; (I, II, III)
- i.* Provision of emergency medical care, including arranging for transportation, in accordance with written policies and procedures of the facility; (I, II, III)
- j.* Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)

[ARC 1398C, IAB 4/2/14, effective 5/7/14; ARC 2560C, IAB 6/8/16, effective 7/13/16]

481—58.20(135C) Duties of health service supervisor. Every nursing facility shall have a health service supervisor who shall:

58.20(1) Direct the implementation of the physician's orders; (I, II)

58.20(2) Plan for and direct the nursing care, services, treatments, procedures, and other services in order that each resident's needs and choices, where practicable, are met; (II, III)

58.20(3) Review the health care needs and choices, where practicable, of each resident admitted to the facility and assist the attending physician in planning for the resident's care; (II, III)

58.20(4) Develop and implement a written health care plan in cooperation with, to the extent practicable, the resident, the resident's family or the resident's legal representative, and others in accordance with instructions of the attending physician as follows:

a. The written health care plan, based on the assessment and reassessment of the resident's health needs and choices, where practicable, is personalized for the individual resident and indicates care to be given, goals to be accomplished, and methods, approaches, and modifications necessary to achieve best results; (III)

b. The health service supervisor is responsible for preparing, reviewing, supervising the implementation, and revising the written health care plan; (III)

c. The health care plan is readily available for use by all personnel caring for the resident; (III)

58.20(5) Initiate preventative and restorative nursing procedures for each resident so as to achieve and maintain the highest possible degree of function, self-care, and independence based on resident choice, where practicable; (II, III)

58.20(6) Supervise health services personnel to ensure they perform the following restorative measures in their daily care of residents:

a. Maintaining good bodily alignment and proper positioning; (II, III)

b. Making every effort to keep the resident active except when contraindicated by physician's orders, and encouraging residents to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities; (III)

c. Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests as necessary; (III)

d. Assisting residents to carry out prescribed therapy exercises between visits of the therapist; (III)

e. Assisting residents with routine range of motion exercises; (III)

58.20(7) Plan and conduct nursing staff orientation and in-service programs and provide for training of nurse's aides; (III)

58.20(8) Plan with the resident and the resident's physician and family and health-related agencies for the care of the resident upon discharge; (III)

58.20(9) Designate a responsible person to be in charge during absences; (III)

58.20(10) Be responsible for all assignments and work schedules for all health services personnel to ensure that the health needs of the residents are met; (III)

58.20(11) Ensure that all nurse's notes are descriptive of the care rendered including the resident's response; (III)

58.20(12) Visit each resident routinely to be knowledgeable of the resident's current condition; (III)

58.20(13) Evaluate in writing the performance of each individual on the health care staff on at least an annual basis. This evaluation shall be available for review in the facility to the department; (III)

58.20(14) Keep the administrator informed of the resident's status; (III)

58.20(15) Teach and coordinate rehabilitative health care including activities of daily living, promotion and maintenance of optimal physical and mental functioning; (III)

58.20(16) Supervise serving of meals to ensure that individuals unable to assist themselves are promptly fed and that special eating adaptive devices are available as needed; (II, III)

58.20(17) Make available a nursing procedure manual which shall include all procedures practiced in the facility; (III)

58.20(18) Participate with the administrator in the formulation of written policies and procedures for resident services; (III)

58.20(19) The person in charge shall immediately notify the family of any accident, injury, or adverse change in the resident's condition requiring physician's notification. (III)

481—58.21(135C) Drugs, storage, and handling.

58.21(1) Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

a. A cabinet with a lock, convenient to nursing service, shall be provided and used for storage of all drugs, solutions, and prescriptions; (III)

b. The drug storage cabinet shall be kept locked when not in use; (III)

c. The medication cabinet key shall be in the possession of the person directly responsible for issuing medications; (II, III)

d. Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a three-day supply and a missing dose can be readily detected. (II)

58.21(2) Drugs for external use shall be stored separately from drugs for internal use. (III)

58.21(3) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items. A method for locking these medications shall be provided. (III)

58.21(4) All potent, poisonous, or caustic materials shall be stored separately from drugs. They shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

58.21(5) All flammable materials shall be specially stored and handled in accordance with applicable local and state fire regulations. (II)

58.21(6) A properly trained person shall be charged with the responsibility of administering nonparenteral 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. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility and work at least 480 hours prior to the start of the medication aide course.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

d. A person who is a nursing student 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.

e. 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.

The requirements of paragraph “c” of this subrule do not apply to this individual.

58.21(7) Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. (II) In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, (II) unless the unit dose system is used.

58.21(8) An accurate written record of medications administered shall be made by the individual administering the medication. (III)

58.21(9) Records shall be kept of all medications received and dispensed in accordance with 42 CFR 483.45(b)(2) and federal interpretive guidelines. (III)

58.21(10) Any unusual resident reaction shall be reported to the physician at once. (II)

58.21(11) A policy shall be established by the facility in conjunction with a licensed pharmacist to govern the distribution of prescribed medications to residents who are on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Notwithstanding the prohibition against paper envelopes in 58.21(14)“a,” non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident’s name, the facility, the medication, its strength, dose, and time of administration.

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy.

c. Medication distributed as above may be issued only by a nurse responsible for administering medication. (I, II, III)

58.21(12) Emergency medications. A nursing facility shall provide emergency medications pursuant to the following requirements: (III)

a. Prescription drugs as well as nonprescription items must be prescribed or approved by the physician, in consultation with the pharmacist, who provides emergency service to the facility; (III)

b. The emergency medications shall be stored in an accessible place; (III)

c. A list of the emergency medications and quantities of each item shall be maintained by the facility; (III)

d. The container holding the emergency medications shall be closed with a seal which may be broken when drugs are required in an emergency or for inspection; (III)

e. Any item removed from the emergency medications shall be replaced within 48 hours; (III)

f. A permanent record shall be kept of each time the emergency medications are used; (III)

g. The emergency medications shall be inspected by a pharmacist at least once every three months to determine the stability of items. (III)

58.21(13) Drug handling.

a. Bulk supplies of prescription drugs shall not be kept in a nursing facility unless a licensed pharmacy is established in the facility under the direct supervision and control of a pharmacist or the prescription drugs are stored in an automated medication distribution system (AMDS) in compliance with standards established by the Iowa board of pharmacy. (III)

b. Inspection of drug storage condition shall be made by the health service supervisor and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the nurse and pharmacist and filed with the administrator. The report shall include, but not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current physician’s order, and drugs improperly stored. (III)

c. If the facility permits licensed nurses to dilute or reconstitute drugs at the nursing station, distinctive supplementary labels shall be available for the purpose. The notation on the label shall be so made as to be indelible. (III)

d. Dilution and reconstitution of drugs and their labeling shall be done by the pharmacist whenever possible. If not possible, the following shall be carried out only by the licensed nurse:

(1) Specific directions for dilution or reconstitution and expiration date should accompany the drug; (III)

(2) A distinctive supplementary label shall be affixed to the drug container when diluted or reconstituted by the nurse for other than immediate use. (III) The label shall bear the following: resident's name, dosage and strength per unit/volume, nurse's name, expiration date, and date and time of dilution. (III)

58.21(14) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident's full name, physician's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. Prescription medications distributed from an AMDS shall follow any labeling standards established by the Iowa board of pharmacy. (III)

b. Medication containers having soiled, damaged, illegible or makeshift labels, or medication samples shall be returned to the issuing pharmacist, pharmacy, or physician for relabeling or disposal. (III)

c. There shall be no medications or any solution in unlabeled containers. (II, III)

d. The medications of each resident shall be kept or stored in the originally received containers. (II, III)

e. Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label of a drug container. (II, III)

f. When a resident is discharged or leaves the facility, the unused prescription shall be sent with the resident or with a legal representative only upon the written order of a physician. (III)

g. Unused prescription drugs prescribed for residents who are deceased shall be returned to the supplying pharmacist. (III)

h. Prescriptions shall be refilled only with the permission of the attending physician. (II, III)

i. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

j. Instructions shall be requested of the Iowa board of pharmacy concerning disposal of unused Schedule II drugs prescribed for residents who have died or for whom the Schedule II drug was discontinued. (III)

k. There shall be a formal routine for the proper disposal of discontinued medications within a reasonable but specified time. These medications shall not be retained with the resident's current medications. Discontinued drugs shall be destroyed by the responsible nurse with a witness and a notation made to that effect or returned to the pharmacist for destruction or resident credit. Drugs listed under the Schedule II drugs shall be disposed of in accordance with the provisions of the Iowa board of pharmacy. (II, III)

l. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic stop order may vary for different types of drugs. The physician, in consultation with the pharmacist serving the home, shall institute policies and provide procedures for review and endorsement of stop orders on drugs. This policy shall be conveniently located for personnel administering medications. (II, III)

m. No resident shall be allowed to keep possession of any medications unless the attending physician has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

n. Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided. (II)

o. No medications or prescription drugs shall be administered to a resident without a written order signed by the attending physician. (II)

p. A qualified nurse shall:

(1) Establish a medication schedule system which identifies the time and dosage of each medication prescribed for each resident, is based on the resident's desired routine, and is approved by the resident's physician. (II, III)

(2) Establish a medication record containing the information specified above needed to monitor each resident's drug regimen. (II, III)

q. Telephone orders shall be taken by a qualified nurse. Orders shall be written into the resident's record and signed by the person receiving the order. Telephone orders shall be submitted to the physician for signature within 48 hours. (III)

r. A pharmacy operating in connection with a nursing facility shall comply with the provisions of the pharmacy law requiring registration of pharmacies and the regulations of the Iowa board of pharmacy. (III)

s. In a nursing facility with a pharmacy or drug supply, service shall be under the personal supervision of a pharmacist licensed to practice in the state of Iowa. (III)

58.21(15) Drug administration.

a. Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician associate (PA). In the case of a resident who has been certified by the resident's physician or physician associate (PA) as capable of taking the resident's own insulin, the resident may inject the resident's own insulin. (II)

b. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident. (II)

c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medications. (II)

[ARC 1050C, IAB 10/2/13, effective 11/6/13; ARC 7033C, IAB 5/31/23, effective 7/5/23; Editorial change: IAC Supplement 6/10/26]

481—58.22(135C) Rehabilitative services. Rehabilitative services shall be provided to maintain function or improve the resident's ability to carry out the activities of daily living.

58.22(1) Physical therapy services.

a. Each facility shall have a written agreement with a licensed physical therapist to provide physical therapy services. (III)

b. Physical therapy shall be rendered only by a physical therapist licensed to practice in the state of Iowa. All personnel assisting with the physical therapy of residents must be under the direction of a licensed physical therapist. (II, III)

c. The licensed physical therapist shall:

(1) Evaluate the resident and prepare a physical therapy treatment plan conforming to the medical orders and goals; (III)

(2) Consult with other personnel in the facility who are providing resident care and plan with them for the integration of a physical therapy treatment program into the overall health care plan; (III)

(3) Instruct the nursing personnel responsible for administering selected restorative procedures between treatments; (III)

(4) Present programs in the facility's in-service education programs. (III)

d. Treatment records in the resident's medical chart shall include:

(1) The prescription for treatment; (III)

- (2) An initial evaluation note by the physical therapist; (III)
- (3) The physical therapy care plan defining clearly the long-term and short-term goals and outlining the current treatment program; (III)
- (4) Notes of the treatments given and changes in the resident's condition; (III)
- (5) A complete discharge summary to include recommendations for nursing staff and family. (III)
- e. There shall be adequate facilities, space, appropriate equipment, and storage areas as are essential to the treatment or examinations of residents. (III)

58.22(2) Other rehabilitative services.

- a. The facility shall arrange for specialized and supportive rehabilitative services when such services are ordered by a physician. (III) These may include audiology and occupational therapy.
- b. Audiology services shall be under the direction of a person licensed in the state of Iowa by the board of speech pathology and audiology. (II, III)
- c. Occupational therapy services shall be under the direction of a qualified occupational therapist who is currently registered by the American Occupational Therapy Association. (II, III)
- d. The appropriate professional shall:
 - (1) Develop the treatment plan and administer or direct treatment in accordance with the prescription and rehabilitation goals; (III)
 - (2) Consult with other personnel within the facility who are providing resident care and plan with them for the integration of a treatment program into the overall health care plan. (III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.23(135C) Dental, diagnostic, and other services.

58.23(1) Dental services.

- a. The nursing facility personnel shall assist residents to obtain regular and emergency dental services. (III)
- b. Transportation arrangements shall be made when necessary for the resident to be transported to the dentist's office. (III)
- c. Dental services shall be performed only on the request of the resident, responsible relative, or legal representative. The resident's physician shall be advised of the resident's dental problems. (III)
- d. All dental reports or progress notes shall be included in the clinical record. (III)
- e. Nursing personnel shall assist the resident in carrying out dentist's recommendations. (III)
- f. Dentists shall be asked to participate in the in-service program of the facility. (III)

58.23(2) Diagnostic services.

- a. The nursing facility shall make provisions for promptly securing required clinical laboratory, X-ray, and other diagnostic services. (III)
- b. All diagnostic services shall be provided only on the written, signed order of a physician. (III)
- c. Agreements shall be made with the local hospital laboratory or independent laboratory to perform specific diagnostic tests when they are required. (III)
- d. Transportation arrangements for residents shall be made, when necessary, to and from the source of service. (III)
- e. Copies of all diagnostic reports shall be requested by the facility and included in the resident's clinical record. (III)
- f. The physician ordering the specific diagnostic service shall be promptly notified of the results. (III)
- g. Simple tests such as customarily done by nursing personnel for diabetic residents may be performed in the facility. (III)

58.23(3) Other services.

- a. The nursing facility shall assist residents to obtain such supportive services as requested by the physician. (III)
- b. Transportation arrangements shall be made when necessary. (III)

c. Services could include the need for prosthetic devices, glasses, hearing aids, and other necessary items. (III)

481—58.24(135C) Dietary.

58.24(1) *Organization of dietetic services.* The facility shall meet the needs of the residents and provide the services listed in this standard. If a service is contracted out, the contractor shall meet the same standard. A written agreement shall be formulated between the facility and the contractor and shall convey to the department the right to inspect the food service facilities of the contractor. (III)

a. There shall be written policies and procedures for dietetic services that include staffing, nutrition, menu planning, therapeutic diets, preparation, food service, ordering, receiving, storage, sanitation, and staff hygiene. The policies and procedures shall be made available for use by dietetic services. (III)

b. There shall be written job descriptions for each position in dietetic services. The job descriptions shall be made available for use by dietetic services. (III)

58.24(2) *Dietary staffing.* The facility shall employ dietary staff in accordance with 42 CFR 483.60(a).

a. Reserved.

b. The supervisor shall have overall supervisory responsibility for dietetic services and shall be employed for a sufficient number of hours to complete management responsibilities that include:

(1) Participating in regular conferences with the consultant dietitian, the administrator and other department heads; (III)

(2) Writing menus with consultation from the dietitian and seeing that current menus are posted and followed and that menu changes are recorded; (III)

(3) Establishing and maintaining standards for food preparation and service; (II, III)

(4) Participating in selection, orientation, and in-service training of dietary personnel; (II, III)

(5) Supervising activities of dietary personnel; (II, III)

(6) Maintaining up-to-date records of residents identified by name, location and diet order; (III)

(7) Visiting residents to learn individual needs and communicating with other members of the health care team regarding nutritional needs of residents when necessary; (II, III)

(8) Keeping records of repairs of equipment in dietetic services. (III)

c. A minimum of one person with supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager who has received training from and passed a test that is part of an American National Standards Institute (ANSI)-accredited Certified Food Protection Manager Program.

d. The facility shall employ sufficient supportive personnel to carry out the following functions:

(1) Preparing and serving adequate amounts of food that are handled in a manner to be bacteriologically safe; (II, III)

(2) Washing and sanitizing dishes, pots, pans and equipment at temperatures required by procedures described in the Food Code as defined in Iowa Code section 137F.2; (II, III)

(3) Serving therapeutic diets as prescribed by the physician or other qualified health care practitioner, including a licensed dietitian if delegated by the physician and within the dietitian's scope of practice, and following the planned menu. (II, III)

e. The facility may assign simultaneous duties in the kitchen and laundry, housekeeping, or nursing service to appropriately trained personnel. Proper sanitary and personal hygiene procedures shall be followed in compliance with the Food and Drug Administration Food Code adopted pursuant to Iowa Code section 137F.2 and 481—Chapter 31. (II, III)

f. If the dietetic service supervisor is not a licensed dietitian, a consultant dietitian is required. The consultant dietitian shall be licensed by the state of Iowa pursuant to Iowa Code chapter 152A.

g. Consultants' visits shall be scheduled to be of sufficient duration and at a time convenient to:

(1) Record, in the resident's medical record, any observations, assessments and information pertinent to medical nutrition therapy; (I, II, III)

- (2) Work with residents and staff on resident care plans; (III)
- (3) Consult with the administrator and others on developing and implementing policies and procedures; (III)
- (4) Write or approve general and therapeutic menus; (III)
- (5) Work with the dietetic supervisor on developing procedures, recipes and other management tools; (III)
- (6) Present planned in-service training and staff development for food service employees and others. Documentation of consultation shall be available for review in the facility by the department. (III)

h. In facilities licensed for more than 15 beds, dietetic services shall be available for a minimum of a 12-hour span extending from the time of preparation of breakfast through supper. (III)

58.24(3) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet the nutritional needs of each resident in accordance with a qualified health care practitioner's orders and in consideration of the resident's allergies, intolerances, choices, and preferences. (II, III)

b. Menus shall be planned to provide 100 percent of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. A current copy of the Simplified Diet Manual or other suitable diet manual shall be available and used in the planning and serving of all meals. (II)

c. At least three meals or their equivalent shall be served daily at regular hours. (II)

(1) There shall be no more than a 14-hour span between a substantial evening meal and breakfast except as provided in subparagraph (3) below. (II, III)

(2) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at nontraditional times or outside of scheduled meal service times, consistent with the resident plan of care and 42 CFR 483.60(f) and federal interpretive guidelines. (II, III)

(3) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast of the following day. The current resident group must agree to this meal span and a nourishing snack must be served. (II)

d. Menus shall include a variety of foods prepared in various ways. (III)

e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic services department for easy use by persons purchasing, preparing and serving food. (III)

f. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by department personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded. (III)

g. A file of tested recipes adjusted to the number of people to be served in the facility shall be maintained. (III)

h. Alternate foods of similar nutritional value shall be offered to residents who refuse the food served. (II, III)

58.24(4) *Therapeutic diets and nutritional status.*

a. The facility shall ensure that each resident has a nutritional assessment completed by the licensed dietitian within 14 days of admission or after the facility determines there has been a significant change in the resident's physical or mental condition that addresses the residents' medical condition and therapeutic dietary needs, desires and rights in regard to their nutritional plan. (I, II, III)

b. Therapeutic diets shall be prescribed by the resident's physician or other qualified health care practitioner. A current edition of the Simplified Diet Manual or other suitable diet manual shall be readily available to physicians, nurses and dietetic services personnel. A current diet manual shall be used as a guide for writing menus for therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and reviewing procedures for preparation and service of food. (II, III)

c. Personnel responsible for planning, preparing and serving therapeutic diets shall receive instructions on those diets. (II, III)

d. The facility shall ensure that each resident maintains acceptable parameters of nutritional status, such as body weight, unless the resident's clinical condition demonstrates that this is not possible. (I, II, III)

58.24(5) *Food handling, preparation and service.* All food shall be handled, prepared and served in compliance with the requirements of the Food and Drug Administration Food Code adopted under provisions of Iowa Code section 137F.2. (I, II, III) In addition, the following shall apply.

a. Methods used to prepare foods shall be those which conserve nutritive value and flavor and meet the taste preferences of the residents. (III)

b. Foods shall be attractively served. (III)

c. Foods shall be cut up, chopped, ground or blended to meet individual needs. (I, II, III)

d. Self-help devices shall be provided as needed. (II, III)

e. Disposables shall not be used routinely. Plasticware, china and glassware that are unsightly, unsanitary or hazardous because of chips, cracks or loss of glaze shall be discarded. (II, III)

f. All food that is transported through public corridors shall be covered. (III)

g. Residents may be allowed in the food preparation area. (III)

h. The food preparation area may be used as a dining area for residents, staff or food service personnel if the facility engages in person-directed care. (III)

i. There shall be effective written procedures established for cleaning all work and serving areas. (III)

j. A schedule of cleaning duties to be performed daily shall be posted. (III)

k. An exhaust system and hood shall be clean, operational and maintained in good repair. (III)

l. The food service area shall be located so it will not be used as a passageway by residents, guests or non-food service staff. (III)

58.24(6) *Paid nutritional assistants.* A paid nutritional assistant means an individual who meets the requirements of this subrule and who is an employee of the facility or an employee of a temporary employment agency employed by the facility. A facility may use an individual working in the facility as a paid nutritional assistant only if that individual has successfully completed a state-approved training program for paid nutritional assistants. (I, II, III)

a. *Training program requirements.*

(1) A state-approved training program for paid nutritional assistants must include, at a minimum, eight hours of training in the following areas:

1. Feeding techniques.

2. Assistance with feeding and hydration.

3. Communication and interpersonal skills.

4. Appropriate responses to resident behavior.

5. Safety and emergency procedures, including the Heimlich maneuver.

6. Infection control.

7. Resident rights.

8. Recognizing changes in residents that are inconsistent with their normal behavior and reporting these changes to the supervisory nurse.

(2) In addition to the training program requirements specified in subparagraph (1), the training program must include at least four hours of classroom study, two hours of supervised laboratory work, and two hours of supervised clinical experience.

(3) A facility that offers a paid nutritional assistant training program must provide sufficient supplies in order to teach the objectives of the course.

(4) All paid nutritional assistant training program instructors shall be registered nurses. Other qualified health care professionals may assist the instructor in teaching the classroom portion and clinical or laboratory experience. The ratio of students to instructor shall not exceed ten students per instructor in the clinical setting.

(5) Each individual enrolled in a paid nutritional assistant training program shall complete a 50-question multiple choice written test and must obtain a score of 80 percent or higher. In addition, the individual must successfully perform the feeding of a resident in a clinical setting. A registered nurse shall conduct the final competency determination.

(6) If an individual does not pass either the written test or competency demonstration, the individual may retest the failed portion a second time. If the individual does not pass either the written test or competency demonstration portion the second time, the individual shall not be allowed to retest.

b. Program approval. A facility or other entity may not offer or teach a paid nutritional assistant training program until the department has approved the program. Individuals trained in a program not approved by the department will not be allowed to function as paid nutritional assistants.

(1) A facility or other institution offering a paid nutritional assistant training program must provide the following information about the training program to the department before offering the program or teaching paid nutritional assistants:

1. Policies and procedures for program administration.
2. Qualifications of the instructors.
3. Maintenance of program records, including attendance records.
4. Criteria for determining competency.
5. Program costs and refund policies.
6. Lesson plans, including the objectives to be taught, skills demonstrations, assignments, quizzes, and classroom, laboratory and clinical hours.

(2) The facility or other institution offering a paid nutritional assistant training program must submit the materials specified in subparagraph (1) for department review. The department shall, within ten days of receipt of the material, advise the facility or institution whether the program is approved, or request additional information to assist the department in determining whether the curriculum meets the requirements for a paid nutritional assistant training program. Before approving any paid nutritional assistant training program, the department shall determine whether the curriculum meets the requirements specified in this subrule. The department shall maintain a list of facilities and institutions eligible to provide paid nutritional assistant training. (I, II, III)

(3) A facility shall maintain a record of all individuals who have successfully completed the required training program and are used by the facility as paid nutritional assistants. The individual shall complete the training program with a demonstration of knowledge and competency skills necessary to serve as a paid nutritional assistant. (I, II, III)

(4) The facility or other institution providing the training shall, within ten calendar days of an individual's successful completion of the training program, provide the individual with a signed and dated certificate of completion. A facility that employs paid nutritional assistants shall maintain on file copies of the completed certificate and skills checklist for each individual who has successfully completed the training program. (I, II, III)

c. Working restrictions.

(1) A paid nutritional assistant must work under the supervision of a registered nurse or a licensed practical nurse. In an emergency, a paid nutritional assistant must call a supervisory nurse on the resident call system for help. (I, II, III)

(2) A facility must ensure that a paid nutritional assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube, parenteral or intravenous feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. (I, II, III)

[ARC 2560C, IAB 6/8/16, effective 7/13/16; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.25(135C) Social services program.

58.25(1) The administrator or designee shall be responsible for developing a written, organized orientation program for all residents. (III)

58.25(2) The program shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the medical or health care, recovery, and rehabilitation of the individual. (III)

58.25(3) The social services plan, including specific goals and regular evaluation of progress, shall be incorporated into the overall plan of care. (III)

481—58.26(135C) Resident activities program.

58.26(1) *Organized activities.* Each nursing facility shall provide an organized resident activity program for the group and for the individual resident which shall include suitable activities for evenings and weekends. (III)

a. The activity program shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's physician. This shall include helping residents continue in their individual interests or hobbies. (III)

b. The program shall include individual goals for each resident. (III)

c. The program shall include both group and individual activities. (III)

d. No resident shall be forced to participate in the activity program. (III)

e. The activity program shall include suitable activities for those residents unable to leave their rooms. (III)

f. The program shall be incorporated into the overall health plan and shall be designed to meet the goals as written in the plan.

58.26(2) *Coordination of activities program.*

a. Each nursing facility shall employ a person to direct the activities program. (III)

b. Staffing for the activity program shall be sufficient to meet the residents' activity needs. (II, III)

c. The activity coordinator shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. These programs shall be approved by the department. (III)

d. There shall be a written plan for personnel coverage when the activity coordinator is absent during scheduled working hours. (III)

58.26(3) *Duties of activity coordinator.* The activity coordinator shall:

a. Have access to all residents' records excluding financial records; (III)

b. Coordinate all activities, including volunteer or auxiliary activities and religious services; (III)

c. Keep all necessary records including:

(1) Attendance; (III)

(2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident's clinical record; (III)

(3) Monthly calendars, prepared in advance. (III)

d. Coordinate the activity program with all other services in the facility; (III)

e. Participate in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

58.26(4) *Supplies, equipment, and storage.*

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III) These may include: books (standard and large print), magazines, newspapers, radio, television, and bulletin boards. Also appropriate would be box games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, outdoor equipment, etc.

b. Storage shall be provided for recreational equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23; Editorial change: IAC Supplement 6/28/23]

481—58.27(135C) Certified volunteer long-term care ombudsman program. Rescinded ARC 7033C, IAB 5/31/23, effective 7/5/23.

481—58.28(135C) Safety. The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)

58.28(1) Fire safety.

a. All nursing facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

58.28(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be posted. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (III)

58.28(3) Resident safety.

a. Residents shall be permitted to smoke only where proper facilities are provided. Smoking shall not be permitted in bedrooms. Smoking by residents considered to be careless shall be prohibited except when the resident is under direct supervision. (II, III)

b. Smoking is prohibited in all rooms where oxygen is being administered or in rooms where oxygen is stored. (II, III)

c. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

d. Smoking shall be permitted only in posted areas. (II, III)

e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)

f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)

[ARC 1398C, IAB 4/2/14, effective 5/7/14]

481—58.29(135C) Resident care.

58.29(1) There shall be a readily available supply of self-help and ambulation devices such as wheelchairs, walkers, and such other devices maintained in good repair that will meet the current needs of all residents. (III)

58.29(2) The facility shall ensure that each ambulatory resident has well-fitting shoes to provide support and prevent slipping. (III)

58.29(3) Equipment for personal care shall be maintained in a safe and sanitary condition. (II, III)

58.29(4) The expiration date for sterile equipment shall be exhibited on its wrappings. (III)

58.29(5) Residents who have been known to wander shall be provided with appropriate means of identification. (II, III)

58.29(6) Electric heating pads, blankets, or sheets shall be used only on the written order of a physician, when allowed by the Life Safety Code or applicable state or local fire regulations. (II, III)

481—58.30 Rescinded, effective 7/14/82.

481—58.31(135C) Housekeeping.

58.31(1) Written procedures shall be established and implemented for daily and weekly cleaning schedules. (III)

58.31(2) Each resident unit shall be cleaned on a routine schedule. (III)

58.31(3) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (III)

58.31(4) A hallway or corridor shall not be used for storage of equipment. (III)

58.31(5) All odors shall be kept under control by cleanliness and proper ventilation. (III)

58.31(6) Clothing worn by personnel shall be clean and washable. (III)

58.31(7) Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

58.31(8) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (III)

58.31(9) Polishes used on floors shall provide a nonslip finish. (III)

58.31(10) *Throw or scatter rugs shall not be permitted. (III)

58.31(11) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

58.31(12) Residents shall not have access to storage areas for all cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials. (II, III)

58.31(13) Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)

58.31(14) Definite procedures shall be established for training housekeeping personnel. (III)

58.31(15) Rescinded IAB 12/6/06, effective 1/10/07.

58.31(16) There shall be provisions for the cleaning and storage of housekeeping equipment and supplies for each nursing unit. (III)

58.31(17) Bathtubs, shower stalls, or lavatories shall not be used for laundering, cleaning of utensils and mops, or for storage. (III)

58.31(18) Bedside utensils shall be stored in enclosed cabinets. (III)

58.31(19) Kitchen sinks shall not be used for the cleaning of mops, soaking of laundry, cleaning of bedside utensils, nursing utensils, or dumping of wastewater. (III)

58.31(20) Personal possessions of residents which may constitute hazards to themselves or others shall be removed and stored. (III)

* Objection. For text of Objection, see IAC Supp., Part I, 9/7/77. For text of Filed rules, 470—Chapter 58, see IAC Supp. 10/5/77.

481—58.32(135C) Maintenance.

58.32(1) Each facility shall establish a maintenance program in writing to ensure the continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout the facility. (III)

58.32(2) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (III)

58.32(3) Draperies and furniture shall be clean and in good repair. (III)

58.32(4) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (III)

58.32(5) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the national electrical code. (III)

58.32(6) All plumbing fixtures shall function properly and comply with the state plumbing code. (III)

58.32(7) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. Documentation of these inspections shall be available for review. (III)

58.32(8) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (III)

58.32(9) The facility shall be kept free of flies, other insects, and rodents. (III)

58.32(10) Maintenance personnel.

a. A written program shall be established for the orientation of maintenance personnel. (III)

b. Maintenance personnel shall:

(1) Follow established written maintenance programs; (III)

(2) Be provided with appropriate, well-constructed, and properly maintained equipment. (III)

481—58.33(135C) Laundry.

58.33(1) All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

58.33(2) Except for related activities, the laundry room shall not be used for other purposes. (III)

58.33(3) Procedures shall be written for the proper handling of wet, soiled, and contaminated linens. (III)

58.33(4) Residents' personal laundry shall be marked with an identification. (III)

58.33(5) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

481—58.34(135C) Garbage and waste disposal.

58.34(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

58.34(2) All containers for refuse shall be watertight, rodent-proof, and have tight-fitting covers. (III)

58.34(3) All containers shall be thoroughly cleaned each time the containers are emptied. (III)

58.34(4) All wastes shall be properly disposed of in compliance with local ordinances and state codes. (III)

58.34(5) Special provision shall be made for the disposal of soiled dressings and similar items in a safe, sanitary manner. (III)

481—58.35(135C) Buildings, furnishings, and equipment.

58.35(1) *Buildings—general requirements.*

a. For purposes of computation of usable floor space in bedrooms and other living areas of the facility, that part of the room having no less than seven feet of ceiling height shall be used. Usable floor space may include irregularities in the rooms such as alcoves and offsets with approval of the department. Usable floor space shall not include space needed for corridor door swings or wardrobes being used as a substitute for closet space. (III)

b. Portable emergency lights in good working condition shall be available at all times, at a ratio of one light per one employee on duty from 6 p.m. to 6 a.m. (III)

c. All windows shall be supplied with curtains and shades or drapes which are kept clean and in good repair. (III)

d. Light fixtures shall be so equipped to prevent glare and to prevent hazards to the residents. (III)

e. Exposed heating pipes, hot water pipes, or radiators in rooms and areas used by residents and within reach of residents shall be covered or protected to prevent injury or burns to residents. (II, III)

f. All fans located within seven feet of the floor shall be protected by screen guards of not more than one-half-inch mesh. (III)

g. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

h. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

i. No part of any room shall be enclosed, subdivided, or partitioned unless such part is separately lighted and ventilated and meets such other requirements as its usage and occupancy dictates, except closets used for the storage of residents' clothing. (III)

58.35(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to its function and in accordance with the department's approved program of care. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a home-like atmosphere. (III)

c. Upholstery materials shall be moisture- and soil-resistant, except on furniture provided by the resident and the property of the resident. (III)

58.35(3) *Dining and living rooms.*

a. Every facility shall have a dining room and a living room easily accessible to all residents. (III)

b. Dining rooms and living rooms shall at no time be used as bedrooms. (III)

c. Dining rooms and living rooms shall be available for use by residents at appropriate times to provide periods of social and diversional individual and group activities. (III)

d. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 58.35(3) "e" are met. (III)

e. Multipurpose rooms. When space is provided for multipurpose dining and activities and recreational purposes, the area shall total at least 30 square feet per licensed bed for the first 100 beds and 27 square feet per licensed bed for all beds in excess of 100. An open area of sufficient size shall be provided to permit group activities such as religious meetings or presentation of demonstrations or entertainment. (III)

f. Living rooms.

(1) Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. (III)

(2) Living rooms shall be suitably provided with parlor furniture, television and radio receivers in good working order, recreational material such as games, puzzles, and cards, and reading material such as current newspapers and magazines. Furnishings and equipment of the room should be such as to allow group activities. (III)

(3) Card tables or game tables shall be made available. The tables should be of a height to allow a person seated in a wheelchair to partake in the games or card playing. (III)

(4) Chairs of proper height and appropriate to their use shall be provided for seating residents at game tables and card tables. (III)

g. Dining rooms.

(1) Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

(2) Dining tables and chairs shall be provided. (III)

(3) Dining tables should be so constructed that a person seated in a wheelchair can dine comfortably. (III)

(4) Tables shall be of sturdy construction with smooth, durable, nonpermeable tops that can be cleaned with a detergent sanitizing solution. (III)

(5) Dining chairs shall be sturdy and comfortable. Some arm chairs should be provided for ease of movement for some residents. (III)

(6) Residents shall be encouraged to eat in the dining room. (III)

58.35(4) *Bedrooms.*

a. Each resident shall be provided with a standard, single, or twin bed that is substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. Seventy-five percent of the beds shall have a spring with an adjustable head and foot section. A resident shall have the right to sleep in a chair per the resident's request and to have the bed removed from the room to allow for additional space. (III)

b. Each bed shall be equipped with the following: casters or glides unless a low bed and mattress are being used for fall precautions; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; clean, comfortable pillows of average size; and moisture-proof covers and sheets as necessary to keep the mattress and pillows dry and clean. (III)

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions. (III)

d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)

e. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

f. Walls, ceilings, and floors shall have easily cleanable surfaces and shall be kept clean and in good repair. (III)

g. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

h. Clothing shall be hung in closets or wardrobes available in each room. (III)

i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)

j. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)

k. Reading lamps shall be provided each resident in the resident's room. (III)

l. Each room shall have sufficient accessible mirrors to serve the resident's needs. Mirrors are not required if the room is located in a CCDI unit and the mirrors cause concern for the resident. (III)

m. Sturdy, adjustable overbed tables shall be provided for each resident who is unable to eat in the dining room. (III)

n. Each resident bedroom shall have a door. The door shall be the swing type and shall not swing into the corridor. (III)

58.35(5) Heating. A centralized heating system capable of maintaining a minimum temperature of 78°F (26°C) shall be provided. Portable units or space heaters are prohibited from being used in the facility except as permitted in the governing Life Safety Code or in an emergency. In the event of emergency use, the facility shall provide notice to the state fire marshal's office within 24 hours. (III)

58.35(6) Water supply.

a. Every facility shall have an adequate water supply from an approved source. A municipal source of supply shall be considered as meeting this requirement. (III)

b. Private sources of supply shall be tested annually and the report submitted with the annual application for license. (III)

c. A bacterially unsafe source of supply shall be grounds for denial, suspension, or revocation of license. (III)

d. The department may require testing of private sources of supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

e. Hot and cold running water under pressure shall be available in the facility. (III)

f. Prior to construction of a new facility or new water source, private sources of supply shall be surveyed and shall comply with the requirements of the department of health. (III)

58.35(7) Nonambulatory residents.

a. All nonambulatory residents shall be housed on the grade level floor. (II, III)

b. These provisions in "a" above relating to nonambulatory residents are not applicable if the facility has a suitably sized elevator.

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.36(135C) Family and employee accommodations.

58.36(1) Children under 14 years of age shall not be allowed into the service areas. (III)

58.36(2) The residents' bedrooms shall not be occupied by employees or family members of the licensee. (III)

58.36(3) In facilities where the total occupancy of family, employees, and residents is five or less, one toilet and one tub or shower shall be the minimum requirement. (III)

58.36(4) In facilities where the total occupancy of family, employees, and residents is more than five, separate bathing and toilet facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

58.36(5) In all health care facilities, if the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for residents. (III)

481—58.37(135C) Animals. Animals may be permitted within the facility with prior approval of the department and under controlled conditions. (III)

481—58.38(135C) Supplies.

58.38(1) *Linen supplies.*

a. There shall be an adequate supply of linen so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Uncrowded and convenient storage shall be provided for linens, pillows, and bedding. (III)

58.38(2) *First-aid kit.* A first-aid emergency kit shall be available on each floor in every facility. (II, III)

58.38(3) *Supplies and equipment for nursing services.*

a. All nursing care equipment shall be properly sanitized or sterilized before use by another resident. (II)

b. There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by generally accepted infection control standards. (I, II, III)

c. Convenient, safe storage shall be provided for bath and toilet supplies, bathroom scales, mechanical lifts, and shower chairs. (III)

d. Sanitary and protective storage shall be provided for all equipment and supplies. (III)

e. All items that must be sterilized shall be autoclaved unless sterile disposable items are furnished which are promptly disposed of after a single use. (III)

f. Supplies and equipment for nursing and personal care sufficient in quantities to meet the needs of the residents shall be provided. (III)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.39(135C) Residents' rights in general.

58.39(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, all of the following provisions (subrules 58.39(2) to 58.39(6)) and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, their families or legal representatives and the public and shall be reviewed annually. (II)

58.39(2) Policies and procedures shall address the admission and retention of persons with histories of dangerous or disturbing behavior. For the purposes of the subrule, persons with histories of dangerous or disturbing behavior are those persons who have been found to be seriously mentally impaired pursuant to Iowa Code section 229.13 within six months of the request for admission to the facility. In addition to establishing the criteria for admission and retention of persons so defined, the policies and procedures shall provide for:

a. Reasonable precautions to prevent the resident from harming self, other residents, or employees of the facility.

b. Treatment of persons with mental illness as defined in Iowa Code section 229.1(1) and which is provided in accordance with the individualized health care plan.

c. Ongoing and documented staff training on individualized health care planning for persons with mental illness.

58.39(3) Policies and procedures regarding the admission, transfer, and discharge of residents shall ensure that:

a. Only those persons are accepted whose needs can be met by the facility directly or in cooperation with community resources or other providers of care with which it is affiliated or has contracts. (II)

b. As changes occur in residents' physical or mental condition, necessitating services or care which cannot be adequately provided by the facility, they are transferred promptly to other appropriate facilities. (II)

58.39(4) Policies and procedures regarding the use of chemical and physical restraints shall define the use of said restraints and identify the individual who may authorize the application of physical restraints in emergencies, and describe the mechanism for monitoring and controlling their use. (II)

58.39(5) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible party and for ensuring a response and disposition by the facility. (II)

58.39(6) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II)

58.39(7) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from them. The facility shall communicate these expectations during the period of not more than two weeks before or five days after admission. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English speaking or deaf or hard of hearing, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities and these questions shall be answered. (II)

c. A statement shall be signed by the resident, or the resident's responsible party, indicating an understanding of these rights and responsibilities, and shall be maintained in the record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party, if applicable. In the case of an intellectually disabled resident, the signature shall be witnessed by a person not associated with or employed by the facility. The witness may be a parent, guardian, Medicaid agency representative, etc. (II)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English speaking, deaf or hard-of-hearing, or blind residents of such changes. (II)

58.39(8) Each resident or responsible party shall be fully informed in a contract as required in rule 481—58.13(135C), prior to or at the time of admission and during the resident's stay, of services available in the facility, and of related charges including any charges for services not covered under the Title XIX program or not covered by the facility's basic per diem rate. (II)

58.39(9) Each resident or responsible party shall be fully informed by a physician of the resident's health and medical condition unless medically contraindicated (as documented by a physician in the resident's record). Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, which may include, but is not limited to, nursing care, nutritional care, rehabilitation, restorative therapies, activities, and social work services. Each resident only participates in experimental research conducted under the U.S. Department of Health and Human Services' protection from research risks policy and then only upon the resident's informed written consent. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a confused or intellectually disabled individual, the responsible party shall be informed by the physician of the resident's medical condition and be afforded the opportunity to participate in the planning of the resident's total care and medical treatment, to be informed of the medical condition, and to refuse to participate in experimental research. (II)

a. The requirement that residents shall be informed of their conditions, involved in the planning of their care, and advised of any significant changes in either shall be communicated to every physician responsible for the medical care of residents in the facility. (II)

b. The administrator or designee shall be responsible for working with attending physicians in the implementation of this requirement. (II)

c. If the physician determines or in the case of a confused or intellectually disabled resident the responsible party determines that informing the resident of the resident's condition is contraindicated, this decision and reasons for it shall be documented in the resident's record by the physician. (II)

d. The resident's plan of care shall be based, in part, on the physician's orders. It shall be developed upon admission by appropriate facility staff and shall include participation by the resident if capable. Residents shall be advised of alternative courses of care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives shall be elicited and honored if feasible.

e. Any clinical investigation involving residents must be under the sponsorship of an institution with a human subjects review board functioning in accordance with the requirements of 45 CFR 46. A resident being considered for participation in experimental research must be fully informed of the nature of the experiment, e.g., medication, treatment, and understand the possible consequences of participating or not participating. The resident's (or responsible party's) written informed consent must be received prior to participation. (II)

This rule is intended to implement Iowa Code section 135C.23(2).

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 5711C, IAB 6/16/21, effective 7/21/21; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.40(135C) Involuntary discharge or transfer.

58.40(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)

58.40(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)

58.40(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)

58.40(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)

58.40(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: (II)

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) 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.

b. The notice shall be personally delivered to the resident and a copy 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; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's office of the long-term care ombudsman. 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 58.40(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 58.40(7).

58.40(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: (II)

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.

b. The notice shall be personally delivered to the resident and a copy 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; the person or agency responsible for the resident's placement, maintenance, and care in the facility; and the department on aging's office of the long-term care ombudsman. 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 58.40(7).

58.40(7) *Hearing.*

a. Request for hearing.

- (1) The resident must request a hearing within 7 days of receipt of the 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 9. The hearing shall be public unless the resident or resident's legal 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, the responsible party, and the office of the long-term care ombudsman not later than 5 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. The office of the long-term care ombudsman shall have the right to appear at the hearing.

f. The administrative law judge's written decision shall be mailed by certified mail to the facility, resident, responsible party, and the office of the long-term care ombudsman 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 agencies as appropriate. Continued payment shall be consistent with rules of those agencies.

58.40(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)

58.40(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 58.40(6) and emergency notice is provided within 48 hours.

58.40(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 58.40(10) "b" does not apply if the discharge has already occurred pursuant to subrule 58.40(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)

58.40(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 60 days must be allowed for an orderly transfer of residents to other facilities.

58.40(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) 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 58.40(12) "a"(5). (II)

(2) As punishment or behavior modification, except as specified in subparagraph 58.40(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 58.40(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 1752C, IAB 12/10/14, effective 1/14/15; ARC 3523C, IAB 12/20/17, effective 1/24/18; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.41(135C) Residents' rights. Each resident shall be encouraged and assisted throughout the resident's period of stay, to exercise rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

58.41(1) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of issues or pending decisions of the facility that affect them and their views shall be solicited prior to action. (II)

58.41(2) The facility shall implement a written procedure for registering and resolving grievances and recommendations by residents or their responsible party. The procedure shall ensure protection of the resident from any form of reprisal or intimidation. The written procedure shall include:

a. Designation of an employee responsible for handling grievances and recommendations. (II)

b. A method of investigating and assessing the validity of a grievance or recommendation. (II)

c. Methods of resolving grievances. (II)

d. Methods of recording grievances and actions taken. (II)

58.41(3) The facility shall post in a prominent area the name, telephone number, and address of the ombudsman, survey agency, local law enforcement agency, and certified volunteer long-term care ombudsman and the text of Iowa Code section 135C.46 to provide to residents a further course of redress. (II)

[ARC 1205C, IAB 12/11/13, effective 1/15/14]

481—58.42(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs, and to the extent, under written authorization by the resident that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

58.42(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

58.42(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

58.42(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24(2). Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a confused or intellectually disabled resident, the resident's responsible party shall designate a method of disbursing the resident's funds. (II)

58.42(4) If the facility makes financial transactions on a resident's behalf, the resident must receive or acknowledge that the resident has seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

58.42(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's guardian. (II)

58.42(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's guardian. The department may report findings that resident funds have been used without written consent to the audits division or the local law enforcement agency, as appropriate. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

481—58.43(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. Each resident shall be free from chemical and physical restraints except as follows: when authorized in writing by a physician for a specified period of time; when necessary in an emergency to protect the resident from injury to the resident or to others, in which case restraints may be authorized by designated professional personnel who promptly report the action taken to the physician; and in the case of an intellectually disabled individual when ordered in writing by a physician and authorized by a designated qualified intellectual disabilities professional for use during behavior modification sessions. Mechanical supports used in normative situations to achieve proper body position and balance shall not be considered to be a restraint. (II)

58.43(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (II)

58.43(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (II)

58.43(3) Drugs such as tranquilizers may not be used as chemical restraints to limit or control resident behavior for the convenience of staff. (II)

58.43(4) Physicians' orders are required to utilize all types of physical restraints and shall be renewed at least quarterly. (II) Physical restraints are defined as the following:

Type I—the equipment used to promote the safety of the individual but is not applied directly to their person. Examples: divided doors and totally enclosed cribs.

Type II—the application of a device to the body to promote safety of the individual. Examples: vest devices, soft-tie devices, hand socks, geriatric chairs.

Type III—the application of a device to any part of the body which will inhibit the movement of that part of the body only. Examples: wrist, ankle or leg restraints and waist straps.

58.43(5) Physical restraints are not to be used to limit resident mobility for the convenience of staff and must comply with life safety requirements. If a resident's behavior is such that it may result in injury to the resident or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure(s) designed to modify the behavioral problems for which the resident is restrained, or as a last resort, after failure of attempted therapy. (I, II)

58.43(6) Each time a Type II or III restraint is used documentation on the nurse's progress record shall be made which includes type of restraint and reasons for the restraint and length of time resident

was restrained. The documentation of the use of Type III restraint shall also include the time of position change. (II)

58.43(7) Each facility shall implement written policies and procedures governing the use of restraints which clearly delineate at least the following:

- a.* Physicians' orders shall indicate the specific reasons for the use of restraints. (II)
- b.* Their use is temporary and the resident will not be restrained for an indefinite amount of time. (I, II)
- c.* A qualified nurse shall make the decision for the use of a Type II or Type III restraint for which there shall be a physician's order. (II)
- d.* A resident placed in a Type II or III restraint shall be checked at least every 30 minutes by appropriately trained staff. No form of restraint shall be used or applied in such a manner as to cause injury or the potential for injury and provide a minimum of discomfort to resident restrained. (I, II)
- e.* Reorders are issued only after the attending physician reviews the resident's condition. (II)
- f.* Their use is not employed as punishment, for the convenience of the staff, or as a substitute for supervision or program. (I, II)
- g.* The opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which Type II and Type III restraints are employed, except when resident is sleeping. However, when resident awakens, this shall be provided. This shall be documented each time. A check sheet may serve this purpose. (I, II)
- h.* Locked restraints or leather restraints shall not be permitted except in life-threatening situations. Straight jackets and secluding residents behind locked doors shall not be employed. (I, II)
- i.* Nursing assessment of the resident's need for continued application of a Type III restraint shall be made every 12 hours and documented on the nurse's progress record. Documentation shall include the type of restraint, reason for the restraint and the circumstances. Nursing assessment of the resident's need for continued application of either a Type I or Type II restraint and nursing evaluation of the resident's physical and mental condition shall be made every 30 days and documented on the nurse's progress record. (II)
- j.* Divided doors shall be of the type that when the upper half is closed the lower section shall close. (II)
- k.* Methods of restraint shall permit rapid removal of the resident in the event of fire or other emergency. (I, II)
- l.* The facility shall provide orientation and ongoing education programs in the proper use of restraints.

58.43(8) In the case of an intellectually disabled individual who participates in a behavior modification program involving use of restraints or aversive stimuli, the program shall be conducted only with the informed consent of the individual's parent or responsible party. Where restraints are employed, an individualized program shall be developed by the interdisciplinary team with specific methodologies for monitoring its progress. (II)

a. The resident's responsible party shall receive a written account of the proposed plan of the use of restraints or aversive stimuli and have an opportunity to discuss the proposal with a representative(s) of the treatment team. (II)

b. The responsible party must consent in writing prior to the use of the procedure. Consent may also be withdrawn in writing. (II)

58.43(9) 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)

58.43(10) and 58.43(11) Rescinded IAB 12/11/13, effective 1/15/14.

This rule is intended to implement Iowa Code sections 135C.14, 235B.3(1), and 235B.3(11).

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1204C, IAB 12/11/13, effective 1/15/14; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.44(135C) Resident records. Each resident shall be ensured confidential treatment of all information contained in the resident's records, including information contained in an automatic data bank. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

58.44(1) The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(2) Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

58.44(3) The resident, or the resident's responsible party, shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request. (II)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.45(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (II)

58.45(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (II)

58.45(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

58.45(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

58.45(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

58.45(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply in emergency conditions. (II)

481—58.46(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code sections 35D.14 and 347B.5. Residents may perform services for the facility if such services are performed in accordance with 42 CFR 483.10(f)(9). (II)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.47(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

58.47(1) Residents shall be permitted to receive visitors in accordance with 42 CFR 483.10(f)(4) and the federal interpretive guidelines. A particular visitor may be restricted by the facility if the visitor's behavior is unreasonably disruptive to the functioning of the facility (this judgment must be made by the administrator and the reasons shall be documented and kept on file). (II)

58.47(2) Decisions to restrict a visitor are reviewed and reevaluated: each time the medical orders are reviewed by the physician, at least quarterly by the facility's staff, or at the resident's request. (II)

58.47(3) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

58.47(4) Telephones shall be available and accessible for residents to make and receive calls with privacy in accordance with 42 CFR 483.10(g)(6) and (7). Residents who need help shall be assisted in using the telephone. (II)

58.47(5) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

58.47(6) Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, qualified intellectual disabilities professional or facility administrator for refusing permission. (II)

58.47(7) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.48(135C) Resident activities. Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the attending physician or qualified intellectual disabilities professional as appropriate in the resident's record. (II)

58.48(1) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

58.48(2) All residents shall have the freedom to refuse to participate in these activities. (II)

[ARC 0766C, IAB 5/29/13, effective 7/3/13]

481—58.49(135C) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided such use is not otherwise prohibited by these rules. (II)

58.49(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a safe location which is convenient to the resident. (II)

58.49(2) Any personal clothing or possessions retained by the facility for the resident during the resident's stay shall be identified and recorded on admission and a record placed on the resident's chart. The facility shall be responsible for secure storage of the items, and they shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

58.49(3) A resident's personal property shall not be used without the written consent of the resident or the resident's guardian. (II)

58.49(4) A resident's personal property shall be returned to the resident when it has been used without the written consent of the resident or the resident's guardian. The department may report findings that a resident's property has been used without written consent to the local law enforcement agency, as appropriate. (II)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.50(135C) Family visits. Each resident, if married, shall be ensured privacy for visits by the resident's spouse; if both are residents in the facility, they shall be permitted to share a room if available. (II)

58.50(1) The facility shall provide for needed privacy in visits between spouses. (II)

58.50(2) Spouses who are residents in the same facility shall be permitted to share a room, if available. (II)

58.50(3) Family members shall be permitted to share a room, if available, if requested by both parties. (II)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.51(135C) Choice of physician and pharmacy. Each resident shall be permitted free choice of a physician. Each resident shall have the right to choose the resident's Medicare prescription drug benefit plan (Part D) pursuant to Section 1860D of the Social Security Act, and the facility shall utilize a pharmacy(ies) that recognizes the Part D plans chosen by that facility's Medicare beneficiaries. Each resident shall have free choice of pharmacy as to medications purchased by the resident outside of Part D plan coverage, although the facility may require the pharmacy selected to utilize a drug distribution system compatible with the system currently used by the facility.

A facility shall not require the repackaging of medications dispensed by the Veterans Administration or an institution operated by the Veterans Administration for the purpose of making the drug distribution system compatible with the system used by the facility. (II)

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.52(135C) Incompetent resident.

58.52(1) Each facility shall provide that all rights and responsibilities of the resident devolve to the resident's responsible party when a resident is adjudicated incompetent in accordance with state law or, in the case of a resident who has not been adjudicated incompetent under the laws of the state, in accordance with 42 CFR 483.10. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II)

58.52(2) The fact that a resident has been adjudicated incompetent does not absolve the facility from advising the resident of these rights to the extent the resident is able to understand them. The facility shall also advise the responsible party, if any, and acquire a statement indicating an understanding of residents' rights. (II)

481—58.53(135C) County care facilities. Rescinded ARC 7033C, IAB 5/31/23, effective 7/5/23.

481—58.54(135C) Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility).

58.54(1) A nursing facility which chooses to care for residents in a distinct part shall obtain a license for a CCDI unit or facility. In the case of a distinct part, this license will be in addition to its nursing facility license. The license shall state the number of beds in the unit or facility. (III)

a. Application for this category of care shall be submitted on a form provided by the department. (III)

b. Plans to modify the physical environment shall be submitted to the department. The plans shall be reviewed based on the requirements of 481—Chapter 61. (III)

58.54(2) A statement of philosophy shall be developed for each unit or facility which states the beliefs upon which decisions will be made regarding the CCDI unit or facility. Objectives shall be developed for each CCDI unit or facility as a whole. The objectives shall be stated in terms of expected results. (II, III)

58.54(3) A résumé of the program of care shall be submitted to the department for approval at least 60 days before a separate CCDI unit or facility is opened. A new résumé of the program of care shall be submitted when services are substantially changed. (II, III)

The résumé of the program of care shall:

- a.* Describe the population to be served; (II, III)
- b.* State philosophy and objectives; (II, III)
- c.* List admission and discharge criteria; (II, III)
- d.* Include a copy of the floor plan; (II, III)
- e.* List the titles of policies and procedures developed for the unit or facility; (II, III)
- f.* Propose a staffing pattern; (II, III)
- g.* Set out a plan for specialized staff training; (II, III)
- h.* State visitor, volunteer, and safety policies; (II, III)
- i.* Describe programs for activities, social services and families; (II, III) and
- j.* Describe the interdisciplinary care planning team. (II, III)

58.54(4) Separate written policies and procedures shall be implemented in each CCDI unit or facility. There shall be:

a. Admission and discharge policies and procedures which state the criteria to be used to admit residents and the evaluation process which will be used. These policies shall require a statement from the attending physician agreeing to the placement before a resident can be moved into a CCDI unit or facility. (II, III)

b. Safety policies and procedures which state the actions to be taken by staff in the event of a fire, natural disaster, emergency medical or catastrophic event. Safety procedures shall also explain steps to be taken when a resident is discovered to be missing from the unit or facility and when hazardous cleaning materials or potentially dangerous mechanical equipment is being used in the unit or facility. The facility shall identify its method for security of the unit or facility and the manner in which the effectiveness of the security system will be monitored. (II, III)

c. Program and service policies and procedures which explain programs and services offered in the unit or facility including the rationale. (III)

d. Policies and procedures concerning staff which state minimum numbers, types and qualifications of staff in the unit or facility. (II, III)

e. Policies about visiting which suggest times and ensure the residents' rights to free access to visitors. (II, III)

f. Quality assurance policies and procedures which list the process and criteria which will be used to monitor and to respond to risks specific to the residents. This shall include, but not be limited to, drug use, restraint use, infections, incidents and acute behavioral events. (II, III)

58.54(5) Preadmission assessment of physical, mental, social and behavioral status shall be completed to determine whether the applicant meets admission criteria. This assessment shall be completed by a registered nurse and a staff social worker or social work consultant and shall become part of the permanent record upon admission of the resident. (II, III)

58.54(6) All staff working in a CCDI unit or facility shall have training appropriate to the needs of the residents. (II, III)

a. Upon assignment to the unit or facility, everyone working in the unit or facility shall be oriented to the needs of people with chronic confusion or dementing illnesses. They shall have special training appropriate to their job description within 30 days of assignment to the unit or facility. (II, III)
The orientation shall be at least six hours. The following topics shall be covered:

- (1) Explanation of the disease or disorder; (II, III)
- (2) Symptoms and behaviors of memory-impaired people; (II, III)
- (3) Progression of the disease; (II, III)
- (4) Communication with CCDI residents; (II, III)
- (5) Adjustment to care facility residency by the CCDI unit or facility residents and their families; (II, III)
- (6) Inappropriate and problem behavior of CCDI unit or facility residents and how to deal with it; (II, III)
- (7) Activities of daily living for CCDI residents; (II, III)
- (8) Handling combative behavior; (II, III) and
- (9) Stress reduction for staff and residents. (II, III)

b. Licensed nurses, certified aides, certified medication aides, social services personnel, housekeeping and activity personnel shall have a minimum of six hours of in-service training annually. This training shall be related to the needs of CCDI residents. The six-hour training shall count toward the required annual in-service training. (II, III)

58.54(7) There shall be at least one nursing staff person on a CCDI unit at all times. (I, II, III)

58.54(8) The CCDI unit or facility license may be revoked, suspended or denied pursuant to Iowa Code chapter 135C and Iowa Administrative Code 481—Chapter 50.

481—58.55(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 physical structure of the facility, if the other business or activity meets the requirements of applicable state and federal laws, administrative rules, and federal regulations.

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 “f” of subrule 58.55(1). (I, II, III)

58.55(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. Noise created by the proposed business or activity;
- c. Odors created by the proposed business or activity;
- d. 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;
- e. Proposed staffing for the business or activity; and
- f. Sharing of services and staff between the proposed business or activity and the facility.

58.55(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

58.55(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 and 481—Chapter 61. (I, II, III)

481—58.56(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 nursing facility which chooses to provide respite care services must meet the following requirements related to respite services and must be licensed as a nursing facility.

58.56(1) A nursing facility certified as a Medicaid nursing facility or Medicare skilled nursing facility must meet all Medicaid and Medicare requirements including 42 CFR 483.15, admission, transfer and discharge rights.

58.56(2) A nursing facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

58.56(3) Rule 481—58.40(135C) regarding involuntary discharge or transfer rights, does not apply to residents who are being cared for under a respite care contract.

58.56(4) Pursuant to rule 481—58.13(135C), 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 under 481—58.13(135C), except the requirements under subrule 58.13(7).

58.56(5) Respite care services shall not be provided by a health care facility to persons requiring a level of care which is higher than the level of care the facility is licensed to provide.

[ARC 7033C, IAB 5/31/23, effective 7/5/23]

481—58.57(135C) Training of inspectors.

58.57(1) Subject to the availability of funding, all nursing facility inspectors shall receive 12 hours of annual continuing education in gerontology, wound care, dementia, falls, or a combination of these subjects.

58.57(2) An inspector shall not be personally liable for financing the training required under subrule 58.57(1).

58.57(3) The department shall consult with the collective bargaining representative of the inspector in regard to the training required under this rule.

[ARC 8433B, IAB 12/30/09, effective 2/3/10]

These rules are intended to implement Iowa Code sections 10A.402, 135C.6(1), 135C.14, 135C.32, 135C.36 and 227.4.

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◇ Two or more ARCs

¹ Effective date of 470—58.15(2)“c” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.
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² See IAB, Inspections and Appeals Department.

CHAPTER 63
RESIDENTIAL CARE FACILITY—THREE- TO FIVE-BED SPECIALIZED LICENSE
[Prior to 7/15/87, Health Department[470] Ch 63]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—63.1(135C) Definitions. For the purpose of these rules, the following terms shall have the meanings indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered to be incorporated verbatim in the rules.

“Accommodation” means the provision of lodging, including sleeping, dining, and living areas.

“Administrator” means a person approved by the department who administers, manages, supervises, and is in general administrative charge of a three- to five-bed residential care facility, whether or not such individual has an ownership interest in such facility, and whether or not the functions and duties are shared with one or more individuals.

“Ambulatory” means the condition of a person who immediately and without aid of another person is physically and mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“Basement” means that part of a building where the finish floor is more than 30 inches below the finish grade of the building.

“Board” means the regular provision of meals.

“Change of ownership” means the purchase, transfer, assignment or lease of a licensed three- to five-bed residential care facility.

“Communicable disease” means a disease caused by the presence within a person’s body of a virus or microbial agents which may be transmitted either directly or indirectly to other persons.

“Department” means the state department of inspections and appeals.

“Interdisciplinary team” means the group of persons who develop a single, integrated, individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian if applicable, the resident’s advocate if desired by the resident, a referral agency representative, other appropriate staff members, other providers of services, and other persons relevant to the resident’s needs.

“Legal representative” means the resident’s guardian or conservator if one has been appointed or the resident’s power of attorney.

“Mechanical restraint” means restriction by the use of a mechanical device of a resident’s mobility or ability to use the hands, arms or legs.

“Medication” means any drug, including over-the-counter substances.

“Nonambulatory” means the condition of a person who immediately and without the aid of another person is not physically or mentally capable of traveling a normal path to safety, including the ascent and descent of stairs.

“Personal care” means assistance with the activities of daily living which the recipient can perform only with difficulty. Examples are help in getting in and out of bed, assistance with personal hygiene and bathing, help with dressing and eating, and supervision over medications which can be self-administered.

“Physical restraint” means direct physical contact on the part of a staff person to control a resident’s physical activity for the resident’s own protection or for the protection of others.

“Primary care provider” means any of the following who provide primary care and meet licensure standards:

1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician associate.

“Program of care” means all services being provided for a resident in a health care facility.

“Prone restraint” means a restraint in which a resident is in a face-down position against the floor or another surface.

“Rate” means that daily fee charged for all residents equally and shall include the cost of all minimum services required in these rules.

“Records” includes electronic records.

“Responsible party” means the person who signs or cosigns the residency agreement required by rule 481—63.12(135C) or the resident’s legal representative. In the event that a resident has neither a legal representative nor a person who signed or cosigned the resident’s residency agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, a religious group, fraternal organization, or foundation that assumes responsibility and advocates for its client patients and pays for their health care.

“Restrains” means the measures taken to control a resident’s physical activity for the resident’s own protection or for the protection of others.

“Specialized residential care facility license” means a license for three- to five-bed residential care facilities serving persons with an intellectual disability, chronic mental illness, a developmental disability or brain injury.

[ARC 3740C, IAB 4/11/18, effective 5/16/18; Editorial change: IAC Supplement 6/10/26]

481—63.2(135C,17A) Waiver. A waiver from these rules may be granted by the director of the department in accordance with 481—Chapter 6. A request for waiver will be granted or denied by the director within 120 calendar days of receipt.

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—63.3(135C) Application for licensure.

63.3(1) *Application and licensing—new facility or change of ownership.* In order to obtain a specialized residential care facility license for a facility not currently licensed as a specialized residential care facility or for a specialized residential care facility when a change of ownership is contemplated, the applicant must:

a. Make application at least 30 days prior to the proposed opening date of the facility. Application shall be made on forms provided by the department.

b. Meet all of the rules, regulations, and standards contained in this chapter and in 481—Chapter 50.

c. Submit a letter of intent and a written résumé of care. The résumé of care shall meet the requirements of subrule 63.3(2).

d. Submit a floor plan of each floor of the residential care facility. The floor plan of each floor shall be drawn on 8½" × 11" paper, show room areas in proportion, room dimensions, window and door locations, designation of the use of each room, and the room numbers for all rooms, including bathrooms.

e. Submit a photograph of the front and side of the residential care facility.

f. Submit the fee for a specialized residential care facility license in accordance with 481—paragraph 50.3(2)“a.”

g. Comply with all other local statutes and ordinances in existence at the time of licensure.

h. Submit a certificate signed by the state or local fire inspection authority as to compliance with fire safety rules and regulations.

63.3(2) *Résumé of care.* The résumé of care shall describe the following:

a. Purpose of the facility;

b. Criteria for admission to the facility;

c. Ownership of the facility;

d. Composition and responsibilities of the governing board;

e. Qualifications and responsibilities of the administrator;

f. Medical services provided to residents, to include the availability of emergency medical services in the area and the designation of a primary care provider to be responsible for residents in an emergency;

g. Dental services provided to residents and available in the area;

h. Nursing services provided to residents, if applicable;

i. Personal services provided to residents, including supervision of or assistance with activities of daily living;

j. Activity program;

k. Dietary services, including qualifications of the person in charge, consultation service (if applicable) and meal service;

l. Other services available as applicable, including social services, physical therapy, occupational therapy, and recreational therapy;

m. Housekeeping;

n. Laundry;

o. Physical plant; and

p. Staffing provided to meet residents' needs.

63.3(3) *Renewal application.* In order to obtain a renewal of the specialized residential care facility license, the applicant must submit the following:

a. The completed application form 30 days prior to the annual license renewal date of the residential care facility license;

b. The fee for a specialized residential care facility license in accordance with 481—paragraph 50.3(2) “a”;

c. An approved current certificate signed by the state or local fire inspection authority as to compliance with fire safety rules and regulations;

d. Changes to the résumé of care, if any; and

e. Changes to the current residency agreement, if any.

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.4(135C) Issuance of license. Licenses are issued to the person, entity or governmental unit with responsibility for the operation of the facility and for compliance with all applicable statutes, rules and regulations.

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.5(135C) General requirements.

63.5(1) The license shall be displayed in the facility in a conspicuous place which is accessible to the public. (III)

63.5(2) The license shall be valid only in the possession of the licensee to whom it is issued.

63.5(3) The posted license shall accurately reflect the current status of the facility. (III)

63.5(4) The license shall expire one year after the date of issuance or as indicated on the license.

63.5(5) The licensee shall:

a. Assume the responsibility for the overall operation of the facility. (I, II, III)

b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III)

c. Provide an organized continuous 24-hour program of care commensurate with the needs of the residents. (I, II, III)

63.5(6) 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. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.6(135C) Required notifications to the department. The department shall be notified:

63.6(1) Thirty days before any proposed change in the residential care facility's functional operation or addition or deletion of required services; (III)

63.6(2) Thirty days before the beginning of the renovation, addition, functional alteration, change of space utilization, or conversion in the residential care facility or on the premises; (III)

63.6(3) Thirty days before closure of the residential care facility; (III)

63.6(4) Within two weeks of any change in administrator; (III)

63.6(5) Ninety days before a change in the category of license; (III)

63.6(6) Thirty days before a change of ownership. The licensee shall:

a. Inform the department of the pending change of ownership; (III)

b. Inform the department of the name and address of the prospective purchaser, transferee, assignee, or lessee; (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 residential care facility to the named prospective purchaser, transferee, assignee, or lessee. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.7(135C) Administrator. Each facility shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these rules. (III)

63.7(1) *Qualifications of an administrator.*

a. The administrator shall be at least 21 years of age and shall have a high school diploma or equivalent. (III) In addition, this person shall meet at least one of the following conditions:

(1) Have a two-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of two years' experience in the field; or (III)

(2) Have a four-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year of experience in the field; or (III)

(3) Have a master's degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year of experience in the field; or (III)

(4) Be a licensed nursing home administrator; or (III)

(5) Have completed a one-year educational training program approved by the department for residential care facility administrators; or (III)

(6) Have passed the National Association of Long Term Care Administrator Boards (NAB) RC/AL administrator licensure examination; or

(7) Have two years of direct care experience and at least six months of administrative experience in a residential care facility. (III)

b. The administrator shall have at least one year of documented experience in a supervisory or direct care position working with persons with an intellectual disability, mental illness, a developmental disability, or brain injury.

c. An individual employed as an administrator on May 16, 2018, will be deemed to meet the requirements of this subrule.

63.7(2) *Duties of an administrator.* The administrator shall:

a. Select and direct competent personnel who provide services for the residential care program. (III)

b. Provide in-service educational programming for all employees with direct resident contact and maintain records of programs and participants. (III) In-service educational programming offered during each calendar year shall include, at minimum, the following topics: (I, II, III)

(1) Infection control.

(2) Emergency preparedness (e.g., fire, tornado, flood, 911).

(3) Meal time procedures/dietary.

- (4) Resident activities.
- (5) Mental illness, brain injury or intellectual disabilities, including behavioral intervention, de-escalation, and crisis intervention techniques.
- (6) Resident safety/supervision.
- (7) Resident rights.
- (8) Medication education, to include administration, storage and drug interactions.
- (9) Resident service plans/programming/goals.

63.7(3) *Administrator serving at more than one residential care facility.* The administrator may be responsible for no more than 150 beds in total if the administrator is an administrator of more than one facility. (II)

a. An administrator of more than one facility shall designate in writing an administrative staff person in each facility who shall be responsible for directing programs in the facility.

b. The administrative staff person designated by the administrator shall:

(1) Have at least one year of documented experience in a supervisory or direct care position working with persons with an intellectual disability, mental illness, a developmental disability, or brain injury; (II, III)

(2) Be knowledgeable of the operation of the facility; (II, III)

(3) Have access to records concerned with the operation of the facility; (II, III)

(4) Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)

(5) Be at least 21 years of age; (III)

(6) Be empowered to act on behalf of the licensee concerning the health, safety and welfare of the residents; and (II, III)

(7) Have training in emergency response, including how to respond to residents' sudden illnesses. (II, III)

c. If an administrator serves more than one facility, the administrator must designate in writing regular and specific times during which the administrator will be available to consult with staff and residents to provide direction and supervision of resident care and services. (II, III)

63.7(4) *Provisional administrator.* A provisional administrator may be appointed on a temporary basis by the residential care facility licensee to assume the administrative responsibilities for a residential care facility for a period not to exceed one year when the facility has lost its administrator and has not been able to replace the administrator, provided that the department has been notified and has approved the provisional administrator prior to the date of the provisional administrator's appointment. (III) The provisional administrator must meet the requirements of paragraph 63.7(3) "b."

63.7(5) *Temporary absence of administrator.*

a. In the temporary absence of the administrator, a responsible person shall be designated in writing to the department to be in charge of the facility. (III) The person designated shall:

(1) Be knowledgeable of the operation of the facility; (III)

(2) Have access to records concerned with the operation of the facility; (III)

(3) Be capable of carrying out administrative duties and of assuming administrative responsibilities; (III)

(4) Be at least 21 years of age; (III)

(5) Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety, and welfare of the residents; (III)

(6) Have training in emergency response, including how to respond to residents' sudden illnesses. (II, III)

b. If the administrator is absent for more than six weeks, a provisional administrator must be appointed pursuant to subrule 63.7(4).

481—63.8(135C) Personnel.

63.8(1) *Alcohol and drug use prohibited.* No person under the influence of intoxicating drugs or alcoholic beverages shall be permitted to provide services in a residential care facility. (I, II)

63.8(2) *Job description.* There shall be a written job description developed for each category of worker. The job description shall include the job title, responsibilities and qualifications. (III)

63.8(3) *Employee criminal record, child abuse 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 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)

63.8(4) *Personnel record.* A personnel record shall be kept for each employee and shall include but not be limited to the following information about the employee: name and address; social security number; date of birth; date of employment; position; job description; experience and education; results of criminal record checks, child abuse checks and dependent adult abuse checks; and date of discharge or resignation. (III)

63.8(5) *Supervision and staffing.*

a. The facility shall provide sufficient staff to meet the needs of the residents served. (I, II, III)

b. Personnel in a specialized residential care facility shall provide 24-hour coverage for residential care services. Personnel shall be available and responsive to residents' needs at all times while on duty. (I, II, III)

c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (I, II, III)

d. Staff shall be aware of and provide supervision levels based on the present needs of the residents in the staff's care. The facility shall document the supervision of residents who require more than general supervision, as defined by facility policy. (I, II, III)

e. The facility shall maintain an accurate record of actual hours worked by employees. (III)

63.8(6) *Physical examination and screening.* Employees shall have a physical examination within 12 months prior to beginning employment and every four years thereafter. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.9(135C) General policies. The licensee shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures shall be available for review by the department, other agencies designated by Iowa Code section 135C.16(3), staff, residents, residents' families or legal representatives, and the public and shall be reviewed by the licensee annually. (II)

63.9(1) *Facility operation.* The licensee shall establish written policies for the operation of the facility, including but not limited to the following: (III)

a. Personnel; (III)

b. Admission; (III)

c. Evaluation services; (II, III)

d. Programming and individual program plans; (II, III)

e. Registered sex offender management; (II, III)

f. Crisis intervention; (II, III)

g. Discharge or transfer; (III)

h. Medication management, including self-administration of medications and chemical restraints; (III)

i. Resident property; (II, III)

j. Resident finances; (II, III)

k. Records; (III)

l. Health and safety; (II, III)

m. Nutrition; (III)

- n. Physical facilities and maintenance; (III)
- o. Resident rights; (II, III)
- p. Investigation and reporting of alleged dependent adult abuse; (II, III)
- q. Investigation and reporting of accidents or incidents; (II, III)
- r. Transportation of residents; (II, III)
- s. Resident supervision; (II, III)
- t. Smoking; (III)
- u. Visitors; (III)
- v. Disaster/emergency planning; (III) and
- w. Infection control. (III)

63.9(2) *Personnel policies.* Written personnel policies shall include the hours of work and attendance at educational programs. (III)

63.9(3) *Infection control.* The facility shall have a written and implemented infection control program, which shall include policies and procedures based on guidelines issued by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. The infection control program shall address the following:

- a. Techniques for hand washing; (I, II, III)
- b. Techniques for the handling of blood, body fluids, and body wastes; (I, II, III)
- c. Dressings, soaks or packs; (I, II, III)
- d. Infection identification; (I, II, III)
- e. Resident care procedures to be used when there is an infection present; (I, II, III)
- f. Sanitation techniques for resident care equipment; (I, II, III)
- g. Techniques for sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags; (I, II, III) and
- h. Techniques for use and disposal of needles, syringes, and other sharp instruments. (I, II, III)

63.9(4) *Resident care techniques.* The facility shall have written and implemented procedures to be followed if a resident needs any of the following treatment or devices:

- a. Intravenous or central line catheter; (I, II, III)
- b. Urinary catheter; (I, II, III)
- c. Respiratory suction, oxygen or humidification; (I, II, III)
- d. Decubitus care; (I, II, III)
- e. Tracheostomy; (I, II, III)
- f. Nasogastric or gastrostomy tubes; (I, II, III)
- g. Sanitary use and reuse of feeding syringes and single-resident use and reuse of urine collection bags. (I, II, III)

63.9(5) *Emergency care.* The facility shall establish written policies for the provision of emergency medical care to residents and employees in case of sudden illness or accident. The policies shall include a list of those individuals to be contacted in case of an emergency. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.10(135C) Admission, transfer and discharge.

63.10(1) *General admission policies.*

- a. Residents shall be admitted to a specialized residential care facility only on a written order signed by a primary care provider or psychiatrist, specifying the level of care, and certifying that the individual being admitted requires no more than personal care and supervision and does not require routine nursing care. (II, III)
- b. No residential care facility shall admit or retain a resident who is in need of greater services than the facility can provide. (I, II, III)
- c. No residential care facility shall admit more residents than the number of beds for which the facility is licensed. (II, III)

d. A residential care facility is not required to admit an individual through court order, referral or other means without the express prior approval of the administrator. (III)

e. The admission of a resident shall not grant the residential care facility the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the safety of the resident and the safe and orderly management of the residential care facility as required by these rules. (III)

f. Individuals under the age of 18 shall not be admitted to a residential care facility without prior written approval by the department. A distinct part of a residential care facility, segregated from the adult section, may be established based on a résumé of care that is submitted by the licensee or applicant and is commensurate with the needs of the residents of the residential care facility and that has received the department's review and approval. (III)

g. No health care facility and no owner, administrator, employee or representative thereof shall act as guardian, trustee, or conservator for any resident's property unless such resident is related within the third degree of consanguinity to the person acting as guardian. (III)

63.10(2) Discharge or transfer.

a. Notification shall be made to the legal representative, primary care provider, psychiatrist, if any, and sponsoring agency, if any, prior to the transfer or discharge of any resident. (III)

b. The licensee shall not refuse to discharge or transfer a resident when the primary care provider, family, resident, or legal representative requests such transfer or discharge. (II, III)

c. Advance notification will be made to the receiving facility prior to the transfer of any resident. (III)

d. When a resident is transferred or discharged, the appropriate record will accompany the resident to ensure continuity of care. "Appropriate record" includes the resident's face sheet, service plan, most recent orders of the primary care provider and any notifications of upcoming scheduled appointments. (II, III)

e. When a resident is transferred or discharged, the resident's unused prescriptions shall be sent with the resident or with a legal representative only upon the written order of a primary care provider. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.11(135C) Involuntary discharge or transfer.

63.11(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. Repeated refusal by the resident to participate in the resident's service plan;
- d. Due to action pursuant to Iowa Code chapter 229; or
- e. Nonpayment for the resident's stay, as described in the residency agreement for the resident's stay.

63.11(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)

63.11(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)

63.11(4) *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: (II)

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 receipt of your request by the department and you will not be transferred prior to a final decision. In emergency circumstances, extension of the 14-day requirement may be permitted upon request to the department's designee. If you lose the hearing, you will not be transferred before the expiration of (1) 30 days following receipt of the original notice of the discharge or transfer, or (2) 5 days following final decision of such hearing, including 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.

b. The notice shall be personally delivered to the resident and a copy 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 a copy has been transmitted to the required parties by using the abbreviation "cc:" and listing the names of all parties to whom copies were sent. (II)

c. The notice required by paragraph 63.11(4) "a" shall be provided at least 30 days in advance of the proposed transfer or discharge unless one of the following occurs: (II)

(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.

d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 63.11(6).

63.11(5) *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 transfer or discharge. (II, III)

a. A copy of this notice must be placed in the resident's file. The notice must 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: (II)

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 the 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 receipt of your request by the department. 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.

b. The notice shall be personally delivered to the resident and a copy 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 a copy has been transmitted to the required parties by using the abbreviation “cc:” and listing the names of all parties to whom copies were sent. (II)

c. A hearing requested pursuant to this subrule shall be held in accordance with subrule 63.11(6).

63.11(6) Hearing.

a. Request for hearing.

(1) The resident must request a hearing within 7 days of receiving the 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 receipt of the request by the department unless the resident 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 the resident’s legal 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 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, the responsible party, and the office of the long-term care ombudsman not later than 5 full business days after 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. A representative of the office of the long-term care ombudsman shall have the right to appear at the hearing.

f. The administrative law judge’s written decision shall be mailed by certified mail to the licensee, resident, responsible party, and the office of the long-term care ombudsman within 10 working days after the hearing has been concluded.

63.11(7) 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)

63.11(8) 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 63.11(5) and emergency notice is provided within 48 hours.

63.11(9) *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 be offered counseling services by the sending facility before the involuntary transfer and by the receiving facility after the involuntary transfer. Counseling, if accepted, shall be provided by a licensed mental health professional as defined in Iowa Code section 228.1(6). Counseling shall be documented in the resident's record. (II)

c. The counseling requirement in paragraph 63.11(9)“b” does not apply if the discharge has already occurred pursuant to subrule 63.11(5) and emergency notice is provided within 48 hours.

d. The receiving health care facility of a resident involuntarily transferred shall immediately formulate and implement a plan of care which takes into account possible adverse effects the transfer may cause. (II)

63.11(10) *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.

63.11(11) *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) Incompatibility with or disturbing to other roommates.

(2) For the welfare of the resident or other residents of the facility.

(3) To allow a new admission to the facility that would otherwise not be possible due to separation of roommates by sex.

(4) 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.

(5) 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 63.11(11)“a”(4). (II)

(2) As punishment or behavior modification, except as specified in subparagraph 63.11(11)“a”(1). (II)

(3) Discrimination on the basis of race or religion. (II)

c. If intrafacility relocation is necessary for reasons outlined in paragraph 63.11(11)“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, III)

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, III)

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 3740C, IAB 4/11/18, effective 5/16/18]

481—63.12(135C) Residency agreement.

63.12(1) Each residency agreement shall:

a. State the base rate or scale per day or per month, the services included, and the method of payment. (III)

b. Contain a complete schedule of all offered services for which a fee may be charged in addition to the base rate. (III) Furthermore, the agreement shall:

(1) Stipulate that no further additional fees shall be charged for items not contained in the complete schedule of services; (III)

(2) State the method of payment for additional charges; (III)

(3) 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)

(4) State that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services provided by a barber, beautician, and such. (III)

c. Contain an itemized list of services to be provided to the resident based on an assessment at the time of the resident's admission and in consultation with the administrator and including the specific fee the resident will be charged for each service and the method of payment. (III)

d. Include the total fee to be charged initially to the resident. (III)

e. State the conditions whereby the facility may make adjustments to its overall fees for resident care as a result of changing costs. (II, III) Furthermore, the agreement shall provide that the facility shall give:

(1) Written notification to the resident, or the responsible party when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of such changes; (II, III)

(2) Notification to the resident, or the responsible party when appropriate, of changes in additional charges, based on a change in the resident's condition. Notification must occur prior to the date such revised additional 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. (II, III)

f. State the terms of agreement in regard to a refund of all advance payments in the event of the transfer, death, or voluntary or involuntary discharge of the resident. (II, III)

g. State the terms of agreement concerning the holding of and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's responsible party. (II, III)

(1) The facility shall ask the resident or responsible party whether the resident's bed should be held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II, III)

(2) The facility shall inform the resident or responsible party that, when requested, the bed may be held beyond the number of days designated by the funding source, as long as payments are made in accordance with the agreement. (II, III)

h. State the conditions under which the involuntary discharge or transfer of a resident would be effected. (II, III)

i. Set forth any other matters deemed appropriate by the parties to the agreement. No agreement or any provision thereof shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (II, III)

63.12(2) Each party to the residency agreement shall be provided a copy of the signed agreement. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.13(135C) Medical examinations.

63.13(1) Each resident in a residential care facility shall have a designated primary care provider who may be contacted when needed. (II, III)

63.13(2) Each resident admitted to a residential care facility shall have a physical examination prior to admission. (II, III)

a. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may be a part of the record in lieu of an additional physical examination. A record of the examination, signed by the primary care provider, shall be a part of the resident's record. (II, III)

b. The record of the admission physical examination and medical history shall portray the current medical status of the resident and shall include the resident's name, sex, age, medical history, physical examination, diagnosis, statement of medical concerns, and results of any diagnostic procedures. (II, III)

c. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)

63.13(3) The person in charge shall immediately notify the primary care provider of any accident, injury or adverse change in the resident's condition that has the potential for requiring further medical treatment. (I, II, III)

63.13(4) Each resident shall be visited by or shall visit the resident's primary care provider at least once each year. The one-year period shall be measured from the date of admission and does not include the resident's preadmission physical. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.14(135C) Records.

63.14(1) *Resident record.* The licensee shall keep a permanent record on all residents admitted to a specialized residential care facility with all entries current, dated, and signed. (III) 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; (III)
- d.* Primary care provider's name, telephone number, and address; (III)
- e.* Dentist's name, telephone number, and address; (III)
- f.* Name, address, and telephone number of next of kin or legal representative; (III)
- g.* Name, address, and telephone number of person to be notified in case of emergency; (III)
- h.* Mortuary's name, telephone number, and address; (III)
- i.* Pharmacist's name, telephone number, and address; (III)
- j.* Physical examination and medical history; (III)
- k.* Certification by the primary care provider that the resident requires no more than personal care and supervision, but does not require nursing care; (III)
- l.* Primary care provider's orders for medication, treatment, and diet in writing and signed by the primary care provider; (III)
- m.* A notation of yearly or other visits to primary care provider or other professional services; (III)
- n.* Any change in the resident's condition; (II, III)

o. If the primary care provider has certified that the resident is capable of taking prescribed medications, the resident shall be required to keep the administrator advised of current medications, treatments, and diet. The administrator shall keep a listing of medication, treatments, and diet prescribed by the primary care provider for each resident; (III)

p. If the primary care provider has certified that the resident is not capable of taking prescribed medication, it must be administered by a qualified person of the facility. A qualified person shall be defined as either a registered or licensed practical nurse or an individual who has completed the state-approved training course in medication administration, including a medication manager or certified medication aide; (II)

q. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication; (II, III)

r. A notation describing the resident's condition on admission, transfer, and discharge; (III)

s. 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 primary care provider were notified of the resident's death; (III)

t. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

u. Disposition of valuables; (III)

v. Current individual program plans. (II, III)

63.14(2) *Confidentiality of resident records.*

a. Each resident shall be ensured confidential treatment of all information contained in the resident's records. The resident's written consent shall be required for the release of information to persons not otherwise authorized under law to receive it. (II)

b. The facility shall limit access to any medical records to staff and consultants providing professional service to the resident. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

c. Similar procedures shall safeguard the confidentiality of residents' personal records, e.g., financial records and social services records. Only those personnel concerned with the financial affairs of the residents may have access to the financial records. This is not meant to preclude access by representatives of state and federal regulatory agencies. (II)

d. The resident or the resident's responsible party shall be entitled to examine all information contained in the resident's record and shall have the right to secure full copies of the record at reasonable cost upon request, unless the primary care provider determines the disclosure of the record or section thereof is contraindicated in which case this information will be deleted before the record is made available to the resident or responsible party. This determination and the reasons for it must be documented in the resident's record. (II)

63.14(3) *Incident record.*

a. Each residential care facility shall maintain an incident record report and shall have available incident report forms. (II, III)

b. Report of incidents shall be in detail on an incident report form. (III)

c. The person in charge at the time of the incident shall oversee the preparation of and sign the incident report. The administrator or designee shall review, sign and date the incident report within 72 hours of the accident, incident or unusual occurrence. (II, III)

d. An incident report shall be completed for every accident or incident where there is apparent injury or where an injury of unknown origin may have occurred. (II)

e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III)

f. A copy of the incident report shall be kept on file in the facility. (II, III)

63.14(4) *Retention of records.*

- a.* Records shall be retained in the facility for five years following the termination of services to a resident. (III)
- b.* Records shall be retained within the facility upon change of ownership. (III)
- c.* When the facility ceases to operate, a copy of the resident's record shall be released to the facility to which the resident is transferred. (III)
- d.* When the facility ceases to operate, records shall be maintained for five years in a clean, dry secured storage area. (III)

63.14(5) *Electronic records.* In addition to the access provided in 481—subrule 50.10(2), an authorized representative of the department shall be provided unrestricted access to electronic records pertaining to the care provided to the residents of the facility. (II, III)

a. If access to an electronic record is requested by the authorized representative of the department, the facility may provide a tutorial on how to use its particular electronic system or may designate an individual who will, when requested, access the system, respond to any questions or assist the authorized representative as needed in accessing electronic information in a timely fashion. (II, III)

b. The facility shall provide a terminal where the authorized representative may access records. (II, III)

c. If the facility is unable to provide direct print capability to the authorized representative, the facility shall make available a printout of any record or part of a record on request in a time frame that does not intentionally prevent or interfere with the department's survey or investigation. (II, III)

63.14(6) *Reports to the department.* The licensee shall furnish statistical information concerning the operation of the facility to the department on request. (III)

63.14(7) *Personnel record.*

a. Personnel records for each employee shall be kept in accordance with subrule 63.8(4). (III)

b. The personnel records shall be made available for review upon request by the department. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.15(135C) Resident care and personal services.

63.15(1) A complete change of bed linens shall be provided at least once a week and more often if necessary. (III)

63.15(2) Residents shall receive sufficient supervision to promote personal cleanliness. (II, III)

63.15(3) Residents shall have clean clothing as needed. Clothing shall be appropriate to residents' activities and to the weather. (III)

63.15(4) Residents shall be encouraged to bathe at least twice a week. (II, III)

63.15(5) All nonambulatory residents shall be housed on the grade level floor unless the facility has a suitably sized elevator. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.16(135C) Drugs.

63.16(1) *Drug storage.*

a. Residents who have been certified in writing by their primary care provider as capable of taking their own medications may retain these medications in their bedroom, but locked storage must be provided, with staff and the resident having access, and the drug storage shall be kept locked when not in use. Monitoring of the storage, administration, and documentation by the resident shall be carried out by a person who meets the requirements of subrule 63.16(3) and is responsible for administering medications. (II, III)

b. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

- (1) Locked storage for drugs, solutions, and prescriptions shall be provided. (III)
- (2) A bathroom shall not be used for drug storage. (III)
- (3) The drug storage shall be kept locked when not in use. (III)

(4) The drug storage key shall be secured and available only to those employees charged with the responsibility of administering medications. (II, III)

(5) Schedule II drugs, as defined by Iowa Code chapter 124, shall be kept in a locked box within the locked drug storage. (II, III)

(6) Medications requiring refrigeration shall be kept locked in a refrigerator and separated from food and other items. (II, III)

(7) Drugs for external use shall be stored separately from drugs for internal use. (II, III)

(8) All potent, poisonous, or caustic materials shall be stored separately from drugs, shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet, or storeroom, and shall be made accessible only to authorized persons. (I, II)

(9) Inspection of drug storage shall be made by the administrator or designee and a registered pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but not be limited to, certification of the absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current primary care provider's order, and drugs improperly stored. (III)

(10) Bulk supplies of prescription drugs for multiresident use shall not be kept in a residential care facility. (III)

63.16(2) Drug safeguards.

a. All prescribed medications shall be clearly labeled indicating the resident's full name, primary care provider's name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or primary care provider issuing the drug. Where unit dose is used, prescribed medications shall, at a minimum, indicate the resident's full name, primary care provider's name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. (III)

b. Sample medications provided by the resident's primary care provider shall clearly identify to whom the medications belong. (III)

c. Medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or primary care provider for relabeling or disposal. (III)

d. The medication for each resident shall be kept or stored in the original containers unless the resident is participating in an individualized medication program. (II, III)

e. Unused prescription drugs shall be destroyed by the person in charge, in the presence of a witness, and with a notation made on the resident's record or shall be returned to the supplying pharmacist. (III)

f. Prescriptions shall be refilled only with the permission of the resident's primary care provider. (II, III)

g. Medications prescribed for one resident shall not be administered to or allowed in the possession of another resident. (I, II)

h. Instructions shall be requested from the Iowa board of pharmacy concerning disposal of unused Schedule II drugs prescribed for a resident who has died or for whom the Schedule II drug was discontinued. (III)

i. Discontinued medications shall be destroyed within a specified time by a responsible person, in the presence of a witness, and with a notation made to that effect or shall be returned to the pharmacist for destruction. Drugs listed under the Schedule II drugs shall be destroyed in accordance with the requirements established by the Iowa board of pharmacy. (II, III)

j. All medication orders which do not specifically indicate the number of doses to be administered or the length of time the drug is to be administered shall be stopped automatically after a given time period. The automatic-stop order may vary for different types of drugs. The resident's primary care provider, in conjunction with the pharmacist, shall institute these policies and provide procedures for review and endorsement. (II, III)

k. No resident shall be allowed to possess any medications unless the primary care provider has certified in writing on the resident's medical record that the resident is mentally and physically capable of doing so. (II)

l. No medications or prescription drugs shall be administered to a resident without a written order signed by the primary care provider. (II)

m. The facility shall establish a policy to govern the distribution of prescribed medications to residents who are on leave from the facility. (II, III)

(1) Medications may be issued to residents who will be on leave from a facility for less than 24 hours. Only those medications needed for the time period that the resident will be on leave from the facility may be issued. Non-child-resistant containers may be used. Instructions shall be provided and include the date, the resident's name, the name of the facility, and the name of the medication, its strength, dose and time of administration. (II, III)

(2) Medication for residents on leave from a facility for longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy. (II, III)

(3) Medication for residents on leave from a facility may be issued only by facility personnel responsible for administering medication. (II, III)

63.16(3) *Drug administration—authorized personnel.*

a. A properly trained person shall be charged with the responsibility of administering medications as ordered by a primary care provider. (II, III)

b. The person shall have knowledge of the purpose of the drugs and their dangers and contraindications. (II, III)

c. The person shall be a licensed nurse or primary care provider or an individual who has completed the state-approved training course in medication administration, including a medication manager or certified medication aide. (II, III)

d. Prior to taking a department-approved medication aide course, the person shall have a letter of recommendation for admission to the medication aide course from the employing facility. (III)

e. A person who is a nursing student or a graduate nurse may take the medication aide challenge examination in place of taking a course. The person shall do all of the following before taking the challenge examination:

(1) Complete a clinical or nursing theory course within six months before taking the challenge examination; (III)

(2) Successfully complete a nursing program pharmacology course within one year before taking the challenge examination; (III)

(3) Provide to the community college a written statement from the nursing program's pharmacology or clinical instructor indicating that the person is competent in medication administration. (III)

f. 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. The requirements of paragraph 63.16(3) "*d*" do not apply to this person. (III)

63.16(4) *Drug administration.*

a. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. In facilities where the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by observing the actual act of swallowing the oral medication and by charting the medication. Medications shall be prepared on the shift of the same day that they are administered unless the unit dose system is used. (II)

b. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, primary care provider or pharmacist. For purposes of this subrule, "injectable medications" does not include an epinephrine autoinjector, e.g., an EpiPen. (II, III)

c. A resident certified by the resident's primary care provider as capable of injecting the resident's own insulin may do so. Insulin may be administered pursuant to paragraph 63.16(4) "b" or as otherwise authorized by the resident's primary care provider. (II, III) Authorization shall:

- (1) Be in writing,
- (2) Be maintained in the resident's record,
- (3) Be renewed quarterly,
- (4) Include the name of the person authorized to administer the insulin,
- (5) Include documentation by the primary care provider that the authorized person is qualified to administer insulin to that resident. (II, III)

d. A resident may participate in the administration of the resident's own medication if the primary care provider has certified in writing in the resident's medical record that the resident is mentally and physically capable of participating and has explained in writing in the resident's medical record what the resident's participation may include.

e. An individual inventory record shall be maintained for each Schedule II drug prescribed for each resident, with an accurate count and authorized signatures at every shift. (II)

f. The facility may use a unit dose system.

g. Medication aides and medication managers may administer PRN medications without contacting a licensed nurse or primary care provider if all of the following apply: (I, II, III)

(1) A written order from the resident's primary care provider specifies the purpose of the PRN medication and the frequency, dosage and strength of the PRN medication.

(2) The resident's primary care provider provides in writing specific criteria for administering PRN medications.

(3) The pharmacist assesses the resident's use of PRN medications when conducting the inspection of drug storage as required by subparagraph 63.16(1) "b"(9).

h. The pharmacist shall assess the use of PRN medications when conducting the inspection of drug storage as required by subparagraph 63.16(1) "b"(9). (II, III)

i. Medications administered by an employee of the facility shall be recorded on a medication record by the individual who administers the medication. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.17(135C) Dental services.

63.17(1) The residential care facility personnel shall assist residents in obtaining annual and emergency dental services and shall arrange transportation for such services. (III)

63.17(2) Dental services shall be performed only on the request of the resident, responsible party, legal representative, or primary care provider. The resident's primary care provider shall be advised of the resident's dental problems. (III)

63.17(3) All dental reports or progress notes shall be included in the resident record as available. The facility shall make reasonable efforts to obtain the records following the provision of services. (III)

63.17(4) Personal care staff shall assist the resident in carrying out the dentist's recommendations. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.18(135C) Dietary.

63.18(1) *Dietary staffing.* Personnel who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. (III)

63.18(2) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider's orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II, III)

b. In facilities where residents plan and prepare their own meals, education and support shall be provided to residents regarding proper food preparation, dietary guidelines, and food safety.

c. In facilities where food is regularly prepared for residents, the following shall apply:

(1) Menus shall be planned and served to include foods and amounts necessary to meet federal dietary guidelines. (II, III)

(2) At least three meals or their equivalent shall be offered daily, at regular hours. (II, III)

1. There shall be no more than a 14-hour span between offering a substantial evening meal and breakfast. (II, III)

2. Unless contraindicated, evening snacks shall be offered routinely to all residents. Special nourishments shall be available when ordered by the primary care provider. (II, III)

(3) Menus shall include a variety of foods prepared in various ways. (III)

(4) Menus shall be written at least one week in advance. The current menu shall be located in an accessible place for easy use by persons purchasing, preparing, and serving food. (III)

(5) Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary or requested, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

(6) The facility shall provide an alternative choice at scheduled meal times. (III)

63.18(3) *Dietary storage, food preparation, and service.*

a. All food shall be handled, prepared, served and stored in compliance with the Food Code adopted pursuant to Iowa Code section 137F.2. (I, II, III)

b. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises. Minimum food portion requirements for a low-cost plan shall conform to information supplied by the bureau of nutrition and health promotion of the department of public health. (II, III)

c. Dishes shall be free of cracks, chips, and stains. (III)

d. If family-style service is used, all leftover prepared food that has been on the table shall be properly handled. (III)

63.18(4) *Sanitation in food preparation area.* There shall be written procedures established for cleaning all work and serving areas. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.19(135C) Orientation and service plan.

63.19(1) *Orientation.* Within 24 hours of admission, each resident shall receive orientation to the facility. The orientation program shall be documented in the resident's file and shall include, but shall not be limited to, a review of the resident's rights, the daily schedule, house rules and the facility's evacuation plan. (II, III)

63.19(2) *Initial service plan.* Within 48 hours of admission, the administrator or the administrator's designee shall develop an initial service plan to address any immediate health and safety needs. The plan shall be based on information gathered from the resident, family, referring party, primary care provider, and other significant persons. The plan shall be followed until the service plan required in subrule 63.19(3) is complete. (I, II, III)

63.19(3) *Service plan.* Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident and the resident's interdisciplinary team, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III)

a. The service plan shall include measurable goals and objectives and the specific service(s) to be provided to achieve the goals. Each goal shall include the date of initiation and anticipated duration of service(s). Any restriction of rights shall be included in the service plan. (I, II, III)

b. The service plan shall include the documentation procedure for each goal and objective. (II, III)

c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III)

d. The service plan shall be reviewed at least quarterly by relevant staff, the resident and appropriate others, such as the resident's family, case manager and responsible party. The review shall include a written report which addresses a summary of the resident's progress toward goals and objectives and the need for continued services. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.20(135C) Resident activities program.

63.20(1) *Activities program.* Each residential care facility shall provide suitable group and individual activities for residents. (III)

a. The activities provided shall be designed to meet the needs and interests of each resident and to assist residents in continuing normal activities within limitations set by the resident's primary care provider. This shall include helping residents continue in their individual interests or hobbies. (III)

b. Residents shall be encouraged, but not required, to participate in activities. (III)

63.20(2) Each resident may participate in activities of social, religious, and community groups at the resident's discretion unless contraindicated for reasons documented by the primary care provider or interdisciplinary team as appropriate in the resident's record. (II)

63.20(3) Residents who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility shall be informed, encouraged, and assisted to do so. (II)

63.20(4) *Supplies, equipment, and storage.*

a. Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. (III)

b. Storage shall be provided for recreational equipment and supplies. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.21(135C) Residents' rights.

63.21(1) Each facility shall ensure that policies and procedures are written and implemented which include, at a minimum, the provisions of this rule and which govern all areas of service provided by the facility. These policies and procedures shall be available to staff, residents, residents' families or legal representatives and the public and shall be reviewed annually. (II, III)

63.21(2) Policies and procedures shall include a method for submitting complaints and recommendations by residents or their responsible parties and for ensuring a response and disposition by the facility. (II, III) The written procedures shall:

a. Ensure the provision of assistance to residents as necessary to complete and submit complaints and recommendations; (II, III)

b. Ensure protection of the resident from any form of reprisal or intimidation; (II, III)

c. Include designation of an employee responsible for handling grievances and recommendations; (II, III)

d. Include a method of investigating and assessing the validity of a grievance or recommendation; (II, III) and

e. Include methods of recording grievances and actions taken. (II, III)

63.21(3) Policies and procedures shall include provisions governing access to, duplication of, and dissemination of information from the residents' records. (II, III)

63.21(4) Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident

conduct and responsibilities. This information must be provided upon the resident's admission or, in the case of residents already in the facility, upon the facility's adoption or amendment of residents' rights policies. (II, III)

a. The facility shall communicate to residents prior to or within five days after admission what residents may expect from the facility and its staff and what is expected from residents. The communication shall be in writing, e.g., in a separate handout or brochure describing the facility, and interpreted verbally, e.g., as part of a preadmission interview, resident counseling, or in individual or group orientation sessions following the resident's admission. (II, III)

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf or hard of hearing, steps shall be taken to translate the information into a foreign or sign language. In the case of blind residents, either Braille or a recording shall be provided. Residents shall be encouraged to ask questions about their rights and responsibilities, and these questions shall be answered. (II, III)

c. A statement shall be signed by the resident, or the resident's responsible party if applicable, indicating an understanding of these rights and responsibilities and shall be maintained in the resident's record. The statement shall be signed no later than five days after admission, and a copy of the signed statement shall be given to the resident or responsible party. (II, III)

d. In order to ensure that residents continue to be aware of these rights and responsibilities during their stay, a written copy shall be prominently posted in a location that is available to all residents. (II, III)

e. All residents shall be advised within 30 days following changes made in the statement of residents' rights and responsibilities. Appropriate means shall be utilized to inform non-English-speaking, deaf or hard-of-hearing, or blind residents of changes. (II, III)

63.21(5) Choice of primary care provider. Each resident shall be permitted free choice of a primary care provider, and pharmacy, if accessible. The facility may require the selected pharmacy to utilize a drug distribution system compatible with the system currently used by the facility. (II)

63.21(6) Each resident shall be afforded the opportunity to participate in the planning of the resident's total care and treatment, which may include, but shall not be limited to, medical care, nutritional needs, activities, and social work services. Each resident has the right to refuse treatment except as provided by Iowa Code chapter 229. In the case of a resident with a responsible party, the responsible party shall be afforded the opportunity to participate in the planning of the resident's total care and medical treatment and to be informed of the resident's medical condition. (II, III)

63.21(7) Each resident shall be encouraged and assisted throughout the resident's period of stay to exercise the resident's rights as a resident and as a citizen and may voice grievances and recommend changes in policies and services to administrative staff or to outside representatives of the resident's choice, free from interference, coercion, discrimination, or reprisal. (II)

63.21(8) The facility shall provide ongoing opportunities for residents to be aware of and to exercise their rights as residents. Residents shall be kept informed of changes in policies and services that are more restrictive, and their views shall be solicited prior to action. (II)

63.21(9) The facility shall post in a prominent area the text of Iowa Code section 135C.46 (Retaliation by facility prohibited) and the name, telephone number, and address of the long-term care ombudsman, the department, and the local law enforcement agency to provide residents a further course of redress. (II)

63.21(10) All rights and responsibilities of the resident devolve to the resident's responsible party or any legal surrogate designated in accordance with state law, to the extent permitted by state law. This subrule is not intended to limit the authority of any individual acting pursuant to Iowa Code chapter 144A. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 5711C, IAB 6/16/21, effective 7/21/21]

481—63.22(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (I, II)

63.22(1) Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. (I, II)

63.22(2) Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping and eating, also times to retire at night and arise in the morning shall be elicited and considered by the facility. (II)

63.22(3) Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated. (II)

63.22(4) Privacy of a resident's body also shall be maintained during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. (II)

63.22(5) Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This shall not apply under emergency conditions. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.23(135C) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents, and may send and receive personal mail unopened. (II)

63.23(1) Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

63.23(2) Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- a.* The resident refuses to see the visitor(s). (II)
- b.* The resident's primary care provider documents specific reasons why such a visit would be harmful to the resident's health. (II)
- c.* The visitor's behavior is unreasonably disruptive to the functioning of the facility. This judgment must be made by the administrator, and the reasons shall be documented and kept on file. (II)

63.23(3) Decisions to restrict a visitor are reviewed and reevaluated:

- a.* Each time the medical orders are reviewed by the primary care provider;
- b.* At least quarterly by the facility's staff; or
- c.* At the resident's request. (II)

63.23(4) Space shall be provided for residents to receive visitors in reasonable comfort and privacy. (II)

63.23(5) Telephones shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

63.23(6) Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

63.23(7) Residents, including residents court-ordered to the facility, shall be permitted to leave the facility at reasonable times unless there are justifiable reasons established in writing by court order, the primary care provider, the interdisciplinary team, or the facility administrator for refusing permission. (II)

63.23(8) Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly

management of the facility and as required by these rules. However, residents shall be encouraged to participate in recreational programs. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.24(135C) Resident property.

63.24(1) Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The facility shall offer the resident the opportunity to have personal property itemized and documented on an inventory sheet upon the resident's admission. The inventory sheet shall be kept in a safe location which is convenient for the resident to review and update. At discharge, residents may sign off on a list of the personal property they are taking with them. (II, III)

63.24(2) The facility shall provide for the safekeeping of personal effects, funds and other property of its residents. The facility may require that items of exceptional value or that would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

63.24(3) Any funds or other property belonging to or due a resident, or expendable for the resident's account, which is received by the facility shall be trust funds; shall be kept separate from the funds and property of the facility and of its other residents, or specifically credited to such resident; and shall be used or otherwise expended only for the account of the resident. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.25(135C) Financial affairs—management. Each resident who has not been assigned a guardian or conservator by the court may manage the resident's own personal financial affairs. To the extent the facility assists in management, under written authorization by the resident, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

63.25(1) The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

63.25(2) An employee shall be designated in writing to be responsible for resident accounts. (II)

63.25(3) The facility shall keep on deposit personal funds over which the resident has control in accordance with Iowa Code section 135C.24. Should the resident request these funds, they shall be given to the resident on request with receipts maintained by the facility and a copy to the resident. In the case of a resident with impaired decision-making skills, the resident's legal representative shall designate a method of disbursing the resident's funds. (II)

63.25(4) If the facility makes financial transactions on a resident's behalf, the facility must document that it has prepared and sent an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

63.25(5) A resident's personal funds shall not be used without the written consent of the resident or the resident's legal representative. (I, II)

63.25(6) A resident's personal funds shall be returned to the resident when the funds have been used without the written consent of the resident or the resident's legal representative. The department may report findings that resident funds have been used without written consent to the department's investigations division or to the local law enforcement agency, as appropriate. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.26(135C) Resident work. No resident may be required to perform services for the facility, except as provided by Iowa Code section 347B.5. (II)

63.26(1) Residents may not be used to provide a source of labor for the facility against their will. Approval by the primary care provider or psychiatrist is required for all work programs. (I, II)

63.26(2) Residents who perform work for the facility must receive compensation unless the work is part of their approved training program. Persons on the resident census who perform work shall not be used to replace paid employees in fulfilling staffing requirements. (II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.27(135C) Resident abuse prohibited. Each resident shall receive kind and considerate care at all times and shall be free from mental, physical, sexual, and verbal abuse, exploitation, neglect, and physical injury. (I, II)

63.27(1) Mental abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation. (I, II)

63.27(2) Physical abuse includes, but is not limited to, corporal punishment and the use of restraints as punishment. (I, II)

63.27(3) Drugs such as tranquilizers shall only be used in accordance with orders of the primary care provider. (I, II)

63.27(4) 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)

63.27(5) Staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. (I, II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.28(135C) Crisis intervention. If a facility utilizes physical restraints, the facility shall have written policies that define the uses of physical restraints, designate the administrator or designee as the person who may authorize their use, establish a mechanism for monitoring and controlling their use, and provide staff with proper training. (I, II)

63.28(1) Temporary physical restraint of residents shall be used only under the following conditions: (I, II)

a. An emergency to prevent injury to the resident or to others; or (I, II)

b. For crisis intervention, but shall not be used for punishment, for the convenience of staff or as a substitution for supervision or programming; (I, II) and

c. No staff person shall use any restraint that obstructs the airway of the resident. (I, II)

63.28(2) Authorization for the use of physical restraints must be prior to or immediately after application of the restraint. (I, II)

63.28(3) Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint. (I, II)

63.28(4) The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the resident's rights and to ensure safety shall be clearly set forth in the resident's record by the responsible staff persons. (I, II)

63.28(5) The primary care provider, the interdisciplinary team and the resident's responsible party shall be notified of any restraints administered. (I, II, III)

63.28(6) The facility shall provide to the staff a department-approved training program by qualified professionals on physical restraint techniques. (I, II)

a. The facility shall keep a record of training for review by the department and shall include attendance. (II, III)

b. Only staff with documented training in physical restraint and techniques shall be authorized to assist with physical restraint of a resident. (I, II)

c. Under no circumstances shall a resident be allowed to actively or passively assist in the restraint of another resident. (I, II)

63.28(7) Residents shall not be kept behind locked doors. (I, II)

63.28(8) Mechanical restraint is prohibited. Staff persons who find themselves involved in the use of a mechanical restraint when responding to an emergency must take immediate steps to end the mechanical restraint. (I, II)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.29(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III)

63.29(1) Fire safety.

a. All residential care facilities shall meet the fire safety rules and regulations as promulgated by the state fire marshal. (I, II)

b. The size of the facility and needs of the residents shall be taken into consideration in evaluating safety precautions and practices.

63.29(2) Safety duties of administrator. The administrator shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (III)

a. The plan shall be prominently posted in a common area of the building. (III)

b. In-service shall be provided to ensure that all employees are knowledgeable of the emergency plan. (II, III)

63.29(3) Resident safety.

a. Smoking shall be prohibited, except as allowed by Iowa Code chapter 142D, the smokefree air Act. (II, III)

b. Whenever full or empty tanks of oxygen are being used or stored, they shall be securely supported in an upright position. (II, III)

c. Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III)

d. Storage areas for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall be locked. Residents permitted to access these materials shall have an order by their primary care provider stating the resident is able to utilize such materials, and staff shall supervise the residents as identified in the resident's service plan. (I, II, III)

e. Sufficient numbers of noncombustible trash containers with covers shall be available. (III)

f. Residents' personal possessions that may constitute a hazard to residents or others shall be removed and stored. (III)

63.29(4) First-aid kit. A first-aid emergency kit shall be available on each floor in every facility. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.30(135C) Housekeeping.

63.30(1) Each resident room shall be cleaned on a routine schedule. (III)

63.30(2) All rooms, corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment and accumulations of refuse. (II, III)

63.30(3) A hallway or corridor shall not be used for storage of equipment. (II, III)

63.30(4) All odors shall be kept under control by cleanliness and proper ventilation. (III)

63.30(5) Clothing worn by personnel shall be clean and washable. (III)

63.30(6) All furniture, bedding, linens, and equipment shall be cleaned periodically and before use by another resident. (II, III)

63.30(7) Polishes used on floors shall provide a nonslip finish. (II, III)

63.30(8) Throw or scatter rugs shall have nonskid backing. (II, III)

63.30(9) Entrances, exits, steps, and outside walkways shall be kept free from ice, snow, and other hazards. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.31(135C) Maintenance.

63.31(1) The building, grounds, and other buildings shall be maintained in a clean, orderly condition and in good repair. (II, III)

63.31(2) Window treatments and furniture shall be clean and in good repair. (II, III)

63.31(3) Cracks in plaster, peeling wallpaper or paint, and tears or splits in floor coverings shall be promptly repaired or replaced in a professional manner. (II, III)

63.31(4) The electrical systems, including appliances, cords, and switches, shall be maintained to guarantee safe functioning and comply with the National Electric Code. (II, III)

63.31(5) All plumbing fixtures shall function properly and comply with the state plumbing code. (II, III)

63.31(6) Yearly inspections of the heating and cooling systems shall be made to guarantee safe operation. (II, III)

63.31(7) The building, grounds, and other buildings shall be kept free of breeding areas for flies, other insects, and rodents. (II, III)

63.31(8) The facility shall be kept free of flies, other insects, and rodents. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.32(135C) Laundry.

63.32(1) Residents' personal laundry shall be marked with an identification if commingled with other residents' personal laundry. (III)

63.32(2) Bed linens, towels, and washcloths shall be clean and stain-free. (III)

63.32(3) If laundry is done in the facility, a clean, dry, well-lit area to accommodate a washer and dryer of adequate size to serve the needs of the facility shall be provided. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.33(135C) Garbage and waste disposal.

63.33(1) All garbage shall be gathered, stored, and disposed of in a manner that will not permit transmission of disease, create a nuisance, or provide a breeding or feeding place for vermin or insects. (III)

63.33(2) All containers for refuse shall be watertight and rodent-proof and have tight-fitting covers. (III)

63.33(3) All unlined containers inside of the facility shall be thoroughly cleaned each time the containers are emptied. (III)

63.33(4) All waste shall be properly disposed of in compliance with local ordinances and state codes. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.34(135C) Supplies.

63.34(1) *Linen supplies.*

a. There shall be an adequate supply of linens so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

b. A complete change of bed linens shall be available in the linen storage area for each bed. (III)

c. Sufficient lightweight, clean, serviceable blankets shall be available. All blankets shall be laundered as often as necessary for cleanliness and freedom from odors. (III)

d. Each bed shall be provided with clean, washable bedspreads. There shall be a supply available when changes are necessary. (III)

e. Adequate storage shall be provided for linens, pillows, and bedding. (III)

63.34(2) *Supplies, equipment and storage.*

a. All equipment shall be properly cleaned and sanitized before use by another resident. (III)

b. Clean and sanitary storage shall be provided for equipment and supplies. (III)

c. Locked storage should be available for potentially dangerous items such as scissors, knives, and toxic materials. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.35(135C) Buildings, furnishings, and equipment.

63.35(1) *Buildings—general requirements.*

a. All windows shall be supplied with window treatments that are kept clean and in good repair. (III)

b. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously. (III)

c. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state building code. (III)

d. The facility shall be located in an area zoned for single- or multiple-family housing or in an unincorporated area and shall be constructed in compliance with applicable local housing codes and rules adopted for this classification of license by the state fire marshal. (II, III)

63.35(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to their function. (III)

b. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere. (III)

63.35(3) *Dining areas and living rooms.*

a. Living rooms shall be maintained for the use of residents and their visitors and may be used for recreational activities. Living rooms shall be suitably furnished. (III)

b. Dining areas shall be furnished with dining tables and chairs appropriate to the size and function of the facility. Dining rooms and furnishings shall be kept clean and sanitary. (III)

63.35(4) *Bedrooms.*

a. Each resident shall be provided with a twin-sized or larger bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered. (III)

d. There shall be drawer space for each resident's clothing. In a bedroom in which more than one resident resides, drawer space shall be assigned to each resident. (III)

e. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

f. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless the radiator is covered so as to protect the resident from contact with it or from excessive heat. (III)

g. There shall be a wardrobe or closet in each resident's room. Minimum clear dimensions shall be 1 foot 10 inches deep by 1 foot 8 inches wide with full hanging space and provide a clothes rod and shelf. In a multiple bedroom, closet or wardrobe space shall be assigned each resident sufficient for the resident's needs. (III)

h. Each room shall have sufficient accessible mirrors to serve resident's needs. (III)

i. Useable floor space of a room shall be no less than 8 feet in any major dimension. (III)

j. Bedrooms shall have a minimum of 60 square feet of useable floor space per bed for a double room, 80 square feet of useable floor space for a single room. (III)

k. There shall be no more than two residents per room. (III)

63.35(5) *Bath and toilet facilities.*

a. All sinks shall have paper towel dispensers and an available supply of soap. (III)

b. Toilet paper shall be readily available to residents. (III)

c. There shall be a minimum of one toilet and bath facility for five residents. (III)

63.35(6) *Heating.* A centralized heating system shall be maintained in good working order and capable of maintaining a comfortable temperature for residents of the facility. Portable units or space heaters are prohibited from being used in the facility except in an emergency. (II, III)

63.35(7) *Water supply.*

a. Private sources of water supply shall be tested annually and the report made available for review by the department upon request. (III)

b. A bacterially unsafe source of water supply shall be grounds for denial, suspension, or revocation of license. (III)

c. The department may require testing of private sources of water supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department. (III)

d. Hot and cold running water under pressure shall be available in the facility. (II, III)

e. Prior to construction of a new facility or new water source, private sources of water supply shall be surveyed and shall comply with the requirements of the department. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18; ARC 4577C, IAB 7/31/19, effective 9/4/19]

481—63.36(135C) Family and employee accommodations. If the family or employees live within the facility, separate living quarters and recreation facilities shall be required for the family or employees distinct from such areas provided for the residents. (III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

481—63.37(135C) Animals. No animals shall be allowed to reside in the facility except with written approval of the department and under controlled conditions. (II, III)

[ARC 3740C, IAB 4/11/18, effective 5/16/18]

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 [Editorial change: IAC Supplement 6/10/26]

◇ Two or more ARCs

- 1 Effective date of 63.15(2)“a” and “b” delayed 70 days by the Administrative Rules Review Committee, IAB 2/26/86.
Effective date of 63.15(2)“a” and “b” delayed until the expiration of 45 calendar days into the 1987 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAC 6/4/86.
- 2 See IAB, Inspections and Appeals Department.
- 3 Rule 481—63.49(135C), effective 7/1/92.
- 4 September 7, 2016, effective date of 57.19(3)“d,” 62.15(2)“d,” and 63.18(3)“d” [ARC 2643C] delayed 70 days by the Administrative Rules Review Committee at its meeting held August 5, 2016.

CHAPTER 65
INTERMEDIATE CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—65.1(135C) Definitions. For the purposes of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 135C.1 shall be considered incorporated verbatim in the rules. The use of the words “shall” and “must” indicate these standards are mandatory.

“Academic services” means those activities provided to assist a person to acquire general information and skills which establish the basis for subsequent acquisition and application of knowledge.

“Activity coordinator” means a person who has completed the state-approved activity coordinator’s course.

“Age appropriate” means those activities, settings, and personal appearance and possessions commensurate with the person’s chronological age.

“Chronic mental illness” (see the definition of “Mental illness”).

“Commission” means the mental health and disability services commission.

“Community living training services” are those activities provided to assist a person to acquire or sustain the knowledge and skills essential to independent functioning to the person’s maximum potential in the physical and social environment. These services may focus on the following areas:

1. Independent living skills which include those skills necessary to sustain oneself in the physical environment and are essential to the management of one’s personal property and business. This includes self-advocacy skills.

2. Socialization skills which include self-awareness and self-control, social responsiveness, group participation, social amenities and interpersonal skills.

3. Communication skills which include expressive and receptive skills in verbal and nonverbal language, including reading and writing.

4. Leisure time and recreational skills which include the skills necessary for a person to use leisure time in a manner which is satisfying and constructive to the person.

5. Parenting skills which include those skills necessary to meet the needs of the person’s child. This service is designed to assist the person with mental illness to acquire or sustain the skills necessary for parenting.

“Department” means the Iowa department of inspections and appeals.

“Dependent adult abuse” is as defined in rule 481—52.1(235E).

“Diagnosis” means the investigation and analysis of the cause or nature of a person’s condition, situation or problem.

“Direct care staff” means those staff persons who provide a homelike environment for the residents and assist or supervise the resident in meeting the goals in the resident’s program plan.

“Evaluation services” means those activities designed to identify a person’s current functioning level and those factors which are barriers to maintaining the current level or achieving a higher level of functioning.

“Exploitation” means the act or process of taking unfair advantage of a resident, or the resident’s physical or financial resources for one’s own personal or pecuniary profit by the use of undue influence, harassment, duress, deception, false representation or false pretenses.

“Goals” means general statements of attainable expected accomplishments to be achieved in meeting identified needs.

“Incident” means all accidental, purposeful, or other occurrences within the facility or on the premises affecting residents, visitors, or employees whether there is apparent injury or where hidden injury may have occurred.

“Individual program plan (IPP)” means a written plan for the provision of services to the resident that is developed and implemented using an interdisciplinary process that is based on the resident’s functional status, strengths, and needs and that identifies service activities designed to enable a person to maintain or move toward independent functioning. The plan identifies a continuum of development and outlines progressive steps and anticipated outcomes of services.

“Informed consent” means an agreement by a person, or by the person’s legally authorized representative, based upon an understanding of:

1. A full explanation of the procedures to be followed including an identification of those that are and are not experimental;
2. A description of the attendant discomforts, risks, and benefits to be expected; and
3. A disclosure of appropriate alternative procedures that would be advantageous for the person.

“Interdisciplinary process” means an approach to assessment, individual program planning, and service implementation in which planning participants function as a team. Each participant utilizing the skills, competencies, insights and perspectives provided by the participant’s training and experience focuses on identifying the service needs of the resident and the resident’s family. The purpose of the process is for participants to review and discuss, face-to-face, all information and recommendations and to reach decisions as a team. Participants share all information and recommendations, and develop as a team, a single, integrated individual program plan to meet the resident’s needs and, when appropriate, the resident’s family’s needs.

“Interdisciplinary team” means the group of persons who develop a single, integrated individual program plan to meet a resident’s needs for services. The interdisciplinary team consists of, at a minimum, the resident, the resident’s legal guardian, if applicable, the resident’s advocate, if desired by the resident, a referral agency representative, other appropriate staff members, the resident’s attending psychiatrist and QMHP, other providers of services, and other persons relevant to the resident’s needs.

“Least restrictive environment” means the environment in which the interventions in the lives of people with mental illness can be carried out with a minimum of limitation, intrusion, disruption, and departure from commonly accepted patterns of living.

It is the environment which allows residents to participate, to the maximum extent possible, in everyday life and to have control over the decisions that affect them. It is an environment that provides needed supports which do not interfere with personal liberty and do not unduly interfere with a person’s access to the normal events of life.

“Legal services” means those activities designed to assist the person in exercising constitutional and legislatively enacted rights.

“Level of functioning” means a person’s current physiological and psychological status and current academic, community living, self-care and vocational skills.

“Mechanical restraint” means a device applied to a person’s limbs, head or body which restricts a person’s movement and includes, but is not limited to, leather straps, leather cuffs, camisoles or handcuffs.

“Mental abuse” means, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

“Mental health counselor” means a person who is certified or eligible for certification as a mental health counselor by the National Academy of Certified Clinical Mental Health Counselors.

“Mental health, mental retardation commission” means the commission described in Iowa Code section 225C.5.

“Mental illness” means a substantial disorder of thought or mood which significantly impairs judgment, behavior, or the capacity to recognize reality or the ability to cope with the ordinary demands of life. Mental illnesses include the organic and functional psychoses, neuroses, personality disorders, alcoholism and drug dependence, behavioral disorders and other disorders as defined by the current edition of “American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.” Mental illness is chronic when it is of long duration or marked by frequent recurrences.

“Normalization” means helping persons, in accordance with their needs and preferences, to achieve a lifestyle that is consistent with the norms and patterns of general society in ways which incorporate the age-appropriate and least restrictive principles.

“Objectives” means specific, time-limited, and measurable statements showing outcomes or accomplishments necessary to progress toward the goal.

“Physical abuse” means, but is not limited to, corporal punishment and the use of restraints as punishment.

“Physical injury” means damage to any bodily tissue to the extent the tissue must undergo a healing process in order to be restored to a sound and healthy condition. It may also mean damage to the extent the bodily tissue cannot be restored to a sound and healthy condition, or results in the death of the resident whose bodily tissue sustained the damage.

“Physical or physiological treatment” means those activities designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the physical or physiological functioning of the human body.

“Physical restraint” means a technique involving the use of one or more of a staff person’s arms, legs, hands or other body areas to restrict or control the movements of a resident. This does not include the use of mechanical restraint.

“Physician” means a person who is currently licensed in Iowa to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy.

“Primary care provider” means any of the following who provide primary care and meet certification standards:

1. A physician who is a family or general practitioner or an internist.
2. An advanced registered nurse practitioner.
3. A physician associate.

“Program” means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for any of the following:

1. Special target populations;
2. The population of a specified geographic area(s);
3. A specified purpose; and
4. A person.

“Psychiatric nurse” means a person who meets the requirements of certified psychiatric-mental health nurse practitioner pursuant to 655—Chapter 7, Iowa Administrative Code, or is eligible for certification.

“Psychiatrist” means a doctor of medicine or osteopathic medicine and surgery who is certified by the American Board of Psychiatry and Neurology or who is eligible for certification.

“Psychologist” means a person who is licensed to practice psychology in the state of Iowa, or is certified by the Iowa department of education as a school psychologist, or is eligible for certification.

“Psychotherapeutic treatment” means those activities designed to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person’s functioning in response to the physical, emotional and social environment.

“Qualified mental health professional (QMHP)” means a person who:

1. Holds at least a master’s degree in a mental health field, including but not limited to: psychology, counseling and guidance, nursing and social work; or is a doctor of medicine (M.D.) or a doctor of osteopathic medicine and surgery (D.O.) or a physician associate; and
2. Holds a current Iowa license when required by the Iowa licensure law; and
3. Has at least two years of postdegree experience, supervised by a mental health professional, in assessing mental problems and needs of individuals and in providing appropriate mental health services for those individuals. See rule 481—65.4(135C) for waiver procedures.

“Resident” means a person who has been admitted to the facility to receive care and services.

“Seclusion” means the isolation of the resident in a locked room which cannot be opened by the resident.

“Self-care training services” means those activities provided to assist a person to acquire or sustain the knowledge, habits and skills essential to the daily needs of the person. The activities focus on personal hygiene, general health maintenance, mobility skills and other activities of daily living.

“Service” means a set of interrelated activities provided to a resident pursuant to the IPP.

“Sexual abuse” means, but is not limited to, the exposing of pubes to a resident, the exposure of a resident’s genitals, pubes, breasts or buttocks for sexual satisfaction, fondling or touching the inner thigh, groin, buttocks, anus or breast of a resident or the clothing covering these areas, sexually suggestive comments or remarks made to a resident, a genital to genital or rectal, or oral to genital or rectal contact, or the commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2.

“Social worker” means a person who is licensed to practice social work in the state of Iowa, or who is eligible for licensure.

“Support services” means those activities provided to or on behalf of a person in the areas of personal care and assistance and property maintenance in order to allow a person to live in the least restrictive environment.

“Transportation services” means those activities designed to assist a person to travel from one place to another to obtain services or carry out life’s activities.

“Verbal abuse” means, but is not limited to, the use of derogatory terms or names, undue voice volume and rude comments, orders or responses to residents.

“Vocational training services” means those activities designed to familiarize a person with production or employment requirements and to maintain or develop the person’s ability to function in a work setting. This service includes programming which allows or promotes the development of skills, attitudes and personal attributes appropriate to the work setting.

“Work” means any activity during which a resident provides goods or services for wages.

“Written, in writing or recorded” means that an account or entry is made in a permanent form.

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 1204C, IAB 12/11/13, effective 1/15/14; ARC 1752C, IAB 12/10/14, effective 1/14/15; ARC 6974C, IAB 4/5/23, effective 5/10/23; Editorial change: IAC Supplement 6/10/26]

481—65.2(135C) Application for license. In order to obtain an initial license for an ICF/PMI, the applicant must comply with the rules and standards contained in Iowa Code chapter 135C and the standards in 481—Chapter 61. Waivers from 481—Chapter 61 regulations are allowed under rule 481—61.2(135C). An application must be submitted to the department which states the type and category of license for which the facility is applying.

65.2(1) Each application shall include:

- a. A floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathroom, and designation of the use to which room will be put and window and door location;
- b. A photograph of the front and side elevation of the facility;
- c. The statutory fee for an intermediate care facility license;
- d. Evidence of a certificate signed by the state fire marshal or deputy state fire marshal as to compliance with fire safety rules.

65.2(2) A résumé of care with a narrative which includes the following information shall be submitted:

- a. The purpose of the facility;
- b. A description of the target population and limitations on resident eligibility;
- c. An identification and description of the services the facility will provide. This shall include at least specific and measurable goals and objectives for each service available in the facility and a description of the resources needed to provide each service including staff, physical facilities and funds;

d. A description of the human service system available in the area, including, but not limited to, social, public health, visiting nurse, vocational training, employment services, sheltered living arrangements, and services of private agencies; and

e. A description of working relationships with the human service agencies when applicable which shall include at least how the facility will coordinate with:

(1) The department of human services to facilitate continuity of care and coordination of services to residents; and

(2) Other agencies to identify unnecessary duplication of services and plan for development and coordination of needed services.

65.2(3) In order to obtain a renewal or change of ownership license of the ICF/PMI the applicant must:

a. Submit to the department the completed application form 30 days prior to annual license renewal or change of ownership date of the ICF/PMI license;

b. Submit the statutory license fee for an ICF/PMI with the application for renewal or change of ownership;

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

d. Submit documentation of review of résumé of care pursuant to subrule 65.2(1), paragraph “a,” and a copy of any revisions to the plan.

This rule is intended to implement Iowa Code sections 135C.7 and 135C.9.

[ARC 1205C, IAB 12/11/13, effective 1/15/14; ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—65.3(135C) Licenses for distinct parts. Separate licenses may be issued for distinct parts which are clearly identifiable parts of a health care facility, containing contiguous rooms in a separate wing or building or on a separate floor of the facility, which provide care and services of separate categories.

The following requirements shall be met for a separate licensing of a distinct part:

1. The distinct part shall serve only residents who require the category of care and services immediately available to them within that part. (III)

2. The distinct part shall meet all the standards, rules and regulations pertaining to the category for which a license is being sought.

3. The distinct part must be operationally and financially feasible.

4. A separate personal care 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)

5. Separately licensed distinct parts may have certain services such as management, building maintenance, laundry and dietary in common with each other.

This rule is intended to implement Iowa Code section 135C.6(2).

481—65.4(135C) Waivers. Waivers from these rules may be granted by the director of the department when:

1. The need for a waiver has been established consistent with the résumé of care or the resident’s individual program plan.

2. There is no danger to the health, safety, welfare or rights of any resident.

3. The waiver will apply only to a specific intermediate care facility for the mentally ill.

Waivers shall be reviewed at least at the time of each licensure survey and any other time by the department to see if the need for the waiver is still acceptable.

65.4(1) To request a waiver, the licensee must:

a. Apply in writing on a form provided by the department;

b. Cite the rule or rules from which a waiver is desired;

c. State why compliance with the rule or rules cannot be accomplished;

- d.* Explain how the waiver is consistent with the résumé of care or the individual program plan; and
- e.* Demonstrate that the requested waiver will not endanger the health, safety, welfare or rights of any resident.

65.4(2) Upon receipt of a request for waiver, the director will:

- a.* Examine the rule from which the waiver is requested;
- b.* Evaluate the requested waiver against the requirement of the rule to determine whether the request is necessary to meet the needs of the residents;
- c.* Examine the effect of the requested waiver on the health, safety or welfare of the residents;
- d.* Consult with the applicant to obtain additional written information if required; and
- e.* Obtain approval of the Iowa mental health and disability services commission, when the request is for a waiver from the requirement for qualification of a mental health professional.

65.4(3) Based upon this information, approval of the waiver will be either granted or denied within 120 days of receipt.

[ARC 0766C, IAB 5/29/13, effective 7/3/13; ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—65.5(135C) General requirements.

65.5(1) A valid license shall be posted in each facility so the public can easily see it. (III)

65.5(2) Each license is valid only for the premises and person named on the license and is not transferable.

65.5(3) The posted license shall accurately reflect the current status of the facility. (III)

65.5(4) 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)

65.5(5) Licenses expire one year after the date of issuance or as indicated on the license.

65.5(6) There shall be no more beds erected than are stipulated on the license. (II, III)

This rule is intended to implement Iowa Code section 135C.8.

481—65.6(135C) Notification required by the department. The department shall be notified within 48 hours, by letter, of any reduction or loss of personal care or dietary staff lasting more than seven days which places the staff ratio below that required for licensing. No additional residents shall be admitted until the minimum staff requirements are achieved. (II, III)

65.6(1) Other required notification and time periods are:

- a.* Within 30 days of any proposed change in the résumé of care for the ICF/PMI; (II, III)
- b.* Thirty days before addition, alteration, or new construction is begun in the ICF/PMI or on the premises; (III)
- c.* Thirty days before the ICF/PMI closes; (III)
- d.* Within two weeks of any change of administrator; (II, III) and
- e.* Within 30 days when any change in the category of license is sought. (III)

65.6(2) Prior to the purchase, transfer, assignment, or lease of an ICF/PMI the licensee shall:

- a.* Inform the department in writing of the pending sale, transfer, assignment, or lease of the facility; (III)
- b.* Inform the department in writing 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) and
- c.* Submit a written authorization to the department permitting the department to release information of whatever kind from the department's files concerning the licensee's ICF/PMI to the named prospective purchaser, transferee, assignee or lessee. (III)

65.6(3) After the authorization has been submitted to the department, the department shall upon request send or give copies of all recent licensure surveys and any other pertinent information

relating to the facility's licensure status to the prospective purchaser, transferee, assignee or lessee. Costs for copies requested shall be paid by the prospective purchaser, transferee, assignee or lessee. No information personally identifying any resident shall be provided to the prospective purchaser, transferee, assignee or lessee. (II, III)

This rule is intended to implement Iowa Code sections 135C.6(3) and 135C.16(2).

481—65.7(135C) Administrator. Each ICF/PMI shall have one person in charge, duly approved by the department or acting in a provisional capacity in accordance with these regulations. (II, III)

65.7(1) The administrator shall be at least 21 years of age and shall meet at least one of the following conditions:

a. Be licensed in Iowa as a nursing home administrator, or certified as a residential care administrator. No residential care facility administrator certified under a waiver from the department shall administrate an intermediate care facility for persons with mental illness. The administrator must have at least two years' experience in direct care or supervision of people with mental illness and at least one year of experience in an administrative capacity; (II, III) or

b. Be a qualified mental health professional (QMHP) with at least one year of experience in an administrative capacity. (II, III)

If an ICF/PMI is a distinct part of a licensed health care facility, the administrator of the facility as a whole may serve as the administrator of the ICF/PMI without meeting the requirements of subrule 65.7(1), paragraph "a" or "b." When this occurs, the person in charge of the ICF/PMI distinct part shall meet the requirements of subrule 65.7(1), paragraph "a" or "b." (II, III)

65.7(2) The administrator of more than one facility shall be responsible for no more than 150 beds in total. (II, III)

a. The distance between the two farthest facilities shall be no greater than 50 miles. (II, III)

b. An administrator of more than one facility must designate an administrative staff person in each facility who shall be responsible for directing programs in the facility during the administrator's absence. (II, III)

65.7(3) The administrative staff person shall be designated in writing and immediately available to the facility on a 24-hour basis when the administrator is absent and residents are in the facility. (II, III)

The person(s) designated shall:

a. Have at least two years' experience or training in a supervisory or direct care position in a mental health setting; (II, III)

b. Be knowledgeable of the operation of the facility; (II, III)

c. Have access to records concerned with the operation of the facility; (II, III)

d. Be capable of carrying out administrative duties and of assuming administrative responsibilities; (II, III)

e. Be at least 21 years of age; (III)

f. Be empowered to act on behalf of the licensee during the administrator's absence concerning the health, safety and welfare of the residents; (II, III) and

g. Have training to carry out assignments and take care of emergencies and sudden illnesses of residents. (II, III)

65.7(4) If an administrator serves more than one facility, a written plan shall be developed, implemented and available for review by the department designating regular and specific times the administrator will be available to meet with the staff and residents to provide direction and supervision of resident care and services. (II, III)

65.7(5) When a facility has been unable to replace the administrator, through no fault of its own, a provisional administrator meeting the qualifications of the administrative staff person may be appointed on a temporary basis by the licensee to assume the administrative responsibilities for the facility. This person shall not serve more than three months without approval from the department. The department must be notified before the appointment of the provisional administrator. (III)

65.7(6) A facility applying for initial licensing shall not have a provisional administrator. (III)
This rule is intended to implement Iowa Code section 135C.14(2).

481—65.8(135C) Administration.

65.8(1) The licensee shall:

- a.* Be responsible for the overall operation of the ICF/PMI; (III)
- b.* Be responsible for compliance with all applicable laws and with the rules of the department; (II, III)
- c.* Establish written policies, which shall be available for review by the department or other agencies designated by Iowa Code section 135C.16(3), for the operation of the ICF/PMI including, but not limited to: (III)

- (1) Personnel; (III)
- (2) Admission; (III)
- (3) Evaluation services; (II, III)
- (4) Programming and individual program plan; (II, III)
- (5) Crisis intervention; (II, III)
- (6) Discharge or transfer; (III)
- (7) Medication management; (II)
- (8) Resident property; (II, III)
- (9) Financial affairs; (II, III)
- (10) Records; (III)
- (11) Health and safety; (II, III)
- (12) Nutrition; (III)
- (13) Physical facilities and maintenance; (III)
- (14) Resident rights; (II, III) and

d. Furnish statistical information concerning the operation of the facility to the department within 30 days of request. (III)

65.8(2) The administrator shall be responsible for the implementation of procedures to support the policies established by the licensee. (III)

This rule is intended to implement Iowa Code section 135C.14.

[ARC 1205C, IAB 12/11/13, effective 1/15/14]

481—65.9(135C) Personnel.

65.9(1) The personnel policies and procedures shall include the following requirements:

a. Written job descriptions for all employees or agreements for all consultants, which include duties and responsibilities, education, experience, or other requirements, and supervisory relationships; (III)

b. Annual performance evaluations of all employees and consultants which are dated and signed by the employee or consultant and the supervisor; (III)

c. Personnel records which are current, accurate, complete and confidential to the extent allowed by law. The record shall contain documentation of how the employee's or consultant's education and experience are relevant to the position for which they were hired; (III)

d. Roles, responsibilities, and limitation of student interns and volunteers; (III)

e. An orientation program for all newly hired employees and consultants which includes introduction to facility personnel policies and procedures and a discussion of the safety plan. Subparagraphs 65.9(1) "f"(3), (5) and (9) shall be included; (II, III)

f. A plan for a continuing education program with a minimum of 12 in-service programs per year. There shall be a written, individualized staff development plan implemented for each employee. The plan shall take into consideration the duties of the employee and the needs of the facility identified in the résumé of care. The plan shall ensure that each employee has the opportunity to

develop and enhance skills and to broaden and increase knowledge needed to provide effective resident care including, but not limited to:

- (1) First aid; (II, III)
- (2) Human needs and behavior; (II, III)
- (3) Problems and needs of persons with mental illness; for example, diagnosis and treatment, suicide assessment and prevention; (II, III)
- (4) Medication; (II, III)
- (5) Crisis intervention; for example, use of restraints and seclusion; (II)
- (6) Delivery of services in accordance with the principles of normalization; (III)
- (7) Infection control and wellness; (III)
- (8) Fire safety, disaster, and tornado preparation; (II, III) and
- (9) Resident rights. (II, III)
- g. Equal opportunity and affirmative action employment practices; (III)
- h. Procedures to be used when disciplining an employee; (III) and
- i. Appropriate dress and personal hygiene for staff and residents. (III)

65.9(2) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements:

- a. Employees shall have a physical examination before employment and at least every four years after beginning employment. (III)
- b. Screening and testing for tuberculosis shall be conducted pursuant to 481—Chapter 59. (I, II, III)
- c. No one shall provide services in a facility if the person has a disease:
 - (1) Which is transmissible through required workplace contact; (I, II, III)
 - (2) Which presents a significant risk of infecting others; (I, II, III)
 - (3) Which presents a substantial possibility of harming others; (I, II, III)
 - (4) For which no reasonable accommodation can eliminate the risk. (I, II, III)

Refer to Guideline for Infection Control in Hospital Personnel, 1998, Centers for Disease Control, U.S. Department of Health and Human Services, to determine (1), (2), (3) and (4).

- d. There shall be written policies for emergency medical care for employees in case of sudden illness or accident. These policies shall include the administrative individuals to be contacted. (III)
- e. Health certificates for all employees shall be available for review by the department. (III)

65.9(3) Staffing. The facility shall establish, subject to approval of the department, the numbers and qualifications of the staff required in an ICF/PMI using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

a. Direct care staff. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. The policies and procedures shall provide for an on-call staff person to be available when residents and staff are absent from the facility. (II, III)

- (1) The on-call staff person shall be designated in writing. (II, III)
- (2) Residents or another responsible person shall be informed of how to contact the on-call person. (II, III)

The staffing plan shall ensure that at least one qualified direct care staff person is on duty to carry out and implement the individual program plans. (II, III)

b. Qualified mental health professional. The ICF/PMI shall, by direct employment or contract, provide for sufficient services of a qualified mental health professional to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Attainment shall be determined by resident assessment and individual plans of care. (I, II, III) Responsibilities of the QMHP shall include, but not be limited to:

- (1) Approval of each resident's individual program plan; (II, III)
- (2) Monitoring the implementation of each resident's individual program plan, including periodic personal contact; (II, III) and

(3) Participation on each resident's interdisciplinary team. (II, III)

c. Nursing staff. Each facility shall have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. Attainment shall be determined by resident assessments and individual plans of care.

(1) The director of nursing (DON) shall be a registered nurse who is employed by the facility at least 40 hours per week. This person shall have two years' experience in direct care or supervision of people with mental illness. (II, III)

(2) The facility shall provide 24-hour service by licensed nurses, including at least one registered nurse on the day tour of duty, seven days a week. (II, III)

(3) If the DON has other institutional responsibilities, a qualified registered nurse shall serve as the DON's assistant so there is the equivalent of a full-time nursing supervisor on duty. (II, III)

(4) The department shall establish, on an individual facility basis, the numbers and qualifications of the staff required in the facility using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. (II, III)

(5) The DON shall not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents. (II, III)

(6) A waived licensed practical nurse shall not be allowed as a charge nurse on any shift. (II, III)

(7) There shall be at least two people capable of rendering nursing service awake, dressed, and on duty at all times. (II, III)

d. Activity staff. Each ICF/PMI shall employ a recreational therapist, occupational therapist or activity coordinator to direct the activity program both inside and outside the facility in accordance with each resident's individual program plan. (III)

Staff for the activity program shall be based on the needs of the residents being served as identified on the IPP. (III)

(1) The activity program director shall attend workshops or educational programs which relate to activity programming. These shall total a minimum of ten contact hours per year. (III)

(2) Personnel coverage shall be provided when the activity program director is absent during scheduled activities. (III)

(3) The activity program director shall have access to all information about residents necessary to carry out the program. (III)

e. Responsibilities of the activity program director shall include:

(1) Coordinating all activities, including volunteer or auxiliary activities and religious services; (III)

(2) Ensuring that all records required are kept; (III)

(3) Coordinating the activity program with all other services in the facility; (III) and

(4) Participating in the in-service training program in the facility. This shall include attending as well as presenting sessions. (III)

65.9(4) Personnel record.

a. A personnel record shall be kept for each employee. (III)

b. The record shall include the employee's:

(1) Name and address, (III)

(2) Social security number, (III)

(3) Date of birth, (III)

(4) Date of employment, (III)

(5) References, (III)

(6) Position in the facility, (III)

(7) Job description, (III)

(8) Documentation of experience and education, (III)

(9) Staff development plan, (III)

(10) Annual performance evaluation, (II, III)

- (11) Documentation of disciplinary action, (II, III)
- (12) Date and reason for discharge or resignation, (III) and
- (13) Current physical examination. (III)

65.9(5) 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)

This rule is intended to implement Iowa Code sections 135C.14(2) and 135C.14(6).

[ARC 0663C, IAB 4/3/13, effective 5/8/13; ARC 0903C, IAB 8/7/13, effective 9/11/13; ARC 1205C, IAB 12/11/13, effective 1/15/14]

481—65.10(135C) General admission policies. There shall be admission policies which address the following:

1. No resident shall be admitted or retained who is in need of greater services than the facility can provide. (II, III)
2. Residents shall be admitted only on a written order signed by a physician. (II, III)
3. A preplacement visit shall be completed prior to admission, except in case of an emergency admission or readmission, to familiarize the applicant with the facility and services offered. The policies and procedures may allow for waiving the requirement at the request of a person seeking admission when the completion of the visit would create a hardship for the person seeking admission. If the distance to be traveled makes it impossible to complete the visit in an eight-hour day, this may be considered to create a hardship. (III)
4. Prior to admission of an applicant, the facility shall obtain sufficient information to determine if its program is appropriate and adequate to meet the person's needs. (III)
5. Admission criteria shall include, but not be limited to, age, sex, current diagnosis from an American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, substance abuse, dual diagnosis and criteria that are consistent with the résumé of care. (III)
6. Each facility shall maintain a waiting list with selection priorities identified. (III)
7. No ICF/PMI may admit more residents than the number of beds for which it is licensed. (II, III)
8. There shall be a written, organized orientation program for all residents which shall be planned and implemented to resolve or reduce personal, family, business, and emotional problems that may interfere with the health care, recovery, and rehabilitation of the individual and which shall be available for review by the department. (III)
9. Infants and children under the age of 18 shall not be admitted as residents to an ICF/PMI for adults unless given prior written approval by the department. A distinct part of an ICF/PMI, segregated from the adult section, may be established based on a résumé of care submitted by the licensee or applicant which is commensurate with the needs of the residents of the health care facility and has received the department's review and approval. (III)
10. 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.

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.

The provisions of this paragraph shall not apply to the admission of an individual as a resident to a state mental health institute for acute psychiatric care. (II, III)

This rule is intended to implement Iowa Code sections 135C.3 and 135C.23.

481—65.11(135C) Evaluation services. Each resident admitted shall have a physical examination and tuberculin test no more than 30 days before admission and a physical examination annually after that. Each annual examination shall be sufficient to ensure the resident has no physical condition which precludes living in the facility. If the resident is admitted directly from a hospital, a copy of the hospital admission physical and discharge summary may meet this requirement. (II, III)

65.11(1) In addition to the required initial physical examination, each resident shall be evaluated to identify physical health, current level of functioning and the need for services. This evaluation shall be completed within 30 days of admission and annually after that. Information from other sources may be used in the evaluation if the information meets the requirements of subrules 65.11(2) and 65.11(3). (II, III)

65.11(2) The portion of the evaluation which describes the resident's physical health shall:

- a. Identify current illnesses and disabilities and include recommendations for physical and physiological treatment and services; (II, III)
- b. Include a description of the resident's ability for health maintenance; (II)
- c. Include a mental status examination and history of mental health and treatments; (II, III) and
- d. Be performed by a physician with a valid license to practice medicine and surgery, osteopathic medicine and surgery or osteopathy in Iowa. If the evaluation is not conducted in Iowa, it must be by a physician who holds a current license in the state in which the examination is performed. If the doctor is not a psychiatrist, a psychiatrist or health service provider in psychology licensed under Iowa Code section 154B.7 shall be consulted regarding the results of the mental status examination. (II, III)

65.11(3) The portion of the evaluation which describes the resident's current functioning level and need for services shall:

- a. Identify the functioning level and need for services in self-care, community living skills, psychotherapeutic treatment, vocational skills, and academic skills as appropriate; (II, III)
- b. Contain sufficient detail about skills and needs to determine appropriate placement; (II, III)
- c. Be made without regard to the availability of services; (III) and
- d. Be performed by a QMHP, consulting with an interdisciplinary team. (III)

65.11(4) Results of all evaluations shall be in writing and maintained in resident records. After the initial evaluation, all subsequent evaluations shall contain sufficient detail to determine changes in the resident's physical and mental health, skills, and need for services. (II, III)

65.11(5) A narrative social history shall be completed for each resident within 30 days of admission. The social history shall be completed and approved by the qualified mental health professional before the IPP is developed. (III)

a. When a social history is secured from another provider, the information shall be reviewed within 30 days of admission. The date of the review and a summary of significant changes in the information shall be entered in the resident's record. The social worker who reviews the history shall sign it. (III)

b. An annual review of the social history information shall be incorporated in the individual program plan progress notes. (III)

c. The social history shall address at least the following areas:

- (1) Referral source and reason for admission; (II, III)
- (2) Legal status; (II, III)
- (3) Previous living arrangements; (III)
- (4) Services received previously and current service involvements; (II, III)

- (5) Significant medical and mental health conditions including at least illnesses, hospitalizations, past and current drug therapy, and special diets; (II, III)
- (6) Substance abuse history; (II, III)
- (7) Work history; (III)
- (8) Education history; (II)
- (9) Relationship with family, significant others, and other support systems; (III)
- (10) Cultural, ethnic and religious background; (II, III)
- (11) Hobbies and leisure time activities; (III)
- (12) Likes, dislikes, habits, and patterns of behavior; (II, III)
- (13) History of aggressive or suicidal behavior; (I, II, III) and
- (14) Impressions and recommendations. (II, III)

This rule is intended to implement Iowa Code section 135C.14(7).

481—65.12(135C) Individual program plan (IPP). An initial program plan shall be developed within 24 hours of admission. This plan shall be based on information gained from the resident, family, physician or referring facility. Services to be provided shall be addressed. Intervention to be provided, if and when the need arises, shall also be addressed in the IPP. The plan shall be followed until the IPP required in subrule 65.12(1) is complete. The initial plan shall be completed by a registered nurse, a qualified social worker or a QMHP. (II, III)

65.12(1) An individual program plan for each resident shall be developed by an interdisciplinary team. The resident or the resident's legal guardian has the ultimate authority to accept or reject the plan unless otherwise determined by the court. The IPP shall be approved and have implementation monitored by the QMHP. (II, III)

a. The IPP shall be based on the individual service plan of the referring agency, if available, the information contained in the social history, the need for services identified in the evaluation, and any other pertinent information. (III)

b. The facility shall assist the resident in obtaining access to academic services, community living skills training, legal services, self-care training, support services, transportation, treatment, and vocational education as needed. These services may be provided by the facility or obtained from other providers. (III)

c. Services to the resident shall be provided in the least restrictive environment and shall incorporate the principle of normalization. (III)

d. If needed services are not available and accessible, the facility shall document the actions taken to locate and obtain those services. The documentation shall identify needs which will not be met because of the lack of available services. (III)

e. The IPP shall be developed within 30 days following admission to the facility and renewed at least annually. (II, III)

f. The IPP shall be written, dated, signed by the interdisciplinary team members, and maintained in the resident's record. (III)

g. Written notice of the meeting to develop an IPP shall be mailed or delivered to everyone included in the interdisciplinary team conference at least two weeks before the scheduled meeting. (III)

65.12(2) The IPP shall include the following:

- a.* Goals, (III)
- b.* Objectives, (III)
- c.* Specific services to be provided, (III)
- d.* People or agency responsible for providing services, (III)
- e.* Beginning date, (III) and
- f.* Anticipated duration of services. (III)

65.12(3) The IPP shall set out the procedure to be used to evaluate whether objectives are achieved. This procedure shall incorporate a process for ongoing review and revision. (III)

65.12(4) The interdisciplinary team shall review the IPP at a team meeting at least quarterly and when the resident's condition changes. (II, III)

a. The interdisciplinary team shall develop a written report which addresses:

- (1) The resident's progress toward objectives; (II, III)
- (2) The need for continued services; (II, III)
- (3) Recommendations concerning alternative services or living arrangements; (II, III) and
- (4) Any recommended change in guardianship, conservatorship or commitment status. (II, III)

b. The report shall reflect those involved in the review, the date of the review, and be maintained in the resident's record. (III)

65.12(5) There shall be procedures for recording the activities of each service provider and a mechanism to coordinate the activities of all service providers. Resident response to all activities shall be recorded. (III)

a. Staff shall create a record at the time of a service required by the IPP. If this is not possible, the record shall be written no more than seven days later. (III)

b. When the services are provided more than once a week, staff may make a monthly summarized entry in the resident's record. (III)

c. Entries shall be dated and signed by the person who provides the service. (III)

d. Entries shall be made when incidents occur. (III)

e. Entries shall be written in terms of behavioral observations and specific activities. Entries that involve subjective interpretations of a resident's behavior or progress shall be clearly identified and shall be supplemented with descriptions of behavior upon which the interpretation was based. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.13(135C) Activity program. Each ICF/PMI shall have an organized activity program which is directed by a person qualified as required by 65.9(3) "d."

65.13(1) An activity program plan for the facility shall be based on needs identified in IPPs and on other interests expressed by residents. The activity program shall include leisure time management. (III)

65.13(2) Activities shall be offered at least daily during the daytime hours if residents are present, twice weekly in the evening and twice on the weekend. (III)

65.13(3) Activities offered shall be varied and shall be planned for individuals, small groups or large groups. (III)

65.13(4) Monthly calendars shall be prepared in advance and shall be kept for review by the department. Substitutions and cancellations shall be noted. (III)

65.13(5) Activities department personnel shall coordinate programs with other facility personnel. (III)

481—65.14(135C) Crisis intervention. There shall be written policies and procedures concerning crisis intervention. (II) These policies and procedures shall be:

1. Directed to maximizing the growth and development of the individual by incorporating a hierarchy of available alternative methods that emphasize positive approaches; (II, III)

2. Available in each program area and living unit; (II, III)

3. Available to individuals and their families; (II, III) and

4. Developed with the participation, as appropriate, of individuals served. (II, III)

65.14(1) Corporal punishment, physical abuse, and verbal abuse, for example, shouting, screaming, swearing, name calling, or any other activity which might damage an individual's self-respect shall be prohibited. All residents shall be treated with fairness and respect as required by rule 481—65.25(135C). (II)

65.14(2) Medication shall not be used as punishment, for the convenience of staff, or as a substitute for a program. Direct care staff shall monitor residents on medication and notify the physician if a resident is too sedated to participate in the IPP. (I, II)

481—65.15(135C) Restraint or seclusion. Physician's orders are required to use any kind of mechanical restraints or seclusion. (I, II, III) Restraints are defined as the following:

1. Type I is physical restraint which uses equipment to promote the safety of the individual. It is not applied directly to a person. Examples: divided doors and side rails.
2. Type II is mechanical restraint applied to someone's body. A device is applied to the body to promote safety of the individual. Examples: vests or soft tie devices, hand socks, geriatric chairs.
3. Type III is mechanical restraint applied to any part of the body which inhibits only the movement of that part of the body. Examples: wrist, ankle or leg restraints and waist straps.

65.15(1) Temporary restraint of residents shall be used only to prevent injury to the resident or to others. (I, II)

65.15(2) Temporary seclusion may be used:

- a. To prevent injury to the resident or to others; (I, II)
- b. To prevent serious disruption to the treatment program of other residents; (I, II)
- c. To decrease stimulation which contributes to psychotic behavior; (I, II) and
- d. When other interventions have failed. (I, II)

Restraint and seclusion shall not be used for punishment, for the convenience of staff, or as a substitution for supervision of program. Seclusion shall be used only in a department approved seclusion room. (I, II)

65.15(3) Restraints shall be stored in an area easily accessible to staff. (I, II, III) Type II and Type III restraints shall be specifically designed, manufactured, and customarily used to restrain individuals hospitalized in licensed psychiatric hospitals. Metal and plastic handcuffs, rope and makeshift devices are prohibited. (I, II)

65.15(4) Under no circumstances shall a resident be allowed to participate in the restraint of another resident. (I, II)

65.15(5) There shall be written policies that address the basic assumption and philosophy that govern the use of seclusion and physical and mechanical restraint. These shall:

- a. Define the uses of seclusion and mechanical restraints; (III)
- b. Designate staff who may authorize its use; (III)
- c. Identify procedures to follow when implementing the policy which shall include provisions to ensure privacy and safety for restrained residents; (III) and
- d. A written plan for treatment following the use of restraint or seclusion.

65.15(6) The physician and QMHP shall be notified immediately of the resident's need for placement in restraint or seclusion. An order for restraint or seclusion identifying the type, purpose and duration of use shall be obtained from the physician. If the resident is in seclusion longer than four hours, the physician and qualified mental health professional shall visit and evaluate the resident before the seclusion order is continued. If the resident is in restraint for two hours, the physician shall be called before the restraint order can be continued. If the resident is in restraint longer than four hours, the physician and QMHP shall visit and evaluate the resident before a restraint order is continued. Standing or PRN orders for seclusion or restraint are prohibited. (I, II)

65.15(7) If a resident is restrained with Type II or Type III restraints for 6 hours or secluded for 12 hours in a 24-hour period; or if the resident is secluded or restrained with Type II or Type III restraints for any amount of time in three consecutive 24-hour periods, the physician and QMHP shall visit the resident and assess the resident's need for a higher level of care. If the need for restraint or seclusion continues, the resident shall be transferred to an acute level of care. (I, II)

65.15(8) During any period of mechanical restraint or seclusion, the facility shall provide for the emotional and physical needs of the resident. (I, II)

65.15(9) The resident shall be informed of the reason for seclusion and restraint and conditions for release. The resident's guardian shall be notified when Type II or Type III restraints or seclusion is used. The facility shall also notify the resident's family or other significant person if the resident has previously signed a form granting consent to do so. (I, II, III)

65.15(10) Each resident's record shall contain all information about restraints or seclusion. The administrator shall maintain a daily record of seclusion use. This record shall be available for review by the department. (II, III)

Documentation of each incident of restraint or seclusion shall include at least:

- a. Clinical assessment before the resident is secluded or restrained; (I, II)
- b. Circumstances that led to seclusion or restraint; (I, II)
- c. Explanation of less restrictive measures used before restraint or seclusion; (I, II)
- d. Physician's order; (I, II)
- e. Visual observation of the resident every 15 minutes, or more frequently if needed, to monitor general well-being including respirations, circulation, positioning and alertness as indicated; (I, II)
- f. Description of the resident's activity at the time of observation to include verbal exchange and behavior; (I, II)
- g. Description of safety procedures taken (removal of dangerous objects, etc.); (I, II)
- h. Vital signs, including blood pressure, pulse and respiration unless contraindicated by resident behavior and reasons documented; (I, II)
- i. Release of each mechanical restraint and exercise and massage every two hours; (I, II, III)
- j. Record of intake of food and fluid; (I, II, III)
- k. Use of toilet; (II, III) and
- l. Number of hours and minutes in seclusion. (II, III)

65.15(11) The facility shall educate staff on restraint and seclusion theory and techniques. The training shall be conducted by people with experience and documented education in the appropriate use of restraint and seclusion. (II, III)

- a. The facility shall keep a record of the training for review by the department and shall include attendance. (II, III)
- b. Only staff who have documented training in restraint and seclusion theory and techniques shall be authorized to assist with seclusion or restraint of a resident. (I, II, III)

65.15(12) The facility shall maintain a record of the hours and minutes of each type of restraint and seclusion used on a monthly basis.

481—65.16(135C) Discharge or transfer. Procedures for the discharge or transfer of the resident shall be established and followed. (II, III)

65.16(1) Discharge plan. The decision to discharge a person and the plan for doing so shall be established through the participation of the resident, members of the interdisciplinary team and other resource personnel as appropriate for the welfare of the individual. (II, III)

- a. Discharge planning shall begin within 30 days of admission and be carried out in accordance with the IPP. (II, III)
- b. As changes occur in a resident's physical or mental condition necessitating services or care which cannot be adequately provided by the facility, the resident shall be transferred promptly to another appropriate facility pursuant to subrule 65.10(1). (II, III)
- c. Notification shall be made to the next of kin, legal representative, attending physician, and sponsoring agency, if any, prior to transfer or discharge of any resident. (III)
- d. Proper arrangements shall be made for the welfare of the resident prior to the transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative. (III)
- e. The licensee shall not refuse to discharge or transfer a resident when directed by the physician, resident, legal representative, or court. (II, III)
- f. Advanced notification by telephone shall be made to the receiving facility prior to the transfer of any resident. (III)
- g. When a resident is transferred or discharged, the current evaluation and treatment plan and progress notes for the last 30 days, as set forth in these rules, shall accompany the resident. (II, III)

h. Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being sent. (II, III)

i. A discharge or transfer authorization and summary shall be prepared for each resident who has been discharged or transferred from the facility. It shall be disseminated to appropriate persons to ensure continuity of care and in accordance with the requirements to ensure confidentiality. (II, III)

j. 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)

65.16(2) *Intrafacility transfer.* Residents shall not be arbitrarily moved from room to room within a health care facility. (II, III)

a. Involuntary relocation may occur only to implement goals and objectives in the IPP and in the following situations:

(1) Incompatibility with or behavior disturbing to roommates, as documented in the residents' records; (I, II)

(2) To allow a new admission to the facility which would otherwise not be possible due to separation of roommates by sex; (II, III)

(3) Reasonable and necessary administrative decisions regarding the use and functioning of the building. (II, III)

b. Unreasonable and unjustified reasons for changing a resident's room without the concurrence of the resident or legal guardian include:

(1) Punishment or behavior modification; (II) and

(2) Discrimination on the basis of race or religion. (II, III)

c. If intrafacility relocation is necessary for reasons outlined in paragraph "*a*," the resident shall be notified at least 48 hours prior to the transfer and the reason shall be explained. The legal guardian shall be notified as soon as possible. The notification shall be documented in the resident's record and signed by the resident or legal guardian within seven days unless documentation indicates that it was not possible to contact the legal guardian or obtain their signature. (II, III)

d. If emergency relocation is required 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 and legal guardian shall be notified immediately, or as soon as possible, of the condition requiring emergency relocation, and the notification shall be documented. (II, III)

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)

65.16(3) *Involuntary discharge or transfer permitted.* A facility may involuntarily discharge or transfer a resident for only one of the following reasons:

a. Medical reasons, based on the resident's needs and determined and documented in the resident's record by the primary care provider;

b. The resident's social, emotional or physical well-being or that of other residents, as documented by the administrator or designee with specific information to support the determination that the resident's continued presence in the facility would adversely affect the resident's own well-being or that of other residents;

c. Due to action pursuant to Iowa Code chapter 229; or

d. Nonpayment for the resident's stay, as described in the admission agreement for the resident's stay. (I, II, III)

65.16(4) *Involuntary transfer or discharge—written notice.* Involuntary transfer or discharge of a resident from a facility shall be preceded by a written notice to the resident or the resident's legal representative. (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. In emergency circumstances, provision may be made for extension of the 14-day requirement upon request to the department designee. If you lose the hearing, you will not be transferred before the expiration date 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 you may write to the department to the attention of: Administrator, Division of Health Facilities, Iowa Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319. (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 legal representative, 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. (II)

c. The notice required by paragraph 65.16(4) "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. (II)

(2) The transfer or discharge is subsequently agreed to by the resident or the resident's legal representative, and notification is given to the legal representative, the resident's primary care provider, and the person or agency responsible for the resident's placement, maintenance, and care in the facility. (II)

d. A hearing requested pursuant to this subrule shall be held in accordance with subrule 65.16(6).

65.16(5) *Involuntary transfer or discharge—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 must be placed in the resident's file. The notice must 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:

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 legal representative, 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 65.16(6).

65.16(6) *Involuntary transfer or discharge—hearing.*

a. Request for hearing.

(1) The resident must request a hearing within 7 days of receiving 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 9. 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 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 resident's legal representative 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 resident's legal representative 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 resident's legal representative within 10 working days after the hearing has been concluded.

65.16(7) *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)

65.16(8) *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 legal representative, 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 65.16(6) and emergency notice is provided within 48 hours.

65.16(9) *Involuntary discharge or transfer—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 65.16(9) "b" does not apply if the discharge has already occurred pursuant to subrule 65.16(5) 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)

65.16(10) *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.

This rule is intended to implement Iowa Code section 135C.14(8).

[ARC 1205C, IAB 12/11/13, effective 1/15/14; ARC 1752C, IAB 12/10/14, effective 1/14/15; ARC 3523C, IAB 12/20/17, effective 1/24/18]

481—65.17(135C) Medication management. Medications shall be prescribed on an individual basis by a person who is authorized by Iowa law to prescribe. (I, II)

1. Medication orders shall be correctly implemented by qualified personnel. (II)

2. Qualified staff shall ensure that residents are able to take their own medication. (I, II)

3. Each physician order allowing a resident to self-administer medications shall specify whether this self-medication shall be without supervision or under the supervision of qualified staff as defined in 65.17(2). (I, II)

65.17(1) A properly trained person shall be charged with the responsibility of administering nonparenteral 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. Prior to taking a department-approved medication aide course, the individual shall:

(1) Successfully complete an approved nurse aide course, nurse aide training and testing program or nurse aide competency examination.

(2) Be employed in the same facility for at least six consecutive months prior to the start of the medication aide course. This requirement is not subject to waiver.

(3) Have a letter of recommendation for admission to the medication aide course from the employing facility.

d. 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.

e. 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.

The requirements of paragraph “c” of this subrule do not apply to this individual.

f. Unit dose medication shall remain in the identifiable unit dose package until given to the resident. (II)

g. Medications that are not contained in unit dose packaging shall be set up, identified by resident name and medication name, and administered by the same person. The medications shall be administered within one hour of preparation. (II)

h. The person administering medications must observe and check to make sure the resident swallows oral medications and must record the date, time, amount and name of each medication given. (II)

i. Injectable medications shall be administered as permitted by Iowa law by a qualified nurse, physician, pharmacist, or physician associate (PA). In the case of a resident who has been certified by the resident’s physician or physician associate (PA) as capable of taking the resident’s own insulin, the resident may prepare and inject the resident’s own insulin. (II)

j. Current and accurate records must be kept on the receipt and disposition of all Schedule II drugs. (II, III)

65.17(2) For each resident who is taking medication with or without supervision, there shall be documentation on the individual’s record to include:

a. Name of resident; (II, III)

b. Name of drug, dose, and schedule; (II, III)

c. Method of administration; (II, III)

d. Identified drug allergies and observed adverse reactions; (I, II)

e. Special precautions for that resident; (I, II) and

f. Documentation of resident’s continuing ability to administer own medication. (I, II)

65.17(3) Medication counseling shall be provided for all residents in accordance with the IPP on an ongoing basis and as part of discharge planning unless contraindicated in writing by the physician with reasons and pursuant to 65.12(2) “c.” (II, III)

Each resident and when appropriate, a family member or other identified caregiver, shall be given verbal and written information about all medications the resident is currently using, including over-the-counter medications. A suggested reference is “USPDI, Advice for the Patient.” (II, III)

The information shall include:

a. Name, reason for, and amount of medication to be taken; (II)

b. Time medication is to be taken and reason that the schedule was established; (II)

c. Possible benefits, risks and side effects of each medication, including over-the-counter medications; (II)

d. A list of resources in the community qualified to answer questions about medications; (II, III) and

e. A list of available resources or agencies which may assist the resident to obtain medication after discharge. (III)

65.17(4) Residents who have been certified in writing by the physician as capable of taking their own medications may retain these medications in a secure centralized location. Individual locked storage shall be utilized. (II, III)

a. Drug storage for residents who are unable to take their own medications and require supervision shall meet the following requirements:

(1) Adequate size cabinet with lock which can be used for storage of drugs, solutions, and prescriptions. A locked drug cart may be used. (II, III)

(2) A bathroom shall not be used for drug storage. (II, III)

(3) The drug storage cabinet shall be kept locked when not in use. (II, III)

(4) The drug storage cabinet key shall be in the possession of the employee charged with the responsibility of administering medication. (II, III)

(5) Medications requiring refrigeration which are stored in a common refrigerator shall be kept in a locked box properly labeled, and separated from food and other items. (II, III)

(6) Drugs for external use shall be stored separately from drugs for internal use. External medications are those to be applied to the outside of the body and include, but are not limited to, salves, ointments, gels, paste, soaps, baths, and lotions. Internal medications are those to be applied inside the body or ingested and include, but are not limited to, oral and injectable medications, eye drops and ointments, ear drops and ointments, and suppositories. Also, eye drops and ear drops shall be separated from each other as well as from other internal and external medications. (II, III)

(7) All potent, poisonous, or caustic materials shall be stored in a separate room from the medications. (II, III)

(8) Inspection of the condition of stored drugs shall be made by the administrator and a licensed pharmacist not less than once every three months. The inspection shall be verified by a report signed by the administrator and the pharmacist and filed with the administrator. The report shall include, but need not be limited to, certifying absence of the following: expired drugs, deteriorated drugs, improper labeling, drugs for which there is no current order, and drugs improperly stored. (III)

(9) Double-locked storage of Schedule II drugs shall not be required under single unit package drug distribution systems in which the quantity stored does not exceed a seven-day supply and a missing dose can be readily detected but must be kept in a locked medication cabinet. Quantities in excess of a seven-day supply must be double-locked. (II)

b. Bulk supplies of prescription drugs shall not be kept. (III)

65.17(5) All labels on medications must be legible. If labels are not legible, the medication shall be sent back to the dispenser as defined in Iowa Code section 147.107 for relabeling. (II, III)

a. The medication for each resident shall be kept or stored in the original dispensed containers. (II, III)

b. The facility shall adopt policies and procedures to destroy unused prescription drugs for residents who die. The policies and procedures shall include, but not be limited to, the following:

(1) Drugs shall be destroyed by the person in charge in the presence of the administrator or the administrator's designee or, if a unit dose system is used, the drugs shall be returned to the supplying pharmacist; (III)

(2) Notation of the destruction shall be made in the resident's chart, with signatures of the persons involved in the destruction; (III)

(3) The manner in which the drugs are disposed of shall be identified (i.e., incinerator, sewer, landfill). (II, III)

c. Reserved.

d. The facility shall also adopt policies and procedures for the disposal of controlled substances as defined by the Iowa board of pharmacy dispensed to residents whose administration has been discontinued by the prescriber. These policies and procedures shall include, but not be limited to, the following:

(1) Procedures for obtaining a release from the resident; (II, III)

(2) The manner in which the drugs were destroyed and by whom, including witnesses to the destruction; (II, III)

(3) Mechanisms for recording the destruction; (II, III)

(4) Procedures to be used when the resident or the conservator or guardian refuses to grant permission for destruction. (II, III)

e. The facility shall adopt policies and procedures for the disposal of unused, discontinued medication. The procedures shall include, but not be limited to:

(1) A specified time after which medication must be destroyed, sent back to the dispenser or placed in long-term storage; (II, III)

(2) Procedures for obtaining permission of the resident, or the conservator or guardian; (II, III)

(3) Procedures to be used when the resident, conservator or guardian refuses to grant permission for disposal; (II, III)

(4) Unused, discontinued medication shall be locked and shall be separate from current medication. (II, III)

f. Reserved.

g. Residents shall not keep any prescription or over-the-counter medication in their possession unless the resident has been determined to be capable of self-administration of medications. (I, II, III)

h. No prescription drugs shall be administered to a resident without a written order signed by a person qualified to prescribe the medication and renewed quarterly. (II)

i. Prescription drugs shall be reordered only with the permission of the attending prescriber. (II, III)

j. No medications prescribed for one resident may be administered to or allowed in the possession of another resident. (II)

65.17(6) Each facility shall establish policies and procedures to govern the administration of prescribed medications to residents on leave from the facility. (III)

a. Medication may be issued to residents who will be on leave from a facility for less than 24 hours. Non-child-resistant containers may be used. Each container may hold only one medication. A label on each container shall indicate the date, the resident's name, the facility, the medication, its strength, dose, and time of administration. (II, III)

b. Medication for residents on leave from a facility longer than 24 hours shall be obtained in accordance with requirements established by the Iowa board of pharmacy examiners. (II, III)

c. Medication distributed as described in this subrule may be issued only by facility personnel responsible for administering medication. (II, III)

65.17(7) Each ICF/PMI that administers controlled substances shall annually obtain a registration from the Iowa board of pharmacy examiners pursuant to Iowa Code section 204.302(1). (III)

This rule is intended to implement Iowa Code section 135C.14.

[ARC 1050C, IAB 10/2/13, effective 11/6/13; Editorial change: IAC Supplement 6/10/26]

481—65.18(135C) Resident property and personal affairs. The admission of a resident does not give the facility or any employee of the facility the right to manage, use, or dispose of any property of the resident except with the written authorization of the resident or the resident's legal guardian. (II, III)

65.18(1) The admission of a resident shall not grant the ICF/PMI the authority or responsibility to manage the personal affairs of the resident except as may be necessary for the resident's safety and for safe and orderly management of the facility as required by these rules and in accordance with the IPP. (III)

65.18(2) An ICF/PMI shall provide for the safekeeping of personal effects, funds, and other property of its residents. The facility may require that items of exceptional value or which would convey unreasonable responsibilities to the licensee be removed from the premises of the facility for safekeeping. (III)

65.18(3) Residents' funds held by the ICF/PMI shall be in a trust account and kept separate from funds of the facility. (III)

65.18(4) No administrator, employee or their representative shall act as guardian, trustee, or conservator for any resident or the resident's property, unless the resident is related to the person acting as guardian within the third degree of consanguinity. (III)

65.18(5) If a facility is a county care facility, upon the verified petition of the county board of supervisors, the district court may appoint, without fee, the administrator of a county care facility as conservator or guardian, or both, of a resident of such a county care facility. The administrator may establish either separate or common bank accounts for cash funds of these residents. (III)

This rule is intended to implement Iowa Code section 135C.24.

481—65.19(135C) Financial affairs. Residents who have not been assigned a guardian or conservator by the court may manage their personal financial affairs, and to the extent, under written authorization by the residents that the facility assists in management, the management shall be carried out in accordance with Iowa Code section 135C.24. (II)

65.19(1) Written account of resident funds. The facility shall maintain a written account of all residents' funds received by or deposited with the facility. (II)

a. An employee shall be designated in writing to be responsible for resident accounts. (II)

b. The facility shall keep on deposit personal funds over which the resident has control when requested by the resident. (II)

c. If the resident requests these funds, they shall be given to the resident with a receipt maintained by the facility and a copy to the resident. If a conservator or guardian has been appointed for the resident, the conservator or guardian shall designate the method of disbursing the resident's funds. (II)

d. If the facility makes a financial transaction on a resident's behalf, the resident or the resident's legal guardian or conservator must receive or acknowledge having seen an itemized accounting of disbursements and current balances at least quarterly. A copy of this statement shall be maintained in the resident's financial or business record. (II)

65.19(2) Contracts. There shall be a written contract between the facility and each resident which meets the following requirements:

a. States the base rate or scale per day or per month, the services included, and the method of payment; (III)

b. Contains a complete schedule of all offered services for which a fee may be charged in addition to the base rate; (III)

c. Stipulates that no further additional fees shall be charged for items not contained in complete schedule of services listed in this subrule; (III)

d. States the method of payment of additional charges; (III)

e. Contains an explanation of the method of assessment of additional charges and an explanation of the method of periodic reassessment, if any, resulting in changing such additional charges; (III)

f. States that additional fees may be charged to the resident for nonprescription drugs, other personal supplies, and services by a barber, beautician, etc.; (III)

g. Contains 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 the program assessment at the time of admission, which is determined in consultation with the administrator; (III)

h. Includes the total fee to be charged initially to the specific resident; (III)

i. States the conditions whereby the facility may make adjustments to its overall fees for residential care as a result of changing costs. (III) Furthermore, the contract shall provide that the facility shall give:

(1) Written notification to the resident and responsible party, when appropriate, of changes in the overall rates of both base and additional charges at least 30 days prior to the effective date of changes; (III)

(2) Notification to the resident and payer, when appropriate, of changes in additional charges based on a change in the resident's condition. Notification must occur prior to the date the revised additional 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) and

(3) The terms of agreement in regard to refund of all advance payments, in the event of transfer, death, or voluntary or involuntary discharge; (III)

j. States the terms of agreement concerning holding and charging for a bed in the event of temporary absence of the resident, which terms shall include, at a minimum, the following provisions:

(1) If a resident has a temporary absence from a facility for medical treatment, the facility shall hold the bed open and shall receive payment for the absent period in accordance with provisions of the contract between the resident or the legal guardian and the facility. (II)

(2) If a resident has a temporary absence from a facility in accordance with the IPP, the facility shall ask the resident and payer if they wish the bed held open. This shall be documented in the resident's record including the response. The bed shall be held open and the facility shall receive payment for the absent periods in accordance with the provisions of the contract between the resident or the legal guardian and the facility. (II)

k. States the conditions under which the involuntary discharge or transfer of a resident would be affected; (III)

l. States the conditions of voluntary discharge or transfer; (III) and

m. Sets forth any other matters deemed appropriate by the parties to the contract. No contract or any provision shall be drawn or construed so as to relieve any health care facility of any requirement or obligation imposed upon it by this chapter or any standards or rules in force pursuant to this chapter. (III)

65.19(3) *Contract—copy to party.* Each party shall receive a copy of the signed contract. (III)

65.19(4) The contract shall state the terms of agreement concerning the holding and charging for a bed when a resident is hospitalized or leaves the facility temporarily for recreational or therapeutic reasons. The terms shall contain a provision that the bed will be held at the request of the resident or the resident's legal representative.

a. The facility shall ask the resident or legal representative if they want the bed held. This request shall be made before the resident leaves or within 48 hours after the resident leaves. The inquiry and the response shall be documented. (II)

b. The facility shall reserve the bed when requested for as long as payments are made in accordance with the contract. (II)

This rule is intended to implement Iowa Code sections 135C.23(1) and 135C.24.

481—65.20(135C) Records.

65.20(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; (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 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, telephone number, and address; (III)
- i.* Pharmacy name, telephone number, and address; (III)
- j.* Results of evaluation pursuant to rule 481—65.11(135C); (III)
- k.* Certification by the physician that the resident requires no higher level of care than the facility is licensed to provide; (III)
- l.* Physician's orders for medication and treatments in writing, signed by the physician quarterly and diet orders renewed yearly; (III)
- m.* A notation of yearly or other visits to physician or other professionals, all consultation reports and progress notes; (III)
- n.* Any change in the resident's condition; (II, III)
- o.* A notation describing the resident's condition on admission, transfer, and discharge; (III)
- p.* 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)

q. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer; (III)

r. Disposition of personal property; (III)

s. Copy of IPP pursuant to subrule 65.12(1); (III) and

t. Progress notes pursuant to subrules 65.12(4) and 65.12(5). (III)

65.20(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 automatic 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 information being released, 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 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 QMHP determines the disclosure of the record or section is contraindicated in which case this information will be deleted prior to making the record 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)

65.20(3) Incident records. Each ICF/PMI 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 and sign the report. (III)

c. A copy of the incident report shall be kept on file in the facility available for review and a part of administrative records. (III)

65.20(4) Retention of records. 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. (III)

When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician. (III)

This rule is intended to implement Iowa Code section 135C.24.

481—65.21(135C) Health and safety.

65.21(1) Physician. Each resident shall have a designated licensed physician who may be called when needed. (III)

65.21(2) Emergency care. Each facility shall have written policies and procedures for emergency medical or psychiatric care to include:

a. A written agreement with a hospital or psychiatric facility or documentation of attempt to obtain a written agreement for the timely admission of a resident who, in the opinion of the attending physician, requires inpatient services; (II, III)

b. Provisions consistent with Iowa Code chapter 229; (II, III) and

c. Immediate notification by the person in charge to the physician or QMHP, as appropriate, of any accident, injury or adverse change in the resident's condition. (I, II)

65.21(3) *First-aid kit.* A first-aid emergency kit shall be available on each floor in every facility. (II, III)

65.21(4) *Infection control.* Each facility shall have a written and implemented infection control program addressing the following:

a. Techniques for hand washing consistent with Guidelines for Handwashing and Hospital Control, 1985, Centers for Disease Control, U.S. Department of Health and Human Services, PB85-923404; (I, II, III)

b. Techniques for handling of blood, body fluids, and body wastes consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

c. Decubitus care; (I, II, III)

d. Infection identification; (I, II, III)

e. Resident care procedures to be used when there is an infection present consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III)

f. Sanitation techniques for resident care equipment; (I, II, III)

g. Techniques for sanitary use and reuse of enteral feeding bags, feeding syringes and urine collection bags; (I, II, III)

h. Techniques for use and disposal of needles, syringes, and other sharp instruments consistent with Guideline for Isolation Precautions in Hospitals, Centers for Disease Control, U.S. Department of Health and Human Services, PB96-138102; (I, II, III) and

i. Aseptic techniques when using:

(1) Intravenous or central line catheter consistent with Guideline for Prevention of Intravascular Device Related Infections, Centers for Disease Control, U.S. Department of Health and Human Services, PB97-130074, (I, II, III)

(2) Urinary catheter, (I, II, III)

(3) Respiratory suction, oxygen or humidification, (I, II, III)

(4) Dressings, soaks, or packs, (I, II, III)

(5) Tracheostomy, (I, II, III)

(6) Nasogastric or gastrostomy tubes, (I, II, III)

(7) Sanitary use and reuse of feeding syringes and single-resident uses and reuse of urine collection bags. (I, II, III)

CDC Guidelines may be obtained from the U.S. Department of Commerce, Technology Administration, National Technical Information Service, 5285 Port Royal Rd., Springfield, Virginia 22161 (1-800-553-6847).

65.21(5) *Disposable items.* There shall be disposable or one-time use items available with provisions for proper disposal to prevent reuse except as allowed by 65.21(4) "g."

65.21(6) *Infection control committee.* Each facility shall establish an infection control committee of representative professional staff responsible for overall infection control in the facility. (III)

a. The committee shall annually review and revise the infection control policies and procedures to monitor effectiveness and suggest improvement. (III)

b. The committee shall meet at least quarterly, submit reports to the administrator, and maintain minutes in sufficient detail to document its proceedings and actions. (III)

c. The committee shall monitor the health aspect and the environment of the facility. (III)

These rules are intended to implement Iowa Code sections 135C.14(3), 135C.14(5) and 135C.14(8).

65.21(7) *Dental services.* The facility shall assist residents to obtain regular and emergency dental services and provide necessary transportation. Dental services shall be performed only on the

request of the resident or legal guardian. The resident's physician shall be advised of the resident's dental problems. (III)

65.21(8) *Safe environment.* The licensee of an ICF/PMI is responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II) The ICF/PMI may have locked exit doors and shall meet the fire and safety rules and regulations as promulgated by the state fire marshal. (I, II)

65.21(9) *Disaster.* The licensee shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency. (II, III)

a. The plan shall be posted. (II, III)

b. Training shall be provided to ensure that all employees and residents are knowledgeable of the emergency plan. The training shall be documented. (II, III)

c. Residents shall be permitted to smoke only in posted areas where proper facilities are provided. Smoking by residents considered to be careless shall be prohibited except under direct supervision and in accordance with the IPP. (II, III)

65.21(10) *Safety precautions.* The facility shall take reasonable measures to ensure the safety of residents and shall involve the residents in learning the safe handling of household supplies and equipment in accordance with the policies and procedures established by the facility. (II)

All potent, poisonous, or caustic materials shall be plainly labeled and stored in a specific locked, well-illuminated cabinet, closet, or storeroom and made accessible only to authorized persons. (I, II)

65.21(11) *Hazards.* Entrances, exits, steps, and outside steps and walkways shall be cleared of ice and snow as soon as possible, and kept free of other hazards. (II, III)

65.21(12) *Laundry.* All soiled linens shall be collected in and transported to the laundry room in closed, leakproof laundry bags or covered, impermeable containers. (III)

a. Except for related activities, the laundry room shall not be used for other purposes. (III)

b. Personal laundry shall be marked with an identification unless the residents are responsible for doing their own laundry as indicated in the individual program plan. (III)

c. There shall be an adequate supply of clean, stain-free linens so that each resident shall have at least three washcloths, hand towels, and bath towels per week. (III)

d. Each bed shall be provided with clean, stain-free washable bedspreads and sufficient lightweight serviceable blankets. A complete change of bed linens shall be available for each bed. Linens on beds shall be clean, stain-free and in good repair at all times. (III)

65.21(13) *Supplies, equipment, and storage.* Each facility shall provide a variety of supplies and equipment of a nature calculated to fit the needs and interests of the residents. These may include: books (standard and large print), magazines, newspapers, radio, television, bulletin boards, board games, game equipment, songbooks, cards, craft supplies, record player, movie projector, piano, and outdoor equipment. Supplies and equipment shall be appropriate to the chronological age of the residents. (III)

Storage shall be provided for recreational equipment and supplies. (III)

This rule is intended to implement Iowa Code section 135C.14(1).

481—65.22(135C) Nutrition. There shall be policies and procedures written and implemented for dietary staffing.

1. The person responsible for planning menus and monitoring the kitchens in each facility shall have completed training, approved by the department, in sanitation and food preparation. (III)

2. In facilities licensed for over 15 beds, food service personnel shall be on duty during a 12-hour span extending from the preparation of breakfast through supper. (III)

3. There shall be written work schedules and time schedules covering each type of job in the food service department for facilities over 15 beds. These work and time schedules shall be posted or kept in a notebook which is available for use in the food service area. (III)

65.22(1) *Nutrition and menu planning.* Residents shall be encouraged to the maximum extent possible to participate in meal planning, shopping, and in preparing and serving the meal and cleaning

up. The facility shall be responsible for helping residents become knowledgeable of what constitutes a nutritionally adequate diet. (III)

a. Menus shall be planned and served to meet nutritional needs of residents in accordance with the physician's diet orders which shall be renewed yearly. Menus shall be planned and served to include foods and amounts necessary to meet the recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. Other foods shall be included to meet energy requirements (calories) to add to the total nutrients and variety of meals. (II, III)

b. At least three meals or their equivalent shall be made available to each resident daily, consistent with those times normally existing in the community. (II, III)

(1) There shall be no more than a 14-hour span between the substantial evening meal and breakfast. (III)

(2) To the extent medically possible, bedtime nourishments, containing a protein source, shall be offered routinely to all residents. Special nourishments shall be available when ordered by the physician. (II, III)

c. Menus shall include a variety of foods prepared in various ways. The same menus shall not be repeated on the same day of the following week. (III)

d. If modified diets are ordered by the physician, the person responsible for writing the menus shall have completed department-approved training in simple therapeutic diets. A copy of a modified diet manual approved by the department and written within the past five years shall be available in the facility. (II, III)

e. Therapeutic diets shall be served accurately. (II, III)

f. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place in the dietetic service department for easy use by persons purchasing, preparing, and serving food. (III)

g. Records of menus as served shall be filed and maintained for 30 days and shall be available for review by departmental personnel. When substitutions are necessary, they shall be of similar nutritive value and recorded on the menu or in a notebook. (III)

h. A file of tested recipes adjusted to the number of people to be fed in the facility shall be maintained. (III)

65.22(2) *Dietary storage, food preparation, service.* In each stage, food shall be handled with maximum care for safety and good health.

a. The use of foods from salvaged, damaged, or unlabeled containers is prohibited. (II, III)

b. No perishable food shall be allowed to stand at room temperature any longer than is required to prepare and serve. (II, III)

c. Canning food is prohibited. The facility may freeze fruits, vegetables, and meats provided strict sanitary procedures are followed and in accordance with recommendations in the "Food Service Sanitation Manual," revised 1976, U.S. Department of Health, Education, and Welfare, Public Health Service, U.S. Government Printing Office, Washington, D.C. (II)

d. Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a three-day period shall be maintained on the premises. (III)

e. If family-style service is used, all leftover prepared food that has been on the table shall be safely handled. (III)

f. Poisonous compounds shall not be kept in food storage or preparation areas except for a sanitizing agent which shall be kept in a locked cabinet. (II, III)

65.22(3) *Sanitation in food preparation area.* The facility shall develop and implement policies and procedures to address sanitation, meal preparation and service in accordance with recommendations in the "Food Service Sanitation Manual" reference in 65.22(2)"c," which shall be used as the established, nationally recognized reference for establishing and determining satisfactory compliance with the department's food service and sanitation rules. (III)

- a.* In facilities of 15 beds or fewer, residents may be allowed in the food preparation area in accordance with their IPP. (III)
- b.* In facilities licensed for over 15 beds, the kitchen shall not be used for serving meals to residents, food service personnel, or other staff. (III)
- c.* All appliances and work areas shall be kept clean and sanitary. (III)
- d.* There shall be written procedures established for cleaning all work and serving areas in facilities over 15 beds and a schedule of duties to be performed daily shall be posted in each food area. (III)
- e.* The food service area shall be located so it will not be used as a passageway by residents, guests, or nonfood service staff in facilities over 15 beds. (III)
- f.* Dirty linen shall not be carried through the food service area unless it is in sealed, leakproof containers. (III)
- g.* Mops, scrub pails, and other cleaning equipment used in the resident areas shall not be stored or used in the dietary area. (III)

65.22(4) *Hygiene of food service personnel.* If food service employees are assigned duties outside the dietetic service, these duties shall not interfere with sanitation, safety, or time required for dietetic work assignments. (II, III)

- a.* Employees shall wear clean, washable uniforms that are not used for duties outside the food service area in facilities over 15 beds. (III)
- b.* Hair nets shall be worn by all food service personnel and residents who do work in the kitchen in facilities over 15 beds and effective hair restraints in facilities with fewer than 15 beds. (III)
- c.* People who handle food shall use correct hand-washing and food-handling techniques as identified in the "Food Service Sanitation Manual." People who handle dirty dishes shall not handle clean dishes without washing their hands. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.23(135C) Physical facilities and maintenance.

65.23(1) *Housekeeping.* The facility shall have written procedures for daily and weekly cleaning (III) which include, but need not be limited to:

- a.* All rooms including furnishings, all corridors, storage areas, linen closets, attics, and basements shall be kept in a clean, orderly condition, free of unserviceable furniture and equipment or accumulations of refuse. (III)
- b.* All resident bedrooms, including furnishings, shall be cleaned and sanitized before use by another resident. (III)
- c.* Polishes used on floors shall provide a slip-resistant finish. (III)

65.23(2) *Equipment.* Housekeeping and maintenance personnel shall be provided with well-constructed and properly maintained equipment appropriate to the function for which it is to be used. (III)

- a.* All facilities shall be provided with clean and sanitary storage for cleaning equipment, supplies, and utensils. In facilities over 15 beds, a janitor's closet shall be provided. It shall be equipped with water for filling scrub pails and a janitor's sink for emptying scrub pails. A hallway or corridor shall not be used for storage of equipment. (III)
- b.* Sufficient numbers of noncombustible trash containers, which have covers, shall be available. (III)
- c.* All containers for trash shall be watertight, rodent-proof, and have tight-fitting covers and shall be thoroughly cleaned each time a container is emptied. (III)
- d.* All wastes shall be properly disposed of in compliance with the local ordinances and state codes. (III)

65.23(3) *Bedrooms.* Each resident shall be provided with a bed, substantially constructed and in good repair. (III)

- a.* Rollaway beds, metal cots, or folding beds are not acceptable. (III)

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately 5 inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size. (III)

c. There shall be a comfortable chair, either a rocking chair or arm chair, per resident bed. The resident's personal wishes shall be considered and documented. (III)

d. There shall be drawer space for each resident's clothing. In a multiple bedroom, drawer space shall be assigned each resident. (III)

e. There shall be a bedside table with a drawer and a reading lamp for each resident. (III)

f. All furnishings and equipment shall be durable, cleanable, and appropriate to its function. (III)

g. All resident areas shall be decorated, painted, and furnished to provide a homelike atmosphere and in a manner which is age and culture appropriate. (III)

h. Upholstery materials shall be moisture- and soil-resistant, except on furniture which is provided and owned by the resident. (III)

i. Beds and other furnishings shall not obstruct free passage to and through doorways. (III)

j. Beds shall not be placed with the side of the bed against a radiator or in close proximity to it unless the radiator is covered to protect the resident from contact with it or from excessive heat. (III)

65.23(4) *Bath and toilet facilities.* All lavatories shall have nonreusable towels or an air dryer and an available supply of soap. (III)

65.23(5) *Dining and living rooms.* Dining rooms and living rooms shall be available for use by residents at appropriate times to allow social, diversional, individual, and group activities. (III)

a. Every facility shall have a dining room and a living room easily accessible to all residents which are never used as bedrooms. (III)

b. A combination dining room and living room may be permitted if the space requirements of a multipurpose room as provided in 481—subrule 61.6(2) are met. (III)

c. Living rooms shall be suitably furnished and maintained for the use of residents and their visitors and may be used for recreational activities. (III)

d. Dining rooms shall be furnished with dining tables and chairs appropriate to the size and function of the facility. These rooms and furnishings shall be kept clean and sanitary. (III)

65.23(6) *Family and employee accommodations.* Resident bedrooms shall not be occupied by employees, family members of employees, or family members of the licensee. (III)

a. In facilities where the total occupancy of family, employees, and residents is five or fewer, one toilet and one tub or shower is the minimum requirement. (III)

b. In all health care facilities, if the family or employees live within the facility, living quarters shall be required for the family or employees separate from areas provided for residents. (III)

65.23(7) *Pets—policies.* Any facility in which a pet is living shall implement written policies and procedures addressing the following:

a. Vaccination schedule; (III)

b. Veterinary visit schedule; (III)

c. Housing or sleeping quarters; (III) and

d. Assignment of responsibility for feeding, bathing and cleanup. (III)

65.23(8) *Maintenance.* Each facility shall establish a program to ensure continued maintenance of the facility, to promote good housekeeping procedures, and to ensure sanitary practices throughout. In facilities over 15 beds, this program shall be in writing and be available for review by the department. (III)

a. The buildings, furnishings and grounds shall be maintained in a clean, orderly condition and be in good repair. (III)

b. The buildings and grounds shall be kept free of flies, other insects, rodents, and their breeding areas. (III)

65.23(9) *Buildings, furnishings, and equipment.*

a. Battery-operated, portable emergency lights in good working condition shall be available at all times, at a ratio of one light per employee on duty from 6 p.m. to 6 a.m. (III)

b. All windows shall be supplied with curtains and shades or drapes which are kept in good repair. (III)

c. Wherever glass sliding doors or transparent panels are used, they shall be marked conspicuously and decoratively. (III)

65.23(10) *Water supply.* Every facility shall have an adequate water supply from an approved source. A municipal source of water shall be considered as meeting this requirement. Private sources of water to a facility shall be tested annually and the report submitted with the annual application for license. (III)

a. A bacterially unsafe source of water shall be grounds for denial, suspension, or revocation of license. (III)

b. The department may require testing of private sources of water to a facility at its discretion in addition to the annual test. The facility shall supply reports of tests as directed by the department. (III)

This rule is intended to implement Iowa Code section 135C.14.

481—65.24(135C) Care review committee. Rescinded **ARC 1205C**, IAB 12/11/13, effective 1/15/14.

481—65.25(135C) Residents' rights in general. Each facility shall ensure that policies and procedures are written and implemented which include at least provisions in subrules 65.25(1) to 65.25(21). These shall govern all services provided to staff, residents, their families or legal representatives. The policies and procedures shall be available to the public and shall be reviewed annually. (II)

65.25(1) *Grievances.* Written policies and procedures shall include a method for submitting grievances and recommendations by residents or their legal representatives and for ensuring a response and disposition by the facility. The written procedure shall ensure protection of the resident from any form of reprisal or intimidation and shall include:

a. An employee or an alternate designated to be responsible for handling grievances and recommendations; (II)

b. Methods to investigate and assess the validity of a grievance or recommendation; (II) and

c. Methods to resolve grievances and take action. (II)

65.25(2) *Informed of rights.* Policies and procedures shall include a provision that residents be fully informed of their rights and responsibilities as residents and of all rules governing resident conduct and responsibilities. This information must be provided upon admission, or when the facility adopts or amends residents' rights policies. It shall be posted in locations accessible to all residents. (II)

a. The facility shall make known to residents what they may expect from the facility and its staff, and what is expected from residents. The facility shall communicate these expectations during a period not more than two weeks before or later than five days after admission. The communication shall be in writing in a separate handout or brochure describing the facility. It shall be interpreted verbally, as part of a preadmission interview, resident counseling, or in individual or group orientation sessions after admission. (II)

b. Residents' rights and responsibilities shall be presented in language understandable to residents. If the facility serves residents who are non-English-speaking or deaf or hard of hearing, steps shall be taken to translate the information into a foreign or sign language. Blind residents shall be provided either Braille or a recording. Residents shall be encouraged to ask questions about their rights and responsibilities. Their questions shall be answered. (II)

c. A statement shall be signed by the resident and legal guardian, if applicable, to indicate the resident understands these rights and responsibilities. The statement shall be maintained in the record.

The statement shall be signed no later than five days after admission. A copy of the signed statement shall be given to the resident or legal guardian. (II)

d. All residents, next of kin, or legal guardian shall be advised within 30 days of changes made in the statement of residents' rights and responsibilities. Appropriate means shall be used to inform non-English-speaking, deaf or hard-of-hearing, or blind residents of changes. (II)

65.25(3) *Resident abuse prohibited.* Each resident shall receive kind and considerate care at all times and shall be free from physical, sexual, mental and verbal abuse, exploitation, neglect, and physical injury. (I, II)

65.25(4) *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)

65.25(5) *Report of abuse.* Rescinded IAB 12/11/13, effective 1/15/14.

65.25(6) *Informed of health condition.* Each resident or legal guardian shall be fully informed by a physician of the health and medical condition of the resident unless a physician documents reasons not to in the resident's record. (II)

65.25(7) *Research.* The resident or legal guardian shall decide whether a resident participates in experimental research. Participation shall occur only when the resident or guardian is fully informed and signs a consent form. (II, III)

Any clinical investigation involving residents must be sponsored by an institution with a human subjects review board functioning in accordance with the requirement of Public Law 93-348, as implemented by Part 46 of Title 45 of the Code of Federal Regulations, as amended December 1, 1981 (45 CFR 46). (III)

65.25(8) *Resident work.* Services performed by the resident for the facility shall be in accordance with the IPP. (II)

a. Residents shall not be used to provide a source of labor for the facility against the resident's will. Physician's approval is required for all work programs and must be renewed yearly. (II, III)

b. If the individual program plan requires activities for therapeutic or training reasons, the plan for these activities must be professionally developed and implemented. Therapeutic or training goals must be clearly stated and measurable and the plan shall be time limited and reviewed at least quarterly. (II, III)

c. A resident engaged in work programs in the ICF/PMI shall be paid wages commensurate with wage and hour regulations for comparable work and productivity. (II)

d. The resident shall have the right to employment options commensurate with training and skills. (II)

e. Residents performing work shall not be used to replace paid employees to fulfill staff requirements. (II)

65.25(9) *Encouragement to exercise rights.* Residents shall be encouraged and assisted throughout their period of stay to exercise resident and citizen rights. Residents may voice grievances and recommend changes in policies and services to administrative staff or to an outside representative of their choice free from interference, coercion, discrimination, or reprisal. (II)

65.25(10) *Posting of names.* The facility shall post in a prominent area the name, telephone number, and address of the survey agency, local law enforcement agency, administrator, members of the board of directors, corporate headquarters, and the protection and advocacy agency designated pursuant to Iowa Code section 135C.2(4) and the text of Iowa Code section 135C.46 to provide to residents another course of redress. (II)

65.25(11) *Dignity preserved.* Residents shall be treated with consideration, respect, and full recognition of their dignity and individuality, including privacy in treatment and in care of personal needs. (II)

a. Staff shall display respect for residents when speaking with, caring for, or talking about them as constant affirmation of the individuality and dignity of human beings. (II)

b. Schedules of daily activities shall allow maximum flexibility for residents to exercise choice about what they will do and when they will do it. Residents' individual preferences regarding such

things as menus, clothing, religious activities, friendships, activity programs, entertainment, sleeping, eating, and times to retire at night and arise in the morning shall be elicited and considered by the facility. The facility shall make every effort to match nonsmokers with other nonsmokers. (II)

c. Residents shall not have their personal lives regulated beyond reasonable adherence to meal schedules, bedtime hours, and other written policies which may be necessary for the orderly management of the facility and as required by these rules; however, residents shall be encouraged to participate in recreational programs. (II)

d. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door shall shield the resident from passersby. People not involved in the care of a resident shall not be present without the resident's consent during examination or treatment. (II)

e. Privacy for each person shall be maintained when residents are being taken to the toilet or being bathed and while they are being helped with other types of personal hygiene, except as needed for resident safety or assistance. (II)

f. Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of response. This does not apply under emergency conditions. (II)

65.25(12) Communications. Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive personal mail unopened unless prohibited in the IPP which has explicit approval of the resident or legal guardian. Telephones consistent with ANSI standards 42 CFR 405.1134(c) (10-1-86) shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone. (II)

Arrangements shall be made to provide assistance to residents who require help in reading or sending mail. (II)

65.25(13) Visiting policies and procedures. Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted. (II)

a. Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- (1) The resident refuses to see the visitor(s). (II)
 - (2) The visit would not be in accordance with the IPP. (II)
 - (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility. (II)
- Reasons for denial of visitation shall be documented in resident records. (II)

b. Decisions to restrict a visitor shall be reevaluated at least quarterly by the QMHP or at the resident's request. (II)

c. Space shall be provided for residents to receive visitors in comfort and privacy. (II)

65.25(14) Resident activities. Each resident may participate in activities of social, religious, and community groups as desired unless contraindicated for reasons documented by the attending physician or qualified mental health professional, as appropriate, in the resident's record. (II)

Residents who wish to meet with or participate in activities of social, religious or community groups in or outside the facility shall be informed, encouraged, and assisted to do so. (II)

Residents shall be permitted to leave the facility and environs at reasonable times unless there are justifiable reasons established in writing by the attending physician, QMHP, or facility administrator for refusing permission. (II)

65.25(15) Resident property. Each resident may retain and use personal clothing and possessions as space permits and provided use is not otherwise prohibited in these rules. (II)

a. Residents shall be permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility. The personal property shall be kept in a secure location which is convenient to the resident. (II)

b. Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry. (II)

c. Any personal clothing or possession retained by the facility for the resident shall be identified and recorded on admission and the record placed on the resident's chart. The facility shall be responsible for secure storage of items. They shall be returned to the resident promptly upon request or upon discharge from the facility. (II)

65.25(16) *Sharing rooms.* Residents, including spouses staying in the same facility, shall be permitted to share a room, if available, if requested by both parties, unless reasons to the contrary are in the IPP. Reasons for denial shall be documented in the resident's record. (II)

65.25(17) *Choice of physician and pharmacy.* Each resident shall be permitted free choice of a physician and a pharmacy. The facility may require the pharmacy selected to use a drug distribution system compatible with the system currently used by the facility. (II)

This rule is intended to implement Iowa Code section 135C.14 and Iowa Code chapter 235E.

[ARC 1205C, IAB 12/11/13, effective 1/15/14; ARC 1204C, IAB 12/11/13, effective 1/15/14; ARC 5711C, IAB 6/16/21, effective 7/21/21]

481—65.26(135C) Incompetent residents. Each facility shall provide that all rights and responsibilities of incompetent residents devolve to the legal guardian when a hearing has been held and the resident is judged incompetent in accordance with state law. (II)

A facility is not absolved from advising incompetent residents of their rights to the extent the resident is able to understand them. The facility shall also advise the legal guardian, if any, and acquire a statement indicating an understanding of resident's rights. (II)

This rule is intended to implement Iowa Code sections 135C.14(8) and 135C.24.

481—65.27(135C) County care facilities. In addition to these rules, county care facilities licensed as intermediate care facilities for persons with mental illness must also comply with department of human services rules 441—Chapter 37. Violation of any standard established by the department of human services is a Class II violation pursuant to 481—56.2(135C).

This rule is intended to implement Iowa Code section 227.4.

481—65.28(135C) Violations. Classification of violations is I, II and III, determined by the division using the provisions in 481—Chapter 56, "Finings and Citations," to enforce a fine to cite a facility.

481—65.29(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)

65.29(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.

65.29(2) Approval of the state fire marshal shall be obtained before approval of the department will be considered.

65.29(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 and 481—Chapter 61. (I, II, III)

481—65.30(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.

65.30(1) A facility which chooses to provide respite care services is not required to obtain a separate license or pay a license fee.

65.30(2) Rules regarding involuntary discharge or transfer rights do not apply to residents who are being cared for under a respite care contract.

65.30(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.

65.30(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 135C.2(6), 135C.4, 135C.6(2), 135C.6(3), 135C.7, 135C.8, 135C.14, 135C.16(2), 135C.23, 135C.24, 135C.25, 135C.31, and 227.4.

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CHAPTER 67
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING
PROGRAMS, AND ADULT DAY SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/11/31

481—67.1(231B,231C,231D) Definitions. The following definitions apply to this chapter and to 481—Chapters 68, 69, and 70.

“Accredited” means that the program has received accreditation from an accreditation entity.

“Activities of daily living” means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting, and ambulation.

“Ambulatory” or *“ambulation”* means physically and cognitively able to walk without aid of another person.

“Applicable requirements” means the requirements in Iowa Code chapters 135C, 231B, 231C, 231D, 235B, 235E, and 562A, this chapter, and 481—Chapters 68, 69, and 70, as applicable, and includes any other applicable administrative rules and provisions of the Iowa Code.

“Assistance” means aid to a tenant who self-directs or participates in a task or activity or who retains the mental or physical ability, or both, to participate in a task or activity. Cueing of the tenant regarding a particular task or activity means the tenant has participated in the task or activity.

“Certified staff” means certified nursing assistants (CNAs) and certified medication assistants (CMAs) employed by the program.

“Change of ownership” means the purchase, transfer, assignment or lease of a program and includes a change in the management company responsible for the day-to-day operation of the program, if the management company is ultimately responsible for any enforcement action taken by the department.

“Dementia” means an illness characterized by multiple cognitive deficits that represent a decline from previous levels of functioning and includes memory impairment and one or more of the following cognitive disturbances: aphasia, apraxia, agnosia and disturbance in executive functioning.

“Department” means the department of inspections, appeals, and licensing.

“Director” means the director of the department.

“Direct supervision” means the provision of guidance and oversight of a delegated nursing task through the physical presence of the licensed nurse to observe and direct certified and noncertified staff.

“Elope” means that a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

“Global Deterioration Scale” or *“GDS”* means the seven-stage scale for assessment of primary degenerative dementia developed by Dr. Barry Reisberg.

“Health care professional” means a physician, physician associate, registered nurse, licensed practical nurse via RN delegation or advanced registered nurse practitioner licensed in Iowa by the respective licensing board or eligible to practice in Iowa through compact licensure agreements.

“Health-related care” means the same as defined in Iowa Code section 231B.1(5) and includes nurse-delegated assistance.

“Human service professional” means an individual with a bachelor’s degree in a human service field, including but not limited to human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of the required education.

“Impaired decision-making ability” means a lack of capacity to make safe and prudent decisions regarding one’s own routine safety as determined by the program manager or nurse or means having a GDS score of five or above.

“Independent reviewer” means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the

department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

“Indirect supervision” means the provision of guidance and oversight of a delegated nursing task through means other than direct supervision, including written and verbal communication.

“Instrumental activities of daily living” means those activities that reflect the tenant’s ability to perform household and other tasks necessary to meet the tenant’s needs within the community, which may include but are not limited to shopping, housekeeping, chores, and traveling within the community.

“In the proximate area” means an area located within a five-minute or less response time.

“Medication setup” means the same as defined in Iowa Code section 231B.1(6).

“Modification” means any addition to or change in physical dimensions or structure, except as incidental to the customary maintenance of the physical structure of the program’s facility.

“Monitoring” means an on-site evaluation of a program, a complaint investigation, or a program-reported incident investigation performed by the department to determine compliance with applicable requirements. A monitor who performs a monitoring for the department shall be a registered nurse, human service professional, or another person with program-related expertise.

“Nonaccredited” means that the program has been certified but has not received accreditation from an accreditation entity.

“Noncertified staff” means unlicensed and uncertified personnel employed by the program.

“Nurse delegation” means the action of a registered nurse, advanced registered nurse practitioner, or licensed practical nurse to direct competent certified and noncertified staff to perform selected nursing tasks in selected situations. The decision of a nurse to delegate is based on the delegation process, including assessment, planning, implementation, supervision, and evaluation of the tenant, nursing tasks, personnel, and the situation. The nurse, as a licensed professional, retains accountability for the delegation process and the decision to delegate. Licensed practical nurses may delegate within the scope of their license with the supervision of a registered nurse.

“Occupancy agreement” or *“contractual agreement”* means the same as defined in Iowa Code sections 231B.1(7) and 231C.2(9).

“Part-time or intermittent care” means licensed nursing services and professional therapies that are provided in combination with nurse-delegated assistance with medications or activities of daily living and do not exceed 28 hours per week or, for adult day services, 4 hours per day.

“Personal care” means the same as defined in Iowa Code section 231B.1(8).

“Preponderance of the evidence” means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true.

“Program” means one or more of the following, as applicable: an elder group home as defined in Iowa Code section 231B.1 and 481—Chapter 68, an assisted living program as defined in Iowa Code section 231C.1 and 481—Chapter 69, or adult day services as defined in Iowa Code section 231D.1 and 481—Chapter 70.

“Program staff” means all employees of the program, regardless of certification or licensure status.

“Qualified professional” means a facility plant engineer familiar with the type of program being provided, or a licensed plumbing, heating, cooling, or electrical contractor who furnishes regular service to such equipment.

“Recognized accrediting entity” means the same as defined in Iowa Code sections 231C.2(11) and 231D.1(11).

“Regulatory insufficiency” means a violation of an applicable requirement.

“Restraints” means any chemical or manual method that restricts freedom of movement or normal access to one’s body or any physical or mechanical device, material or equipment that is attached or adjacent to the tenant’s body that the tenant cannot remove easily and that restricts freedom of movement or normal access to one’s body.

“Routine” means more often than not or on a regular customary basis.

“Self-administration” means a tenant’s taking personal responsibility for all phases of medication except for any component assigned to the program under medication setup, and may include the tenant’s use of an automatic pill dispenser.

“Service plan” means the document that defines all services necessary to meet the needs and preferences of a tenant, whether or not the services are provided by the program or other service providers.

“Significant change” means the same as defined in Iowa Code section 231C.2(12).

“Substantial compliance” means the same as defined in Iowa Code section 231C.2(13) regarding a level of compliance with applicable requirements.

“Tenant” means the same as defined in Iowa Code sections 231B.1(9) and 231C.2(14). In the context of adult day services, “tenant” means a “participant” as defined in 481—Chapter 70.

“Tenant advocate” means the same as defined in Iowa Code section 231B.1(10).

“Tenant’s legal representative” means the same as defined in Iowa Code section 231B.1(11). In the context of adult day services, “tenant’s legal representative” means a “participant’s legal representative” as defined in 481—Chapter 70.

[ARC 0063D, IAB 2/4/26, effective 3/11/26; Editorial change: IAC Supplement 6/10/26]

481—67.2(231B,231C,231D) Program policies and procedures.

67.2(1) A program’s policies and procedures must meet the minimum standards set by applicable requirements. All programs shall have policies and procedures related to the following:

a. Reporting of incidents, including allegations of dependent adult abuse on incident report forms to provide a detailed incident report completed at the time of the incident and include statements from individuals, if any, who witnessed the incident. The program will identify in the program’s policy who of the program staff is responsible for completion of the initial report. The report will remain accessible for a minimum of three years. All accidents or unusual occurrences within the program’s building or on the premises that affect tenants will be reported as incidents.

b. Allegations of dependent adult abuse consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, reporting requirements for staff and employees, and requirements that the victim and alleged abuser be separated.

c. Evaluation of each tenant or participant. A copy of the evaluation tool or tools to be used to identify the functional, cognitive and health status of each tenant or participant will be included.

d. Service plans.

e. Medical needs of tenants or participants.

f. Food service, including policies and procedures related to staffing, nutrition, menu planning, therapeutic diets, and food preparation, service and storage.

g. Transportation.

h. Staffing and training.

i. Emergencies, including policies and procedures related to natural disasters, with an evacuation plan and procedures for notifying legal representatives in emergency situations as applicable.

j. Managing risk and upholding tenant or participant autonomy when decision-making results in poor outcomes for the tenant or participant or others.

k. Accidents and emergency response.

l. Addressing sexual relationships between tenants and staff and between tenants with dementia greater than Stage 5 on the Global Deterioration Scale.

m. Extraordinary lifesaving measures, including policies and procedures related to cardiopulmonary resuscitation (CPR).

n. Narcotics protocol, including policies and procedures related to reconciliation and destruction.

67.2(2) The program shall follow the policies and procedures established by the program.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:

67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

67.3(2) To receive care, treatment and services that are adequate and appropriate.

67.3(3) To receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract.

67.3(4) To be free from mental and physical abuse.

67.3(5) To receive from the manager and staff of the program a reasonable response to all requests.

67.3(6) To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour.

67.3(7) To manage the tenant's own financial affairs unless a tenant's legal representative has been appointed for the purpose of managing the tenant's financial affairs.

67.3(8) To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.

67.3(9) To be free from restraints.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

67.4(1) Of any accident causing major injury, including a substantial injury.

a. "Major injury" is defined as any injury that:

(1) Results in death; or

(2) Requires admission to a higher level of care for treatment, other than for observation; or

(3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis.

b. The following are not reportable accidents:

(1) An ambulatory tenant who falls when neither the program nor its employees have culpability related to the fall, even if the tenant sustains a major injury;

(2) Spontaneous fractures;

(3) Hairline fractures.

67.4(2) When damage to the program is caused by a natural or other disaster, including physical impairments affecting operating (e.g., failure of a heating or cooling system or water heater failure).

67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. "Pattern" means two or more times within a 30-day period.

67.4(4) When a tenant elopes from a program.

67.4(5) When a tenant attempts suicide, regardless of injury.

67.4(6) When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant.

67.4(7) When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period.

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapters 235B and 235E, which require reporting of dependent adult abuse.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.5(231B,231C,231D) Medications.

67.5(1) If a program handles, stores, or administers controlled substances, the program shall be registered with the Iowa board of pharmacy as a care facility in accordance with 481—Chapter 551.

67.5(2) Each program shall follow its own written medication policy, including the following:

a. The program will not prohibit a tenant from self-administering medications.

b. A tenant will self-administer medications unless:

(1) The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.

(2) The tenant delegates medication setup to someone other than the program.

(3) The program assumes partial control of medication setup at the direction of the tenant. The medication plan will not be implemented by the program unless the program deems it appropriate under applicable requirements, including those in Iowa Code section 231C.16A and subrule 67.9(4).

c. A tenant will keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program, including the tenant's choice related to storage.

d. When a tenant has delegated medication administration to the program, the program will maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response, but the tenant remains responsible for the accuracy of the list.

e. When medications are administered traditionally by the program:

(1) The administration of medications will be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa, by an individual who has successfully completed a department-approved medication aide or medication manager course and passed the respective department-approved medication aide or manager examination, or by a physician associate (PA) in accordance with 481—Chapter 781. Injectable medications will be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or PA.

(2) The program will maintain a list of each tenant's medications and document the medications administered.

(3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA.

[ARC 0063D, IAB 2/4/26, effective 3/11/26; Editorial change: IAC Supplement 6/10/26]

481—67.6(231B,231C,231D) Another business or activity located in a program.

67.6(1) A business or activity serving persons other than tenants of a program is allowed in a designated part of the physical structure in which the program is located if the other business or activity meets the requirements of applicable state and federal codes, administrative rules, and federal regulations.

67.6(2) A business or activity conducted in the designated part of the physical structure in which the program is located shall not interfere with the use of the program by tenants or with services provided to tenants or disturb tenants or reduce access, space, services, or staff available to tenants or necessary to meet the needs of tenants.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program.

67.7(1) *Time-limited waiver.* Upon receipt of a program's request for waiver of the criteria for retention of a tenant, the department may grant a waiver of the criteria under applicable requirements

for a time-limited basis. Absent extenuating circumstances, a waiver of the criteria for retention of a tenant is limited to a period of six months or less.

67.7(2) *Waiver petition procedures.* The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant:

a. A program will submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.

b. The department will respond in writing to a waiver request within 15 working days of receipt of all required documentation. In consultation with the program, the department may take an additional 15 working days to report its determination regarding the waiver request.

c. The program will provide to the department within five working days written notification of any changes in the condition of the tenant as described in the approved waiver request.

67.7(3) *Factors for consideration for waiver of criteria for retention of a tenant.* In addition to the criteria established in Iowa Code section 17A.9A(2), the following factors may be demonstrative in determining whether the criteria for issuance of a waiver have been met:

a. It is the informed choice of the tenant or the tenant's legal representative, if applicable, to remain in the program;

b. The program is able to provide the staff necessary to meet the tenant's service needs in addition to the service needs of the other tenants;

c. The waiver will not jeopardize the health, safety, security or welfare of the tenant, program staff, or other tenants;

d. The tenant has been diagnosed with a terminal illness and has been admitted to hospice, and the tenant exceeds the criteria for retention and admission for a temporary period of less than six months. A terminal diagnosis means the tenant is within six months of the end of life.

67.7(4) *Conditional waiver.* A conditional waiver may be granted contingent upon the department's receipt of additional information or performance of monitoring.

a. If a waiver has been in effect for six months, a monitoring may be conducted to determine whether the tenant meets the criteria to continue on a waiver.

b. The department may seek additional information during the period to determine if a waiver should be granted.

67.7(5) *Appeals.* The denial of a waiver request may be appealed by the program pursuant to Iowa Code chapter 17A.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.8(231B,231C,231D) All other waiver requests. Waiver requests relating to topics other than retention of a tenant in a program shall be filed in accordance with 481—Chapter 6.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.9(231B,231C,231D) Staffing.

67.9(1) *Number of staff.* A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

67.9(2) *Emergency procedures.* All program staff shall be able to implement the accident, fire safety, and emergency procedures.

67.9(3) *Documentation.* The program shall have training records and staffing schedules on file and maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.

67.9(4) *Nurse delegation procedures.* The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall include the following:

a. The program's newly hired nurse will within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

b. Within 30 days of beginning employment, all program staff will receive training by the program's nurse(s).

c. Training for noncertified staff will include the provision of activities of daily living and instrumental activities of daily living.

d. Direct care staff will receive training regarding service plan tasks in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

e. The program's nurse(s) will provide direct or indirect supervision of all direct care staff as necessary in the professional judgment of the program's nurse(s) and in accordance with the needs of the tenants and staff.

f. Services will be provided to tenants in accordance with the training provided.

g. The program will have in place a system by which direct care staff communicate in writing occurrences that differ from the tenant's normal health and functional and cognitive status. The program's nurse or designee will train staff on reporting to the program's nurse(s) or designee(s) and documenting occurrences that differ from the tenant's normal health and functional and cognitive status. The written communication required by this paragraph will be retained by the program for a period of not less than three years and be accessible to the department upon request.

h. In the absence of the program's nurse(s) due to vacation or other temporary circumstances, the nurse(s) assuming the duties of the program's nurse(s) will have access to staff training in relation to tenant needs.

67.9(5) *Prohibited services.* A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption.

67.9(6) *Dependent adult abuse training.* Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.10(17A,231B,231C,231D) Monitoring.

67.10(1) *Frequency of monitoring.* The department will monitor a certified program at least once during a 24-month period.

67.10(2) *Standard for determining whether a regulatory insufficiency exists.* The department will use a preponderance-of-the-evidence standard when determining whether a regulatory insufficiency exists. A preponderance-of-the-evidence standard does not require that the monitor shall have personally witnessed the alleged violation.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure.

67.11(1) *Complaints.* The process for filing a complaint is as follows:

a. Any person with concerns regarding the operation or service delivery of a program may file a complaint with the Department of Inspections, Appeals, and Licensing, Complaints Unit, 6200 Park Avenue, Des Moines, Iowa 50321; by use of the complaint hotline, 1.877.686.0027; by facsimile sent to 515.281.7106; or through the website address: dial.iowa.gov.

b. When the nature of the complaint is outside of the department's authority, the department will forward the complaint or refer the complainant, if known, to the appropriate investigatory entity.

c. The complainant will include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the program or tenant; and the reason for the complaint. The complainant's name shall be confidential information and shall not be released by the department. The department will act on anonymous complaints unless the department determines that the complaint is intended to harass the program. If the department, upon preliminary review, determines that the complaint is intended as harassment or is without reasonable basis, the department may dismiss the complaint.

67.11(2) *Program-reported incident reports.* When the program is required pursuant to applicable requirements to report an incident, the program will make the report to the department via:

- a. The web-based reporting tool accessible from the following website, dia-hfd.iowa.gov;
- b. Mail by sending the complaint to the Department of Inspections, Appeals, and Licensing, Complaints Unit, 6200 Park Avenue, Des Moines, Iowa 50321;
- c. The complaint hotline, 1.877.686.0027; or
- d. Facsimile sent to 515.281.7106.

67.11(3) *Time frames for investigation of complaints or program-reported incident reports.* Upon receipt of a complaint or program-reported incident report made in accordance with this rule, the department will conduct a preliminary review of the complaint or report to determine if a potential regulatory insufficiency has occurred. If a potential regulatory insufficiency exists, the department will institute a monitoring of the program within the following time frames: within 2 working days of receipt of the complaint or incident report if there is the possibility of immediate danger, including that the potential regulatory insufficiency has caused or is likely to cause serious injury, harm, impairment, or death to a resident; or within 20 working days of receipt of the complaint or incident report if the potential regulatory insufficiency has caused or may cause harm that negatively impacts a tenant's mental, physical, or psychosocial status or function and is of such consequence to the tenant's well-being that a rapid response is warranted; or within 45 working days of receipt of the complaint or incident report for any other complaint or incident investigation, including a potential regulatory insufficiency that may have caused harm of limited consequence and does not significantly impair the tenant's mental, physical, or psychosocial status or function.

67.11(4) *Standard for determining whether a complaint is substantiated.* The department will apply a preponderance-of-the-evidence standard in determining whether or not a complaint or program-reported incident report is substantiated.

67.11(5) *Notification of program and complainant.* The department will notify the program and, if known, the complainant of the final report regarding the complaint investigation.

67.11(6) *Notification of accrediting entity.* For any credible report of alleged improper or inappropriate conduct or conditions within an accredited program, the department will notify the accrediting entity by the most expeditious means possible of any actions taken by the department with respect to certification enforcement.

67.11(7) *Notification of complainant when complaint not investigated.* The department will notify the complainant if the department does not investigate a complaint, including the reasons for not investigating the complaint.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.12(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction.

67.12(1) *Exit interview.* The department will provide an exit interview pursuant to Iowa Code sections 231B.8 and 231C.8.

67.12(2) *Final report.* The department will issue the final report pursuant to Iowa Code sections 231B.8(2) and 231C.8(2).

67.12(3) *Plan of correction.* Within ten working days following receipt of the final report, the program shall submit a plan of correction to the department, which shall include:

- a. Elements detailing how the program will correct each regulatory insufficiency, including at the system level;
- b. The date by which the regulatory insufficiency will be corrected not to exceed 30 days from receipt of the final report without approval of the department;
- c. What measures will be taken to ensure the problem does not recur;
- d. How the program plans to monitor performance to ensure compliance; and
- e. Any other required information.

The department will review the plan of correction and may request additional information or suggest revisions to the plan.

67.12(4) *Monitoring revisit.* The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.13(17A,231B,231C,231D,85GA,HF2365) Response to final report. The program shall respond pursuant to Iowa Code sections 231B.9A, 231C.9A, and 231D.9A in the following manner.

67.13(1) *If not contesting.* If the program does not seek an informal conference or contest the final report and civil penalty, if assessed, the program shall remit to the department the amount of the civil penalty, if assessed. If a program has been assessed a civil penalty, the civil penalty will be reduced by 35 percent if the requirements of subrule 67.16(5) are met.

67.13(2) *Informal conference.*

a. Request for informal conference. The request for an informal conference must be in writing and include the following:

- (1) Identification of the regulatory insufficiency(ies) being disputed;
- (2) The type of informal conference requested: virtual or telephone conference;
- (3) A request for monitor's notes for the regulatory insufficiency(ies) being disputed, if desired.

b. Submission of documentation. The program will submit the following within ten working days from the date of the program's written request for an informal conference:

- (1) The names of those who will be attending the informal conference, including legal counsel;
- (2) Documentation supporting the program's position. The program will highlight or use some other means to identify written information pertinent to the disputed regulatory insufficiency(ies). Supporting documentation that is not submitted with the request for an informal conference will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the program has shown good cause, the independent reviewer shall consider what circumstances kept the program from submitting the supporting documentation within the required time frame.

c. Virtual or telephone conference. A virtual or telephone conference, if requested, will be scheduled to occur within ten working days of the receipt of the written request, all supporting documentation and the plan of correction required by subrule 67.12(3).

- (1) Failure to submit supporting documentation will not delay scheduling.

(2) The conference will be scheduled for one hour. The program will informally present information and explanation concerning the contested regulatory insufficiency(ies). The department will have time to respond to the program's presentation. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested by the independent reviewer during the informal conference, the program will have two working days to deliver the additional materials to the independent reviewer.

(4) When extenuating circumstances exist, the program may be given one opportunity to reschedule.

d. Results. The results of the informal conference will generally be sent within ten working days after the date of the informal conference or within ten working days after the receipt of additional information, if requested.

(1) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) final report if changes result from the informal conference.

(2) The program must submit to the department a new plan of correction for the amended or corrected report within ten calendar days from the date of the letter conveying the results of the conference.

(3) If the informal conference results in dismissal of a regulatory insufficiency for which a civil penalty was assessed, the corresponding civil penalty will be rescinded.

67.13(3) *Procedure after informal conference.* After the conclusion of an informal conference:

a. If the program does not desire to further contest an affirmed or modified final report, the program shall, within five working days after receipt of the written decision of the independent reviewer, remit to the department the civil penalty, if assessed.

b. If the program does desire to further contest an affirmed or modified final report, the program shall, within five working days after receipt of the written decision of the independent reviewer, notify the department in writing that it desires to formally contest the final report.

67.13(4) *Contested case hearings.* Contested case hearings shall be conducted by the department's administrative hearings division pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.14(17A,231B,231C,231D) Denial, suspension or revocation of a certificate.

67.14(1) *Notice and request for hearing.* The denial, suspension or revocation of a certificate shall be effected by delivering to the applicant or certificate holder by restricted certified mail or by personal service a notice setting forth the particular reasons for such actions. A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice, unless the applicant or certificate holder gives the department written notice requesting a hearing within the 30-day period. If a timely request for hearing is made, the notice shall be deemed suspended pending the outcome of the hearing unless subrule 67.14(3) or 67.14(4) applies. If an enforcement action has been implemented immediately in accordance with subrule 67.14(3) or 67.14(4), the enforcement action remains in effect regardless of a request for hearing.

67.14(2) *Hearings.* Hearings shall be conducted by the administrative hearings division of the department pursuant to Iowa Code chapter 17A and 481—Chapter 9.

67.14(3) *Immediate suspension of a certificate.* When the department finds that an imminent danger to the health or safety of tenants of a program exists that requires action on an emergency basis, the department may direct removal of all tenants from the program and suspend the certificate or require additional remedies to ensure the ongoing safety of the program's tenants prior to a hearing.

67.14(4) *Immediate imposition of enforcement action.* When the department finds that an imminent danger to the health or safety of tenants exists that requires action on an emergency basis, the department may immediately impose a conditional certificate and accompanying conditions upon the program in lieu of immediate suspension of the certificate and removal of the tenants from the program if the department finds that tenants' health and safety would still be protected. The program may request a hearing, but the immediate enforcement action remains in effect regardless of the request for hearing.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.15(17A,231B,231C,231D) Conditional certification.

67.15(1) *Conditional certification.* In lieu of denial, suspension or revocation of a certificate, the department may issue a conditional certificate for a period of up to one year. Notwithstanding subrule 67.14(4), a conditional certificate shall be issued only when regulatory insufficiencies pose no greater risk to tenant health or safety than the potential for causing minimal harm.

a. The department will specify the reasons for the conditional certificate in the notice issuing the conditional certificate.

b. The department may place conditions upon a certificate, such as requiring additional training; restriction of the program from accepting additional tenants for a period of time; or any other action or combination of actions deemed appropriate by the department.

c. Failure by the program to adhere to the plan of correction or conditions placed on the certificate may result in suspension or revocation of the conditional certification and further enforcement action as available under applicable requirements.

d. A program must be in substantial compliance with applicable requirements before the removal of a conditional certificate by the department. Prior to lifting a conditional certificate, the department may conduct a monitoring to verify substantial compliance.

67.15(2) *Appeal of conditional certificate.* A written request for hearing must be received by the department within 30 days after the mailing or service of notice. The conditional certificate will not be suspended pending the hearing. Hearings will be conducted by the administrative hearings division of the department pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.16(17A,231B,231C,231D) Civil penalties.

67.16(1) *When civil penalties may be issued.* Civil penalties may be issued when the director finds that any of the following has occurred:

a. A program that does not comply with applicable requirements and the noncompliance results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than \$10,000.

b. A program that continues to fail or refuses to comply with applicable requirements within prescribed time frames established by the department or approved by the department in the program's plan of correction and the noncompliance has a direct relationship to the health, safety, or security of tenants may be assessed a civil penalty of not more than \$5,000.

c. A program that prevents, interferes with or attempts to impede in any way any duly authorized representative of the department in the lawful enforcement of applicable requirements may be assessed a civil penalty of not more than \$1,000.

d. A program that discriminates or retaliates in any way against a tenant, tenant's family, or an employee of the program who has initiated or participated in any proceeding authorized by Iowa Code chapter 231B, 231C or 231D and the corresponding administrative rules may be assessed a civil penalty of not more than \$5,000.

67.16(2) *Duplicate civil penalties prohibited.* The department shall not impose duplicate civil penalties on a program for the same set of facts and circumstances.

67.16(3) *Factors in determining the amount of a civil penalty.* The department will consider the following factors when determining the amount of a civil penalty:

a. The frequency and length of time the regulatory insufficiency occurred (i.e., whether the regulatory insufficiency was an isolated or a widespread occurrence, practice, or condition);

b. The past history of the program as it relates to the nature of the regulatory insufficiency (the department will not consider more than the current certification period and the immediately previous certification period);

c. The culpability of the program as it relates to the reasons the regulatory insufficiency occurred;

d. The extent of any harm to the tenants or the effect on the health, safety, or security of the tenants that resulted from the regulatory insufficiency;

e. The relationship of the regulatory insufficiency to any other types of regulatory insufficiencies that have occurred in the program;

f. The actions of the program after the occurrence of the regulatory insufficiency, including when corrective measures, if any, were implemented and whether the program notified the director as required;

g. The accuracy and extent of records kept by the program that relate to the regulatory insufficiency, and the availability of such records to the department;

h. The rights of tenants to make informed decisions;

i. Whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

67.16(4) *Civil penalties due.* The civil penalty shall be paid to the department within 30 days following the program's receipt of the final report and demand letter. The program may appeal in

accordance with rule 481—67.13(17A,231B,231C,231D,85GA,HF2365). If the program appeals, the civil penalty will be deemed suspended until the appeal is resolved.

67.16(5) *Reduction of civil penalty.* If a program has been assessed a civil penalty, the civil penalty will be reduced by 35 percent if both of the following requirements are met:

a. The program does not request a formal hearing pursuant to rule 481—67.13(17A,231B,231C,231D,85GA,HF2365) or withdraws its request for formal hearing within 30 calendar days of the date that the civil penalty was assessed; and

b. The civil penalty is paid and payment is received by the department within 30 calendar days of receipt of the final report.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.17(17A,231B,231C,231D) Judicial review. Judicial review shall be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 9.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.18(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.

67.18(1) *Definitions.* The following definitions apply for the purposes of this rule.

“Background check” or “record check” means criminal history, child abuse and dependent adult abuse record checks.

“Comprehensive preliminary background check” means a criminal history check of all states in which the applicant has worked or resided over the seven-year period immediately prior to applying for employment that is conducted by an approved third-party vendor.

“Direct services” means services provided through person-to-person contact. “Direct services” excludes services provided by individuals such as building contractors, repair workers, or others who are in a program for a very limited purpose, who are not in the program on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

“Employed in a program” or “employment within a program” means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An employee of an assisted living program certified under Iowa Code chapter 231C, if the employee provides direct services to consumers;

2. An employee of an elder group home certified under Iowa Code chapter 231B, if the employee provides direct services to consumers;

3. An employee of an adult day services program certified under Iowa Code chapter 231D, if the employee provides direct services to consumers.

“Employee” means any individual who is paid, either by the program or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

“Evaluation” means review by the department of health and human services (HHS) to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person’s being prohibited from employment in a program.

“Indirect services” means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

“Program,” for purposes of this rule, means the following, if the provider is regulated by the state or receives any federal or state funding:

1. An assisted living program certified under Iowa Code chapter 231C;

2. An elder group home certified under Iowa Code chapter 231B;

3. An adult day services program certified under Iowa Code chapter 231D.

67.18(2) *Explanation of “crime.”* For purposes of this rule, the term “crime” does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

67.18(3) *Requirements for employer prior to employing an individual.* Prior to employment of a person in a program, the program shall complete the background check requirements set forth below.

a. Informing the prospective employee. A program will ask each person seeking employment by the program, “Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions in this state or any other state?” The person will be informed that a background check will be conducted and sign an acknowledgment.

b. Conducting a background check. The program will either request that the department of public safety perform a criminal history check and that HHS perform child and dependent adult abuse record checks of the person in this state or access the single contact repository (SING) to perform the required background check. If SING is used, the program will submit the person’s maiden name, if applicable, with the background check request.

c. If a person considered for employment has been convicted of a crime under the law of any state. The program will request that HHS perform an evaluation to determine whether the crime warrants prohibition of the person’s employment in the program.

d. If a person considered for employment has a record of founded child abuse or dependent adult abuse under the laws of any state. The program will request that HHS perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.

e. Employment pending evaluation. The program may provisionally employ a person prior to completion of the required record check and evaluation by HHS, as applicable, subject to all of the following:

(1) The program shall have accessed SING to perform the required record check and be awaiting results from SING or awaiting evaluation by HHS, as applicable;

(2) If applicable, the program shall request an evaluation by HHS in accordance with paragraph 67.18(3) “c” or “d” within 30 days of receipt of SING record check results;

(3) The program shall have utilized an approved third-party vendor to perform a comprehensive preliminary background check;

(4) If the comprehensive preliminary background check determines that the person being considered for employment has been convicted of a crime, the crime does not constitute a felony as defined in Iowa Code section 701.7 and is not a crime specified pursuant to Iowa Code chapter 708, 708A, 709, 709A, 710, 710A, 711, or 712 or pursuant to Iowa Code section 726.3, 726.7, or 726.8;

(5) The comprehensive preliminary background check shall have determined that the person being considered for employment does not have a record of founded child abuse or dependent adult abuse, or if the comprehensive preliminary background check determines the person being considered for employment does have a record of founded child abuse or dependent adult abuse, subrule 67.18(8) is applicable;

(6) The provisional employment may continue until such time as the required record check through SING and evaluation by HHS, as applicable, are completed.

67.18(4) *Validity of background check results.* The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.

67.18(5) *Employment prohibition.* Except as provided in paragraph 67.18(3) “e,” a person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by HHS.

67.18(6) *Transfer of an employee to another program owned or operated by the same person without a lapse in employment.* The program is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

67.18(7) *Transfer of ownership of a program.* At the time of transfer of ownership of a program, the background check required by this rule will be performed for each employee for whom there is no documentation that such background check has been performed. The program may continue to employ such employee pending the performance of the background check and any related evaluation.

67.18(8) *Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.* A person with a criminal or abuse record who is or was employed by a certified program and is hired by another certified program shall be subject to the background check.

a. A reevaluation of the latest record check is not required, and the person may commence employment with the other certified program if the following requirements are met:

(1) HHS previously performed an evaluation concerning the person's criminal or abuse record and concluded the record did not warrant prohibition of the person's employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed;

(4) Any restrictions placed on the person's employment in the previous evaluation by HHS and still applicable remain applicable in the person's subsequent employment;

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a current record check evaluation will be performed.

b. For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

c. The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

d. The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 67.18(8) "a" may be authorized.

67.18(9) *Employee notification of criminal convictions or founded abuse after employment.* If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

a. The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access SING to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from HHS, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.18(3) "c" and "d."

c. The employer may continue to employ the person pending the performance of an evaluation by HHS.

d. A person who is required by this subrule to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

e. The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

67.18(10) *Program receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the program receives credible information, as determined by the program, from someone other than the employee, that the employee has been convicted of a crime

or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 67.18(9), the program shall take the following actions:

a. The program will act to verify credible information within seven calendar days of receipt. “Verify,” for purposes of this subrule, means to access SING to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from HHS, to conduct an online search through the Iowa Courts Online website, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.18(3) “c” and “d.”

67.18(11) *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.19(17A,231C,231D) Emergency removal of tenants. If the department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the department will use the following procedures to ensure a safe and orderly transfer.

67.19(1) The department will notify HHS, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:

- a.* To alert them to the need to transfer tenants from a program;
- b.* To request assistance in identifying alternative programs or other appropriate settings;
- c.* To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.

67.19(2) The department will notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.19(1).

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.20(231C) Nursing assistant work credit.

67.20(1) A program may add an employee to the direct care worker registry by calling 515.281.4077 or by registering through the website at dia-hfd.iowa.gov.

67.20(2) A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may be obtained by telephone at 515.281.4077 or via the website at dia-hfd.iowa.gov.

67.20(3) A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at 515.281.4077 or via the website at dia-hfd.iowa.gov.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

481—67.21(231B,231C,231D) Public or confidential information.

67.21(1) *Public information.*

a. *Public disclosure of findings.* The program shall provide copies of the final report resulting from a monitoring in a prominent public place. Copies are available upon request from the Department of Inspections, Appeals, and Licensing, Adult Services Bureau, 6200 Park Avenue, Des Moines, Iowa 50323; by telephone at 515.281.6325; or via the website at dia-hfd.iowa.gov.

b. *Open records.* The following records are open records available for inspection:

- (1) Certification applications, certification status, and accompanying materials;

- (2) Final findings of state monitorings, including a monitoring that results from a complaint or program-reported incident;
- (3) Reports from the fire safety bureau;
- (4) Plans of correction submitted by a program;
- (5) Official notices of certification sanctions, including enforcement actions;
- (6) Findings of fact, conclusions of law, decisions and orders issued pursuant to rules 481—67.10(17A,231B,231C,231D) and 481—67.12(17A,231B,231C,231D,85GA,HF2365);
- (7) Waivers, including the department's approval and denial letter and any letter requesting the waiver.

67.21(2) *Confidential information.* Confidential information includes the following:

- a.* Information that does not comprise a final report resulting from a monitoring, complaint investigation, or program-reported incident investigation. Information that does not comprise a final report may be made public in a legal proceeding concerning a denial, suspension or revocation of certification;
- b.* Names of all complainants;
- c.* Names of tenants of a program, identifying medical information, copies of documentation appointing a legal representative, and the address of anyone other than an owner or operator;
- d.* Social security numbers or employer identification numbers (EIN).

67.21(3) *Redaction of confidential information.* If a record normally open for inspection contains confidential information, the confidential information shall be redacted before the records are provided for inspection.

[ARC 0063D, IAB 2/4/26, effective 3/11/26]

These rules are intended to implement Iowa Code chapters 231B, 231C, and 231D.

[Filed ARC 8174B (Notice ARC 7877B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 69 ASSISTED LIVING PROGRAMS

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/11/31

481—69.1(231C) Definitions. In addition to the definitions in 481—Chapter 67 and Iowa Code chapter 231C, the following definitions apply:

“Applicable requirements” means the requirements in Iowa Code chapter 231C, this chapter, and 481—Chapter 67 and includes any other applicable administrative rules and provisions of the Iowa Code.

“CARF” means the Commission on Accreditation of Rehabilitation Facilities.

“Cognitive disorder” means a disorder characterized by cognitive dysfunction presumed to be the result of illness that does not meet the criteria for dementia, delirium, or amnesic disorder.

“Dementia-specific assisted living program” means an assisted living program certified under this chapter that:

1. Serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or
2. Serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or
3. Holds itself out as providing specialized care for persons with dementia, such as Alzheimer’s disease, in a dedicated setting.

“Dwelling unit” means a single unit that provides complete, independent living facilities for one or more persons, including permanent provisions for living, sleeping and sanitation, and that may include permanent provisions for eating and cooking. “Sanitation” for purposes of this definition means bathroom fixtures as required by this chapter.

“Maximal assistance with activities of daily living” means routine total dependence on staff for the performance of a minimum of four activities of daily living for a period that exceeds 21 days.

“Medically unstable” means that a tenant has a condition or conditions:

1. Indicating physiological frailty as determined by the program’s staff in consultation with a physician or physician extender;
 2. Resulting in three or more significant hospitalizations within a consecutive three-month period for more than observation; and
 3. Requiring frequent supervision of the tenant for more than 21 days by a registered nurse.
- For example, a tenant who has a condition such as congestive heart failure that results in three or more significant hospitalizations during a quarter and that requires that the tenant receive frequent supervision may be considered medically unstable.

“Unmanageable incontinence” means a condition that requires staff provision of total care for an incontinent tenant who lacks the ability to assist in bladder or bowel continence care.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.2(231C) Program certification. A program may obtain certification by meeting all applicable requirements or may be voluntarily accredited by a recognized accreditation entity.

69.2(1) Posting requirements. A program’s current certificate shall be visibly displayed within the designated operation area of the program. The latest monitoring report, fire safety bureau report, and food establishment inspections report issued pursuant to Iowa Code chapter 137F shall be made available to the public by the program upon request.

69.2(2) Dementia-specific programs. If a program meets the definition of a dementia-specific assisted living program during two sequential certification monitorings, the program shall meet all requirements for a dementia-specific program, including the requirements set forth in rule 481—69.30(231C); subrules 69.29(2), 69.29(4), 69.32(2), and 69.32(3); and paragraph 69.35(1) “d,” within 90 days of receiving the final report from the second sequential certification monitoring. If the

number of tenants served who have dementia between Stages 4 and 7 on the GDS goes below that which is required by the definition of dementia-specific program at any time after the program has been deemed dementia-specific by definition and the program is not holding itself out as providing dementia care in a specialized setting, the program will no longer be considered dementia-specific.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.3(231C) Certification of a nonaccredited program—application process.

69.3(1) The applicant shall complete an application packet obtained from the department's health facilities division website at dia-hfd.iowa.gov; by mail from the Department of Inspections, Appeals, and Licensing, Adult Services Bureau, 6200 Park Avenue, Des Moines, Iowa 50321; or by telephone at 515.381.7272.

69.3(2) The applicant shall submit one copy of the completed application and all supporting documentation to the department at least 90 calendar days prior to the expected date of beginning operation.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.4(231C) Nonaccredited program—application content. An application for certification or recertification of a nonaccredited program shall include the following:

69.4(1) The names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

- a. The real estate owner or lessor;
- b. The lessee;
- c. The management company responsible for the day-to-day operation of the program.

The program will notify the department of any changes in the list no later than ten working days after the effective date of the change.

69.4(2) A statement disclosing whether the individuals listed in subrule 69.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

69.4(3) A statement disclosing whether any of the individuals listed in subrule 69.4(1) meet the criteria set out in Iowa Code section 231C.10(1)“g,” including for licensed health care facility as defined in Iowa Code section 135C.1 or licensed hospital as defined in Iowa Code section 135B.1.

69.4(4) The tenant occupancy agreement and all attachments.

69.4(5) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

69.4(6) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

69.4(7) The fee set forth in Iowa Code section 231C.18.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.5(231C) Initial certification process for a nonaccredited program.

69.5(1) Upon receipt of all completed documentation, including building code and fire safety bureau approval and structural and evacuation review approval, the department will determine whether the proposed program meets applicable requirements.

69.5(2) If the department determines the proposed program meets the requirements for certification, a provisional certification will be issued to the program to begin operation and accept tenants.

69.5(3) Within 180 calendar days following issuance of provisional certification, the department will conduct a monitoring to determine the program's compliance with applicable requirements.

69.5(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) will be followed.

69.5(5) The department will make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

69.5(6) The department will notify the program of a final certification decision within ten working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

69.5(7) If the decision is to continue certification, the department will issue a full two-year certification effective from the date of the original provisional certification.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.6(231C) Expiration of the certification of a nonaccredited program. Unless conditionally issued, suspended or revoked, certification of a program will expire at the end of the time period specified on the certificate.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.7(231C) Recertification process for a nonaccredited program. To obtain recertification, a program shall:

69.7(1) Submit one copy of the completed application, associated documentation, and the recertification fee as listed in Iowa Code section 231C.18 to the department at least 30 calendar days prior to the expiration of the program's certification.

69.7(2) Submit additional documentation that each of the following has been inspected by a qualified professional and found to be maintained in conformance with the manufacturer's recommendations and nationally recognized standards: heating system, cooling system, water heater, electrical system, plumbing, sewage system, artificial lighting, and ventilation system and, if located on site, garbage disposal, kitchen appliances, washing machines and dryers, and elevators.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.8(231C) Notification of recertification for a nonaccredited program.

69.8(1) The department will review the application and associated documentation and fees. After all finalized documentation is received, including building code and fire safety bureau approval, the department will determine the program's compliance with applicable requirements.

69.8(2) If the facility is in good standing, the department will issue the program a two-year certification effective from the date of the expiration of the previous certification.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.9(231C) Certification or recertification of an accredited program—application process.

An applicant for certification or recertification of a program accredited by a recognized accrediting entity shall:

69.9(1) Submit a completed application packet obtained from the department health facilities division website at dia-hfd.iowa.gov; by mail from the Department of Inspections, Appeals, and Licensing, Adult Services Bureau, 6200 Park Avenue, Des Moines, Iowa 50321; or by telephone at 515.281.7272.

69.9(2) Submit a copy of the current accreditation outcome from the recognized accrediting entity.

69.9(3) Maintain compliance with the building code and fire safety bureau's requirements.

69.9(4) Submit the appropriate fees as set forth in Iowa Code section 231C.18.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.10(231C) Certification or recertification of an accredited program—application content. An application for certification or recertification of an accredited program shall comply with rule 481—69.3(231C) and include a copy of the current accreditation outcome from the recognized accrediting entity.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.11(231C) Initial certification process for an accredited program.

69.11(1) Within 20 working days of receiving all finalized documentation, including building code and fire safety bureau approval, the department will notify the accredited program whether the program meets applicable requirements and whether certification will be issued.

69.11(2) If the decision is to certify, a certification will be issued for the term of the accreditation not to exceed three years unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

69.11(3) If the decision is to deny certification, the department will provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

69.11(4) Unless conditionally issued, suspended or revoked, certification for a program will expire at the end of the time period specified on the certificate.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.12(231C) Recertification process for an accredited program.

69.12(1) To obtain recertification, an accredited program shall comply with rule 481—69.9(231C) at least 30 calendar days prior to the expiration of the program's certification.

69.12(2) If the facility is in good standing, a full certification will be issued for the term of the accreditation not to exceed three years unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

69.12(3) If the decision is to deny recertification, the department will provide the applicant an opportunity for hearing in accordance with rule 481—67.14(17A,231B,231C,231D).

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.13(231C) Listing of all certified programs. The department will maintain a list of all certified programs, which is available online at dia-hfd.iowa.gov.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.14(231C) Recognized accrediting entity.

69.14(1) The department designates CARF as a recognized accrediting entity for programs.

69.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an entity shall submit a letter of request, and its standards shall meet the applicable requirements for programs.

69.14(3) The designation will remain in effect for as long as the accreditation standards meet the applicable requirements for programs.

69.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.15(231C) Requirements for an accredited program. Each accredited program that is certified by the department shall:

69.15(1) Provide the department a copy of all survey reports, including outcomes, quality improvement plans and annual conformance to quality reports generated or received, as applicable, within ten working days of receipt of the reports.

69.15(2) Notify the department by the most expeditious means possible of all credible reports of alleged improper or inappropriate conduct or conditions within the program and any actions taken by the accrediting entity with respect thereto.

69.15(3) Notify the department immediately of the expiration, suspension, revocation or other loss of the program's accreditation.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.16(231C) Maintenance of program accreditation.

69.16(1) An accredited program will continue to be recognized for certification by the department if both of the following requirements are met:

- a.* The program complies with the requirements outlined in rule 481—69.15(231C).
- b.* The program maintains its voluntary accreditation status for the duration of the time-limited certification period.

69.16(2) A program that does not maintain its voluntary accreditation status must become certified by the department prior to any lapse in accreditation or cease operation as a program.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.17(231C) Change of ownership—notification to the department.

69.17(1) Certification, unless conditionally issued, suspended or revoked, may be transferable. If the program's certification has been conditionally issued, the department must approve a change of ownership prior to the transfer of the certification.

69.17(2) In order to transfer certification, the applicant must:

- a.* Meet the requirements of the rules, regulations and standards contained in Iowa Code chapter 231C and 481—Chapter 67 and this chapter;
- b.* At least 30 days prior to the change of ownership of the program, provide application and supporting documentation to the department.

69.17(3) The department may conduct a monitoring within 90 days following a change in the program's ownership to ensure that the program complies with applicable requirements. If a regulatory insufficiency is found, the department will take any necessary enforcement action authorized by applicable requirements.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.18(231C) Plan reviews of a building for a new program.

69.18(1) Before a building is constructed or remodeled for use in a new program, the state building code and fire safety bureau of the department shall review the construction documents and do fire inspections for compliance with requirements pursuant to this chapter. Construction or remodeling includes new construction, remodeling of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building.

69.18(2) A program applicant shall submit construction documents to the building code bureau's online portal at dial.iowa.gov/licenses/building/plan-review.

69.18(3) The plan review fee must be paid before construction documents are uploaded to the project folder.

69.18(4) The building code bureau of the department will notify the Iowa-licensed architect or Iowa-licensed engineer in writing regarding the status of compliance with requirements.

69.18(5) The Iowa-licensed architect or Iowa-licensed engineer shall respond to the building code bureau regarding how any noncompliance will be resolved.

69.18(6) Upon final notification by the building code bureau that the construction documents meet the bureau's requirements, construction or remodeling of the building may commence.

69.18(7) The fire safety bureau will schedule an on-site visit of the building site with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the construction or remodeling process to ensure compliance with the approved construction documents. Any noncompliance must be resolved prior to approval for certification.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.19(231C) Plan review prior to the remodeling of a building for a certified program.

69.19(1) Before a building for a certified program is remodeled as defined in subrule 69.18(1), the building code bureau will review the construction documents for compliance with requirements set forth in rule 481—69.35(231C).

69.19(2) A certified program shall submit construction documents to the building code bureau's online portal at dial.iowa.gov/licenses/building/plan-review.

69.19(3) The plan review fee must be paid before construction documents are uploaded to the project folder.

69.19(4) Upon final notification by the building code bureau that the construction documents meet structural and life safety requirements, remodeling of the building may commence.

69.19(5) The building code and fire safety bureaus shall schedule an on-site visit of the building with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the remodeling process to ensure compliance with the approved construction documents. Any noncompliance must be resolved prior to approval for continued certification or recertification of the program.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.20(231C) Cessation of program operation that includes seeking decertification.

69.20(1) At least 90 days in advance of cessation, the program shall provide to the department and the office of long-term care ombudsman written notification of the date on which the program will cease operation or decertify.

69.20(2) At the time a program decides to cease operation, the program shall submit a plan to the department and make arrangements for the safe and orderly transfer or transition of all tenants within the 90-day period specified by subrule 69.20(1).

69.20(3) The department may conduct a monitoring during the 90-day period to ensure the safety of tenants during the transfer process or transition process.

69.20(4) When a program ceases operation, representatives from the office of long-term care ombudsman shall be allowed by the program to privately meet with tenants to provide education and service options.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.21(231C) Occupancy agreement.

69.21(1) The occupancy agreement shall be in 12-point type or larger, written in plain language using commonly understood terms and be easy for the tenant or the tenant's legal representative to understand.

69.21(2) In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include the following information in the body of the agreement or in the supporting documents and attachments:

- a.* The telephone number for filing a complaint with the department.
- b.* The telephone number for the office of long-term care ombudsman.
- c.* The telephone number for reporting dependent adult abuse.
- d.* A copy of the program's statement on tenants' rights.
- e.* A statement that the tenant landlord law applies to assisted living programs.
- f.* A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, except in cases of emergency.

69.21(3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.

69.21(4) A copy of the occupancy agreement shall be provided to the tenant or the tenant's legal representative, if any, and a copy kept by the program.

69.21(5) A copy of the most current occupancy agreement shall be made available to the general public upon request.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.22(231C) Evaluation of tenant.

69.22(1) *Evaluation prior to occupancy.* A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program,

including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the GDS shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.

69.22(2) *Evaluation within 30 days of occupancy.* A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.

69.22(3) *Evaluation annually and with significant change.* A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.23(231C) Criteria for admission and retention of tenants.

69.23(1) *Persons who may not be admitted or retained.* A program shall not knowingly admit or retain a tenant who:

- a. Is bed-bound; or
- b. Requires routine, two-person assistance with standing, transfer or evacuation; or
- c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who:
 - (1) Despite intervention, chronically elopes or is sexually, verbally, or physically aggressive or abusive; or
 - (2) Displays behavior that places another tenant at risk; or
- d. Is in an acute stage of alcoholism, drug addiction, or uncontrolled mental illness; or
- e. Is under the age of 18; or
- f. Requires more than part-time or intermittent health-related care; or
- g. Has unmanageable incontinence on a routine basis despite an individualized toileting program; or
- h. Is medically unstable; or
- i. Requires maximal assistance with activities of daily living; or
- j. Despite intervention, chronically urinates or defecates in places that are not considered acceptable according to societal norms.

69.23(2) *Disclosure of additional occupancy and transfer criteria.* A program may have additional occupancy or transfer criteria if the criteria are disclosed in the written occupancy agreement prior to the tenant's occupancy.

69.23(3) *Assistance with transfer from the program.* A program shall assist a tenant and the tenant's legal representative, if applicable, to ensure a safe and orderly transfer from the program when the tenant exceeds the program's criteria for admission and retention.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.24(231C) Involuntary transfer from the program.

69.24(1) *Program initiation of transfer.* The program shall comply with Iowa Code section 231C.6 and the following:

- a. The program will provide the tenant, or the tenant's legal representative, the contact information for the office of long-term care ombudsman.
- b. The program will immediately provide to the office of long-term care ombudsman, by mail or email, a copy of the notification and notify the tenant's treating physician, if any.
- c. Pursuant to statute, the office of long-term care ombudsman will offer the notified tenant or tenant's legal representative assistance with the program's internal appeal process.

69.24(2) *Transfer pursuant to results of monitoring or complaint or program-reported incident investigation by the department.* If one or more tenants are identified as exceeding the admission and retention criteria for tenants and need to be transferred as a result of a monitoring or a complaint or program-reported incident investigation conducted by the department, the following procedures shall apply.

a. Program agreement with the department's finding. If the program agrees with the department's finding and the program begins involuntary transfer proceedings, the program's internal appeal process in subrule 69.24(1) will be utilized for appeals.

b. Program disagreement with the department's finding. If the program does not agree with the department's finding that the tenant exceeds admission and retention criteria, the program may appeal the department's final report as provided in rule 481—67.14(17A,231B,231C,231D,85GA,HF2365). If an appeal is filed, the tenant who exceeds admission and retention criteria will be allowed to continue living at the program until all administrative appeals have been exhausted. Appeals filed that relate to the tenant's exceeding admission and retention criteria will be heard within 30 days of receipt, and appropriate services to meet the tenant's needs will be provided during that period of time.

c. Request for waiver of criteria for retention of a tenant in a program. To allow a tenant to remain in the program, the program may request a waiver of criteria for retention of a tenant pursuant to rule 481—67.7(231B,231C,231D) from the department within ten working days of the receipt of the report.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.25(231C) Tenant documents.

69.25(1) Documentation for each tenant shall be maintained by the program and include:

a. An occupancy record, including the tenant's name, birth date, and home address; identification numbers; date of occupancy; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;

b. Application forms;

c. The initial evaluations and updates;

d. A nutritional assessment as necessary;

e. The initial individual service plan and updates;

f. Signed authorizations for permission to release medical information, photographs, or other media information as necessary;

g. A signed authorization for the tenant to receive emergency medical care as necessary;

h. A signed managed risk policy and signed managed risk consensus agreements, if any;

i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;

j. Medication lists, which will be maintained in conformance with 481—paragraph 67.5(2) "d";

k. Advance health care directives as applicable;

l. A complete copy of the tenant's occupancy agreement, including any updates;

m. A written acknowledgment that the tenant or the tenant's legal representative, if applicable, has been fully informed of the tenant's rights;

n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;

o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the tenant's medical record);

p. A copy of waivers of admission or retention criteria, if any;

q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of

routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks will be part of the medication administration records (MARs);

r. Authorizations for the release of information, if any.

69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after termination of services.

69.25(3) All records shall be protected from loss, damage and unauthorized use.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.26(231C) Service plans.

69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with rule 481—69.22(231C) and be designed to meet the specific needs of the individual tenant.

69.26(2) Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan.

69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative.

a. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.

b. If a significant change relates to a recurring or chronic condition, a previous evaluation and service plan of the recurring condition may be utilized without new signatures being obtained.

69.26(4) The service plan shall be individualized and indicate:

a. The tenant's identified needs and preferences for assistance;

b. Any services and care to be provided pursuant to the occupancy agreement;

c. The service provider(s), if other than the program;

d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests;

e. Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.27(231C) Nurse review.

69.27(1) If a tenant does not receive personal or health-related care but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted.

69.27(2) If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders;

b. To ensure that health care professionals' orders are current for tenants who receive professional-directed health care from the program;

c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status;

d. To provide the program with written documentation of the nurse review, showing the time, date and signature.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.28(231C) Food service.

69.28(1) The program shall provide or coordinate with other community providers to provide a hot or other appropriate meal(s) at least once a day or arrange for the availability of meals.

69.28(2) Meals and snacks provided by the program but not prepared on site shall be obtained from or provided by an entity that meets the standards of state and local health laws and ordinances concerning the preparation and serving of food.

69.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program:

- a.* A minimum of 33⅓ percent if the program provides one meal per day;
- b.* A minimum of 66⅔ percent if the program provides two meals per day; and
- c.* One hundred percent if the program provides three meals per day.

69.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician associate, advanced registered nurse practitioner or ordered by a licensed dietitian authorized by a qualified medical provider. A therapeutic diet provides food, fluids or nutrients by oral, enteral, or parenteral routes and is used in the treatment of a disease or clinical condition to modify, eliminate, decrease or increase specific macro- or micronutrients, or to provide mechanically altered food when medically indicated. The thirteenth edition of the Iowa Simplified Diet Manual published by the Iowa dietetic association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets.

69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and have annual in-service training on food protection.

a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by:

- (1) Obtaining certification as a dietary manager; or
- (2) Obtaining certification as a food protection professional; or
- (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling.

b. If the person is in the process of completing a course or certification listed in paragraph 69.28(5)“*a*,” the requirement relating to completion of a state-approved food protection program will be considered to have been met.

69.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following:

- a.* All main meals and planned menu items will be prepared offsite and transferred to the program kitchen for service to tenants.
- b.* Baked goods that do not require temperature control for safety and single-service juice or milk may be stored in the program's kitchen and provided as part of a continental breakfast.

c. Ingredients used for food-related activities with tenants may be stored in the program's kitchen. Tenant activities may include the preparation and cooking of food items in the program's kitchen if the activity occurs on an irregular or sporadic basis and the items prepared are not part of the program's menu.

d. Appropriately trained staff may prepare in the program's kitchen individual quantities of tenant-requested menu-substitution food items that require limited or no preparation, such as peanut butter or cheese sandwiches or a single-service can of soup. The food items necessary to prepare the menu substitution may be stored in the program's kitchen. These food items may not be cooked in the program's kitchen but may be reheated in a microwave. A two- or four-slice toaster may be used for tenant-requested menu-substitution items, but there will be no bare-hand contact.

e. Tenants may take food items left over from a meal back to their apartments, but no leftovers will be stored in the program's kitchen.

f. Warewashing may be done in the program's kitchen as long as the program utilizes a commercial dishwasher and documents daily testing of sanitizer chemical ppm and proper water temperatures. Verification by the department of these practices may be conducted during on-site visits.

69.28(7) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above.

[ARC 0065D, IAB 2/4/26, effective 3/11/26; Editorial change: IAC Supplement 6/10/26]

481—69.29(231C) Staffing. In addition to the general staffing requirements in rule 481—67.9(231B,231C,231D), the following requirements apply to staffing in programs.

69.29(1) Each tenant will have access to a 24-hour personal emergency response system that automatically identifies the tenant in distress and can be activated with one touch.

69.29(2) In lieu of providing access to a personal emergency response system, a program serving one or more tenants with cognitive disorder or dementia will follow a system, program, or written staff procedures that address how the program will respond to the emergency needs of the tenant(s).

69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and the target population.

69.29(4) A dementia-specific assisted living program will have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff will be awake and on duty 24 hours a day on site and in the proximate area.

A non-dementia-specific assisted living program will have one or more staff persons who monitor tenants as indicated in each tenant's service plan, be able to respond to a call light or other emergent tenant needs, and be in the proximate area 24 hours a day on site.

69.29(5) All programs employing a new program manager after January 1, 2010, will require the manager within six months of hire to complete an assisted living management class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living programs. Managers who have completed a similar training prior to January 1, 2010, will not be required to complete additional training to meet this requirement.

69.29(6) All programs employing a new delegating nurse after January 1, 2010, will require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program will complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training will train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule.

69.29(7) The program will notify the department in writing within ten business days of a change in the program's manager.

69.29(8) The program must develop and implement policy and procedure for addressing sexual relationships between tenants and staff and between tenants with dementia greater than Stage 5 on the GDS.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.30(231C) Dementia-specific education for program personnel.

69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.

69.30(2) The dementia-specific education or training shall include:

- a. An explanation of dementia and related disorders;
- b. The program's specialized dementia care philosophy and program;
- c. Skills for communicating with persons with dementia;
- d. Skills for communicating with family and friends of persons with dementia;
- e. An explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the care-giving role, and family dynamics;
- f. The importance of planned and spontaneous activities;
- g. Skills in assistance with instrumental activities of daily living;
- h. The importance of the service plan and social history information;
- i. Skills in working with challenging tenants;
- j. Techniques for simplifying, cueing, and redirecting;
- k. Staff support and stress reduction;
- l. Medication management and nonpharmacological interventions.

69.30(3) Dementia-specific continuing education.

a. Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually.

b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually.

c. Contracted personnel who have no contact with tenants (e.g., persons providing lawn maintenance or snow removal) are not required to receive the two hours of training required in paragraph 69.30(3) "a."

d. The contracting agency may provide the program with documentation of dementia-specific continuing education that meets the requirements of this subrule.

69.30(4) An employee or contractor who provides documentation of completion of a dementia-specific education or training program within the past 12 months will be exempt from the education and training requirement of subrule 69.30(1).

69.30(5) Dementia-specific training will include hands-on training and any of the following: classroom instruction, web-based training, and case studies of tenants in the program.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.31(231C) Managed risk policy and managed risk consensus agreements. The program shall have a managed risk policy that will be provided to the tenant along with the occupancy agreement and include:

69.31(1) An acknowledgment of the shared responsibility for identifying and meeting the needs of the tenant and the process for managing risk and for upholding tenant autonomy when tenant decision making could result in poor outcomes for the tenant or others;

69.31(2) A consensus-based process to address specific risk situations. Program staff and the tenant will participate in the process. The result of the consensus-based process may be a managed risk consensus agreement that will include the signature of the tenant and all others who participated in the process and be included in the tenant's file.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.32(231C) Life safety—emergency policies and procedures and structural safety requirements.

69.32(1) The program shall submit to the department and follow written emergency policies and procedures, including:

- a. An emergency plan with procedures for natural disasters that is located for easy reference;
- b. Fire safety procedures;
- c. Other general or personal emergency procedures, including head injury protocols;
- d. Provisions for amending or revising the emergency plan;
- e. Provisions for periodic training of all employees;
- f. Procedures for fire drills;
- g. Regulations regarding smoking;
- h. Monitoring and testing of smoke-control systems;
- i. Tenant evacuation procedures;
- j. Procedures for reporting and documentation;
- k. Extraordinary lifesaving measures, such as cardiopulmonary resuscitation (CPR).

69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

69.32(3) The program shall obtain approval from the fire safety bureau of the department before the installation of any specialized door locking systems.

69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have written procedures regarding:

- a. Alarm systems, if an alarm system is in place.
- b. Appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior.
- c. Appropriate staff response if a tenant with cognitive disorder or dementia is missing.

69.32(5) The program's structure and procedures and the facility in which a program is located shall meet the requirements adopted for assisted living programs in administrative rules promulgated by the building code and fire safety bureaus. Approval of both bureaus indicating that the building complies with these requirements is necessary for certification of a program.

69.32(6) The program shall have the means to control the maximum temperature of water at sources accessible by a tenant to prevent scalding and control the maximum water temperature for tenants with cognitive impairment or dementia or at a tenant's request.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.33(231C) Transportation. When transportation services are provided directly or under contract with the program, the following shall apply:

69.33(1) The vehicle will be accessible and appropriate to the tenants who use it, with consideration for any physical disabilities and impairments.

69.33(2) Every tenant transported will have a seat in the vehicle, except for a tenant who remains in a wheelchair during transport.

69.33(3) Vehicles will have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers.

69.33(4) Wheelchairs will be secured when the vehicle is in motion.

69.33(5) During loading and unloading of a tenant, the driver will be in the proximate area of the tenants in a vehicle.

69.33(6) The driver will have a valid and appropriate Iowa driver's license or commercial driver's license as required by law for the vehicle being utilized for transport, or be so licensed in another state. The driver will meet any state or federal requirements for licensure or certification for the vehicle operated.

69.33(7) Each vehicle will have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.34(231C) Activities. The program shall have a policy related to activities, including the following:

69.34(1) The program will provide appropriate activities for each tenant reflecting individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement.

69.34(2) Activities will be planned to support the tenant's service plan consistent with occupancy policies.

69.34(3) A written schedule of activities will be developed at least monthly and made available to tenants and their legal representatives.

69.34(4) Tenants will be given the opportunity to choose their levels of participation in all activities offered in the program.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.35(231C) Structural requirements.

69.35(1) *General requirements.*

- a. The structure of the program will be designed and operated to meet the needs of the tenants.
- b. The buildings and grounds will be well-maintained, clean, safe and sanitary.
- c. Programs will have private dwelling units with a single-action, lockable entrance door.
- d. A program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, will have the means to disable or remove the lock on an entrance door and disable or remove the lock if its presence presents a danger to the health and safety of the tenant.
- e. The structure in which a program is housed shall comply with the administrative rules promulgated by the building code and fire safety bureaus.
- f. Programs may have individual cooking facilities within the private dwelling units. Any program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, will have the means to disable or easily remove appliances and disable or remove them if their presence presents a danger to the health and safety of the tenant or others.

69.35(2) *Programs certified prior to July 4, 2001.* Facilities for programs certified prior to July 4, 2001, shall meet the following requirements:

- a. Each dwelling unit will have at least one room that will have not less than 120 square feet of floor area. Other habitable rooms will have an area of not less than 70 square feet.
- b. Each dwelling unit will have not less than 190 square feet of floor area, excluding bathrooms.
- c. A dwelling unit used for double occupancy will have not less than 290 square feet of floor area, excluding bathrooms.
- d. The program will have a minimum of 15 square feet of common area per tenant.

69.35(3) *New construction built on or after July 4, 2001.* Programs operated in new construction built on or after July 4, 2001, shall meet the following requirements:

- a. Each dwelling unit will have at least one room that will have not less than 120 square feet of floor area. Other habitable rooms will have an area of not less than 70 square feet.
- b. Each dwelling unit used for single occupancy will have a total square footage of not less than 240 square feet of floor area, excluding bathrooms and door swing.
- c. A dwelling unit used for double occupancy will have a total square footage of not less than 340 square feet of floor area, excluding bathrooms and door swing.
- d. Each dwelling unit will contain a bathroom, including a toilet, sink and bathing facilities. A program serving persons with cognitive impairment or dementia, whether in a general or dementia-specific setting, will have the means to disable or remove the sink or bathing facility water control and

will disable or remove the water control if its presence presents a danger to the health and safety of the tenant.

e. Self-closing doors are not required for individual dwelling units, whether in a general or dementia-specific setting, unless the authority with jurisdiction determines that the level of hazard has increased to require the installation of closure hardware (for example, presence of a stove, range or oven).

69.35(4) *Structure being converted to or remodeled for use by a program on or after July 4, 2001.* A program operating in a structure that was converted or remodeled for use for a program on or after July 4, 2001, shall meet the following requirements:

a. Each dwelling unit will have at least one room that has not less than 120 square feet of floor area. Other habitable rooms will have an area of not less than 70 square feet.

b. Each dwelling unit used for single occupancy will have a total square footage of not less than 190 square feet of floor area, excluding bathrooms and door swing.

c. A dwelling unit used for double occupancy will have a total square footage of not less than 290 square feet of floor area, excluding bathrooms and door swing.

d. Each dwelling unit will have a bathroom, including a toilet, sink and bathing facility.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.36(231C) Dwelling units in dementia-specific programs. Dementia-specific programs are exempt from the requirements in subrules 69.35(2) through 69.35(4) as follows:

69.36(1) For a program built in a family or neighborhood design:

a. Each dwelling unit used for single occupancy will have a total square footage of not less than 150 square feet of floor area, excluding a bathroom; and

b. Each dwelling unit used for double occupancy will have a total square footage of not less than 250 square feet of floor area, excluding a bathroom.

69.36(2) Dementia-specific programs may choose not to provide bathing facilities in the dwelling units.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.37 Reserved.

481—69.38(83GA,SF203) Identification of veteran's benefit eligibility.

69.38(1) Within 30 days of a tenant's admission to an assisted living program that receives reimbursement through the medical assistance program under Iowa Code chapter 249A, the program shall ask the tenant or the tenant's personal representative whether the tenant is a veteran or whether the tenant is the spouse, widow, or dependent of a veteran and document the response.

69.38(2) If the tenant may be a veteran or the spouse, widow, or dependent of a veteran, the program shall report the tenant's name along with the name of the veteran, if applicable, as well as the name of the contact person for this information, to the department of veterans affairs. The program may report such information to the department of health and human services.

69.38(3) If a tenant is eligible for benefits through the U.S. Department of Veterans Affairs or other third-party payor, the program first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

481—69.39(231C) Respite care services. "Respite care services" means an organized program of temporary supportive care provided for 24 hours or more to a person in order to relieve the usual caregiver of the person from providing continual care to the person, or on request of the tenant as a trial of the program. An assisted living program that chooses to provide respite care services must meet the following requirements related to respite care services and be certified as an assisted living program.

69.39(1) *Length of stay.* Respite care services will be provided for no more than 30 consecutive days and for a total of no more than 60 days in a consecutive 12-month period beginning on the first day the individual stays in the program.

69.39(2) *No separate certificate.* An assisted living program that chooses to provide respite care services is not required to obtain a separate certificate or pay a certification fee.

69.39(3) *Assessment.* The program nurse will assess the individual prior to the individual's stay and will document:

- a. Safety and supervision needs;
- b. Medical needs;
- c. Dietary needs;
- d. Bowel and bladder function.

69.39(4) *Written direction to staff.* The program nurse will document the care needs of the individual based on the assessment conducted pursuant to subrule 69.39(3) and provide the documentation to staff.

69.39(5) *Involuntary termination of respite care services.* The program may terminate the respite care services for the individual. Rule 481—69.24(231C) will not apply. The program will make proper arrangements for the welfare of the individual prior to involuntary termination of respite care services, including notification of the individual's family or legal representative.

69.39(6) *Contract.* The program will have a contract with each individual, including:

- a. The time period during which the individual will be considered to be receiving respite care services, not to exceed 30 consecutive days.
- b. A description of all fees, charges, and rates for respite care services, and any additional and optional services and their related costs.
- c. A statement that respite care services may be involuntarily terminated. Rule 481—69.24(231C) will not apply.
- d. Identification of the party responsible for payment of fees and identification of the respite care individual's legal representative, if any.
- e. Identification of emergency contacts, including but not limited to the individual's family member(s) and physician.
- f. A statement that all individual information will be maintained in a confidential manner to the extent required under state and federal law.
- g. The refund policy, if applicable.
- h. A statement regarding billing and payment procedures.

69.39(7) *Admission to program.*

- a. Individuals receiving respite care will not be considered an admission to the program.
- b. Individuals receiving respite care will be included in the program's census.
- c. The program will not enter into multiple 30-day contracts with an individual receiving respite care in order to lengthen the individual's stay in the program.
- d. If an individual receiving respite care remains in the program beyond 30 consecutive days and is eligible for admission, the department will consider the individual a tenant in the program. The program will follow all requirements for admission to the program.

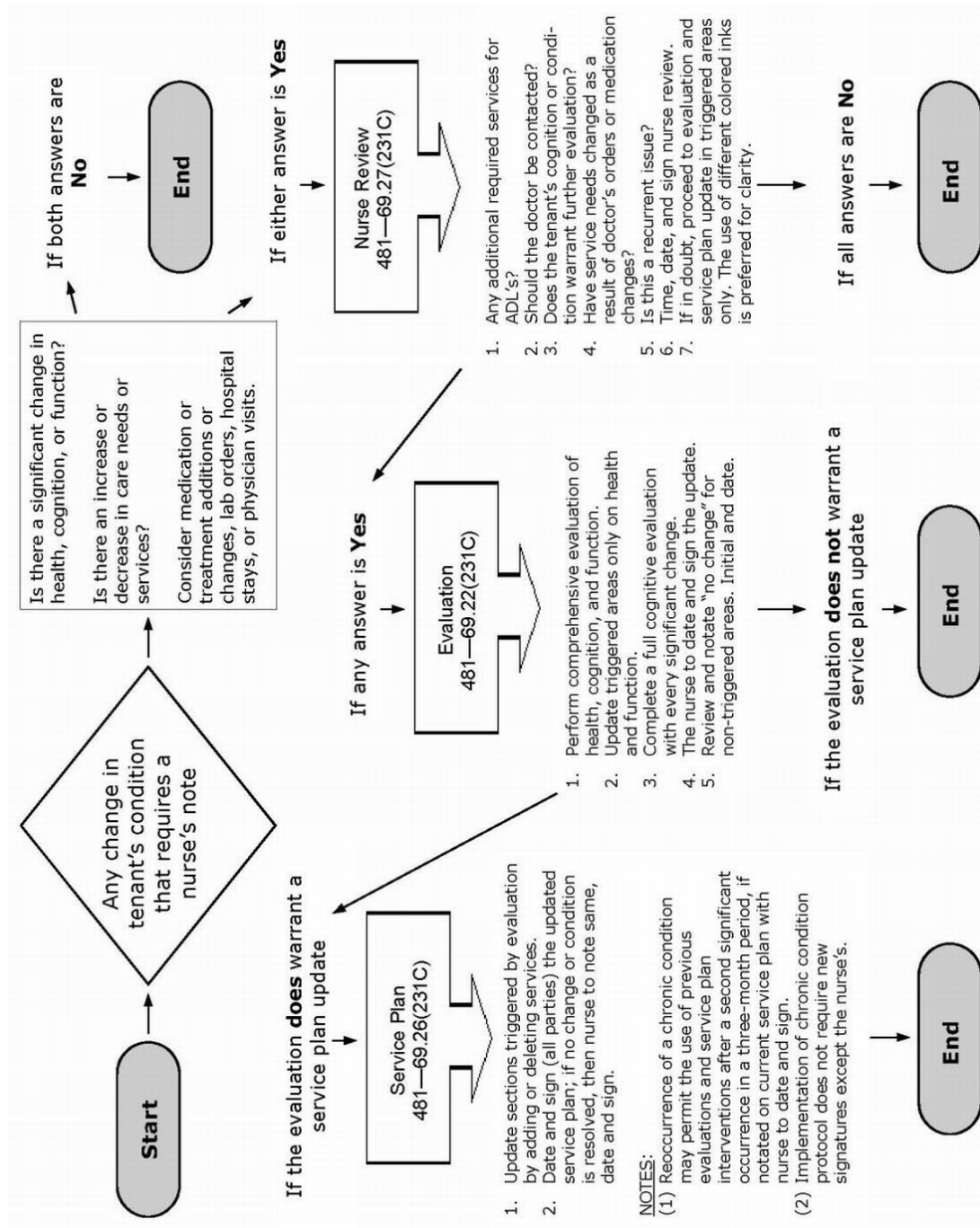
69.39(8) *Level of care criteria.* Individuals receiving respite care must meet the criteria found in subrule 69.23(1) for admission and retention of tenants. Respite care services will not be provided by an assisted living program to persons requiring a level of care that is higher than the level of care the program is certified to provide.

69.39(9) *Accessibility by the department.* The department shall have the same access to respite care services records as provided in 481—subrule 67.10(2).

[ARC 0065D, IAB 2/4/26, effective 3/11/26]

These rules are intended to implement Iowa Code chapter 231C.

Table A



[Filed ARC 8176B (Notice ARC 7878B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]
 [Filed ARC 1376C (Notice ARC 1291C, IAB 1/22/14), IAB 3/19/14, effective 4/23/14]
 [Filed ARC 1667C (Notice ARC 1511C, IAB 6/25/14), IAB 10/15/14, effective 11/19/14]
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 [Filed ARC 2463C (Notice ARC 2200C, IAB 10/14/15), IAB 3/16/16, effective 4/20/16]
 [Filed ARC 4976C (Notice ARC 4867C, IAB 1/15/20), IAB 3/11/20, effective 4/15/20]
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 [Filed ARC 0065D (Notice ARC 9783C, IAB 12/10/25), IAB 2/4/26, effective 3/11/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 70 ADULT DAY SERVICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/11/31

481—70.1(231D) Definitions. In addition to the definitions in 481—Chapter 67 and Iowa Code chapter 231D, the following definitions apply:

“Applicable requirements” means the requirements in Iowa Code chapter 231D, this chapter, 481—Chapter 67 and includes any other applicable administrative rules and provisions of the Iowa Code.

“CARF” means the Commission on Accreditation of Rehabilitation Facilities.

“Cognitive disorder” means a disorder characterized by cognitive dysfunction presumed to be the result of illness that does not meet criteria for dementia, delirium, or amnesic disorder.

“Dementia-specific adult day services program” means an adult day services program certified under this chapter that:

1. Serves fewer than 55 participants and has 5 or more participants who have dementia between Stages 4 and 7 on the Global Deterioration Scale, or
2. Serves 55 or more participants and 10 percent or more of the participants have dementia between Stages 4 and 7 on the Global Deterioration Scale, or
3. Holds itself out as providing specialized care for persons with dementia, such as Alzheimer’s disease, in a dedicated setting.

“Maximal assistance with activities of daily living” means routine total dependence on staff for the performance of a minimum of four activities of daily living for a period that exceeds 21 days.

“Medically unstable” means that a participant has a condition or conditions:

1. Indicating physiological frailty as determined by the program’s staff in consultation with a physician or physician extender;
2. Resulting in three or more significant hospitalizations within a consecutive three-month period for more than observation; and
3. Requiring frequent supervision of the participant for more than 21 days by a registered nurse.

For example, a participant who has a condition such as congestive heart failure that results in three or more significant hospitalizations during a quarter and that requires that the participant receive frequent supervision may be considered medically unstable.

“Unmanageable incontinence” means a condition that requires staff provision of total care for an incontinent participant who lacks the ability to assist in bladder or bowel continence care.

“Visiting day(s)” means up to 16 hours in a two-day period during which a person may visit a program prior to admission for the purpose of assessing eligibility for the program and personal satisfaction.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.2(231D) Program certification. A program may obtain certification by meeting all applicable requirements or being voluntarily accredited by a recognized accreditation entity.

70.2(1) Posting requirements. A program’s current certificate shall be visibly displayed within the designated operation area of the program. The latest monitoring report, fire safety bureau report, and food establishment inspections report issued pursuant to Iowa Code chapter 137F shall be made available to the public by the program upon request.

70.2(2) Dementia-specific programs. If a program meets the definition of a dementia-specific adult day services program during two sequential certification monitorings, the program shall meet all requirements for a dementia-specific program, including the requirements set forth in rule 481—70.30(231D) and in subrule 70.32(2).

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.3(231D) Certification of a nonaccredited program—application process.

70.3(1) The applicant shall complete an application packet obtained from the department health facilities division website at dia-hfd.iowa.gov; by mail from the Department of Inspections, Appeals, and Licensing, Adult Services Bureau, 6200 Park Avenue, Des Moines, Iowa 50321; or by telephone at 515.281.7272.

70.3(2) The applicant shall submit one copy of the completed application and all supporting documentation to the department at the above address at least 90 calendar days prior to the expected date of beginning operation.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.4(231D) Nonaccredited program—application content. An application for certification or recertification of a nonaccredited program shall include the following:

70.4(1) The names, addresses, and percentage of stock, shares, partnership or other equity interest of all officers, members of the board of directors and trustees, as well as stockholders, partners or any individuals who have greater than a 10 percent equity interest in each of the following, as applicable:

- a. The real estate owner or lessor;
- b. The lessee;
- c. The management company responsible for the day-to-day operation of the program.

The program will notify the department of any changes in the list no later than ten working days after the effective date of the change.

70.4(2) A statement disclosing whether the individuals listed in subrule 70.4(1) have been convicted of a felony or an aggravated or serious misdemeanor or found to be in violation of the child abuse or dependent adult abuse laws of any state.

70.4(3) A statement disclosing whether any of the individuals listed in subrule 70.4(1) fall under the provisions in Iowa Code section 231D.5, including for a licensed health care facility as defined in Iowa Code section 135C.1 or a licensed hospital as defined in Iowa Code section 135B.1.

70.4(4) The contractual agreement and all attachments.

70.4(5) If the program contracts for personal care or health-related care services from a certified home health agency, a mental health center or a licensed health care facility, a copy of that entity's current license or certification.

70.4(6) A copy of the state license for the entity that provides food service, whether the entity is the program or an outside entity or a combination of both.

70.4(7) The fee set forth in Iowa Code section 231D.4.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.5(231D) Initial certification process for a nonaccredited program.

70.5(1) Upon receipt of all completed documentation, including building code and fire safety bureau approval and structural and evacuation review approval, the department will determine whether the proposed program meets applicable requirements.

70.5(2) If the department determines the proposed program meets the requirements for certification, a provisional certification will be issued to the program to begin operation and accept participants.

70.5(3) Within 180 calendar days following issuance of provisional certification, the department will conduct a monitoring to determine the program's compliance with applicable requirements.

70.5(4) If a regulatory insufficiency is identified as a result of the monitoring, the process in rule 481—67.10(17A,231B,231C,231D) will be followed.

70.5(5) The department will make a final certification decision based on the results of the monitoring and review of an acceptable plan of correction.

70.5(6) The department will notify the program of a final certification decision within ten working days following the finalization of the monitoring report or receipt of an acceptable plan of correction, whichever is applicable.

70.5(7) If the decision is to continue certification, the department will issue a full two-year certification effective from the date of the original provisional certification.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.6(231D) Expiration of the certification of a nonaccredited program. Unless conditionally issued, suspended or revoked, certification of a program will expire at the end of the time period specified on the certificate.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.7(231D) Recertification process for a nonaccredited program. To obtain recertification, a program shall:

70.7(1) Submit one copy of the completed application, associated documentation, and the recertification fee as listed in Iowa Code section 231D.4 to the department at the address stated in subrule 70.3(1) at least 30 calendar days prior to the expiration of the program's certification.

70.7(2) Submit additional documentation that each of the following has been inspected by a qualified professional and found to be maintained in conformance with the manufacturer's recommendations and nationally recognized standards: heating system, cooling system, water heater, electrical system, plumbing, sewage system, artificial lighting, and ventilation system; and, if located on site, garbage disposal, kitchen appliances, washing machines and dryers, and elevators.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.8(231D) Notification of recertification for a nonaccredited program.

70.8(1) The department will review the application, associated documentation and fees. After all finalized documentation is received, including building code and fire safety bureau approval, the department will determine the program's compliance with applicable requirements.

70.8(2) If the facility is in good standing, the department will issue the program a two-year certification effective from the date of the expiration of the previous certification.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.9(231D) Certification or recertification of an accredited program—application process. An applicant for certification or recertification of a program accredited by a recognized accrediting entity shall:

70.9(1) Submit a completed application packet obtained from the department health facilities division website at dia-hfd.iowa.gov; by mail from the Department of Inspections, Appeals, and Licensing, Adult Services Bureau, 6200 Park Avenue, Des Moines, Iowa 50321; or by telephone at 515.281.7272.

70.9(2) Submit a copy of the current accreditation outcome from the recognized accrediting entity.

70.9(3) Maintain compliance with the requirements of the building code and fire safety bureau of the department pursuant to this chapter.

70.9(4) Submit the appropriate fees as set forth in Iowa Code section 231D.4.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.10(231D) Certification or recertification of an accredited program—application content. An application for certification or recertification of an accredited program shall comply with rule 481—70.4(231D) and include a copy of the current accreditation outcome from the recognized accrediting entity.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.11(231D) Initial certification process for an accredited program.

70.11(1) Within 20 working days of receiving all finalized documentation, including building code and fire safety bureau approval, the department will notify the accredited program whether the accredited program meets applicable requirements and whether certification will be issued.

70.11(2) If the decision is to certify, a certification will be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity.

70.11(3) If the decision is to deny certification, the department will provide the applicant an opportunity for hearing in accordance with rule 481—67.13(17A,231B,231C,231D).

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.12(231D) Recertification process for an accredited program.

70.12(1) To obtain recertification, an accredited program shall comply with rule 481—70.9(231D) at least 30 calendar days prior to the expiration of the program's certification.

70.12(2) If the facility is in good standing, a full certification shall be issued for the term of the accreditation not to exceed three years, unless the certification is conditionally issued, suspended or revoked by either the department or the recognized accrediting entity. If the decision is to deny recertification, the department will provide the applicant an opportunity for hearing in accordance with rule 481—67.14(17A,231B,231C,231D).

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.13(231D) Listing of all certified programs. The department will maintain a list of all certified programs, which is available online at dia-hfd.iowa.gov/DIA_HFD/Home.do.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.14(231D) Recognized accrediting entity.

70.14(1) The department designates CARF as a recognized accrediting entity for programs.

70.14(2) To apply for designation by the department as a recognized accrediting entity for programs, an accrediting entity shall submit a letter of request and its standards shall meet the applicable requirements for programs.

70.14(3) The designation will remain in effect for as long as the accreditation standards meet the applicable requirements for programs.

70.14(4) An accrediting entity shall provide annually to the department, at no cost, a current edition of the applicable standards manual and survey preparation guide, and training thereon, within 120 working days after the publications are released.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.15(231D) Requirements for an accredited program. Each accredited program that is certified by the department shall:

70.15(1) Provide the department a copy of all survey reports including outcomes, quality improvement plans and annual conformance to quality reports generated or received, as applicable, within ten working days of receipt of the reports.

70.15(2) Notify the department by the most expeditious means possible of all credible reports of alleged improper or inappropriate conduct or conditions within the program and any actions taken by the accrediting entity with respect thereto.

70.15(3) Notify the department immediately of the expiration, suspension, revocation or other loss of the program's accreditation.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.16(231D) Maintenance of program accreditation.

70.16(1) An accredited program will continue to be recognized for certification by the department if both of the following requirements are met:

a. The program complies with the requirements outlined in rule 481—70.15(231D).

b. The program maintains its voluntary accreditation status for the duration of the time-limited certification period.

70.16(2) A program that does not maintain its voluntary accreditation status must become certified by the department prior to any lapse in accreditation or cease operation as a program.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.17(231D) Change of ownership—notification to the department.

70.17(1) Certification, unless conditionally issued, suspended or revoked, may be transferable. If the program's certification has been conditionally issued, the department must approve a change of ownership prior to the transfer of the certification.

70.17(2) In order to transfer certification, the applicant must:

a. Meet the requirements of the rules, regulations and standards contained in Iowa Code chapter 231D and 481—Chapter 67 and this chapter;

b. At least 30 days prior to the change of ownership of the program, provide application and supporting documentation to the department.

70.17(3) The department may conduct a monitoring within 90 days following a change in the program's ownership to ensure that the program complies with applicable requirements. If a regulatory insufficiency is found, the department will take any necessary enforcement action authorized by applicable requirements.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.18(231D) Plan reviews of a building for a new program.

70.18(1) Before a building is constructed or remodeled for use in a new program, the state building code bureau shall review the blueprints for compliance with requirements pursuant to this chapter. Construction or remodeling includes new construction, remodeling of any part of an existing building, addition of a new wing or floor to an existing building, or conversion of an existing building.

70.18(2) A program applicant shall submit construction documents to the building code bureau's online portal at dial.iowa.gov/licenses/building/plan-review.

70.18(3) The plan review fee must be paid before construction documents are uploaded to the project folder.

70.18(4) The building code bureau will notify the Iowa-licensed architect or Iowa-licensed engineer in writing regarding the status of compliance with requirements.

70.18(5) The Iowa-licensed architect or Iowa-licensed engineer shall respond to the building code bureau regarding how any noncompliance will be resolved.

70.18(6) Upon final notification by the building code bureau that the construction documents meet requirements, construction or remodeling of the building may commence.

70.18(7) The building code and fire safety bureaus will schedule an on-site visit of the building site with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the construction or remodeling process to ensure compliance with the approved construction documents. Any noncompliance must be resolved prior to approval for certification.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.19(231D) Plan review prior to the remodeling of a building for a certified program.

70.19(1) Before a building for a certified program is remodeled as defined in subrule 70.18(1), the building code bureau shall review the construction documents for compliance with requirements set forth in rule 481—70.35(231D).

70.19(2) A certified program shall submit construction documents to the building code bureau's online portal at dial.iowa.gov/licenses/building/plan-review.

70.19(3) The documents won't be reviewed until the fee is received.

70.19(4) The building code bureau will review the documents within 35 working days of receipt and notify the Iowa-licensed architect or Iowa-licensed engineer in writing regarding the status of compliance with requirements.

70.19(5) The Iowa-licensed architect or Iowa-licensed engineer shall respond to the building code bureau in 20 working days to state how any noncompliance will be resolved.

70.19(6) Upon final notification by the building code bureau that the construction documents meet structural and life safety requirements, remodeling of the building may commence.

70.19(7) The building code and fire safety bureaus will schedule an on-site visit of the building with the contractor, or Iowa-licensed architect or Iowa-licensed engineer, during the remodeling process to ensure compliance with the approved construction documents. Any noncompliance must be resolved prior to approval for continued certification or recertification of the program.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.20(231D) Cessation of program operation that includes seeking decertification.

70.20(1) The program shall provide, at least 90 days in advance of cessation, unless there is some type of emergency, written notification to the department of the date on which the program will cease operation.

70.20(2) At the time a program decides to cease operation, the program shall submit a plan to the department and make arrangements for the safe and orderly discharge or transition of all participants within the 90-day period specified by subrule 70.20(1).

70.20(3) The department may conduct a monitoring during the 90-day period to ensure the safety of participants during the discharge process or transition process.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.21(231D) Contractual agreement.

70.21(1) The contractual agreement shall be in 12-point type or larger, written in plain language using commonly understood terms and easy for the participant or the participant's legal representative to understand.

70.21(2) In addition to the requirements of Iowa Code section 231D.17, the written contractual agreement shall include the following information in the body of the agreement or in the supporting documents and attachments:

- a. The telephone number for filing a complaint with the department.
- b. The telephone number for reporting dependent adult abuse.
- c. A copy of the program's statement on participants' rights.
- d. A statement that the program will notify the participant at least 90 days in advance of any planned program cessation, except in cases of emergency.
- e. A copy of the program's admission criteria.

70.21(3) The contractual agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.

70.21(4) A copy of the contractual agreement shall be provided to the participant or the participant's legal representative, if any, and a copy shall be kept by the program.

70.21(5) A copy of the most current contractual agreement shall be made available to the general public upon request.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.22(231D) Evaluation of participant.

70.22(1) *Evaluation prior to participation.* A program shall evaluate each prospective participant's functional, cognitive and health status prior to the participant's signing the contractual agreement and participating in the program, with the exception of visiting day(s), to determine the participant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall be appropriate to the population served. When the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the participant subsequently returns to the participant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional, human service professional, or licensed practical nurse via nurse delegation.

70.22(2) *Evaluation within 30 days of participation and with significant change.* A program shall evaluate each participant's functional, cognitive and health status within 30 days of the participant's beginning participation in the program. A program shall evaluate each participant's

functional, cognitive and health status as needed with significant change, but not less than annually, to determine the participant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, human service professional, or licensed practical nurse via nurse delegation.

70.22(3) *Requirements for visiting day(s).* Evaluation of the participant is not required during visiting day(s), but the program shall provide the participant or the participant's legal representative with a written explanation of the expectations for the visiting day(s).

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.23(231D) Criteria for admission and retention of participants.

70.23(1) *Persons who may not be admitted or retained.* Criteria are set forth in Iowa Code section 231D.19.

70.23(2) *Disclosure of additional participation and discharge criteria.* A program may have additional participation or discharge criteria if the criteria are disclosed in the written contractual agreement prior to the participant's participation in the program.

70.23(3) *Assistance with discharge from the program.* A program shall assist a participant and the participant's legal representative, if applicable, to ensure a safe and orderly discharge from the program when the participant exceeds the program's criteria for admission and retention.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.24(231D) Involuntary discharge from the program.

70.24(1) *Program initiation of discharge.* If a program initiates the involuntary discharge of a participant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the participant or participant's legal representative contests the discharge, the procedures in Iowa Code section 231D.18 shall apply.

70.24(2) *Discharge pursuant to results of monitoring or complaint or program-reported incident investigation by the department.* If one or more participants are identified as exceeding the admission and retention criteria for participants and need to be discharged as a result of a monitoring or a complaint or program-reported incident investigation conducted by the department, the following procedures shall apply.

a. Notification of the program. Within 20 working days of the monitoring or complaint or program-reported incident investigation, the department will notify the program, in writing, of the identification of any participant who exceeds admission and retention criteria.

b. Notification of others. Each identified participant, the participant's legal representative, if applicable, and other providers of services to the participant will be notified of their opportunity to provide responses within ten days of receipt of the notice, including specific input, written comment, information, and documentation directly addressing any agreement or disagreement with the identification.

c. Program agreement with the department's finding. If the program agrees with the department's finding and the program begins involuntary discharge proceedings, the program's internal appeal process in subrule 70.24(1) shall be utilized for appeals.

d. Program disagreement with the department's finding. If the program does not agree with the department's finding that the participant exceeds admission and retention criteria, the program may collect and submit all responses to the department, including those from other interested parties, within ten working days of receipt of the notice. In the program's response, the program will identify the participant, list the known responses from others, and note the program's agreement or disagreement with the responses from others. Submission of a response does not eliminate the applicable requirements, including submission of a plan of correction under 481—subrule 67.13(3). Other persons may also submit information directly to the department.

(1) *Consideration of response.* Within ten working days of receipt of the program's response for each identified participant, the department will consider the response and make a final finding regarding the continued retention of a participant.

(2) Amending the regulatory insufficiency. If the department's determination is to amend the regulatory insufficiency based on the response, the department will modify the report of findings.

(3) Retaining regulatory insufficiency. If the department retains the regulatory insufficiency, the department will review the plan of correction in accordance with this chapter and 481—Chapter 67. The department will notify the program of the opportunity to appeal the report findings as they relate to the admission and retention decision.

(4) Effect of the filing of an appeal. If an appeal is filed, the participant who exceeds admission and retention criteria will be allowed to continue to participate in the program until all administrative appeals have been exhausted. Appeals filed that relate to the participant's exceeding admission and retention criteria will be heard within 30 days of receipt, and appropriate services to meet the participant's needs will be provided during that period of time.

(5) Request for waiver of criteria for retention of a participant in a program. To allow a participant to continue to participate in the program, the program may request a waiver of criteria for retention of a participant pursuant to rule 481—67.7(231B,231C,231D) from the department within ten working days of the receipt of the report.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.25(231D) Participant documents.

70.25(1) Documentation for each participant shall be maintained by the program and include:

- a.* A participation record including the participant's name, birth date, and home address; identification numbers; date of beginning participation; name, address and telephone number of health professional(s); diagnosis; and names, addresses and telephone numbers of family members, friends or other designated people to contact in the event of illness or an emergency;
- b.* Application forms;
- c.* The initial evaluations and updates;
- d.* A nutritional assessment as necessary;
- e.* The initial individual service plan and updates;
- f.* Signed authorizations for permission to release medical information, photographs, or other media information as necessary;
- g.* A signed authorization for the participant to receive emergency medical care as necessary;
- h.* A signed managed risk policy and signed managed risk consensus agreements, if any;
- i.* When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception;
- j.* Medication lists, which will be maintained in conformance with 481—paragraph 67.5(2) "d";
- k.* Advance health care directives as applicable;
- l.* A complete copy of the participant's contractual agreement, including any updates;
- m.* A written acknowledgment that the participant or the participant's legal representative, if applicable, has been fully informed of the participant's rights;
- n.* A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative;
- o.* Incident reports involving the participant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports need not be included in the participant's medical record);
- p.* A copy of waivers of admission or retention criteria, if any;
- q.* When the participant is unable to advocate on the participant's own behalf or the participant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks will be part of the medication administration records (MARs);
- r.* Authorizations for the release of information, if any.

70.25(2) The program records relating to a participant shall be retained for a minimum of three years after termination of service.

70.25(3) All records shall be protected from loss, damage and unauthorized use.
[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.26(231D) Service plans.

70.26(1) A service plan shall be developed for each participant based on the evaluations conducted in accordance with rule 481—70.22(231D) and designed to meet the specific service needs of the individual participant.

70.26(2) Prior to the participant's signing the contractual agreement and participating in the program, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the participant and, at the participant's request, with other individuals identified by the participant, and, if applicable, with the participant's legal representative. All persons who develop the plan and the participant or the participant's legal representative shall sign the plan.

70.26(3) When a participant needs personal care or health-related care, the service plan shall be updated within 30 days of the participant's participation and as needed with significant change, but not less than annually. The updated service plan shall be signed and dated by all parties.

a. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.

b. If a significant change relates to a recurring or chronic condition, a previous evaluation and service plan of the recurring condition may be utilized without new signatures being obtained.

70.26(4) The service plan shall be individualized and indicate:

- a.* The participant's identified needs and preferences for assistance;
- b.* Any services and care to be provided pursuant to the contractual agreement;
- c.* The service provider(s), if other than the program;
- d.* For participants who are unable to plan their own activities, including participants with dementia, planned and spontaneous activities based on the participant's abilities and personal interests.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.27(231D) Nurse review. If a participant does not receive personal or health-related care, but an observed significant change in the participant's condition occurs, a nurse review shall be conducted. If a participant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

70.27(1) To monitor, at least every 90 days, or after a significant change in the participant's condition, any participant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders;

70.27(2) To ensure that health care professionals' orders are current for participants who receive health care professional-directed care from the program;

70.27(3) To assess and document the health status of each participant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the participant's health status;

70.27(4) To provide the program with written documentation of the activities under the service plan, as set forth in rule 481—70.26(231D), showing the time, date and signature.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.28(231D) Food service.

70.28(1) The program shall provide or coordinate with other community providers to provide a hot or other appropriate meal(s) at least once a day or arrange for the availability of meals, unless otherwise noted in the contractual agreement.

70.28(2) Meals and snacks provided by the program but not prepared on site shall be obtained from or provided by an entity that meets the standards of state and local health laws and ordinances concerning the preparation and serving of food.

70.28(3) Menus shall be planned to provide the following percentage of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences based on the number of meals provided by the program:

- a. A minimum of 33⅓ percent if the program provides one meal per day;
- b. A minimum of 66⅔ percent if the program provides two meals per day; and
- c. One hundred percent if the program provides three meals per day.

70.28(4) Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician associate, or advanced registered nurse practitioner, or ordered by a licensed dietitian authorized by a qualified medical provider. A therapeutic diet provides food, fluids, or nutrients by oral, enteral, or parenteral routes and is used in the treatment of a disease or clinical condition to modify, eliminate, decrease, or increase specific macro- or micronutrients, or to provide mechanically altered food when medically indicated. A copy of the Iowa Simplified Diet Manual, Thirteenth Edition, published by the Iowa Academy of Nutrition and Dietetics shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets.

70.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection.

a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by:

- (1) Obtaining certification as a dietary manager; or
- (2) Obtaining certification as a food protection professional; or
- (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling.

b. If the person is in the process of completing a course or certification listed in paragraph 70.28(5)“a,” the requirement relating to completion of a state-approved food protection program will be considered to have been met.

70.28(6) Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and be licensed pursuant to Iowa Code chapter 137F. The department will not require the program to be licensed as a food establishment if the program limits food activities to the following:

a. All main meals and planned menu items will be prepared offsite and transferred to the program kitchen for service to participants.

b. Baked goods that do not require temperature control for safety and single-service juice or milk may be stored in the program's kitchen and provided as part of a continental breakfast.

c. Ingredients used for food-related activities with participants may be stored in the program's kitchen. Participant activities may include the preparation and cooking of food items in the program's kitchen if the activity occurs on an irregular or sporadic basis and the items prepared are not part of the program's menu.

d. Appropriately trained staff may prepare in the program's kitchen individual quantities of participant-requested menu-substitution food items that require limited or no preparation, such as peanut butter or cheese sandwiches or a single-service can of soup. The food items necessary to

prepare the menu substitution may be stored in the program's kitchen. These food items may not be cooked in the program's kitchen but may be reheated in a microwave. A two- or four-slice toaster may be used for participant-requested menu-substitution items, but no bare-hand contact.

e. Warewashing may be done in the program's kitchen as long as the program utilizes a commercial dishwasher and documents daily testing of sanitizer chemical ppm and proper water temperatures. Verification by the department of these practices may be conducted during on-site visits.

[ARC 0066D, IAB 2/4/26, effective 3/11/26; Editorial change: IAC Supplement 6/10/26]

481—70.29(231D) Staffing. In addition to the general staffing requirements in rule 481—67.9(231B,231C,231D), the following requirements apply to staffing in programs.

70.29(1) No fewer than two staff persons who monitor participants will be awake and on duty during all hours of operation when two or more participants are participating in the program.

70.29(2) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.

70.29(3) A program that serves one or more participants with cognitive disorders or dementia will follow written procedures that address how the program will respond to the emergency needs of the participants.

70.29(4) The program will notify the department in writing within ten business days of a change in the program's manager.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.30(231D) Dementia-specific education for program personnel.

70.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable.

70.30(2) The dementia-specific education or training shall include the following:

- a.* An explanation of Alzheimer's disease and related disorders;
- b.* The program's specialized dementia care philosophy and program;
- c.* Skills for communicating with persons with dementia;
- d.* Skills for communicating with family and friends of persons with dementia;
- e.* An explanation of family issues such as role reversal, grief and loss, guilt, relinquishing the care-giving role, and family dynamics;
- f.* The importance of planned and spontaneous activities;
- g.* Skills in assistance with instrumental activities of daily living;
- h.* The importance of the service plan and social history information;
- i.* Skills in working with challenging participants;
- j.* Techniques for simplifying, cueing, and redirecting;
- k.* Staff support and stress reduction;
- l.* Medication management and nonpharmacological interventions.

70.30(3) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually.

70.30(4) An employee or contractor who provides documentation of completion of a dementia-specific education or training program within the past 12 months will be exempt from the education and training requirement of subrule 70.30(1).

70.30(5) Dementia-specific training will include hands-on training and include: classroom instruction, web-based training, and case studies of participants in the program.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.31(231D) Managed risk policy and managed risk consensus agreements. The program shall have a managed risk policy that will be provided to the participant along with the contractual agreement and include:

70.31(1) An acknowledgment of the shared responsibility for identifying and meeting the needs of the participant and the process for managing risk and for upholding participant autonomy when participant decision making results in poor outcomes for the participant or others;

70.31(2) A consensus-based process to address specific risk situations. Program staff and the participant will participate in the process. The result of the consensus-based process may be a managed risk consensus agreement that will include the signature of the participant and the signatures of all others who participated in the process and be included in the participant's file.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.32(231D) Life safety—emergency policies and procedures and structural safety requirements.

70.32(1) The program shall submit to the department and follow written emergency policies and procedures, including:

- a. An emergency plan, with procedures for natural disasters that is located for easy reference;
- b. Fire safety procedures;
- c. Other general or personal emergency procedures, including head injury protocols;
- d. Provisions for amending or revising the emergency plan;
- e. Provisions for periodic training of all employees;
- f. Procedures for fire drills;
- g. Regulations regarding smoking;
- h. Monitoring and testing of smoke-control systems;
- i. Participant evacuation procedures;
- j. Procedures for reporting and documentation;
- k. Extraordinary lifesaving measures, such as cardiopulmonary resuscitation (CPR).

70.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. A program serving a person(s) with cognitive disorder or dementia, whether in a general or dementia-specific setting, shall have written procedures regarding:

- a. Alarm systems and appropriate staff response when a participant's service plan indicates a risk of elopement or a participant exhibits wandering behavior.
- b. Appropriate staff response if a participant with cognitive disorder or dementia is missing.

The program shall obtain approval from the fire safety bureau before the installation of any specialized door locking systems.

70.32(3) The program's structure and procedures and the facility in which a program is located shall meet the requirements adopted for adult day services programs in administrative rules promulgated by the building code and fire safety bureaus. Approval of both bureaus indicating that the building complies with these requirements is necessary for certification of a program.

70.32(4) The program shall have the means to control the maximum temperature of water at sources accessible by a participant to prevent scalding and control the maximum water temperature for participants with cognitive impairment or dementia or at a participant's request.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.33(231D) Transportation. When transportation services are provided directly or under contract with the program the following shall apply:

70.33(1) The vehicle will be accessible and appropriate to the participants who use it, with consideration for any physical disabilities and impairments.

70.33(2) Every participant transported will have a seat in the vehicle, except for a participant who remains in a wheelchair during transport.

70.33(3) Vehicles will have adequate seat belts and securing devices for ambulatory and wheelchair-using passengers.

70.33(4) Wheelchairs will be secured when the vehicle is in motion.

70.33(5) During loading and unloading of a participant, the driver will be in the proximate area of the participants in a vehicle.

70.33(6) The driver will have a valid and appropriate Iowa driver's license or commercial driver's license as required by law for the vehicle being utilized for transport, or be so licensed in another state. The driver will meet any state or federal requirements for licensure or certification for the vehicle operated.

70.33(7) Each vehicle will have a first-aid kit, fire extinguisher, safety triangles and a device for two-way communication.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.34(231D) Activities.

70.34(1) The program shall provide appropriate activities for each participant reflecting individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement.

70.34(2) Activities shall be planned to support the participant's service plan and be consistent with the program statement and participation policies.

70.34(3) A written schedule of activities shall be developed at least monthly and made available to participants and their legal representatives.

70.34(4) Participants shall be given the opportunity to choose their levels of participation in all activities offered in the program.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.35(231D) Structural requirements.

70.35(1) The structure, equipment and physical environment of the program will be designed and operated to meet the needs of the participants. The building, grounds and equipment will be well-maintained, clean, safe and sanitary.

70.35(2) There will be at least one toilet for every ten participants and staff members.

70.35(3) Toilets and bathing and toileting appliances will be equipped for use by participants with multiple disabilities.

70.35(4) There will be a ratio of at least one hand-washing sink for every two toilets. The sink(s) will be proximate to the toilets. Hand-washing facilities will be readily accessible to participants and staff.

70.35(5) Shower and tub areas, if provided, will be equipped with grab bars and slip-resistant surfaces.

70.35(6) Signaling emergency call devices will be installed or placed in all bathroom areas, restroom stalls and showers.

70.35(7) A telephone will be available to participants to make and receive calls in a private manner and for emergency purposes.

70.35(8) A storage area(s) will be provided for storage of program supplies and participants' possessions, which will be stored in such a manner that, when not in use, will prevent personal injury to participants and staff.

70.35(9) The program will provide a separate area to permit privacy for evaluations and to isolate participants who become ill.

70.35(10) The program will meet other building and public safety codes, including rules pertaining to accessibility contained in the state building code and provisions of the state building code relating to persons with disabilities.

70.35(11) The program will meet the requirements in subrule 70.32(4).

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

481—70.36(231D) Identification of veteran's benefit eligibility.

70.36(1) Within 30 days of a participant's participation in an adult day services program that receives reimbursement through the medical assistance program under Iowa Code chapter 249A, the program shall ask the participant or the participant's personal representative whether the participant is a veteran or whether the participant is the spouse, widow or dependent of a veteran and document the response.

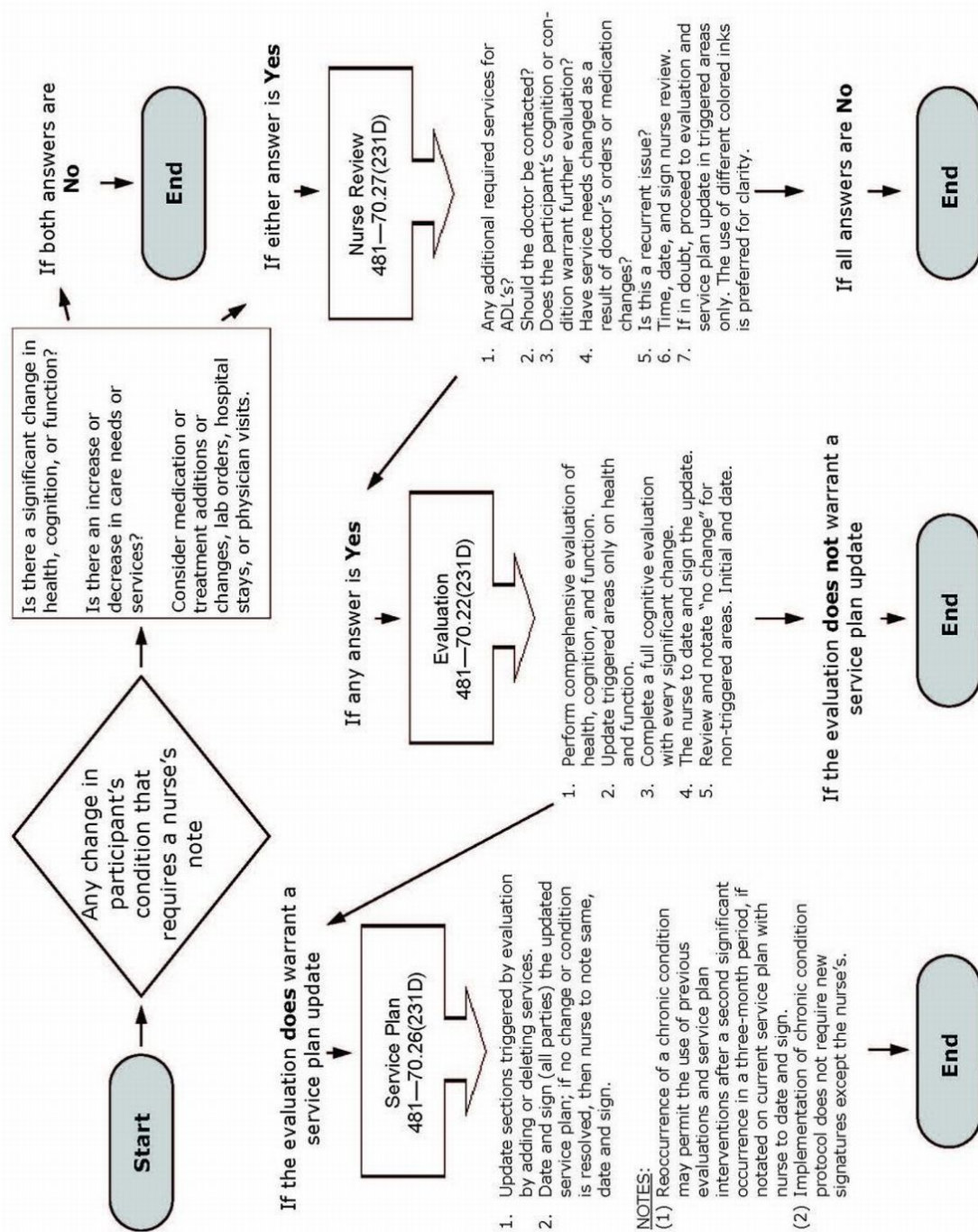
70.36(2) If the participant may be a veteran or the spouse, widow, or dependent of a veteran, the program shall report the participant's name along with the name of the veteran, if applicable, as well as the name of the contact person for this information, to the Iowa department of veterans affairs. The program may also report such information to the Iowa department of health and human services.

70.36(3) If a participant is eligible for benefits through the U.S. Department of Veterans Affairs or other third-party payor, the program first shall seek reimbursement from the identified payor source before seeking reimbursement from the medical assistance program established under Iowa Code chapter 249A.

[ARC 0066D, IAB 2/4/26, effective 3/11/26]

These rules are intended to implement Iowa Code chapter 231D.

Table A



[Filed ARC 8177B (Notice ARC 7959B, IAB 7/15/09), IAB 9/23/09, effective 1/1/10]

[Filed ARC 1376C (Notice ARC 1291C, IAB 1/22/14), IAB 3/19/14, effective 4/23/14]

[Filed ARC 1547C (Notice ARC 1472C, IAB 5/28/14), IAB 7/23/14, effective 8/27/14]

[Filed ARC 1927C (Notice ARC 1860C, IAB 2/4/15), IAB 4/1/15, effective 5/6/15]

[Filed ARC 2463C (Notice ARC 2200C, IAB 10/14/15), IAB 3/16/16, effective 4/20/16]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 71
SUBACUTE MENTAL HEALTH CARE FACILITIES

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

481—71.1(135G) Purpose—subacute mental health services. Subacute mental health services are intended to be short-term, intensive, recovery-oriented services designed to stabilize an individual who is experiencing a decreased level of functioning due to a mental health condition.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.2(135G) Definitions. For the purpose of these rules, the following terms shall have the meanings indicated in this chapter. The definitions set out in Iowa Code section 135G.1 are adopted by reference in the rules.

“Administrator” means an individual who administers, manages, supervises, and is in general administrative charge of a subacute care facility, whether or not such individual has an ownership interest in the facility and whether or not the functions and duties are shared with one or more individuals.

“Assessment” means the evaluation of a person in psychiatric crisis in order to ascertain the person’s current and previous level of functioning, psychiatric and medical history, potential for dangerousness, current psychiatric and medical condition factors contributing to the crisis and support systems that are available.

“Distinct part” means a clearly identifiable area or section within a health care facility, consisting of at least a residential unit, wing, floor, or building containing contiguous rooms.

“Incident” means an unusual occurrence within a facility or on its premises affecting residents, visitors, or employees whether or not there is apparent injury or where hidden injury may have occurred.

“Medication” means any drug including over-the-counter substances ordered and administered under the direction of a physician, physician associate or advanced registered nurse practitioner.

“Peer support” means services that are provided by individuals in recovery from serious mental illness and delivered to others who also have mental illness.

“Psychiatric care” means the provision of care to patients in a psychiatric unit of an acute care hospital; a freestanding psychiatric hospital; or a mental health clinic.

“Recovery” means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

“Recovery principles” means the ten guiding principles of recovery outlined by the federal Substance Abuse and Mental Health Services Administration (www.samhsa.gov): hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, and respect.

“Responsible party” means the person who signs or cosigns the admission agreement required in rule 481—71.13(135G) or the resident’s guardian or conservator if one has been appointed. In the event that a resident does not have a guardian, conservator or other person signing the admission agreement, the term “responsible party” shall include the resident’s sponsoring agency, e.g., the department of human services, the U.S. Department of Veterans Affairs, a religious group, fraternal organization, or foundation that assumes responsibility and advocates for its client patients and pays for their health care.

“Restraint” means the application of physical force, use of a chemical agent, or a mechanical device for the purpose of restraining the free movement of an individual’s body to protect the individual or others from immediate harm. Restraint does not include briefly holding without undue force an individual to calm or comfort the individual or holding an individual’s hand to safely escort the individual from one area to another.

“*Restricted means of egress*” means an exit door alarm system for safety of the residents and the public.

“*Seclusion*” means the involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19; Editorial change: IAC Supplement 6/10/26]

481—71.3(135G) Application for licensure.

71.3(1) *Initial application and licensing.* In order to obtain an initial license for a subacute care facility, the applicant must meet all the requirements of the rules, regulations, and standards contained in Iowa Code chapter 135G and in this chapter and must make application at least 30 days prior to the proposed licensure date of the subacute care facility on forms provided by the department. The applicant must:

- a. Submit a résumé of care with a narrative which includes the following information:
 - (1) The purpose of the facility.
 - (2) A description of the target population and limitations on resident eligibility.
 - (3) Identification and description of the services the facility will provide, which shall minimally include specific and measurable goals and objectives for each of the services to be made available by the facility and a description of the resources needed to provide each of the services, including staff, physical facilities and funds.
 - (4) A description of the human services system available in the area including, but not limited to, social, public health, visiting nurse, vocational training, and employment services, residential living arrangements, and services of private agencies.
 - (5) A description of working relationships with human services agencies when applicable, which shall include at a minimum:
 1. A description of how the facility will coordinate with human services agencies to facilitate continuity of care and coordination of services to residents; and
 2. A description of how the facility will coordinate with human services agencies to identify unnecessary duplication of services and plan for development and coordination of needed services;
- b. Submit a floor plan of each floor of the facility drawn on 8½- × 11-inch paper showing room areas in proportion, room dimensions, room numbers for all rooms, including bathrooms, the designation of the use to which each room will be put, and window and door location;
- c. Submit a photograph of the front and side elevation of the facility;
- d. Submit the statutory fee for a subacute care facility license;
- e. Show evidence of a certificate signed by the state fire marshal or deputy state fire marshal, or the designee of either, certifying compliance with fire safety rules.

71.3(2) *Conversion from an intermediate care facility for persons with mental illness.* An intermediate care facility for persons with mental illness may be converted to a subacute care facility pursuant to Iowa Code section 135G.4(2) if the facility:

- a. Provides written notice to the department that the facility has employed a full-time psychiatrist and desires to make the conversion; and
- b. Submits an application to the department.

71.3(3) *Renewal application or change of ownership.* In order to obtain a renewal or change of the subacute care facility license, the applicant must:

- a. Submit to the department the completed application form 30 days prior to the annual license renewal or change of ownership date;
- b. Submit the statutory license fee for a subacute care facility with the application for renewal or change of ownership;
- c. Have an approved, current certificate signed by the state fire marshal or deputy state fire marshal, or the designee of either, certifying compliance with fire safety rules and regulations; and

d. Submit appropriate changes in the résumé of care to reflect any changes in the resident care program or other services.

71.3(4) Issuance of license. Licenses are issued to the person or governmental unit with 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.

71.3(5) Beds per facility. A single facility shall not be licensed for more than 16 beds.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 2068C, IAB 7/22/15, effective 8/26/15; ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.4(135G) Licenses for distinct parts.

71.4(1) Separate licenses may be issued for distinct parts of a health care facility which are clearly identifiable, include specifically designated rooms within the facility, and provide separate categories of care and services.

71.4(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 the residents within that part;

b. The distinct part shall meet all the standards, rules, and regulations pertaining to the category for which a license is being sought;

c. A distinct part must be operationally and financially feasible.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.5(135G) Waivers.

71.5(1) Waivers from these rules may be granted by the director of the department if, in addition to the requirements of 481—Chapter 6:

a. The need for a waiver has been established consistent with the résumé of care or the resident's individual program plan; and

b. There is no danger to the health, safety, welfare, or rights of any resident.

71.5(2) The waiver will apply only to a subacute care facility.

71.5(3) Waivers shall be reviewed by the department at the time of each licensure survey to verify whether the facility is still eligible for the waiver.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 5719C, IAB 6/16/21, effective 7/21/21]

481—71.6(135G) Provisional license.

71.6(1) Provisional license procedure. The department may issue a provisional license to a subacute care facility pursuant to Iowa Code section 135G.8. The procedure for issuance of a provisional license shall be as follows:

a. The department shall first issue to the facility a report which identifies the deficiency.

b. Within 10 working days after receipt of the report, the facility shall provide the department with a written plan of correction.

c. The department shall review the written plan of correction within 10 working days of receipt. The department may request additional information or revision to the plan, which shall be provided as requested.

d. After accepting the written plan of correction, the department shall then issue a provisional license to the facility, which shall not exceed one year in duration.

71.6(2) Written plan of correction. The written plan of correction shall contain:

a. How the facility will correct the deficient practice;

b. How the facility will act to protect residents;

c. The measures the facility will take or the systems it will alter to ensure that the deficient practice does not recur; and

d. The date when the plan of correction will be completed, not to exceed 30 days from the date of the department's report.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.7(135G) General requirements.

71.7(1) The license shall be displayed in the facility in a conspicuous place which is viewed by the public.

71.7(2) The license shall be valid only for the premises and person named on the license and is not transferable.

71.7(3) The posted license shall accurately reflect the current status of the subacute care facility's license.

71.7(4) A license shall expire one year after the date of issuance or as indicated on the license.

71.7(5) There shall be no more beds added than are stipulated on the license.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.8(135G) Required notifications to the department.

71.8(1) The department shall be notified:

a. Thirty days in advance of any proposed change in the subacute care facility's functional operation or the addition or deletion of required services;

b. Thirty days before any addition, alteration, or new construction is begun in the subacute care facility or on the premises;

c. Thirty days in advance of any closure of the subacute care facility;

d. Within two weeks of any change in administrator;

e. Within 30 days of the date on which any change in the category of license is sought;

f. Within 30 days of any proposed change in the résumé of care for the subacute care facility.

71.8(2) Prior to the purchase, transfer, assignment, or lease of a subacute care facility, the licensee shall:

a. Inform the department of the pending sale, transfer, assignment, or lease of the facility; and

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.

71.8(3) Within 24 hours, or the next business day, by the most expeditious means available, the department shall be notified:

a. Of any accident causing major injury. "Major injury" shall be defined as any injury which:

(1) Results in death; or

(2) Requires admission to a higher level of care for treatment, other than for observation; or

(3) Requires consultation with the attending physician, designee of the physician, physician associate, or advanced registered nurse practitioner who determines, in writing, on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the resident, and the resident's prognosis;

b. When a resident attempts suicide, regardless of injury;

c. When damage to the facility is caused by a natural or other disaster;

d. When a fire occurs in a facility and the fire requires the notification of emergency services, requires full or partial evacuation of the facility, or causes physical injury to a resident;

e. When a defect or failure occurs in the fire sprinkler system for more than 10 hours or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal or the state fire marshal's designee.)

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19; ARC 6974C, IAB 4/5/23, effective 5/10/23; Editorial change: IAC Supplement 6/10/26]

481—71.9(135G) Reports of dependent adult abuse. Reports of suspected dependent adult abuse shall be made to the department of human services.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.10(135G) Administrator.

71.10(1) *Administrator required.* Each subacute care facility shall have one person in charge who is duly approved by the department or acting in a provisional capacity in accordance with these rules.

71.10(2) *Qualifications of an administrator.* The administrator shall be at least 21 years of age and shall have a high school diploma or equivalent. In addition, the person shall meet at least one of the following conditions:

a. Be a mental health professional, as defined in Iowa Code section 228.1(7), with at least one year of experience in an administrative capacity; or

b. Have a four-year degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field and have a minimum of one year of experience in the field; or

c. Have a master's degree in human services, psychology, sociology, nursing, health care administration, public administration, or a related field; or

d. Be a licensed nursing home administrator.

71.10(3) *Administrator—distinct part.* If a subacute care facility is a distinct part of a licensed health care facility, the administrator of the facility as a whole may serve as the administrator of the subacute care facility.

71.10(4) *Provisional administrator.* A provisional administrator may be appointed on a temporary basis by the subacute care facility licensee to assume the administrative responsibilities of the facility for a period not to exceed 12 months when the facility has, through no fault of its own, lost its administrator and has not been able to replace the administrator, provided the department has been notified and has approved the provisional administrator prior to the date of the administrator's appointment. The provisional administrator must meet the requirements of subrule 71.10(2).

71.10(5) *Administrator—initial licensing of facility.* A facility applying for an initial license shall not have a provisional administrator.

71.10(6) *Duties of administrator.* An administrator shall:

a. Be responsible for the implementation of procedures to support the policies established by the licensee;

b. Select and direct competent personnel who provide services for the subacute care facility;

c. Make a policies and procedures manual available to all staff;

d. Be responsible for a monthly in-service educational program for all employees and maintain records of programs and participants;

e. Make staff payroll records available for departmental review as needed;

f. Furnish to the department within 30 days of the department's request statistical information concerning the operation of the facility.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.11(135G) Administration.

71.11(1) The licensee shall:

a. Assume the responsibility for the overall operation of the subacute care facility;

b. Be responsible for compliance with all applicable laws and with the rules of the department;

c. Establish written policies, which shall be available for review, for the operation of the subacute care facility.

71.11(2) The policy and procedures shall include:

a. Personnel;

b. Admission;

c. Evaluation services;

d. Treatment and discharge plan;

e. Crisis intervention, including restraint and seclusion;

f. Involuntary discharge or transfer;

- g.* Medication management;
- h.* Records;
- i.* Resident rights.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.12(135G) Personnel.

71.12(1) Staffing requirements. Availability of personnel must be sufficient to meet psychiatric and medical treatment needs of the residents served.

71.12(2) Staffing shall include at minimum:

- a.* Twenty-four-hour-per-day, seven-day-per-week availability of on-call psychiatrist or advanced registered nurse practitioner with at least one year of experience in psychiatric care;
- b.* Twenty-four-hour-per-day, seven-day-per-week availability of on-call registered nurse with at least two years of experience in psychiatric care or a registered nurse with a bachelor of science in nursing (BSN) and at least one year of experience in psychiatric care;
- c.* A mental health professional as defined in Iowa Code section 228.1(7);
- d.* Direct care staff with at least one year of experience in a mental health care setting; and
- e.* Social service staff at the bachelor level with at least one year of experience in a mental health care setting.

71.12(3) Personnel policies and procedures shall include the following requirements:

- a.* Written job descriptions for all employees or agreements for all consultants, which include duties and responsibilities, education, experience, or other requirements, and supervisory relationships.
- b.* Annual performance evaluations of all employees and consultants which are dated and signed by the employee or consultant and the supervisor.
- c.* Personnel records which are current, accurate, complete, and confidential to the extent allowed by law.
 - (1) The record shall contain documentation of how the employee's or consultant's education and experience are relevant to the position for which the employee or consultant was hired.
 - (2) The record shall contain documentation of criminal history, child abuse and dependent adult abuse record checks, which shall be conducted prior to employment.
- d.* Roles, responsibilities, and limitations of student interns and volunteers.
- e.* An orientation program for all newly hired employees and consultants that includes an introduction to the facility's personnel policies and procedures and a discussion of the facility's safety plan.
- f.* Equal opportunity and affirmative action employment practices.
- g.* Procedures to be used when disciplining an employee.
- h.* Appropriate dress and personal hygiene for staff.
- i.* An overview of recovery principles, person-centered planning and residents' rights.

71.12(4) The facility shall require regular health examinations for all personnel. Employees shall have a health examination within 12 months prior to beginning employment and regular examinations thereafter at least every four years. The examination shall include, at a minimum, the health status of the employee, including screening and testing for tuberculosis as described in 481—Chapter 59.

- a.* No person shall be allowed to provide services in a facility if the person has a disease:
 - (1) Which is transmissible through required workplace contact;
 - (2) Which presents a significant risk of infecting others;
 - (3) Which presents a substantial possibility of harming others; and
 - (4) For which no reasonable accommodation can eliminate the risk.
- b.* There shall be written policies for emergency medical care for employees in case of sudden illness or accident. These policies shall include the administrative individuals to be contacted.
- c.* Health certificates for all employees shall be available for review by the department.

71.12(5) Personnel record.

- a. A personnel record shall be kept for each employee.
- b. The record shall include the employee's:
 - (1) Name and address,
 - (2) Social security number,
 - (3) Date of birth,
 - (4) Date of employment,
 - (5) References,
 - (6) Position in the facility,
 - (7) Job description,
 - (8) Documentation of experience and education,
 - (9) Criminal history, child abuse and dependent adult abuse background checks,
 - (10) Staff training records,
 - (11) Annual performance evaluation,
 - (12) Documentation of disciplinary action,
 - (13) Date and reason for discharge or resignation,
 - (14) Current physical examination.

71.12(6) Orders for medications and treatments shall be correctly implemented by qualified personnel.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.13(135G) Admission, transfer, and discharge.

71.13(1) *General admission policies.*

- a. A subacute care facility shall not admit or retain a resident who is in need of greater services than the facility can provide.
- b. Prior to admission of an applicant, the facility shall obtain sufficient information to determine if its program is appropriate and adequate to meet the individual's needs.
- c. A subacute care facility shall admit only as many residents as indicated by the number of beds for which the facility is licensed.
- d. A subacute care facility shall adopt policies regarding the admission requirements outlined in subrule 71.13(2).

71.13(2) *Admission requirements.*

- a. Eligibility for individualized subacute mental health services will be determined by the standardized preadmission screening utilized by the facility. The screening shall be conducted by a mental health professional as defined in Iowa Code section 228.1(7), a physician, a physician associate, or an advanced registered nurse practitioner.
- b. In order to be admitted, the individual must:
 - (1) Be 18 years or older;
 - (2) During the past year, have had a diagnosable mental, behavioral or emotional disorder that meets the diagnostic criteria specified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM);
 - (3) Demonstrate a high degree of impairment through significantly impaired mental, social, or educational functioning arising from the psychiatric condition or serious emotional disturbance;
 - (4) Demonstrate an impairment that severely limits the skills necessary to maintain an adequate level of functioning outside a treatment program and requires active treatment to obtain an adequate level of functioning;
 - (5) Demonstrate a low level of stability through any two of the following conditions:
 1. The individual presents moderate to high risk of danger to self or others.
 2. The individual lacks adequate skills or social support to address mental health symptoms.
 3. The individual is medically stable but requires observation and care for stabilization of a mental health condition or impairment.

71.13(3) Admission agreement. A subacute care facility shall provide an admission agreement to each resident upon admission to the facility. Each admission agreement shall include:

- a. Method of payment;
- b. Schedule of services and any additional fees;
- c. The facility's policies regarding length of stay, discharge and transfer.

71.13(4) Exclusion criteria.

- a. A subacute care facility shall not admit an individual into the facility if:
 - (1) The individual manifests behavioral or psychiatric symptoms that require acute care;
 - (2) The individual can be safely maintained and effectively treated with less intensive services in a community setting; or
 - (3) The symptoms of the individual do not meet admission criteria in subrule 71.13(2).
- b. An individual's lack of adequate place of residence, placement, or housing is not reason to receive subacute mental health services.

71.13(5) Continued stay criteria policies. By the tenth day following admission and every ten calendar days thereafter, the mental health professional shall conduct and document an assessment of the resident and determine if:

- a. The severity of the behavioral and emotional symptoms continues to require the subacute level of intervention and the DSM diagnosis remains the principal diagnosis.
- b. The prescribed interventions remain consistent with the intended treatment plan outcomes.
- c. There is documented evidence of active, individualized discharge planning.
- d. There is a reasonable likelihood of substantial benefit in the resident's mental health condition as a result of active intervention of the 24-hour supervised program.
- e. Symptoms and behaviors that required admission are continuing.
- f. A less intensive level of care would be insufficient to stabilize the resident's condition.
- g. New issues that meet the admission guidelines in subrule 71.13(2) have appeared.
- h. The resident requires further stabilization subsequent to acute care to treat active mental health symptoms such as psychosis, depression or mood disorder.

71.13(6) Discharge criteria policies. A resident may be discharged from subacute level of care if:

- a. The resident's treatment plan goals and objectives for subacute services have been met and a discharge plan to outpatient or other community-based services is in place.
- b. The resident's physical condition necessitates transfer to a more intensive level of care.
- c. The resident is not making progress toward treatment goals and there is no reasonable expectation of progress at the subacute level of care.
- d. The resident becomes a danger to self, others, or facility structure and requires an emergency transfer to a higher level of care.
- e. The resident repeatedly refuses to participate in the resident's treatment plan.

71.13(7) Discharge or transfer.

- a. The facility shall give prior notification to the resident, as well as the resident's next of kin, legal representative, attending physician or advanced registered nurse practitioner, and sponsoring agency, if any, prior to transfer or discharge of any resident.
- b. The subacute care facility shall make proper arrangements for the welfare of the resident prior to transfer or discharge in the event of an emergency or inability to reach the next of kin or legal representative.
- c. The facility shall make advance notification to the receiving facility prior to the transfer of any resident if the resident is to be transferred to another facility.
 - (1) Notification shall be made no less than 24 hours prior to transfer unless paragraph 71.13(6) "d" applies.
 - (2) Prior to the transfer or discharge of a resident to another health care facility, arrangements to provide for continuity of care shall be made with the facility to which the resident is being transferred.

d. The appropriate record as set forth in subrule 71.20(1) shall accompany the resident when the resident is transferred or discharged.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 2068C, IAB 7/22/15, effective 8/26/15; ARC 4431C, IAB 5/8/19, effective 6/12/19; Editorial change: IAC Supplement 6/10/26]

481—71.14(135G) Treatment plan.

71.14(1) A treatment plan must be developed with each resident. The plan must be based on initial and ongoing assessment of need, be designed to resolve the acute or crisis mental health symptoms or the imminent risk of acute or crisis mental health symptoms, and be completed within six hours of admission, or no later than 12 noon following admission if the resident is admitted between 8 p.m. and 6 a.m.

71.14(2) The treatment plan must be documented in the resident's record and must include the following:

- a.* The resident's name.
- b.* The date the plan is developed.
- c.* Standardized diagnostic formulations, including but not limited to the current Diagnostic and Statistical Manual (DSM) or the current International Statistical Classification of Diseases and Related Health Problems (ICD).
- d.* Problems and strengths of the resident that are to be addressed.
- e.* Observable and measurable individual objectives that relate to the specific problems identified.
- f.* Interventions that address specific objectives, identification of staff responsible for interventions, and planned frequency of interventions.
- g.* Signatures of mental health professionals responsible for developing the plan, including the qualified prescriber.
- h.* Signatures of the resident and any parent, guardian, conservator, or legal custodian. Reasons for refusal to sign or inability to participate in treatment plan development must be documented.
- i.* A projected discharge date and anticipated postdischarge needs, including documentation of resources needed in the community.
- j.* Review of the treatment plan by the appropriate treatment staff at least daily and upon completion of the stated goals or objectives and documentation of the following:
 - (1) Progress toward each treatment objective, with revisions as indicated; and
 - (2) Status of discharge plans, including availability of resources needed by the resident in the community, with revisions as indicated.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.15(135G) Crisis intervention.

71.15(1) There shall be written policies and procedures concerning crisis intervention. These policies and procedures shall be:

- a.* Directed to maximizing the growth and development of the individual by incorporating a hierarchy of available alternative methods that emphasize positive approaches;
- b.* Available in each program area and living unit;
- c.* Available to individuals and their families; and
- d.* Developed with the participation, as appropriate, of individuals served.

71.15(2) An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior and to the individual's chronological and developmental age, size, gender, physical, medical, and psychiatric condition and personal history, including any history of physical or sexual abuse.

[ARC 1740C, IAB 11/26/14, effective 12/31/14]

481—71.16(135G) Seclusion and restraint.

71.16(1) *Use of a seclusion room.* Pursuant to Iowa Code section 135G.3(2), a seclusion room used by a subacute care facility must meet the conditions of 42 CFR § 483.364(b).

a. A subacute care facility utilizing a seclusion room shall have written policies regarding its use. The policy shall:

- (1) Specify the types of behavior that may result in seclusion room placement.
- (2) Delineate the licensed personnel who may authorize use of the seclusion room.
- (3) Require documentation of the time in the seclusion room, the reasons for use of the seclusion room, and the reasons for any extension of time beyond one hour. Under no circumstances shall the use of the seclusion room exceed four hours.

(4) Require notice to residents of the types of behavior that may result in seclusion room placement.

b. A staff member shall always be in hearing distance of the seclusion room, and the resident shall be visually checked by the staff at least every 15 minutes. Every check shall be documented in writing.

c. A seclusion room shall not be used for punishment, for the convenience of staff, or as a substitution for supervision. A seclusion room shall only be used when a less restrictive alternative has failed and:

- (1) In an emergency to prevent injury to the resident or to others; or
- (2) For crisis intervention.

71.16(2) *Use of restraints.* There shall be written policies that define the use of restraint, designate the staff member who may authorize its use, and establish a mechanism for monitoring and controlling its use.

a. Restraint shall not be used for punishment, for the convenience of staff, or as a substitution for supervision. Restraint shall only be used:

- (1) In an emergency to prevent injury to the resident or to others; or
- (2) For crisis intervention.

b. Restraint must not result in harm or injury to the resident and must be used only to ensure the safety of the resident or others during an emergency situation until the emergency situation has ceased, even if the restraint order has not expired.

c. The use of restraint should be selected only when other less restrictive measures have been found to be ineffective to protect the resident or others. The staff shall demonstrate effective treatment approaches and alternatives to the use of restraint.

d. Under no circumstances shall a resident be allowed to actively or passively assist in the restraint of another resident.

e. Staff trained in the use of emergency safety interventions must be physically present and continually assessing and monitoring the well-being of the resident and the safe use of restraint throughout the duration of the emergency situation.

71.16(3) *Orders for restraint or seclusion.* An order for restraint or seclusion shall not be written as a standing order or on an as-needed basis.

a. Each order for restraint or seclusion shall include:

- (1) The name of the ordering physician, physician associate or advanced registered nurse practitioner.
- (2) The date and time the order is obtained.
- (3) The emergency safety intervention ordered, including the length of time for which restraint or seclusion is authorized.

b. Orders for restraint or seclusion must be by a physician, physician associate or advanced registered nurse practitioner.

(1) Verbal orders must be received while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends and must be verified in writing in the resident's record by the physician, physician associate or advanced registered nurse practitioner.

(2) Once the one-time order for the specific resident in an emergency safety situation has expired, it may not be renewed on a planned, anticipated, or as-needed basis.

71.16(4) *Simultaneous use prohibited.* Restraint and seclusion shall not be used simultaneously.

71.16(5) *Documentation of use of restraint or seclusion.* Staff must document in the resident's record and in a centralized tracking system any use of restraint or seclusion.

a. Documentation must be completed by the end of the shift in which the intervention occurs or during the shift in which it ends.

b. Documentation shall include:

- (1) The order for restraint or seclusion.
- (2) The time the emergency safety intervention began and ended.
- (3) The emergency safety situation that required restraint or seclusion.
- (4) The name of staff involved in the emergency safety intervention.
- (5) The interventions used and their outcomes.
- (6) The signature of the physician, physician associate or advanced registered nurse practitioner.

71.16(6) *Meeting to process restraint or seclusion.* As soon as reasonably possible after the restraint or seclusion of a resident has terminated, staff must meet to process the restraint or seclusion occurrence and document in writing the meeting.

71.16(7) *Multiple occasions of restraint or seclusion.* A resident who requires restraint or seclusion on multiple occasions should be considered for a higher level of care.

71.16(8) *Staff training.* The facility shall provide to the staff training by qualified professionals on physical restraint and seclusion theory and techniques.

a. The facility shall keep a record of the training, including attendance, for review by the department.

b. Only staff who have documented training in physical restraint and seclusion theory and techniques shall be authorized to assist with the seclusion or physical restraint of a resident.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19; Editorial change: IAC Supplement 6/10/26]

481—71.17(135G) Medication management.

71.17(1) Medications must be ordered by qualified prescribers and administered by qualified personnel. For purposes of this subrule, "qualified personnel" means, at a minimum, a certified medication aide.

71.17(2) Prescription medication must be legally dispensed and labeled according to state law.

71.17(3) All medication errors, drug reactions and suspected drug overmedication must be documented and reported to the practitioner who prescribed the medication.

71.17(4) All medications and other preparations intended for internal or external human use must be stored in medicine cabinets or drug rooms. When preservation of the medication or other preparation requires refrigeration, the facility must provide a means of securely refrigerating these items. Such cabinets or drug rooms must be kept securely locked when not in use, and the key must be in the possession of the supervising nurse or other authorized person.

71.17(5) Schedule II drugs must be stored within two separately locked compartments at all times and accessible only to qualified personnel in charge of administering medication.

71.17(6) Any unused portions of program-prescribed medication(s) must be either turned over to the resident with written authorization and directions by the qualified prescriber or returned to a pharmacy for proper disposition by the pharmacist.

71.17(7) Whenever a resident brings the resident's own prescribed medications into the facility, such medications must not be administered unless identified by a qualified prescriber or pharmacist and ordered by a qualified prescriber. If such medications cannot be administered, they must be packaged, sealed, and returned to an adult member of the resident's immediate family or the legal guardian or securely stored and returned to the resident upon discharge. However, if previously prescribed medication would prove harmful to the resident, the medication may be withheld from

the resident and disposed of in accordance with subrule 71.17(6). There must be documentation by the qualified prescriber in the resident's clinical record citing the dangers or contraindications of the medication being withheld.

71.17(8) All potent, poisonous, or caustic materials shall be stored separately from medications. All potent, poisonous, or caustic materials shall be plainly labeled and stored in a specific, well-illuminated cabinet, closet or storeroom and made accessible only to authorized personnel.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.18(135G) Dietary.

71.18(1) *Nutrition and menu planning.*

a. Menus shall be planned and followed to meet the nutritional needs of residents.
b. Menus shall be planned and served to include foods and amounts necessary to meet federal dietary guidelines.

c. At least three meals or their equivalent shall be served daily, at regular hours.

71.18(2) *Dietary storage, food preparation, and service.* All food shall be handled, prepared, served and stored in compliance with the Food Code adopted pursuant to Iowa Code section 137F.2.

[ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.19(135G) Buildings, furnishings, and equipment.

71.19(1) *Buildings—general requirements.*

a. All windows shall be supplied with window treatments that are kept clean and in good repair.
b. Whenever glass sliding doors or transparent panels are used, they shall be marked conspicuously.

c. The facility shall meet the equivalent requirements of the appropriate group occupancy of the state fire code.

71.19(2) *Furnishings and equipment.*

a. All furnishings and equipment shall be durable, cleanable, and appropriate to their function.
b. Upholstery materials shall be moisture- and soil-resistant as needed, except on furniture provided by the resident and the property of the resident.

71.19(3) *Dining area and common area.* Every facility shall have a dining area and a common area easily accessible to all residents.

a. A common area shall be maintained for the use of residents and their visitors and may be used for recreational activities. Common areas shall be suitably furnished.

b. Dining areas shall be furnished with dining tables and chairs appropriate to the size and function of the facility. Dining areas and furnishings shall be kept clean and sanitary.

71.19(4) *Bedrooms.*

a. Each resident shall be provided with a twin-sized or larger bed, substantially constructed and in good repair. Rollaway beds, metal cots, or folding beds are not acceptable.

b. Each bed shall be equipped with the following: casters or glides; clean springs in good repair; a clean, comfortable, well-constructed mattress approximately five inches thick and standard in size for the bed; and clean, comfortable pillows of average bed size.

c. Each resident shall have a bedside table with a drawer to accommodate personal possessions.

d. There shall be a comfortable chair, either a rocking chair or armchair, per resident bed. The resident's personal wishes shall be considered.

e. There shall be drawer space for each resident's clothing. In a bedroom in which more than one resident resides, drawer space shall be assigned to each resident.

f. Beds and other furnishings shall not obstruct free passage to and through doorways.

g. Beds shall not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless the radiator is covered so as to protect the resident from contact with it or from excessive heat.

h. There shall be no more than two residents per room.

71.19(5) *Bath and toilet facilities.*

a. There shall be a minimum of one toilet and one sink for each four residents and one shower for each eight residents. For example, a facility with the maximum of 16 beds shall have four toilets and sinks and two showers.

b. All sinks shall have paper towel dispensers and an available supply of soap.

c. Toilet paper shall be readily available to residents.

71.19(6) Heating. A centralized heating system shall be maintained in good working order and capable of maintaining a comfortable temperature for residents of the facility. Portable units or space heaters are prohibited from being used in the facility except in an emergency.

71.19(7) Water supply.

a. Private sources of water supply shall be tested annually and the report made available for review by the department upon request.

b. A bacterially unsafe source of water supply shall be grounds for denial, suspension, or revocation of license.

c. The department may require testing of private sources of water supply at its discretion in addition to the annual test. The facility shall supply reports of such tests as directed by the department.

d. Hot and cold running water under pressure shall be available in the facility.

e. Prior to construction of a new facility or new water source, private sources of water supply shall be surveyed and shall comply with the requirements of the department.

[ARC 4431C, IAB 5/8/19, effective 6/12/19]

481—71.20(135G) Records.

71.20(1) Resident record. The licensee shall keep a permanent record about each resident with all entries current, dated, and signed. The record shall include:

a. Name and previous address of resident;

b. Birth date, sex, and marital status of resident;

c. Provisional or admitting diagnosis;

d. A biopsychosocial history sufficient to provide data on the resident's relevant past history, present situation, social support system, community resource contacts, and other information relevant to appropriate treatment and discharge planning;

e. The name, telephone number and address of the licensed mental health professional completing the biopsychosocial history;

f. Name, address and telephone number of next of kin or legal representative;

g. Name, address and telephone number of the person to be notified in case of emergency;

h. Pharmacy name, telephone number, and address;

i. Written orders for treatment and medications, signed by a physician, physician associate or advanced registered nurse practitioner;

j. Any change in the resident's condition;

k. Notations describing the resident's condition on admission, transfer, and discharge;

l. A copy of instructions given to the resident, legal representative, or facility in the event of discharge or transfer;

m. Individualized treatment and discharge or transfer plan pursuant to rule 481—71.14(135G);

n. Progress notes, including any use of seclusion or restraint pursuant to rule 481—71.16(135G), recorded by the physician, physician associate, advanced registered nurse practitioner or mental health professional and, when appropriate, others significantly involved in active treatment modalities. Progress notes must contain a concise assessment of the resident's progress and recommendations for revising the treatment plan as indicated by the resident's condition;

o. The discharge summary, including a recapitulation of the resident's hospitalization, recommendations for appropriate services concerning follow-up, and a brief summary of the resident's condition on discharge.

71.20(2) Confidentiality of resident records. The facility shall have policies and procedures providing that each resident shall be assured confidential treatment of all information, including information contained in electronic records.

a. The facility shall limit access to any resident records to staff and consultants providing professional services 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. This restriction shall not preclude access by representatives of state or federal regulatory agencies.

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, physician associate, advanced registered nurse practitioner or mental health professional determines the disclosure of the record or a section thereof is contraindicated, in which case the designated information will be redacted prior to making the record available to the resident. This determination and the reasons for it must be documented in the resident's record.

71.20(3) Incident records.

a. Each subacute care facility shall maintain an incident record report and shall have available incident report forms.

b. A report of every unusual occurrence shall be detailed on the printed incident report form.

c. The person in charge at the time of the unusual occurrence shall oversee the preparation of and sign the incident report.

d. A copy of the incident report shall be kept on file in the facility and shall be available for review and a part of administrative records.

71.20(4) Retention of records.

a. 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.

b. When the facility ceases to operate, the resident's record shall be released to the facility to which the resident is transferred. If no transfer occurs, the record shall be released to the individual's physician or advanced registered nurse practitioner.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19; Editorial change: IAC Supplement 6/10/26]

481—71.21(135G) Residents' rights in general.

71.21(1) Policies and procedures. Each facility shall ensure that policies and procedures are written and implemented, include all of the following subrules, and govern all areas of service provided to staff and residents, their families or legal representatives. The policies and procedures shall be available to the public and shall be reviewed annually by the facility.

71.21(2) Grievances. Written policies and procedures shall include a method for submission of grievances and recommendations by residents or their responsible parties and a method to ensure a response and disposition by the facility. The written grievance procedure shall ensure protection of the resident from any form of reprisal or intimidation and shall include:

a. The name of an employee or an alternate staff person designated to be responsible for handling grievances and recommendations; and

b. Methods to investigate and assess the validity of a grievance or recommendation, resolve grievances, and take action.

71.21(3) Informed of rights and responsibilities. Policies and procedures shall include a provision that each resident shall be fully informed of the resident's rights and responsibilities as a resident and of all rules governing resident conduct and responsibilities. This information must be provided upon admission.

a. The facility shall inform residents about what they may expect from the facility and its staff and what is expected from residents.

b. Residents' rights and responsibilities shall be presented in language understandable to the resident. If the facility serves residents who are non-English-speaking or deaf or hard of hearing, steps

shall be taken to translate the information into the person's native language or sign language. In the case of visually impaired residents, either Braille or a recording shall be provided.

c. A statement shall be signed by the resident and legal guardian, if applicable, indicating an understanding of these rights and responsibilities, and the statement shall be maintained in the record. A copy of the signed statement shall be given to the resident or legal guardian.

71.21(4) *Informed of health condition.* Each resident or legal guardian shall be fully informed by a physician, physician associate, advanced registered nurse practitioner or mental health professional of the resident's health and medical condition unless medically contraindicated as documented by a physician, physician associate, advanced registered nurse practitioner or mental health professional in the resident's record.

71.21(5) *Posting of names.* The facility shall post in a prominent area the name, telephone number, and address of the survey agency, the local law enforcement agency and the protection and advocacy agency designated to provide to residents another course of redress.

71.21(6) *Dignity preserved.* Each resident shall be treated with consideration, respect, and full recognition of the resident's dignity and individuality, including privacy in treatment and in care of personal needs.

a. Corporal punishment, verbal abuse, or any other activity that would be damaging to an individual's self-respect shall be prohibited by written policy.

b. Medication shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

c. Staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of the individuality and dignity of human beings.

d. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door shall shield the resident from passersby. People not involved in the care of the residents shall not be present without the resident's consent while the resident is being examined or treated.

e. Staff shall knock and be acknowledged before entering a resident's room unless the resident is not capable of a response. This requirement does not apply under emergency conditions.

71.21(7) *Communications.* Each resident may communicate, associate, and meet privately with persons of the resident's choice, unless to do so would infringe upon the rights of other residents. Each resident may send and receive personal mail unopened unless prohibited in the treatment plan, which requires explicit approval of the resident or legal guardian.

71.21(8) *Visiting hours.* Subject to reasonable scheduling restrictions, visiting policies and procedures shall permit residents to receive visits from anyone they wish. Visiting hours shall be posted.

a. Reasonable, regular visiting hours shall not be less than 12 hours per day and shall take into consideration the special circumstances of each visitor. A particular visitor(s) may be restricted by the facility for one of the following reasons:

- (1) The resident refuses to see the visitor(s).
- (2) The visit would not be in accordance with the treatment plan.
- (3) The visitor's behavior is unreasonably disruptive to the functioning of the facility.

b. Reasons for denial of visitation shall be documented in the resident's records.

71.21(9) *Privacy.* Space shall be provided for residents to receive visitors in comfort and privacy.

71.21(10) *Telephone calls.* Telephones shall be available and accessible for residents to make and receive calls with privacy. Residents who need help shall be assisted in using the telephone.

71.21(11) *Mail.* Arrangements shall be made to provide assistance to residents who require help in reading or sending mail.

71.21(12) *Permission to leave premises.* Residents shall be permitted to leave the facility and environs at reasonable times if permitted in writing by the physician, physician associate, advanced registered nurse practitioner, mental health professional, or administrator.

71.21(13) Resident activities. Each resident may participate in recreational activities as desired unless contraindicated for reasons documented in the resident's record.

71.21(14) Resident property. Each resident may retain and use personal clothing and possessions, as space permits, and cash and other financial instruments, provided that the use of such items is not otherwise prohibited.

a. The personal property shall be kept in a secure location which is convenient to the resident.

b. Residents shall be advised, prior to or at the time of admission, of the kinds and amounts of clothing and possessions permitted for personal use and whether the facility will accept responsibility for maintaining these items, e.g., cleaning and laundry.

c. Any personal clothing or possessions retained by the facility for the resident shall be identified and recorded on admission and the record placed on the resident's chart. The facility shall be responsible for secure storage of items, and the items shall be returned to the resident promptly upon request or upon discharge from the facility.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19; ARC 5711C, IAB 6/16/21, effective 7/21/21; Editorial change: IAC Supplement 6/10/26]

481—71.22(135G) Health and safety.

71.22(1) Emergency care. Each facility shall have written policies and procedures for emergency medical and psychiatric treatment, which shall include immediate notification by the person in charge to the physician, physician associate, advanced registered nurse practitioner or mental health professional of any accident, injury or adverse change in the resident's condition. "Immediate" for purposes of this subrule means within 24 hours.

71.22(2) First-aid kit. A first-aid emergency kit shall be available on each floor.

71.22(3) Infection control. Each facility shall have a written and implemented infection control program.

71.22(4) Safe environment. The licensee of a subacute care facility is responsible for the provision and maintenance of a safe environment for residents and personnel. The subacute care facility shall meet the fire and safety rules as promulgated by the state fire marshal or the state fire marshal's designee.

71.22(5) Disaster. The licensee shall have a written emergency plan to be followed in the event of fire, tornado, explosion, or other emergency.

a. The plan shall be posted.

b. Training shall be provided to ensure that all employees are knowledgeable of the emergency plan. The training shall be documented.

71.22(6) Smoking. A subacute care facility shall follow the smokefree air Act, Iowa Code chapter 142D.

[ARC 1740C, IAB 11/26/14, effective 12/31/14; ARC 4431C, IAB 5/8/19, effective 6/12/19; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 135G.

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[Filed ARC 5711C (Notice ARC 5567C, IAB 4/21/21), IAB 6/16/21, effective 7/21/21]

[Filed ARC 5719C (Notice ARC 5560C, IAB 4/21/21), IAB 6/16/21, effective 7/21/21]

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[Editorial change: IAC Supplement 6/10/26]

IOWA ATHLETIC COMMISSION

CHAPTER 250

GENERAL REQUIREMENTS FOR ATHLETIC COMMISSION EVENTS

[Prior to 7/9/25, see Labor Services Division[875] Ch 169]

Chapter rescission date pursuant to Iowa Code section 17A.7: 2/26/30

481—250.1(90A) Scope and application. Unless otherwise noted, this chapter applies to each event covered by Iowa Code chapter 90A.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—250.2(92) Definitions. The following definitions apply to 481—Chapters 250 through 260:

“*Commissioner*” means the state commissioner of athletics, who is also the director of the department of inspections, appeals, and licensing, or the director’s designee.

“*Physician*” includes a physician associate unless otherwise noted.

“*Professional wrestling*” is an exhibition in which the participants display their skills in a physical struggle against each other for entertainment and does not comprise a bona fide athletic contest or competition.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25; Editorial change: IAC Supplement 6/10/26]

481—250.3(90A) Prohibited events. No promoter shall arrange or advertise:

250.3(1) A match between persons of the opposite sex;

250.3(2) A match between more than two contestants; or

250.3(3) A match with a contestant who is younger than 18 years of age.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—250.4(90A) Advance notice of event. A promoter shall submit advance notice of an event, other than a professional wrestling event, to the commissioner on the form provided by the commissioner at least 60 days prior to the event but not more than six months prior to the event. The advance notice includes:

250.4(1) The date, time, type, and location of the event;

250.4(2) The promoter’s name and contact information;

250.4(3) One-half of the required event license fee;

250.4(4) Whether the event is indoors or outdoors; and

250.4(5) Other relevant information requested by the commissioner on the form.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—250.5(90A) Event license. A promoter may hold a mixed martial arts match, professional boxing match, or wrestling match only if the commissioner has issued an event license.

250.5(1) Application. The promoter shall submit a completed application for a license on the form provided by the commissioner.

a. For a professional wrestling event, the application shall be submitted at least seven days prior to the event and include each of the following:

(1) The promoter’s name, address, telephone number and other contact information as requested by the commissioner;

(2) The event date, venue name, and venue address;

(3) A nonrefundable \$100 event license fee;

(4) The promoter’s signature; and

(5) A bond as described in subparagraph 250.5(1)“*b*”(10).

b. For any other covered event, the application shall be submitted at least 60 days prior to the event and include each of the following:

(1) The date, time, type, and location of the event;

(2) The promoter’s name, address, and contact information;

- (3) One-half of the required event license fee;
- (4) A copy of the medical license of the ringside physician or physician associate;
- (5) The date, time, and location for the weighing of the contestants;
- (6) The emergency medical services company, and the security company;
- (7) The name and contact information for the certified law enforcement officer who will attend the event;
- (8) The date, time, and location of the ringside physician's or physician associate's examination of the contestants;
- (9) Certificates of insurance;
- (10) A bond in the sum of \$5,000, payable to the State of Iowa, conditioned upon the payment of the tax and penalties imposed by Iowa Code chapter 90A, unless the promoter has a current valid bond on file with the department;
- (11) The name and telephone number of the person designated to clean between rounds; and
- (12) Other information requested by the commissioner.

250.5(2) *Event license fees.* The nonrefundable event license fee is \$100 for a professional wrestling event and \$450 for all other covered events. A professional wrestling promoter shall submit the event license fee with the event license application at least 7 days prior to the event. For all other covered events, the promoter shall submit one-half of the event license fee with the advance notice of the event at least 60 days prior to the event, and one-half of the event license fee with the event license application at least 7 days prior to the event.

250.5(3) *Issuance.* The decision to issue an event license is solely within the discretion of the commissioner. The following factors will be considered by the commissioner when deciding whether to issue an event license:

- a.* Date the promoter filed advance notice of event.
- b.* The promoter's prior compliance with Iowa Code chapter 90A and applicable rules.
- c.* Applications for conflicting events.
- d.* Ability of the commissioner to provide staff.
- e.* The promoter's history of canceling events.
- f.* Anticipated tax revenue.
- g.* Completeness of application package.
- h.* Whether the event is indoors or outdoors.

250.5(4) *Revocation.* When the commissioner finds that failure to provide adequate security to maintain public safety requires emergency action, the commissioner may immediately suspend the event license, pending license revocation procedures pursuant to Iowa Code chapter 17A.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25; Editorial change: IAC Supplement 6/10/26]

481—250.6(90A) Promoter responsibilities. The promoter of a professional wrestling event is responsible for subrules 250.6(1) through 250.6(6). All other promoters are responsible for each of the following:

- 250.6(1)** Ensure compliance with Iowa Code chapter 90A and applicable rules.
- 250.6(2)** Ensure that the referees are familiar with and enforce the rules.
- 250.6(3)** Be responsible for the conduct and attendance of all officials and participants.
- 250.6(4)** Ensure that adequate public safety is maintained at all events. Adequate personnel provided by a private security company and at least one certified law enforcement officer shall be furnished by the promoter.
- 250.6(5)** Ensure that a referee inspects the gloves, bandages, and body of each contestant for foreign substances that might be detrimental to an opponent.
- 250.6(6)** Ensure that contestants have closely trimmed fingernails.
- 250.6(7)** Provide officials and participants who are subject to approval by the commissioner.
- 250.6(8)** Be available to the commissioner throughout an event or identify a designee who will be:

- a.* Available to the commissioner throughout an event; and
- b.* Authorized by the promoter to address issues that may arise.

250.6(9) Enter into a written contract with each contestant using the form furnished by the commissioner. Other adequate proof of acceptance of terms will be considered an agreement between a contestant, the contestant's manager and the promoter, pending the actual signing of the contract.

250.6(10) Provide appropriate gloves.

250.6(11) Provide and maintain a container with a solution able to clean bodily fluids from any part of the cage, cage enclosure, or floor.

250.6(12) Ensure that an ambulance and ambulance service authorized at the EMT-B, EMT-I, EMT-P or paramedic specialist level are present at the event. A promoter is fully responsible for all charges assessed by the ambulance service related to the event except:

- a.* Charges covered by insurance.
- b.* Charges for services provided to persons other than participants and officials.

250.6(13) Ensure that contestants are wearing appropriate attire, gloves, and other necessary equipment.

250.6(14) Provide a suitable, clean, and private space for contestants to change clothes.

250.6(15) Submit to the ringside physician or physician associate no later than at the time of the physicals test results showing that each contestant scheduled for the event tested negative for the human immunodeficiency, hepatitis B, and hepatitis C viruses within 12 months prior to the event. The contestant shall not participate and the physician or physician associate shall notify the promoter that the contestant is prohibited from participating for medical reasons if any of the following occurs:

- a.* The promoter does not produce timely proof of testing;
- b.* The test results are positive;
- c.* The laboratory is not properly certified;
- d.* The test was performed more than 12 months prior to the event; or
- e.* The test results are otherwise deficient.

250.6(16) Obtain from a company authorized to do business in the state of Iowa \$10,000 of health insurance coverage on each contestant to provide for medical, surgical and hospital care for injuries sustained and illnesses contracted during the event. If there is a deductible, it shall not exceed \$1,500. If the contestant pays for covered care, the insurance proceeds shall be paid to the contestant or the contestant's beneficiaries as reimbursement for payment. In the event of a claim, payment of the deductible is the sole responsibility of the promoter.

250.6(17) Obtain from a company authorized to do business in the state of Iowa no less than \$10,000 of life insurance coverage on each contestant to cover death caused by injuries sustained or illnesses contracted during the event.

250.6(18) No later than the day of the event, ensure that each contestant makes available to the commissioner's representative suitable proof of age consisting of one of the following documents:

- a.* A certified birth certificate;
- b.* A passport;
- c.* A certified baptismal record;
- d.* A U.S. visa;
- e.* An identification card issued to the contestant by a governmental entity and that includes the contestant's photograph and birth date; or
- f.* A U.S. resident alien card.

250.6(19) Ensure that participants and officials behave in a professional manner at all times.

250.6(20) Ensure that participants and officials refrain from:

- a.* Fighting with anyone other than a scheduled opponent;
- b.* Fighting outside the ring;
- c.* Throwing objects; and
- d.* Making obscene gestures.

250.6(21) Establish through mixedmartialarts.com that no contestant on an amateur card has participated in a reported professional mixed martial arts match.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25; Editorial change: IAC Supplement 6/10/26]

481—250.7(90A) Taxes. No later than 20 days after an event, a promoter shall file with the commissioner a report and pay all taxes due from the event. The report is submitted on the form provided by the commissioner and includes the promoter's business name, name of a contact for the promoter, date of the event, event license number, location of the event, each price for which tickets were offered or sold, number of tickets sold at each price, total gate receipts, and signatures of the licensee and the person who completed the report. The promoter shall submit with the report:

250.7(1) Proof of the number of tickets sold and the price of each ticket, which includes appropriate documentation from a ticketing service, if applicable.

250.7(2) Payment to the Iowa department of inspections, appeals, and licensing for the amount calculated using the report.

[ARC 8835C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

These rules are intended to implement Iowa Code chapter 90A.

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[Editorial change: IAC Supplement 7/9/25]

[Editorial change: IAC Supplement 11/26/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 252 ELIMINATION TOURNAMENTS

[Prior to 9/24/86, Athletics Commissioner[110] Ch 3]

[Prior to 10/21/98, see 347—Ch 98]

[Prior to 8/16/06, see 875—Ch 98]

[Prior to 7/9/25, see Labor Services Division[875] Ch 174]

Chapter rescission date pursuant to Iowa Code section 17A.7: 2/26/30

481—252.1(90A) Purpose and scope. These rules apply to elimination tournaments, which are boxing matches where contestants box one another, two at a time, with one contestant eliminated from the tournament. The elimination continues with winners from the various bouts competing until only one contestant remains undefeated in the weight division. Elimination tournaments are governed by the rules in 481—Chapter 251 and this chapter. Any conflicts between 481—Chapter 251 and this chapter will be resolved in favor of this chapter.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.2(90A) Bouts, rounds and rest periods.

252.2(1) Each bout consists of no more than three rounds. Each round is two minutes in length. A rest period of 90 seconds shall be provided between rounds. No contestant shall be permitted to compete in more than three bouts in any 20-hour period.

252.2(2) In national elimination tournaments, when the ability and conditioning of the contestants are assured, the athletics commissioner may authorize two contestants to participate in a fourth bout that determines the championship, provided all bouts are comprised of three 90-second rounds. Under no circumstances will any participant be permitted to compete more minutes in any one 20-hour period than is authorized under the rule allowing three bouts consisting of three two-minute rounds as set forth in this rule.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.3(90A) Required protective equipment.

252.3(1) Hand protection. Practice wraps (training hand wraps) may be used in lieu of compliance with 481—Chapter 251. Gloves weighing 16 ounces shall be worn by both contestants.

252.3(2) Body protection. All male contestants shall wear a foul proof protective cup. All female contestants shall wear foul proof pelvic area protection and breast protection.

252.3(3) Head protection. The promoter shall provide and the contestants shall wear protective headgear unless the contestant signs a waiver from it.

252.3(4) Mouth protection. A mouthpiece shall be worn by all contestants throughout the bout. If the mouthpiece is knocked from a contestant's mouth, it shall be replaced with no penalty. Any contestant who deliberately spits out a mouthpiece shall be cautioned the first time, the referee shall deduct one point from each judge's scorecard the second time and the contestant will be disqualified the third time. Before being replaced, the mouthpiece will be washed.

252.3(5) Hair protection. Where necessary, hair will be secured in a manner that it will not interfere with the vision or safety of either contestant.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.4(90A) Weight restrictions. Permission must be received from the commissioner before any contestant will be permitted to box an opponent with a weight differential greater than the following:

Contestants	Weight Differential
Under 135 pounds	6 pounds
135-160 pounds	12 pounds
160-190 pounds	18 pounds

Over 190 pounds

No restriction

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.5(90A) Down. In determining a technical knockout (TKO) under 481—Chapter 251, a down includes a standing eight count where a contestant is still standing but is in a semiconscious state and cannot, in the opinion of the referee, continue the bout.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.6(90A) Suspension. A contestant who suffers a knockout or where the referee stops a fight on a technical knockout (TKO) shall not be permitted to box in the state for a period of 30 days. Before being permitted to fight again, the contestant shall be examined by a physician or physician associate approved by the commissioner.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25; Editorial change: IAC Supplement 6/10/26]

481—252.7(90A) Training requirements. Each contestant will have been involved in conditioning for at least 30 days prior to competing in any elimination tournament. Conditioning means a combination of roadwork or jogging and usual training center conditioning exercises. The promoter shall obtain from each contestant prior to the physical examination a written declaration from the contestant, witnessed by at least one other person, that the contestant has met these training requirements.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.8(90A) Judges. Three judges, each located on different sides of the ring, will separately score bouts. The referee will not be permitted to act as a judge in scoring a bout.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.9(90A) Impartiality of timekeeper. The use of lights on each ring post to indicate the final seconds of a round shall not be considered as signals to interested parties. Corner lights may be used only if consistently activated throughout the elimination tournament and all contestants and officials are informed prior to the start of the tournament about the information conveyed by the round lights.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—252.10(90A) Ringside. No person may sit or stand at ringside unless authorized by the commissioner.

[ARC 8840C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

These rules are intended to implement Iowa Code sections 90A.2 and 90A.5.

[Filed emergency 5/4/81—published 5/27/81, effective 5/4/81]

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[Editorial change: IAC Supplement 7/9/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 255
PROFESSIONAL KICKBOXING

[Prior to 10/21/98, see 347—Ch 100]

[Prior to 8/16/06, see 875—Ch 100]

[Prior to 7/9/25, see Labor Services Division[875] Ch 176]

Chapter rescission date pursuant to Iowa Code section 17A.7: 2/26/30

481—255.1(90A) Scope and purpose. Professional kickboxing is a contest within the scope of Iowa Code chapter 90A. The commissioner shall have final decision-making authority concerning the enforcement, implementation, and interpretation of the rules in this chapter.

[ARC 8842C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—255.2(90A) GLORY rules adopted by reference. The commissioner adopts by reference the kickboxing rules and regulations of GLORY Kickboxing as of January 1, 2023. The GLORY Kickboxing rules shall be used for all GLORY Kickboxing matches and events.

[ARC 8842C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—255.3(90A) Professional boxing rules followed. Professional kickboxing will conform to the rules in 481—Chapter 251 on:

1. Limitations on number of bouts;
2. Contestants' arrival; and
3. Attendance of commissioner.

[ARC 8842C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—255.4(90A) Additional provisions.

255.4(1) Officials. The designation of officials, referees, physicians, physician associates, timekeepers, judges, kick counters, scorekeepers, contestants, seconds, and managers is subject to the approval of the commissioner or designee.

255.4(2) “Battles royal” or bouts in which more than two kickboxing contestants are to appear in the ring at the same time shall not be approved.

[ARC 8842C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 90A.

[Filed emergency 9/11/87—published 10/7/87, effective 9/11/87]

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[Editorial change: IAC Supplement 7/9/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 475 ASBESTOS REMOVAL AND ENCAPSULATION

[Prior to 10/18/00, see 875—Chs 81 and 82]

[Prior to 7/9/25, see Labor Services Division[875] Ch 155]

Chapter rescission date pursuant to Iowa Code section 17A.7: 2/26/30

481—475.1(88B) Definitions.

“Business entity” means a partnership, firm, association, corporation, sole proprietorship, or other business concern. A business entity that uses its own employees in removing or encapsulating asbestos for the purpose of renovating, maintaining or repairing its own facilities is not included.

“Contractor/supervisor” means a person who supervises workers on asbestos projects or a person who enters into contracts to perform asbestos projects and personally completes the work.

“Department” means the department of inspections, appeals, and licensing.

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

“Friable asbestos material” means any material containing more than 1 percent asbestos by weight and that can be crumbled, pulverized, or reduced to powder by hand pressure when dry.

“Inspector” means a person who inspects for asbestos-containing building materials in a school or a public or commercial building.

“License” means an authorization issued by the department permitting an individual to be employed as a worker, contractor/supervisor, inspector, management planner, or project designer.

“Management planner” means a person who prepares asbestos management plans for a school building.

“Permit” means an authorization issued by the department permitting a business entity to remove or encapsulate asbestos.

“Project designer” means a person who designs asbestos response or maintenance projects for a school or a public or commercial building.

“Worker” means a person who performs response or maintenance activities on one or more asbestos projects.

“Working days” means Monday through Friday including holidays that fall on Monday through Friday. The first working day shall be the date of actual delivery or the postmark date, whichever is earlier. However, documents with Saturday or Sunday postmark dates will be treated as though postmarked on the following Monday.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.2(88B) Permit application procedures.

475.2(1) Application. To apply for or to renew a permit, a business entity shall complete and submit the form provided by the department. All requested applicable information and attachments must be provided. A \$500 nonrefundable application fee shall accompany each permit application.

475.2(2) Action on application. A new permit is valid for one year from the date of issuance. A renewal permit is valid for one year from the expiration date of the applicant’s prior permit. A permit may be denied for the reasons set forth in rule 481—475.8(17A,88B,252J,272D) or if the application package is incomplete. Within 60 days of receiving a completed application package for a new permit, the department will issue a permit or deny the application. Within 30 days of receiving a completed application package for a permit renewal, the department will issue a permit or deny the application. Applications received after expiration of a prior permit will be considered applications for new permits rather than renewals.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.3(88B) Other asbestos regulations. Regulation of encapsulation, removal and abatement procedures are found in 481—Chapters 210 and 211 and 567—Chapter 23. Nothing in this chapter provides an exemption, waiver, or variance from any otherwise applicable regulation or statute.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.4(88B) Asbestos project records. The permittee shall keep a record of each asbestos project it performs and make the record available to the department at any reasonable time. Records required by this rule shall be kept for at least six years. These records include:

475.4(1) The name, address, and license number of the individual who supervised the asbestos project and of each employee or agent who worked on the project.

475.4(2) The location and a description of the project and the amount of asbestos material that was removed.

475.4(3) The start and completion dates of each instance of removal or encapsulation.

475.4(4) A summary of the procedures that were used to comply with all applicable standards.

475.4(5) The name and address of each asbestos disposal site where the asbestos-containing waste was deposited.

475.4(6) A receipt from the asbestos disposal site indicating the amount of asbestos and disposal date.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.5(88B) Ten-day notices.

475.5(1) General. Permittees shall notify the department at least ten working days before an asbestos project begins. A project begins when site preparations for asbestos abatement, encapsulation, or removal begin; when asbestos abatement, encapsulation, or removal begins; or when any demolition begins, whichever is soonest. Legible electronic transmissions of ten-day notices in the proper format will be accepted. If work on the asbestos-removal project does not commence within 30 calendar days of the original start date identified in the ten-day notice given by permittees to the department, a revised ten-day notice shall be submitted to the department.

475.5(2) Emergency. When there is an immediate danger to life, health or property, the permittee may file the notice within five days after beginning the project. An explanation of the emergency must be included.

475.5(3) Format. The notice shall be submitted online or be on an 8½" by 11" sheet of paper and contain the following information:

a. The name, address, and telephone number of a contact person for the permittee performing the project.

b. The name, address, and telephone number of the project.

c. A description of the structure and work to be performed, including type and quantity of asbestos-containing material.

d. The scheduled dates of the project's start and end.

e. Designation of the asbestos disposal site.

f. The signature and printed name of the person who completed the form.

g. The shift or work schedule on which the project will be performed.

475.5(4) Disaster emergency proclamations. For structures that are both located in an area that is subject to a disaster emergency proclamation pursuant to Iowa Code section 29C.6 and damaged by circumstances related to those that caused the disaster emergency proclamation, the permittee shall file the notice described by this rule as early as possible, but not later than the working day following the initiation of the project. A description of the disaster and the disaster emergency proclamation shall be included in the notice.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.6(88B) License application procedures.

475.6(1) Application form. Except as noted in this subrule, the applicant must complete and submit the entire form provided by the department with the necessary attachments. Respirator fit tests and medical examinations must have occurred within the past 12 months. Only worker and contractor/supervisor license applicants must submit the respiratory protection and physician's or physician associate's certification forms.

475.6(2) *Training.* A certificate of appropriate training as established by the U.S. Environmental Protection Agency must accompany all applications. Applicants for a license must be trained by training providers other than themselves. Applicants who completed initial training under a prior set of applicable rules will not be required to take another initial training course if they complete all annual refresher courses.

475.6(3) *Photograph.* A photograph clearly showing the applicant's face shall accompany all license applications.

475.6(4) *Worker licenses.* All persons seeking a license as an asbestos abatement worker shall complete an initial four-day training course and thereafter complete an annual one-day asbestos abatement worker refresher training course. A nonrefundable fee of \$20 shall accompany the application.

475.6(5) *Contractor/supervisor licenses.* All persons seeking a license as an asbestos abatement contractor/supervisor shall complete an initial five-day training course and thereafter complete an annual one-day asbestos abatement contractor/supervisor refresher training course. A nonrefundable fee of \$50 shall accompany the application.

475.6(6) *Inspector licenses.* All persons seeking a license as an asbestos inspector shall complete an initial three-day training course and thereafter complete an annual one-half-day asbestos inspector refresher training course. A nonrefundable fee of \$20 shall accompany the application.

475.6(7) *Management planner licenses.* All persons seeking a license as an asbestos management planner shall complete an initial three-day inspector training course and an initial two-day management planning training course. Thereafter, an annual one-half-day asbestos inspector refresher training course plus an additional one-half-day course on management planning are required. A nonrefundable fee of \$20 shall accompany the application.

475.6(8) *Abatement project designer licenses.* All persons seeking a license as an asbestos abatement project designer shall complete an initial three-day abatement project designer training course. Thereafter, an annual one-day asbestos abatement project designer refresher training course is required. A nonrefundable fee of \$50 shall accompany the application.

475.6(9) *Action on application.* Within 30 days of receiving a completed application, the department will issue a license or deny the application. If a license is issued, it will expire one year from the date the training was completed. An application may be denied for the reasons set forth in rule 481—475.8(17A,88B,252J,272D) or if the application package is incomplete.

475.6(10) *License on job site.* While conducting asbestos work that requires a license, the license or a legible copy of the license shall be in the licensee's possession at the work site. However, if the department's website reflects that a license has been issued to a particular person, that person may perform work consistent with the type of license issued without the license or a copy of the license for up to 14 days from the issuance date.

475.6(11) *Disaster emergency proclamations.* For work on structures that are both located in an area that is subject to a disaster emergency proclamation pursuant to Iowa Code section 29C.6 and damaged by circumstances related to those that caused the disaster emergency proclamation, the director deems an individual to be licensed and authorized for asbestos abatement if all of the criteria in either paragraph 475.6(11) "a" or "b" are met:

a. The individual contractor, supervisor, or worker makes the following immediately available on the work site:

(1) A copy of a certificate for training that was provided within the past 12 months as established by the U.S. Environmental Protection Agency and that pertains to the work being performed;

(2) A copy of a physician's or physician associate's statement indicating that a licensed physician or physician associate has examined the individual within the past 12 months and approved the individual to work while wearing a respirator;

(3) For a worker wearing or intending to wear a tight-fitting respirator, documentation of a respirator fit test within the past 12 months;

(4) A valid, current asbestos license issued by another state that pertains to the type of work being performed; and

(5) A photo identification card; or

b. The individual working as a project designer, inspector, or management planner makes the following immediately available on the work site:

(1) A copy of a certificate for training as established by the U.S. Environmental Protection Agency and that pertains to the work being performed;

(2) A valid, current asbestos license issued by another state that pertains to the type of work being performed; and

(3) A photo identification card.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25; Editorial change: IAC Supplement 6/10/26]

481—475.7(88B) Duplicate permits and licenses. Duplicate original permits and licenses are available from the department for a \$10 fee.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.8(17A,88B,252J,272D) Denial, suspension and revocation.

475.8(1) Grounds. In addition to the grounds in Iowa Code section 88B.8, the department may deny an application or suspend or revoke a permit or license when an investigation reasonably determines any of the following:

a. The department received a certificate of noncompliance from the centralized collection unit of the department of revenue or the child support recovery unit of the department of health and human services.

b. Penalties or other debts are owed by the applicant to the department and are 30 days or more in arrears.

475.8(2) Relinquishing license or permit. A licensee or permittee must return the original license or permit to the department when a revocation or suspension becomes final.

475.8(3) Suspension period. Unless ordered otherwise, a suspension lasts for 12 months.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

481—475.9(17A,88B) Contested cases.

475.9(1) Scope. This rule applies to civil penalty assessments and to denials, revocations and suspensions of asbestos licenses and permits.

475.9(2) Procedures. The director shall serve a notice of intended action by restricted certified mail, return receipt requested, or by other service as permitted by Iowa Code section 17A.18. A notice of contest must be received by the director within 20 days after service of the notice of intended action. If a notice of contest is not timely filed, the action stated in the notice of intended action shall automatically be effective. Hearing procedures for asbestos contested cases are set forth in 481—Chapter 9. However, if a contested case is based on receipt by the department of a certificate of noncompliance, procedures outlined in Iowa Code chapter 252J or 272D apply.

[ARC 8834C, IAB 1/22/25, effective 2/26/25; Editorial change: IAC Supplement 7/9/25]

These rules are intended to implement Iowa Code chapters 17A, 88B, 252J, and 272D.

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¹ Effective date of Ch 81 delayed seventy days by the Administrative Rules Review Committee.

Exception: See rule 82.11(88B).

Effective date of Ch 82 delayed seventy days by the Administrative Rules Review Committee, IAB 6/5/85.

Effective date (5/15/85) of 82.3(1)“a”(11) delayed by the Administrative Rules Review Committee until the expiration of forty-five calendar days into the 1986 session of the General Assembly pursuant to Iowa Code section 17A.8(9), IAB 7/31/85.

CHAPTER 505
MODEL RULES FOR LICENSEE REVIEW COMMITTEE
[Prior to 7/10/24, see Public Health Department[641] Ch 193]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/8/29

481—505.1(272C) Definitions. For the purpose of these rules, the following definitions apply:

“*Committee*” means the licensee review committee established by a licensing board pursuant to the authority of Iowa Code section 272C.3(1) “k.”

“*Contract*” means the written document establishing the terms for participation in the program.

“*Impairment*” means a condition identified in Iowa Code section 272C.3(1) “k” that renders or, if left untreated, is reasonably likely to render a licensee unable to practice the licensee’s profession with reasonable skill and safety.

“*Initial agreement*” means the written document establishing the initial terms for participation in the program.

“*Licensing board*” or “*board*” means the same as defined in Iowa Code section 272C.1(6).

“*Licensee*” means a person licensed by a licensing board.

“*Self-report*” means written notification provided by the licensee to the program that the licensee has had, has, or may have an impairment. A self-report can be made even if the applicable licensing board has received a complaint or a third party has alleged the same.

[ARC 7753C, IAB 4/3/24, effective 5/8/24; Editorial change: IAC Supplement 7/10/24]

481—505.2(272C) Purpose. The committee assists and monitors the recovery or rehabilitation of practitioners who self-report potential impairments or who are referred by the board. The program is both an advocate for participant health and a means to protect the health and safety of the public.

[ARC 7753C, IAB 4/3/24, effective 5/8/24; Editorial change: IAC Supplement 7/10/24]

481—505.3(272C) Composition of the committee. The division of licensing appoints the members of the committee.

505.3(1) Membership. The committee may be composed of but not limited to members with the following qualifications:

a. A health care professional who has expertise in the area of substance use and addiction treatment.

b. A health care professional who has expertise in the diagnosis and treatment of mental health conditions.

c. A psychiatrist who holds a current, active Iowa license as defined in rule 653—9.1(147,148,150,150A).

d. A licensee who has maintained recovery for a period of no less than two years since successfully completing a recovery program, a board-ordered probation for substance use, or a comparable monitoring program.

e. A licensed physician, physician associate or advanced registered nurse licensee whose specialty area is family practice, internal medicine, or emergency medicine or who has expertise in substance use disorders, mental health conditions or both.

f. A licensed psychiatric pharmacist.

g. A public member.

h. Non-voting members, which may include the board’s executive director, the bureau chief or designee, the bureau chief of monitoring, and, if requested to join the committee for consultation during a participant review, an executive officer or board member under which a participant is regulated.

505.3(2) Officers. At the last meeting of each calendar year, the committee elects co-chairpersons to serve a one-year term beginning January 1.

505.3(3) Terms. Committee members are appointed for a three-year term, for a maximum of three terms. Each term expires on December 31 of the third year of the term. Initial terms are for a period of one to three years as designated by the division to provide continuity to the committee.

[ARC 7753C, IAB 4/3/24, effective 5/8/24; Editorial change: IAC Supplement 7/10/24; Editorial change: IAC Supplement 6/10/26]

481—505.4(272C) Eligibility.

505.4(1) Eligibility. To be eligible for participation in the program, a prospective participant must self-report or be referred by the board for an impairment or potential impairment. The committee will determine for each self-report or referral whether the prospective participant is an appropriate candidate for participation in the program. A prospective participant is ineligible if the committee finds sufficient evidence that the prospective participant:

- a. Diverted medication for distribution to third parties or for personal profit;
- b. Adulterated, misbranded, or otherwise tampered with medication intended for a patient;
- c. Provided inaccurate, misleading, or fraudulent information or failed to fully cooperate with the committee; or
- d. Caused injury or harm to a patient or client.

505.4(2) Board referral. The board may refer a licensee to the program privately, in a public disciplinary order, or other public order if a complaint or investigation reveals an impairment or potential impairment or the board determines that the licensee is an appropriate candidate for review by the committee.

505.4(3) Discretion. Eligibility for participation in the program is at the sole discretion of the committee. No person is entitled to participate in the program.

505.4(4) Limitations. The committee establishes the terms and monitors a participant's compliance with the program specified in the contract. The committee is not responsible for participants who fail to comply with the terms of the program or successfully complete the program. Participation in the program shall not relieve the participant's board of any duties nor divest the board of any authority or jurisdiction otherwise provided. Any violation of the statutes or rules governing the practice of the participant's profession and unrelated to their impairment will be referred to the board for appropriate action.

[ARC 7753C, IAB 4/3/24, effective 5/8/24; Editorial change: IAC Supplement 7/10/24]

481—505.5(272C) Terms of participation in the impaired practitioner recovery program. A participant is responsible for complying with the terms of participation established in the initial agreement and the contract, and for all expenses incurred to comply with the terms imposed by the program. Terms of participation specified in the contract shall include, but not be limited to:

505.5(1) Duration. Length of participation in the program may vary depending upon the review of all relevant information and the nature of the impairment.

505.5(2) Noncompliance. Participants are responsible for notifying the committee of any instance of noncompliance. Notification of noncompliance made to the committee by the participant, a monitoring provider, or another party may result in notice to the board for its consideration of disciplinary action.

a. *First instance.* After a first instance of significant noncompliance, including a relapse, the committee may give notice to the board identifying the participant by number, describing the relevant terms of the participant's contract and the noncompliance, and including the committee's recommendation for continued participation in the program.

b. *Second instance.* After a second instance of significant noncompliance, including a relapse, the committee may refer the case and the participant's identity to the board. In its referral, the committee may make recommendations as to continued participation in the program.

c. *Referral at any time.* The committee may make a referral to the board for noncompliance that identifies the participant by name at any time the circumstances warrant such a referral.

505.5(3) Practice limitations. The committee may impose limitations on a participant's practice as a term of the contract until such time as the committee receives a report from an approved

evaluator that the licensee is capable of practicing with reasonable safety and skill. Participation in the program is conditioned upon participants agreeing to limit practice as requested by the committee and established in accordance with the terms specified in the contract. If a participant refuses to agree to or comply with the limitations established in the initial agreement or contract, the committee will refer the licensee to the board for appropriate action.

505.5(4) *Staff discretion.* Staff, in consultation with legal counsel, may provide guidance and direction to participants between regularly scheduled committee meetings, including program descriptions, interim limitations on practice, and negotiation and execution of initial agreements and contracts on behalf of the committee. The committee retains authority to review all interim decisions at its discretion. Staff may consult with the committee chairperson or medical director if needed.

[ARC 7753C, IAB 4/3/24, effective 5/8/24; Editorial change: IAC Supplement 7/10/24]

481—505.6(272C) Confidentiality. Information in the possession of the board or the committee is subject to the confidentiality requirements of Iowa Code section 272C.6.

505.6(1) Participants must report their participation to the applicable monitoring program or licensing authority in any state in which the participant is currently licensed or in which the participant seeks licensure.

505.6(2) The committee is authorized to communicate information about a participant to any person assisting in the participant's treatment, recovery, rehabilitation, monitoring, or maintenance for the duration of the initial agreement or contract.

505.6(3) The committee is authorized to communicate information about a participant to the board if a participant does not comply with the terms of the contract as set forth in rule 481—505.5(272C).

505.6(4) The committee is authorized to communicate information about a current or former participant to the board if reliable information held by the committee reasonably indicates that a significant risk to the public exists.

505.6(5) If the board initiates disciplinary or other action against a participant or former participant as a result of communication from the committee, the board may include information from the program file in the public documents.

[ARC 7753C, IAB 4/3/24, effective 5/8/24; Editorial change: IAC Supplement 7/10/24; Editorial change: IAC Supplement 4/2/25]

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[Editorial change: IAC Supplement 4/2/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 507
PROFESSIONAL LICENSING DIVISION FEES
[Prior to 9/18/24, see Professional Licensure Division[645] Ch 5]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/31/29

481—507.1(147,152D) Athletic training license fees. All fees are nonrefundable.

- 507.1(1)** License fee for license to practice athletic training is \$120.
- 507.1(2)** Temporary license fee for license to practice athletic training is \$120.
- 507.1(3)** Biennial license renewal fee for each biennium is \$120.
- 507.1(4)** Late fee for failure to renew before expiration is \$60.
- 507.1(5)** Reactivation fee is \$180.
- 507.1(6)** Duplicate or reissued license certificate fee is \$20.
- 507.1(7)** Verification of license fee is \$20.
- 507.1(8)** Returned check fee is \$25.
- 507.1(9)** Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapters 17A, 147, 152D and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.2 Reserved.

481—507.3(147,154D) Behavioral science license fees. All fees are nonrefundable.

507.3(1) License fee for license to practice marital and family therapy or mental health counseling is \$120.

507.3(2) Temporary license fee for license to practice marital and family therapy or mental health counseling is \$120.

507.3(3) License fee for license to practice as a behavior analyst or assistant behavior analyst is \$120. Behavior analyst and assistant behavior analyst licenses issued for less than one year shall not be subject to a renewal fee for the first renewal.

- 507.3(4)** Biennial license renewal fee for each biennium is \$120.
- 507.3(5)** Late fee for failure to renew before expiration is \$60.
- 507.3(6)** Reactivation fee is \$180.
- 507.3(7)** Duplicate or reissued license certificate fee is \$20.
- 507.3(8)** Verification of license fee is \$20.
- 507.3(9)** Returned check fee is \$25.
- 507.3(10)** Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 154D and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.4(151) Chiropractic license fees. All fees are nonrefundable.

- 507.4(1)** License fee for license to practice chiropractic is \$270.
- 507.4(2)** Fee for issuance of annual temporary certificate is \$120.
- 507.4(3)** Biennial license renewal fee is \$120.
- 507.4(4)** Late fee for failure to renew before the expiration date is \$60.
- 507.4(5)** Reactivation fee is \$180.
- 507.4(6)** Duplicate or reissued license certificate fee is \$20.
- 507.4(7)** Fee for verification of license is \$20.
- 507.4(8)** Returned check fee is \$25.
- 507.4(9)** Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapters 17A, 151 and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.5(147,157) Barbering and cosmetology arts and sciences license fees. All fees are nonrefundable.

507.5(1) License fee for license to practice barbering and cosmetology arts and sciences, license by endorsement, license by reciprocity, or an instructor's license is \$60.

507.5(2) Biennial license renewal fee for each license for each biennium is \$60.

507.5(3) Late fee for failure to renew before expiration is \$60.

507.5(4) Reactivation fee for applicants licensed to practice barbering and cosmetology arts and sciences is \$120; for establishments, \$144; and for schools, \$330.

507.5(5) Duplicate or reissued license certificate fee is \$20.

507.5(6) Fee for verification of license is \$20.

507.5(7) Returned check fee is \$25.

507.5(8) Disciplinary hearing fee is a maximum of \$75.

507.5(9) Fee for license to conduct a school teaching barbering and cosmetology arts and sciences is \$600.

507.5(10) Fee for renewal of a school license is \$270 annually.

507.5(11) Establishment license fee is \$80.

507.5(12) Biennial license renewal fee for each establishment license for each biennium is \$80.

507.5(13) Demonstrator and not-for-profit temporary permit fee is \$42 for the first day and \$12 for each day thereafter that the permit is valid.

507.5(14) An initial fee or a reactivation fee for certification to administer microdermabrasion or utilize a certified laser product or an intense pulsed light (IPL) device is \$25 for each type of procedure or certified laser product or IPL device.

507.5(15) An initial fee or a reactivation fee for certification of barbers and cosmetologists to perform shaving for hair removal or administer chemical peels is \$25.

507.5(16) An initial fee and renewal fee for the one-year permit allowing limited services outside of a licensed establishment as outlined in rules 481—943.16(157) and 481—943.22(157) is \$40.

This rule is intended to implement Iowa Code section 147.80 and chapter 157.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.6(147,152A) Dietetics license fees. All fees are nonrefundable.

507.6(1) License fee for license to practice dietetics, license by endorsement, or license by reciprocity is \$120.

507.6(2) Biennial license renewal fee for each biennium is \$120.

507.6(3) Late fee for failure to renew before expiration is \$60.

507.6(4) Reactivation fee is \$180.

507.6(5) Duplicate or reissued license certificate fee is \$20.

507.6(6) Verification of license fee is \$20.

507.6(7) Returned check fee is \$25.

507.6(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 152A and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.7(147,154A) Hearing aid specialists license fees. All fees are nonrefundable.

507.7(1) Application fee for a license to practice by examination, endorsement, or reciprocity is \$156.

507.7(2) Renewal of license fee is \$60.

507.7(3) Temporary permit fee is \$42.

507.7(4) Late fee is \$60.

507.7(5) Reactivation fee is \$120.

507.7(6) Duplicate or reissued license certificate fee is \$20.

507.7(7) Verification of license fee is \$20.

507.7(8) Returned check fee is \$25.

507.7(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapter 154A.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.8(147) Massage therapy license fees. All fees are nonrefundable.

507.8(1) License fee for license to practice massage therapy is \$120.

507.8(2) Biennial license renewal fee for each biennium is \$60.

507.8(3) Temporary license fee for up to one year is \$120.

507.8(4) Late fee for failure to renew before expiration is \$60.

507.8(5) Reactivation fee is \$120.

507.8(6) Duplicate or reissued license certificate fee is \$20.

507.8(7) Verification of license fee is \$20.

507.8(8) Returned check fee is \$25.

507.8(9) Disciplinary hearing fee is a maximum of \$75.

507.8(10) Initial application fee for approval of massage therapy education curriculum is \$120.

This rule is intended to implement Iowa Code chapters 17A, 147 and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.9(147,156) Mortuary science license fees. All fees are nonrefundable.

507.9(1) License fee for license to practice funeral directing is \$120.

507.9(2) Biennial funeral director's license renewal fee for each biennium is \$120.

507.9(3) Late fee for failure to renew before expiration is \$60.

507.9(4) Reactivation fee for a funeral director is \$180 and for a funeral establishment or cremation establishment is \$150.

507.9(5) Duplicate or reissued license certificate fee is \$20.

507.9(6) Verification of license fee is \$20.

507.9(7) Returned check fee is \$25.

507.9(8) Disciplinary hearing fee is a maximum of \$75.

507.9(9) Funeral establishment or cremation establishment fee is \$90.

507.9(10) Three-year renewal fee of funeral establishment or cremation establishment is \$90.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 156 and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.10(147,155) Nursing home administrators license fees. All fees are nonrefundable.

507.10(1) License fee for license to practice nursing home administration is \$120.

507.10(2) Biennial license renewal fee for each license for each biennium is \$60.

507.10(3) Late fee for failure to renew before expiration is \$60.

507.10(4) Reactivation fee is \$120.

507.10(5) Duplicate or reissued license certificate fee is \$20.

507.10(6) Verification of license fee is \$20.

507.10(7) Returned check fee is \$25.

507.10(8) Disciplinary hearing fee is a maximum of \$75.

507.10(9) Provisional license fee is \$120.

This rule is intended to implement Iowa Code section 147.80 and chapter 155.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.11(147,148B) Occupational therapy license fees. All fees are nonrefundable.

507.11(1) License fee for an occupational therapist or occupational therapist assistant license to practice occupational therapy is \$120.

507.11(2) Biennial license renewal fee to practice occupational therapy is \$60.

507.11(3) Biennial license renewal fee for an occupational therapy assistant is \$60.

- 507.11(4) Late fee for failure to renew before expiration is \$60.
- 507.11(5) Reactivation fee is \$120.
- 507.11(6) Duplicate or reissued license certificate fee is \$20.
- 507.11(7) Verification of license fee is \$20.
- 507.11(8) Returned check fee is \$25.
- 507.11(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148B and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.12(147,154) Optometry license fees. All fees are nonrefundable.

507.12(1) License fee for license to practice optometry, license by endorsement, or license by reciprocity is \$300.

- 507.12(2) Biennial license renewal fee for each biennium is \$144.
- 507.12(3) Late fee for failure to renew before expiration date is \$60.
- 507.12(4) Reactivation fee is \$204.
- 507.12(5) Duplicate or reissued license certificate fee is \$20.
- 507.12(6) Verification of license fee is \$20.
- 507.12(7) Returned check fee is \$25.
- 507.12(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code chapters 17A, 147, 154 and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.13(147,148A) Physical therapy license fees. All fees are nonrefundable.

507.13(1) License fee for license to practice physical therapy or as a physical therapist assistant is \$120.

- 507.13(2) Biennial license renewal fee for a physical therapist is \$60.
- 507.13(3) Biennial license renewal fee for a physical therapist assistant is \$60.
- 507.13(4) Late fee for failure to renew before expiration is \$60.
- 507.13(5) Reactivation fee is \$120.
- 507.13(6) Duplicate or reissued license certificate fee is \$20.
- 507.13(7) Verification of license fee is \$20.
- 507.13(8) Returned check fee is \$25.
- 507.13(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148A and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.14(148C) Physician associates license fees. All fees are nonrefundable.

- 507.14(1) Application fee for a license is \$120.
- 507.14(2) Fee for a temporary license is \$120.
- 507.14(3) Renewal of license fee is \$120.
- 507.14(4) Late fee for failure to renew before expiration is \$60.
- 507.14(5) Reactivation fee is \$180.
- 507.14(6) Duplicate or reissued license certificate fee is \$20.
- 507.14(7) Fee for verification of license is \$20.
- 507.14(8) Returned check fee is \$25.
- 507.14(9) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148C and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—507.15(147,148F,149) Podiatry license fees. All fees are nonrefundable.

507.15(1) License fee for license to practice podiatry, license by endorsement, or license by reciprocity is \$400.

507.15(2) License fee for temporary license to practice podiatry is \$200.

507.15(3) The fee for a license to practice orthotics, prosthetics, or pedorthics received on or before July 1, 2015, shall be \$600. The fee for a license to practice orthotics, prosthetics, or pedorthics received after July 1, 2015, shall be \$400.

507.15(4) Biennial license renewal fee is \$400 for each biennium.

507.15(5) Reactivation fee is \$460.

507.15(6) Temporary license renewal fee is \$200.

507.15(7) Late fee for failure to renew before expiration is \$60.

507.15(8) Duplicate or reissued license certificate fee is \$20.

507.15(9) Verification of license fee is \$20.

507.15(10) Returned check fee is \$25.

507.15(11) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 148F, 149 and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.16(147,154B) Psychology license fees. All fees are nonrefundable.

507.16(1) License fee for license to practice psychology is \$120.

507.16(2) Biennial license renewal fee is \$170.

507.16(3) Late fee for failure to renew before expiration is \$60.

507.16(4) Reactivation fee is \$230.

507.16(5) Duplicate or reissued license certificate fee is \$20.

507.16(6) Verification of license fee is \$20.

507.16(7) Returned check fee is \$25.

507.16(8) Disciplinary hearing fee is a maximum of \$75.

507.16(9) Processing fee for exemption to licensure is \$60.

507.16(10) Certification fee for a health service provider is \$60.

507.16(11) Biennial renewal fee for certification as a certified health service provider in psychology is \$60.

507.16(12) Reactivation fee for certification as a certified health service provider in psychology is \$60.

507.16(13) Provisional license fee is \$120.

507.16(14) Provisional license renewal fee is \$170.

This rule is intended to implement Iowa Code sections 147.80 and 154B.6 and chapters 17A, 154B and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.17(147,152B) Respiratory care and polysomnography license fees. All fees are nonrefundable.

507.17(1) Initial license fee.

a. The initial license fee for a respiratory care practitioner license is \$75, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

b. The initial license fee for a polysomnographic technologist license is \$75, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa DCI and the FBI.

c. The initial license fee for a respiratory care and polysomnography practitioner license is \$90, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa DCI and the FBI.

507.17(2) Biennial license renewal fee for each biennium.

a. The biennial license renewal fee for each biennium for a respiratory care practitioner license is \$75.

b. The biennial license renewal fee for each biennium for a polysomnographic technologist license is \$75.

c. The biennial license renewal fee for each biennium for a respiratory care and polysomnography practitioner license is \$90.

507.17(3) Late fee for failure to renew before expiration is \$60.

507.17(4) Reactivation fee.

a. The reactivation fee to practice respiratory care is \$135, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa DCI and the FBI if the license has been on inactive status for two or more years.

b. The reactivation fee to practice as a polysomnographic technologist is \$135, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa DCI and the FBI if the license has been on inactive status for two or more years.

c. The reactivation fee to practice respiratory care and polysomnography is \$150, plus the cost for evaluation of the fingerprint packet and the criminal history background checks by the Iowa DCI and the FBI if the license has been on inactive status for two or more years.

507.17(5) Duplicate or reissued license certificate fee is \$20.

507.17(6) Verification of license fee is \$20.

507.17(7) Returned check fee is \$25.

507.17(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.8 and chapters 17A, 152B and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.18(147,154E) Sign language interpreters and transliterators license fees. All fees are nonrefundable.

507.18(1) License fee for license to practice interpreting or transliterating is \$120.

507.18(2) License fee for temporary license to practice interpreting or transliterating is \$120.

507.18(3) Biennial license renewal fee for each biennium is \$120.

507.18(4) Late fee for failure to renew before expiration is \$60.

507.18(5) Duplicate or reissued license certificate fee is \$20.

507.18(6) Verification of license fee is \$20.

507.18(7) Returned check fee is \$25.

507.18(8) Disciplinary hearing fee is a maximum of \$75.

507.18(9) Reactivation fee is \$180.

This rule is intended to implement Iowa Code chapters 17A, 147, 154E and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.19(147,154C) Social work license fees. All fees are nonrefundable.

507.19(1) License fee for license to practice social work is \$120.

507.19(2) Biennial license renewal fee for a license at the bachelor's level is \$72; at the master's level, \$120; and at the independent level, \$144.

507.19(3) Late fee for failure to renew before expiration is \$60.

507.19(4) Reactivation fee for a license at the bachelor's level is \$132; at the master's level, \$180; and at the independent level, \$204.

507.19(5) Duplicate or reissued license certificate fee is \$20.

507.19(6) Verification of license fee is \$20.

507.19(7) Returned check fee is \$25.

507.19(8) Disciplinary hearing fee is a maximum of \$75.

This rule is intended to implement Iowa Code section 147.80 and chapters 17A, 154C and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

481—507.20(147) Speech pathology and audiology license fees. All fees are nonrefundable.

507.20(1) License fee for license to practice speech pathology or audiology, temporary clinical license, license by endorsement, or license by reciprocity is \$120.

507.20(2) Biennial license renewal fee for each biennium is \$96.

507.20(3) Late fee for failure to renew before expiration is \$60.

507.20(4) Reactivation fee is \$156.

507.20(5) Duplicate or reissued license certificate fee is \$20.

507.20(6) Verification of license fee is \$20.

507.20(7) Returned check fee is \$25.

507.20(8) Disciplinary hearing fee is a maximum of \$75.

507.20(9) Temporary clinical license renewal fee is \$60.

507.20(10) Temporary permit fee is \$30.

This rule is intended to implement Iowa Code chapters 17A, 147 and 272C.

[ARC 8078C, IAB 6/26/24, effective 7/31/24; Editorial change: IAC Supplement 9/18/24]

[Filed 3/19/08, Notice 11/21/07—published 4/9/08, effective 5/14/08]

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[Filed ARC 1192C (Notice ARC 0942C, IAB 8/7/13), IAB 11/27/13, effective 1/1/14]

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[Filed ARC 4557C (Notice ARC 4389C, IAB 4/10/19), IAB 7/17/19, effective 8/21/19]

[Filed ARC 5751C (Notice ARC 5367C, IAB 12/30/20), IAB 7/14/21, effective 8/18/21]

[Filed ARC 6464C (Notice ARC 6180C, IAB 2/9/22), IAB 8/10/22, effective 9/14/22]

[Filed ARC 6549C (Notice ARC 6401C, IAB 7/13/22), IAB 10/5/22, effective 11/9/22]

[Filed ARC 6938C (Notice ARC 6769C, IAB 12/28/22), IAB 3/8/23, effective 4/12/23]

[Filed ARC 6983C (Notice ARC 6814C, IAB 1/11/23), IAB 4/19/23, effective 5/24/23]

[Filed ARC 8078C (Notice ARC 7306C, IAB 1/24/24), IAB 6/26/24, effective 7/31/24]

[Editorial change: IAC Supplement 9/18/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 655
STANDARDS OF PRACTICE AND PRINCIPLES OF MEDICAL ETHICS

[Prior to 5/4/88, see 470—135.251 through 135.402]

[Prior to 6/11/25, see Medicine Board[653] Ch 13]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

481—655.1(148,272C) Standards of practice—packaging, labeling and records of prescription drugs dispensed by a physician.

655.1(1) A physician shall dispense a prescription drug only in a container that meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. Sections 1471-1476 (2001), unless otherwise requested by the patient, and of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. Section 301 et seq. (2001).

655.1(2) A label affixed to a container in which a prescription drug is dispensed by a physician shall include:

- a. The name and address of the physician.
- b. The name of the patient.
- c. The date dispensed.
- d. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician.
- e. The name and strength of the prescription drug in the container.

655.1(3) The provisions of subrules 655.1(1) and 655.1(2) shall not apply to packaged drug samples.

655.1(4) Physicians must document all prescription drugs dispensed to patients, including required label information. Noting such information on the patient's chart or record maintained by the physician is sufficient.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.2(124,148,272C) Standards of practice—appropriate pain management.

655.2(1) Standards. This rule establishes standards of practice for the management of acute and chronic pain. The board encourages the use of nonopioid pharmacologic therapy and nonpharmacologic therapy.

a. This rule is intended to encourage appropriate pain management, including the use of opioids for the treatment of pain, while stressing the need to establish safeguards to minimize the potential for substance abuse and drug diversion.

b. The goal of pain management is to treat each patient's pain in relation to the patient's overall health. At the end of life, the goals may shift to palliative care.

c. Pain management is an important part of medical practice. Unmanaged or inappropriately treated pain impacts patients' quality of life, reduces patients' ability to be productive members of society, and increases patients' use of health care services.

d. Physicians treating pain with opioids in a manner consistent with appropriate pain management practices should not fear board action. Dosage is not the sole measure of determining whether a physician has complied with appropriate pain management practices. The board recognizes the complexity of treating patients with chronic pain or a substance abuse history. Generally, the board is concerned about a pattern of improper pain management or a single occurrence of willful or gross overtreatment or undertreatment of pain.

e. Inappropriate pain management is a departure from the acceptable standard of practice in Iowa and may be grounds for disciplinary action.

655.2(2) Definitions. For the purposes of this rule, the following terms are defined as follows:

"Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Generally, acute pain is self-limited, lasting no more than a few weeks following the initial stimulus.

“Addiction” means a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

“Chronic pain” means pain that lasts longer than three months or past the time of normal tissue healing.

“Pain” means an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Pain is an individual, multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.

“Physical dependence” means a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

“Pseudoaddiction” means an iatrogenic syndrome resulting from the misinterpretation of relief-seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief-seeking behaviors resolve upon institution of effective analgesic therapy.

“Substance abuse” means the use of a drug, including alcohol, by the patient in an inappropriate manner that may cause harm to the patient or others, or the use of a drug for an indication other than that intended by the prescribing clinician. An abuser may or may not be physically dependent on or addicted to the drug.

“Tolerance” means a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

“Undertreatment of pain” means the failure to properly assess, treat and manage pain or the failure to appropriately document a sound rationale for not treating pain.

655.2(3) *Laws and regulations.* Nothing in this rule relieves a physician from fully complying with applicable federal and state laws and regulations.

655.2(4) *Undertreatment of pain.* The undertreatment of pain is a departure from the acceptable standard of practice in Iowa. Undertreatment may include a failure to recognize symptoms and signs of pain, a failure to treat pain within a reasonable amount of time, a failure to allow interventions, e.g., analgesia, to become effective before invasive steps are taken, a failure to address pain needs in patients with reduced cognitive status, a failure to use opioids for terminal pain due to the physician’s concern with addicting the patient, or a failure to use an adequate level of pain management.

655.2(5) *Assessment and treatment of acute and chronic pain.* Appropriate assessment of the etiology of the pain is essential to the appropriate treatment of acute and chronic pain.

a. Prescribing opioids for the treatment of acute and chronic pain should only be accomplished within an established physician-patient relationship and should be based on clearly diagnosed and documented pain. Appropriate management of acute and chronic pain should include an assessment of the mechanism, type and intensity of pain. The patient’s medical record should clearly document a medical history, a pain history, a clinical examination, a medical diagnosis and a treatment plan.

b. A physician who prescribes, dispenses or administers opioids to patients for the treatment of chronic pain should become familiar with the U.S. Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain published on March 15, 2016.

655.2(6) *Effective management of chronic pain.* To ensure that chronic pain is properly assessed and treated, a physician who prescribes, dispenses or administers opioids to a patient for the treatment of chronic pain shall exercise sound clinical judgment and establish an effective pain management plan in accordance with the following:

a. Patient evaluation. Prior to the patient starting treatment, a patient evaluation must be conducted that includes a physical examination, a comprehensive medical history, pain assessment,

and examination of physical and psychological function. This evaluation should also cover diagnostic studies, past interventions, medication and substance abuse history, and any underlying conditions. Depending on the complexity of the case and the physician's expertise, consultation or referral to specialists in pain medicine, addiction medicine, or areas associated with the patient's pain may be necessary. Interdisciplinary evaluation is recommended.

b. Treatment plan. The physician must create a tailored treatment plan addressing the patient's individual needs, outlining treatment objectives such as pain relief or improved functioning, and indicating any planned diagnostic evaluations or treatments. The plan should include other treatment modalities and rehabilitation programs used. Short- and long-term pain relief needs should be considered, along with the patient's ability to request pain relief and the patient's setting. Whenever possible, opioids should be prescribed by one physician and filled at one pharmacy.

c. Informed consent. A discussion of the risks and benefits of opioids with the patient or person representing the patient must be documented.

d. Periodic review. The physician must regularly review the patient's drug treatment course and pain source. Drug therapy should be adjusted to meet individual patient needs, based on progress toward treatment plan objectives. If reviews show treatment plan objectives are not being met or indicate diversion or substance abuse patterns, the physician should reconsider drug therapy and explore other treatment options. Long-term opioid use may lead to tolerance and abnormal pain sensitivity, meaning increasing doses may not improve pain control or function.

e. Consultation/referral. A specialty consultation, including with a physician with expertise in addiction medicine or substance abuse counseling, may be considered if there is evidence of significant adverse effects, lack of response to the medication, diversion, or a pattern of substance abuse. The board encourages a multidisciplinary approach to chronic pain management.

f. Documentation. The physician shall keep accurate, timely, and complete records that detail compliance with this subrule, including patient evaluation, diagnostic studies, treatment modalities, treatment plan, informed consent, periodic review, consultation, and any other relevant information about the patient's condition and treatment.

g. Pain management agreements. Physicians treating chronic pain with opioids should consider implementing a pain management agreement with each patient outlining medication use rules and consequences for misuse. The decision to use such an agreement should be based on individual patient evaluation, weighing risks and benefits of long-term opioid treatment. If opioid treatment exceeds 90 days for chronic pain, and there is a concern for drug abuse or diversion, a pain management agreement should be used. If a physician opts not to use a pain management agreement, reasons should be documented in the patient's medical records. Pain management agreements are not required for hospice or nursing home patients.

h. Substance abuse history or comorbid psychiatric disorder. A patient's prior history of substance abuse does not necessarily contraindicate appropriate pain management. However, treatment of patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care and communication with the patient, monitoring, documentation, and consultation with or referral to an expert in the management of such patients. The board strongly encourages a multidisciplinary approach for pain management of such patients that incorporates the expertise of other health care professionals.

i. Drug testing. A physician who prescribes opioids to a patient for more than 90 days for the treatment of chronic pain should consider utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications or if the physician has reason to believe that the patient is at risk of drug abuse or diversion.

j. Termination of care. The physician should consider termination of patient care if there is evidence of noncompliance with the rules for medication use, drug diversion, or a repeated pattern of substance abuse.

655.2(7) *Pain management for terminal illness.* The provisions of this subrule apply to patients who are at the stage in the progression of cancer or other terminal illness when the goal of pain

management is comfort care. When the goal of treatment shifts to comfort care rather than cure of the underlying condition, the board recognizes that the dosage level of opioids to control pain may exceed dosages recommended for chronic pain and may come at the expense of patient function. The determination of such pain management should involve the patient, if possible, and others the patient has designated for assisting in end-of-life care.

655.2(8) *Prescription monitoring program.* The board of pharmacy established a prescription monitoring program pursuant to Iowa Code sections 124.551 through 124.558 to help prescribers and pharmacists track controlled substance prescriptions. Physicians must register for this program when applying for or renewing their controlled substance prescribing registration. Before prescribing opioids, physicians or their agents must use the program to guide treatment decisions and enhance patient care quality. However, utilization is not required for patients in inpatient hospice care or long-term residential facilities. Orders in hospital settings are not considered prescriptions under these rules, as patient safety is managed within these settings.

655.2(9) *Electronic prescriptions.* Beginning January 1, 2020, all prescriptions (controlled and noncontrolled substances) are to be transmitted electronically as electronic prescriptions pursuant to Iowa Code section 124.308. A prescription shall be transmitted to a pharmacy by the physician or the physician's authorized agent in compliance with federal law and regulation for electronic prescriptions of controlled substances.

655.2(10) *Pain management resources.* The board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain. This list is provided for the convenience of licensees, and the publications included are not intended to be incorporated in the rule by reference.

a. American Academy of Hospice and Palliative Medicine or AAHPM is the American Medical Association-recognized specialty society of physicians who practice in hospice and palliative medicine in the United States. The mission of the AAHPM is to enhance the treatment of pain at the end of life.

b. American Academy of Pain Medicine or AAPM is the American Medical Association-recognized specialty society of physicians who practice pain medicine in the United States. The mission of the AAPM is to enhance pain medicine practice by promoting a climate conducive to the effective and efficient practice of pain medicine.

c. American Pain Society or APS is the national chapter of the International Association for the Study of Pain, an organization composed of physicians, nurses, psychologists, scientists and other professionals who have an interest in the study and treatment of pain. The mission of the APS is to serve people in pain by advancing research, education, treatment and professional practice.

d. DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain. On August 28, 2006, the Drug Enforcement Agency (DEA) issued a policy statement establishing guidelines for practitioners who dispense controlled substances for the treatment of pain. This policy statement may be helpful to practitioners who treat pain with controlled substances.

e. Interagency Guideline on Prescribing Opioids for Pain. Developed by the Washington State Agency Medical Directors' Group in collaboration with an expert advisory panel, actively practicing providers and public stakeholders, the guideline focuses on evidence-based treatment for chronic-pain patients. The guideline was published in 2007 and updated in 2015.

f. Responsible Opioid Prescribing: A Physician's Guide. In 2007, in collaboration with author Scott Fishman, M.D., the Federation of State Medical Boards' (FSMB's) Research and Education Foundation published a book on responsible opioid prescribing based on the FSMB Model Policy for the Use of Controlled Substances for the Treatment of Pain.

g. World Health Organization: Pain Relief Ladder. Cancer pain relief and palliative care. Technical report series 804. Geneva: World Health Organization.

h. CDC Guideline for Prescribing Opioids for Chronic Pain as referenced in paragraph 655.2(4) "b."

655.2(11) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules, the rules found in 481—Chapter 661, or any of the following:

- a.* A physician who prescribes opioids in dosage amounts exceeding what would be prescribed by a reasonably prudent physician in the state of Iowa acting in the same or similar circumstances.
- b.* A physician who knowingly fails to comply with the confidentiality requirements of Iowa Code section 124.553 or who delegates program information access to another individual except as provided in Iowa Code section 124.553.
- c.* A physician who knowingly fails to comply with other requirements of Iowa Code chapter 124.

655.2(12) *Unlawful access, disclosure, or use of information.* A person who intentionally or knowingly accesses, uses, or discloses information from the prescription monitoring program in violation of Iowa Code section 124.553, unless otherwise authorized by law, is guilty of a class “D” felony. This subrule shall not preclude a physician who requests and receives information from the prescription monitoring program consistent with the requirements of Iowa Code section 124.553 from otherwise lawfully providing that information to any other person for medical care purposes.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.3(147,148) Standards of practice—chelation therapy. Chelation therapy or disodium ethylene diamine tetra acetic acid (EDTA) may only be used for the treatment of heavy metal poisoning or in the clinical setting when a licensee experienced in clinical investigations conducts a carefully controlled clinical investigation of its effectiveness in treating other diseases or medical conditions under a research protocol that has been approved by an institutional review board of the University of Iowa or Des Moines University—Osteopathic Medical Center.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.4(79GA,HF726) Standards of practice—automated dispensing systems. A physician who dispenses prescription drugs via an automated dispensing system or a dispensing system that employs technology may delegate nonjudgmental dispensing functions to staff assistants in the absence of a pharmacist or physician provided that the physician utilizes an internal quality control assurance plan that ensures that the medication dispensed is the medication that was prescribed. The physician must be physically present to determine the accuracy and completeness of any medication that is reconstituted prior to dispensing.

655.4(1) An internal quality control assurance plan shall include the following elements:

- a.* The name of the physician responsible for the plan and testing;
- b.* Methods that the dispensing system employs to ensure the accuracy of the patient’s name and medication, dosage, directions and amount of medication prescribed;
- c.* Standards that the physician expects to be met to ensure the accuracy of the dispensing system and the training and qualifications of staff members assigned to dispense via the dispensing system;
- d.* The procedures utilized to ensure that the physician(s) dispensing via the automated system provide(s) patients counseling regarding the prescription drugs being dispensed;
- e.* Staff training and qualifications for dispensing via the dispensing system;
- f.* A list of staff members who meet the qualifications and who are assigned to dispense via the dispensing system;
- g.* A plan for testing the dispensing system and each staff member assigned to dispense via the dispensing system;
- h.* The results of testing that show compliance with the standards prior to implementation of the dispensing system and prior to approval of each staff member to dispense via the dispensing system;
- i.* A plan for interval testing of the accuracy of dispensing, at least annually; and
- j.* A plan for addressing inaccuracies, including discontinuing dispensing until the accuracy level can be reattained.

655.4(2) Those dispensing systems already in place shall show evidence of a plan and testing within two months of August 31, 2001.

655.4(3) The internal quality control assurance plan shall be submitted to the board of medicine upon request.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.5(147,148,272C) Standards of practice—office practices.

655.5(1) *Termination of the physician-patient relationship.* A physician may choose whom to serve. Having undertaken the care of a patient, the physician may not neglect the patient. A physician must provide a patient written notice of the termination of the physician-patient relationship. A physician shall ensure that emergency medical care is available to the patient during the 30-day period following notice of the termination of the physician-patient relationship.

655.5(2) *Patient referrals.* A physician shall not pay or receive compensation for patient referrals.

655.5(3) *Confidentiality.* A physician shall maintain the confidentiality of all patient information obtained in the practice of medicine. Information shall be divulged by the physician when authorized by law or the patient or when required for patient care.

655.5(4) *Sexual conduct.* It is unprofessional and unethical conduct, and is grounds for disciplinary action, for a physician to engage in conduct that violates the following prohibitions:

a. In the course of providing medical care, a physician shall not engage in contact, touching, or comments of a sexual nature with a patient, or with the patient's parent or guardian if the patient is a minor or under a guardianship.

b. A physician shall not engage in any sexual conduct with a patient when that conduct occurs concurrent with the physician-patient relationship, regardless of whether the patient consents to that conduct.

c. A physician shall not engage in any sexual conduct with a former patient unless the physician-patient relationship was completely terminated before the sexual conduct occurred. In considering whether that relationship was completely terminated, the board will consider the duration of the physician-patient relationship, the nature of the medical services provided, the lapse of time since the physician-patient relationship ended, the degree of dependence in the physician-patient relationship, and the extent to which the physician used or exploited the trust, knowledge, emotions, or influence derived from the physician-patient relationship.

d. A psychiatrist, or a physician who provides mental health counseling to a patient, shall never engage in any sexual conduct with a current or former patient, or with that patient's parent or guardian if the patient was a minor or under guardianship, regardless of whether the patient consents to that conduct.

655.5(5) *Disruptive behavior.* A physician shall not engage in disruptive behavior. Disruptive behavior is defined as a pattern of contentious, threatening, or intractable behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff.

655.5(6) *Sexual harassment.* A physician shall not engage in sexual harassment. Sexual harassment is defined as verbal or physical conduct of a sexual nature that interferes with another health care worker's performance or creates an intimidating, hostile or offensive work environment.

655.5(7) *Transfer of medical records.* A physician must provide a copy of all medical records generated by the physician in a timely manner to the patient or another physician designated by the patient, upon written request when legally requested to do so by the subject patient or by a legally designated representative of the subject patient, except as otherwise required or permitted by law.

655.5(8) *Retention of medical records.*

a. A physician shall retain all medical records, not appropriately transferred to another physician or entity, for at least seven years from the last date of service for each patient, except as otherwise required by law.

b. A physician must retain all medical records of minor patients, not appropriately transferred to another physician or entity, for a period consistent with that established by Iowa Code section 614.8.

c. Beginning July 1, 2023, a physician must appoint another Iowa-licensed physician, or other representative or entity that is held to the same standards of confidentiality as the physician, to ensure that all requirements of this subrule are met in the event of the physician's death or incapacitation. Upon request by the board, the physician must be able to establish by sufficient proof the appointment of a representative pursuant to this paragraph.

d. Upon a physician's death or retirement, the sale of a medical practice, or a physician's departure from the physician's medical practice:

(1) The physician or the physician's representative must ensure that all medical records are transferred to another physician or entity that is held to the same standards of confidentiality and agrees to act as custodian of the records.

(2) The physician or the physician's representative shall notify all active patients that their records will be transferred to another physician or entity that will retain custody of their records and that, at their written request, the records will be sent to the physician or entity of the patient's choice.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.6(148,272C) Standards of practice—medical directors at medical spas—delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians. This rule establishes standards of practice for a physician or surgeon or osteopathic physician or surgeon who serves as a medical director at a medical spa. This rule does not apply to the standards of practice for a nonphysician licensed health professional who serves as a medical director at a medical spa pursuant to the rules of the professional's licensing authority.

655.6(1) Definitions. As used in this rule:

"Alter" means to change the cellular structure of living tissue.

"Capable of" means any means, method, device or instrument that, if used as intended or otherwise to its greatest strength, has the potential to alter or damage living tissue below the superficial epidermal cells.

"Damage" means to cause a harmful change in the cellular structure of living tissue.

"Delegate" means to entrust or transfer the performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians.

"Medical aesthetic service" means the diagnosis, treatment, or correction of human conditions, ailments, diseases, injuries, or infirmities of the skin, hair, nails and mucous membranes by any means, methods, devices, or instruments including the use of a biological or synthetic material, chemical application, mechanical device, or displaced energy form of any kind if it alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells, with the exception of hair removal. Medical aesthetic service includes, but is not limited to, the following services: ablative laser therapy; vaporizing laser therapy; nonsuperficial light device therapy; injectables; tissue alteration services; nonsuperficial light-emitting diode therapy; nonsuperficial intense pulse light therapy; nonsuperficial radiofrequency therapy; nonsuperficial ultrasonic therapy; nonsuperficial exfoliation; nonsuperficial microdermabrasion; nonsuperficial dermaplane exfoliation; nonsuperficial lymphatic drainage; collagen induction therapy (microneedling); fat-freezing treatment (cool sculpting); botox injections; collagen injections; and tattoo removal.

"Medical director" means a physician who assumes the role of, or holds oneself out as, medical director at a medical spa. The medical director is responsible for implementing policies and procedures to ensure quality patient care and for the delegation and supervision of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa. The medical director is ultimately responsible for all medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians at a medical spa.

“Medical spa” means any entity, however organized, that is advertised, announced, established, or maintained for the purpose of providing medical aesthetic services. Medical spa shall not include a dermatology practice that is wholly owned and controlled by one or more Iowa-licensed physicians if at least one of the owners is actively practicing at each location.

“Nonsuperficial” means that the therapy alters or damages or is capable of altering or damaging living tissue below the superficial epidermal cells.

“Qualified laser technician” means any person, licensed or unlicensed, who has successfully completed a minimum of 120 hours of training, including a minimum of 40 hours of didactic study and 80 hours of clinical training, in the safe and effective use of lasers in the performance of medical aesthetic services at an accredited laser training program. For the purposes of this rule, a qualified laser technician may only use lasers in the performance of delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa. An unlicensed qualified laser technician may not perform any other medical aesthetic services defined in this rule.

“Qualified licensed or certified nonphysician person” means any person who is not licensed to practice medicine and surgery or osteopathic medicine and surgery but who is licensed or certified by another health- or skin care-related licensing board in Iowa and is qualified to perform delegated medical aesthetic services under the supervision of a qualified supervising physician at a medical spa.

“Supervision” means the oversight of qualified licensed or certified nonphysician persons or qualified laser technicians who perform medical aesthetic services delegated by a medical director.

655.6(2) *Delegation by a medical director.* A medical aesthetic service shall only be performed by qualified licensed or certified nonphysician persons or qualified laser technicians if the service has been delegated by a medical director who is responsible for supervision of the services performed at a medical spa in Iowa. Nothing in this rule shall be interpreted to prevent a qualified nonphysician licensed health professional from serving as a medical director at a medical spa or from appropriately delegating medical aesthetic services pursuant to the rules of the professional’s licensing authority.

655.6(3) *Medical director.* A medical director at a medical spa shall:

- a. Hold an active unrestricted Iowa medical license to supervise each delegated medical aesthetic service;
- b. Possess the appropriate education, training, experience and competence to safely supervise each delegated medical aesthetic service;
- c. Retain responsibility for the supervision of each medical aesthetic service performed by qualified licensed or certified nonphysician persons or qualified laser technicians;
- d. Ensure that advertising activities do not include false, misleading, or deceptive representations; and
- e. Be clearly identified as the medical director in all advertising activities, internet websites and signage related to the medical spa.

655.6(4) *Delegated medical aesthetic service.* When a medical director delegates a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians, the service shall be:

- a. Within the medical director’s scope of practice and medical competence to supervise;
- b. Of the type that a reasonable and prudent physician would conclude is within the scope of sound medical judgment to delegate; and
- c. A routine and technical service, the performance of which does not require the skill of a licensed physician.

655.6(5) *Supervision.* A medical director who delegates performance of a medical aesthetic service to qualified licensed or certified nonphysician persons or qualified laser technicians is responsible for providing appropriate supervision. The medical director shall:

- a. Ensure that all licensed or certified nonphysician persons or qualified laser technicians are qualified and competent to safely perform each delegated medical aesthetic service by personally assessing the person’s education, training, experience and ability;

b. Ensure that a qualified licensed or certified nonphysician person does not perform any medical aesthetic services that are beyond the scope of that person's license or certification unless the person is supervised by a qualified supervising physician or other qualified supervising nonphysician licensed health professional;

c. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians receive direct, in-person, on-site supervision from the medical director or other qualified licensed physician or other qualified supervising nonphysician licensed health professional at least four hours each week and that the regular supervision is documented;

d. Provide on-site review of medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians each week and review at least 10 percent of patient charts for medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

e. Be physically located, at all times, within 60 miles of the location where delegated medical aesthetic services are performed;

f. Be available, in person or electronically, at all times, to consult with qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services, particularly in case of injury or an emergency;

g. Assess the legitimacy and safety of all equipment or other technologies being used by qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services;

h. Develop and implement protocols for responding to emergencies or other injuries suffered by persons receiving delegated medical aesthetic services performed by qualified licensed or certified nonphysician persons or qualified laser technicians;

i. Ensure that all qualified licensed or certified nonphysician persons or qualified laser technicians maintain accurate and timely medical records for the delegated medical aesthetic services they perform;

j. Ensure that each patient provides appropriate informed consent for medical aesthetic services performed by the medical director or other qualified licensed physician and all qualified licensed or certified nonphysician persons or qualified laser technicians and that such informed consent is timely documented in the patient's medical record;

k. Ensure that the identity and licensure and certification of the medical director, other qualified licensed physicians, and all qualified licensed or certified nonphysician persons or qualified laser technicians are visibly displayed at each medical spa where they perform medical aesthetic services and provided in writing to each patient receiving medical aesthetic services at a medical spa; and

l. Ensure that the board receives written verification of the education and training of all qualified licensed or certified nonphysician persons or qualified laser technicians who perform delegated medical aesthetic services at a medical spa, within 14 days of a request by the board.

655.6(6) Continuing medical education. A medical director shall complete and shall ensure that all other physicians, qualified licensed or certified nonphysician persons, and qualified laser technicians who practice at the medical spa complete a minimum of 20 hours of continuing medical education in the safe and effective performance of medical aesthetic services each year.

655.6(7) Exceptions. This rule is not intended to apply to physicians who serve as medical directors of licensed medical facilities, clinics or practices that provide medical aesthetic services as part of or incident to their other medical services.

655.6(8) Other qualified nonphysician licensed health professionals. Nothing in this rule shall be interpreted to contradict or supersede the rules established in 481—Chapters 780 and 781 and 655—Chapter 7.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.7(147,148,272C) Standards of practice—interventional chronic pain management. This rule establishes standards of practice for the practice of interventional chronic pain management.

The purpose of this rule is to assist physicians who consider interventional techniques to treat patients with chronic pain.

655.7(1) Definition. As used in this rule:

“Interventional chronic pain management” means diagnosing and treating pain-related disorders using interventional techniques for subacute, chronic, persistent, and intractable pain. These techniques include percutaneous needle placement for drug injection, nerve ablation, and certain surgeries. Common procedures involve injecting steroids, analgesic, and anesthetics into targeted areas such as the spine, joints, or nerves. This may include lumbar, thoracic, and cervical spine injections; nerve blocks; and processes like vertebroplasty. Fluoroscopy is used to assess chronic pain causes or aid in identifying anatomical landmarks during these techniques. Specific procedures include joint injections, nerve blocks, epidural injections, and nerve destruction.

655.7(2) Interventional chronic pain management. The practice of interventional chronic pain management shall include the following:

- a. Comprehensive assessment of the patient;
- b. Diagnosis of the cause of the patient’s pain;
- c. Evaluation of alternative treatment options;
- d. Selection of appropriate treatment options;
- e. Termination of prescribed treatment options when appropriate;
- f. Follow-up care; and
- g. Collaboration with other health care providers.

655.7(3) Practice of medicine. Interventional chronic pain management is the practice of medicine.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.8(147,148,272C) Standards of practice—physicians who prescribe or administer abortion-inducing drugs.

655.8(1) Definition. As used in this rule:

“Abortion-inducing drug” means a drug, medicine, mixture, or preparation, when it is prescribed or administered with the intent to terminate the pregnancy of a woman known to be pregnant.

655.8(2) Review of patient record. A physician shall not induce an abortion by providing an abortion-inducing drug unless the physician has first reviewed the lab results, ultrasound images, and medical history provided by the patient to determine, and document in the woman’s medical record, the gestational age and intrauterine location of the pregnancy. A physician may utilize telemedicine pursuant to rule 481—655.9(147,148,272C).

655.8(3) Follow-up appointment required. If an abortion is induced by an abortion-inducing drug, the physician or designee shall use all reasonable efforts to ensure a follow-up appointment is scheduled with the patient at the same facility within 12 to 18 days after the patient’s use of an abortion-inducing drug to confirm the termination of the pregnancy and evaluate the woman’s medical condition.

655.8(4) Parental notification regarding pregnant minors. A physician shall not induce an abortion by providing an abortion-inducing drug to a pregnant minor prior to compliance with the requirements of Iowa Code chapter 135L and rules 641—89.12(135L) and 641—89.21(135L).

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481—655.9(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

655.9(1) Definitions. As used in this rule:

“Asynchronous store-and-forward transmission” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

“Board” means the Iowa board of medicine.

“In-person encounter” means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

“Licensee” means a medical physician or osteopathic physician licensed by the board.

“Telemedicine” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

“Telemedicine technologies” means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

655.9(2) Practice guidelines. A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

655.9(3) Iowa medical license required. A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 481—subrule 652.2(2).

655.9(4) Standards of care and professional ethics. A licensee who uses telemedicine is held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

655.9(5) Scope of practice. A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee’s scope of practice, including the licensee’s education, training, experience, ability, licensure, and certification.

655.9(6) Identification of patient and physician. A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

655.9(7) Physician-patient relationship.

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

- (1) The person with a health-related matter seeks assistance from a licensee;
- (2) The licensee agrees to undertake diagnosis and treatment of the person; and
- (3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

- (1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;
- (2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient’s care; or

(3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

655.9(8) *Medical history and physical examination.* Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

655.9(9) *Nonphysician health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

655.9(10) *Informed consent.* A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

655.9(11) *Coordination of care.* A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

655.9(12) *Follow-up care.* A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

655.9(13) *Emergency services.* A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

655.9(14) *Medical records.* A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

655.9(15) *Privacy and security.* A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act of 1996, PL 104-191, August 21, 1996, 110 Stat. 1936, and any amendments as of October 16, 2024, to ensure that all patient communications and records are secure and remain confidential.

- a. Written protocols shall be established that address the following:
 - (1) Privacy;
 - (2) Health care personnel who will process messages;
 - (3) Hours of operation;
 - (4) Types of transactions that will be permitted electronically;
 - (5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;
 - (6) Archiving and retrieval; and
 - (7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

655.9(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

- a. Comply with relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;
- b. Be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and
- c. Be compliant with the Health Insurance Portability and Accountability Act of 1996, PL 104-191, August 21, 1996, 110 Stat. 1936, and any amendments as of October 16, 2024.

655.9(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

- a. Types of services provided;
- b. Contact information for the licensee;
- c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;
- d. Limitations in the drugs and services that can be provided via telemedicine;
- e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;
- f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);
- g. Appropriate uses and limitations of the technologies, including in emergency situations;
- h. Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;
- i. To whom patient health information may be disclosed and for what purpose;
- j. Rights of patients with respect to patient health information; and
- k. Information collected and passive tracking mechanisms utilized.

655.9(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

- a. To access, supplement and amend patient-provided personal health information;
- b. To provide feedback regarding the quality of the telemedicine services provided; and
- c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

655.9(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, internet services may provide links to general health information

sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

655.9(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

- a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;
- b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;
- c. Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- d. Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient;
- e. Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician associate or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;
- f. Emergency situations in which the life or health of the patient is in imminent danger;
- g. Emergency situations that constitute an immediate threat to the public health including but not limited to empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;
- h. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and
- i. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

655.9(21) *Prescribing based solely on an internet request, internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an internet request or internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 655.9(20).

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25; Editorial change: IAC Supplement 6/10/26]

481—655.10(135,147,148,272C,280) Standards of practice—prescribing epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility.

655.10(1) Definition. For purposes of this rule:

“Authorized facility” means a facility as defined in Iowa Code section 135.185(1), a school district, or an accredited nonpublic school.

655.10(2) Notwithstanding any other provision of law to the contrary, a physician may prescribe epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A.

655.10(3) A physician who prescribes epinephrine auto-injectors, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists in the name of an authorized facility to be maintained for use pursuant to Iowa Code sections 135.185, 135.190, 280.16 and 280.16A, provided the physician has acted reasonably and in good faith, is not liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector, bronchodilator canisters, bronchodilator canisters and spacers, or opioid antagonists.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.11(144E,147,148,272C) Standards of practice—experimental treatments for patients with a terminal illness.

655.11(1) *Exemption from discipline.* To the extent consistent with state law, the board will not revoke, fail to renew, suspend, or take any action against a physician's license based solely on the physician's recommendations to an eligible patient regarding access to or treatment with an investigational drug, biological product, or device.

655.11(2) *Eligible patient.* A physician shall ensure that a patient meets all of the following conditions prior to the use of an investigational drug, biological product, or device pursuant to this rule:

- a. The patient has a terminal illness, attested to by the patient's treating physician.
- b. The patient has considered and rejected or has tried and failed to respond to all other treatment options approved by the U.S. Food and Drug Administration (FDA).
- c. The patient has received a recommendation from the patient's physician for an investigational drug, biological product, or device.
- d. The patient has given written informed consent for the use of the investigational drug, biological product, or device.
- e. The patient has documentation from the patient's physician that the patient meets the requirements of this rule.

655.11(3) *Investigational drug, biological product, or device.* A physician may recommend access to or treatment with an investigational drug, biological product, or device that has successfully completed phase 1 of an FDA-approved clinical trial but has not yet been approved for general use by the FDA and remains under investigation in an FDA-approved clinical trial.

655.11(4) *Terminal illness.* A physician shall ensure that a patient has a terminal illness prior to the use of an investigational drug, biological product, or device pursuant to this rule. A terminal illness is a progressive disease or medical or surgical condition that entails significant functional impairment and that is not considered by a treating physician to be reversible even with administration of treatments approved by the FDA and that, without life-sustaining procedures, will result in death.

655.11(5) *Written informed consent.* A physician shall obtain written informed consent prior to the use of an investigational drug, biological product, or device pursuant to this rule. Written informed consent is a written document that is signed by a patient, a parent of a minor patient, or a legal guardian or other legal representative of the patient and attested to by the patient's treating physician and a witness and that includes all of the following:

- a. An explanation of the products and treatments approved by the FDA for the disease or condition from which the patient suffers.
- b. An attestation that the patient concurs with the patient's treating physician in believing that all products and treatments approved by the FDA are unlikely to prolong the patient's life.
- c. Clear identification of the specific proposed investigational drug, biological product, or device that the patient is seeking to use.
- d. A description of the best and worst potential outcomes of using the investigational drug, biological product, or device and a realistic description of the most likely outcome. The description to include the possibility that new, unanticipated, different, or worse symptoms might result and that death could be hastened by use of the proposed investigational drug, biological product, or device.

The description is based on the treating physician's knowledge of the proposed investigational drug, biological product, or device in conjunction with an awareness of the patient's condition.

e. A statement that the patient's health plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational drug, biological product, or device, unless the patient's health plan or third-party administrator and provider are specifically required to do so by law or contract.

f. A statement that the patient's eligibility for hospice care may be withdrawn if the patient begins curative treatment with the investigational drug, biological product, or device and that hospice care may be reinstated if treatment ends and the patient meets hospice eligibility requirements.

g. A statement that the patient understands that the patient is liable for all expenses consequent to the use of the investigational drug, biological product, or device and that this liability extends to the patient's estate unless a contract between the patient and the manufacturer of the investigational drug, biological product, or device states otherwise.

655.11(6) *Assisting suicide.* This rule is not to be construed to allow a patient's treating physician to assist the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

655.11(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of this rule or 481—Chapter 661. Grounds for discipline include but are not limited to the following:

a. The physician recommends access to or treatment with an investigational drug, biological product, or device to an individual who is not an eligible patient pursuant to this rule.

b. The physician fails to obtain appropriate written informed consent prior to recommending access to or treatment with an investigational drug, biological product, or device pursuant to this rule.

c. The physician assists the patient in committing or attempting to commit suicide as prohibited in Iowa Code section 707A.2.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.12(147,148,272C) Standards of practice—tick-borne disease diagnosis and treatment.

655.12(1) *Exemption from discipline.* A person licensed by the board under Iowa Code chapter 148 shall not be subject to discipline under this chapter or the board's enabling statute based solely on the physician's recommendation or provision of a treatment method for Lyme disease or other tick-borne disease if the recommendation or provision of such treatment meets all the following criteria:

a. The treatment is provided after an examination is performed and informed consent is received from the patient.

b. The physician identifies a medical reason for recommending or providing the treatment.

c. The treatment is provided after the physician informs the patient about other recognized treatment options and describes to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne disease.

d. The physician uses the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.

e. The treatment will not, in the opinion of the physician, result in the direct and proximate death of or serious bodily injury to the patient.

655.12(2) *Lyme disease treatment.* Most cases of Lyme disease can be treated successfully with a few weeks of antibiotics. Over the past several years, the International Lyme and Associated Diseases Society (ILADS) has supported longer courses of antibiotics for some patients, versus the prescribed treatment durations identified by the Infectious Diseases Society of America (IDSA) and referenced by the CDC. While IDSA has expressed concern about overtreatment, ILADS points out that treatment decisions should be based on a risk-benefit analysis. Both groups have published evidence-based guidelines.

655.12(3) *Tick-borne diseases.* According to the CDC, tick-borne diseases include:

a. *Anaplasmosis* is transmitted to humans by tick bites primarily from the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the United States (U.S.) and the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

b. *Babesiosis* is caused by microscopic parasites that infect red blood cells. Most human cases of babesiosis in the U.S. are caused by *Babesia microti*. *Babesia microti* is transmitted by the blacklegged tick (*Ixodes scapularis*) and is found primarily in the northeastern and upper midwestern regions of the U.S.

c. *Borrelia mayonii* infection has recently been described as a cause of illness in the upper midwestern region of the U.S. This infection has been found in blacklegged ticks (*Ixodes scapularis*) in Minnesota and Wisconsin. *Borrelia mayonii* is a new species and is the only species besides *B. burgdorferi* known to cause Lyme disease in North America.

d. *Borrelia miyamotoi* infection has recently been described as a cause of illness in the U.S. This infection is transmitted by the blacklegged tick (*Ixodes scapularis*) and has a geographic range similar to that of Lyme disease.

e. *Bourbon virus* infection has been identified in a limited number of patients in the midwestern and southern regions of the U.S. At this time, it is not known if the virus might be found in other areas of the U.S.

f. *Colorado tick fever* is caused by a virus transmitted by the Rocky Mountain wood tick (*Dermacentor andersoni*). Colorado tick fever occurs in the Rocky Mountain states at elevations of 4,000 to 10,500 feet.

g. *Ehrlichiosis* is transmitted to humans by the lone star tick (*Amblyomma americanum*), found primarily in the south central and eastern regions of the U.S.

h. *Heartland virus* cases have been identified in the midwestern and southern regions of the U.S. Studies suggest that lone star ticks (*Amblyomma americanum*) can transmit the virus. It is unknown if the virus may be found in other areas of the U.S.

i. *Lyme disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) in the northeastern and upper midwestern regions of the U.S. and by the western blacklegged tick (*Ixodes pacificus*) along the Pacific coast.

j. *Powassan disease* is transmitted by the blacklegged tick (*Ixodes scapularis*) and the groundhog tick (*Ixodes cookei*). Cases have been reported primarily from northeastern states and the Great Lakes region.

k. *Rickettsia parkeri rickettsiosis* is transmitted to humans by the Gulf Coast tick (*Amblyomma maculatum*).

l. *Rocky Mountain spotted fever* is transmitted by the American dog tick (*Dermacentor variabilis*), Rocky Mountain wood tick (*Dermacentor andersoni*), and the brown dog tick (*Rhipicephalus sanguineus*) in the U.S. The brown dog tick and other tick species are associated with Rocky Mountain spotted fever in Central America and South America.

m. *Southern tick-associated rash illness* is transmitted via bites from the lone star tick (*Amblyomma americanum*) found in the southeastern and eastern regions of the U.S.

n. *Tick-borne relapsing fever* is transmitted to humans through the bite of infected soft ticks. Tick-borne relapsing fever has been reported in 15 states: Arizona, California, Colorado, Idaho, Kansas, Montana, Nevada, New Mexico, Ohio, Oklahoma, Oregon, Texas, Utah, Washington, and Wyoming and is associated with sleeping in rustic cabins and vacation homes.

o. *Tularemia* is transmitted to humans by the dog tick (*Dermacentor variabilis*), the wood tick (*Dermacentor andersoni*), and the lone star tick (*Amblyomma americanum*). Tularemia occurs throughout the U.S.

p. *364D rickettsiosis* (*Rickettsia phillipi*) is transmitted to humans by the Pacific Coast tick (*Dermacentor occidentalis*). This is a new disease that has been found in California.

655.12(4) Grounds for discipline. A physician may be subject to disciplinary action for violation of these rules or the rules found in 481—Chapter 661. Grounds for discipline include but are not limited to the following:

- a.* The physician fails to perform and document an appropriate examination or fails to obtain and document appropriate informed consent from the patient.
- b.* The physician fails to identify and document a medical reason for recommending or providing the treatment.
- c.* The physician fails to inform the patient about other recognized treatment options or fails to describe to the patient the physician's education, experience, and credentials regarding the treatment of Lyme disease or other tick-borne diseases.
- d.* The physician fails to use the physician's own medical judgment based on a thorough review of all available clinical information and Lyme disease or other tick-borne disease literature to determine the best course of treatment for the individual patient.
- e.* The treatment provided, in the opinion of the physician, will likely result in the direct and proximate death of or serious bodily injury to the patient.

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481—655.13(124E,147,148,272C) Standards of practice—medical cannabidiol.

655.13(1) *Definitions.* For purposes of this rule:

"Bordering state" means the same as defined in Iowa Code section 331.910.

"Debilitating medical condition" means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson's disease.
9. Chronic pain.
10. Ulcerative colitis.
11. Severe, intractable autism with self-injurious or aggressive behaviors.
12. Corticobasal degeneration.
13. Post-traumatic stress disorder.

"Department" means the Iowa department of public health.

"Form and quantity" means the types and amounts of medical cannabidiol allowed to be dispensed to a patient or primary caregiver as approved by the department subject to recommendation by the medical cannabidiol board and approval by the board of medicine.

"Medical cannabidiol" means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and adopted by the department pursuant to rule.

"Medical cannabidiol board" means the board established pursuant to Iowa Code section 124E.5.

"Primary caregiver" means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the

well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of this chapter.

“Untreatable pain” means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

“Written certification” means a document signed by a physician licensed pursuant to Iowa Code chapter 148 with whom the patient has established a patient-physician relationship and who is the patient’s primary care provider that states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

655.13(2) *Written certification.* A physician who is a patient’s primary care provider may provide the patient a written certification of diagnosis if, after examining and treating the patient, the physician determines, in the physician’s medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

a. The physician shall provide explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

b. Subsequently, the physician shall do the following:

(1) Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, may issue the patient a new written certification of that diagnosis.

(2) Otherwise comply with all requirements established by the department pursuant to rule.

c. A physician may provide, but has no duty to provide, a written certification pursuant to this rule.

655.13(3) *Adding or removing debilitating medical conditions and amending form and quantity of medical cannabidiol.* Recommendations made by the medical cannabidiol board pursuant to Iowa Code section 124E.5 relating to the addition or removal of allowable debilitating medical conditions for which the medical use of cannabidiol would be medically beneficial or to the amendment of the form and quantity of allowable medical uses of cannabidiol shall be made to the board of medicine for consideration. The medical cannabidiol board shall submit a written recommendation, a copy of the petition and all other information received during consideration of the petition. The board of medicine shall consider the information received from the medical cannabidiol board and may seek information from other sources if it is deemed relevant by the board of medicine. The decision regarding a recommendation by the medical cannabidiol board is at the sole discretion of the board of medicine. The board of medicine shall make its decision within 180 days of receipt of the recommendation from the medical cannabidiol board. If the recommendation is approved by the board of medicine, it shall be adopted by rule.

655.13(4) *Financial interests.* A physician shall not share office space with, accept referrals from, or have any financial relationship with a medical cannabidiol manufacturer or dispensary.

655.13(5) *Criminal prosecution.* A physician, including any authorized agent or employee thereof, shall not be subject to prosecution for the unlawful certification, possession, or administration of marijuana under the laws of this state for activities arising directly out of or directly related to the certification or use of medical cannabidiol in the treatment of a patient diagnosed with a debilitating medical condition as authorized by Iowa Code chapter 124E.

655.13(6) *Civil or disciplinary penalties.* A physician, including any authorized agent or employee thereof, shall not be subject to any civil or disciplinary penalties by the board of medicine or any business, occupational, or professional licensing board or entity, solely for activities conducted relating to a patient’s possession or use of medical cannabidiol as authorized by Iowa Code chapter 124E. Nothing in this rule prevents the board of medicine from taking action in response to violations of any other sections of law or rule.

655.13(7) *Grounds for discipline.* A physician may be subject to disciplinary action for violation of these rules or the rules found in 481—Chapter 661. Grounds for discipline include but are not limited to the following:

a. The physician provides an individual a written certification without establishing a patient-physician relationship, including examining and treating the individual, or without being the individual's primary care provider.

b. The physician provides a patient a written certification without determining, in the physician's medical judgment, that the patient suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E.

c. The physician provides a patient a written certification without providing explanatory information as provided by the department to the patient about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

d. The physician provides an individual a new written certification without determining, on an annual basis, that the patient continues to suffer from a debilitating medical condition.

e. The physician shares office space with, accepts referrals from, or has a financial relationship with a medical cannabidiol manufacturer or dispensary.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.14(146A) Abortion prerequisites.

655.14(1) *Written certification.* At least 24 hours prior to performing an abortion, a physician shall obtain written certification from the pregnant woman of each prerequisite as required in Iowa Code sections 146A.1(1)“a” through 146A.1(1)“d”(1). The written certification shall list each required prerequisite separately and shall include a line for date and signature of the pregnant woman. The physician shall maintain a copy of the certification as part of the pregnant woman's medical records.

655.14(2) *Exceptions.* This rule shall not apply to abortions performed in a medical emergency, as provided in Iowa Code section 146A.1(2).

655.14(3) *Discipline.* Failure to comply with this rule or the requirements of Iowa Code section 146A.1 may constitute grounds for discipline.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.15(135L,146A,146E,147,148,272C) Standards of practice for physicians who perform or induce abortions—definitions—detection of fetal heartbeat—fetal heartbeat exceptions—discipline.

655.15(1) *Standards of practice.* This rule sets forth the standards of practice for physicians who perform or induce abortions. More information is contained in Iowa Code section 146E.2(5).

655.15(2) *Definitions.* As used in this rule or in Iowa Code chapter 146E:

“*Private health agency*” means any establishment, facility, organization, or other entity that is not owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;
3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

“*Public health agency*” means any establishment; facility; organization; administrative division; or entity that is owned by a federal, state, or local government that either is a health care provider or employs or provides the services of a health care provider. Establishments, facilities, organizations, administrative divisions, or other entities that are health care providers include the following:

1. A hospital as defined in Iowa Code section 135B.1;
2. A health care facility as defined in Iowa Code section 135C.1;

3. A health facility as defined in Iowa Code section 135P.1; or
4. A similar entity that either is a health care provider or employs or provides the services of a health care provider.

“*Standard medical practice*” means the degree of skill, care, and diligence that a physician of the same medical specialty would employ in like circumstances. As applied to the method used to determine the presence of a fetal heartbeat for purposes of Iowa Code chapter 146E and this rule, “standard medical practice” includes employing the appropriate means of detection depending on the estimated gestational age of the unborn child and the condition of the woman and her pregnancy.

“*The pregnancy is the result of a rape*” means a circumstance in which the pregnancy is the result of conduct that would constitute an offense under Iowa Code section 709.2, 709.3, 709.4, or 709.4A when perpetrated against a female, regardless of where the conduct occurred.

“*The pregnancy is the result of incest*” means a circumstance in which a sex act occurs between closely related persons that involves a vaginal penetration that causes a pregnancy. The closely related persons must be related, either legitimately or illegitimately, as an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew. For purposes of this rule, a closely related person includes a stepparent, stepchild, or stepsibling, including siblings through adoption.

“*Unborn child*” means an individual organism of the species *Homo sapiens* from fertilization to live birth—that is, at all stages of development, including embryo and fetus.

“*Woman*” means a female individual regardless of her age.

655.15(3) *Detection of fetal heartbeat.* A physician who intends to perform or induce an abortion must determine via ultrasound whether the woman is carrying an unborn child with a detectable fetal heartbeat.

a. Obligation. The obligation under this rule requires a bona fide effort to detect a fetal heartbeat in the unborn child. This effort must be made in good faith and according to standard medical practice and reasonable medical judgment.

b. Method. The physician shall perform a transabdominal pelvic ultrasound on the woman to determine whether the unborn child has a detectable fetal heartbeat. This shall be performed in a manner consistent with standard medical practice, with real-time ultrasound equipment with a transducer of appropriate frequency. The equipment must be properly maintained and in proper functioning order.

655.15(4) *Fetal heartbeat exceptions.* The following applies to a physician who intends to perform or induce an abortion under a fetal heartbeat exception as defined in Iowa Code chapter 146E and this rule:

a. Incest or rape. For purposes of this rule, a pregnancy resulting from incest or rape may be reported within the appropriate time frame to a licensed physician whose services are retained for an abortion procedure.

(1) To determine whether the pregnancy is the result of incest, a physician who intends to perform or induce an abortion must use the following information:

1. Whether the sex act occurred between the woman and a closely related person, meaning, either legitimately or illegitimately, an ancestor, descendant, brother or sister of the whole or half blood, aunt, uncle, niece, or nephew, including a stepparent, stepchild, or stepsibling to include an adopted sibling.

2. The date the act occurred.

3. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the act was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for incest applies. This information does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman’s medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

(2) To determine whether the pregnancy is the result of a rape, a physician who intends to perform or induce an abortion must use the following information:

1. The date the sex act that caused the pregnancy occurred.
2. The age of the woman seeking an abortion at the time of that sex act.
3. Whether the sex act constituted a rape.
4. Whether the rape was perpetrated against the woman seeking an abortion.
5. If initial reporting was to someone other than the physician who intends to perform or induce an abortion, the date the rape was reported to a law enforcement agency, public health agency, private health agency, or family physician.

The physician who intends to perform or induce an abortion shall use this information to determine whether the fetal heartbeat exception for rape applies. This rule does not prescribe the manner in which the physician is to obtain this information. This information and its source shall be documented in the woman's medical records.

The physician who intends to perform or induce an abortion may rely on the information received upon a good-faith assessment that the information is true. The physician who intends to perform or induce an abortion may require the person providing the information to sign a certification form attesting that the information is true.

b. Fetal abnormality. A certification from an attending physician that a fetus has a fetal abnormality that in the attending physician's reasonable medical judgment is incompatible with life must contain the following information:

- (1) The diagnosis of the abnormality;
- (2) The basis for the diagnosis, including the tests and procedures performed, the results of those tests and procedures, and why those results support the diagnosis; and
- (3) A description of why the abnormality is incompatible with life.

The diagnosis and the attending physician's conclusion must be reached in good faith following a bona fide effort, consistent with standard medical practice and reasonable medical judgment, to determine the health of the fetus. The certification must be signed by the attending physician. A physician who intends to perform or induce an abortion may rely in good faith on a certification from an attending physician if the physician who intends to perform or induce an abortion has a copy of the certification. The certification must be included in the woman's medical records by the physician who intends to perform or induce an abortion.

655.15(5) Discipline. Failure to comply with this rule or the requirements of Iowa Code chapter 146E may constitute grounds for discipline.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.16(147,148) Principles of medical ethics. The Code of Medical Ethics (2002-2003) prepared and approved by the American Medical Association and the Code of Ethics (2002-2003) prepared and approved by the American Osteopathic Association is utilized by the board as guiding principles in the practice of medicine and surgery and osteopathic medicine and surgery in this state.

655.16(1) Conflict of interest. A physician should not provide medical services under terms or conditions that tend to interfere with or impair the free and complete exercise of the physician's medical judgment and skill or tend to cause a deterioration of the quality of medical care.

655.16(2) Fees. Any fee charged by a physician shall be reasonable.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—655.17(147A) Emergency medical care provider. A physician with a license in good standing may be staffed on an authorized emergency medical services (EMS) program provided the physician can document equivalency through education and additional skills training essential in the delivery

of out-of-hospital emergency care. The equivalency shall be accepted when documentation has been reviewed and approved at the local level by the medical director of the authorized EMS service program and the department of health and human services bureau of emergency medical and trauma services in accordance with the form adopted by the department of health and human services.

[ARC 9115C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

These rules are intended to implement Iowa Code chapters 124, 124E, 144E, 146E, 148 and 272C and sections 147.55, 148.6, 147.107, 272C.3 and 272C.4.

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[Editorial change: IAC Supplement 6/11/25]

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¹ Effective date of 13.2(148,272C) delayed 70 days by the Administrative Rules Review Committee at its meeting held May 14, 1996.

CHAPTER 658
LICENSURE OF GENETIC COUNSELORS
[Prior to 6/11/25, see Medicine Board[653] Ch 20]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

481—658.1(148H) Scope of chapter. This chapter does not apply to any of the following:

1. A physician or surgeon or an osteopathic physician or surgeon licensed under Iowa Code chapter 148, a registered nurse or an advanced registered nurse practitioner licensed under Iowa Code chapter 152, a physician associate licensed under Iowa Code chapter 148C, or other persons licensed under Iowa Code chapter 147 when acting within the scope of the person's profession and doing work of a nature consistent with the person's education and training.
2. A person who is certified by the American Board of Medical Genetics and Genomics as a doctor of philosophy and is not a genetic counselor licensed pursuant to Iowa Code chapter 148H.
3. A person employed as a genetic counselor by the federal government or an agency thereof if the person provides genetic counseling services solely under the direction and control of the entity by which the person is employed.
4. A genetic counseling intern.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25; Editorial change: IAC Supplement 6/10/26]

481—658.2(148H) Definitions. The definitions stated in Iowa Code chapter 148H, in addition to those listed below, apply to this chapter.

"American Board of Genetic Counseling" or *"ABGC"* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

"American Board of Medical Genetics and Genomics" or *"ABMGG"* means the United States-based commission, or its equivalent or successor organization, that validates entry-level competency in the practice of genetic counseling through professional certification.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.3(148H) Titles used. A genetic counselor licensed under Iowa Code chapter 148H may use the words "genetic counselor" or "licensed genetic counselor" or the corresponding abbreviation "LGC" after the person's name. Persons who possess a provisional license shall add the designation "provisional licensed genetic counselor."

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.4(148H) Qualifications for licensure.

658.4(1) Each applicant for licensure under Iowa Code chapter 148H shall:

- a. Submit an application form and supporting documentation.
- b. Hold active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

658.4(2) A licensee shall maintain active certification as a genetic counselor by the American Board of Genetic Counseling, as a genetic counselor by the American Board of Medical Genetics and Genomics, or as a medical geneticist by the American Board of Medical Genetics and Genomics, or the successor to any of the aforementioned organizations.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.5(148H) Qualifications for provisional licensure. The board may issue a provisional license to an applicant who meets all of the requirements for licensure except for the certification component and who has been granted active candidate status by the American Board of Genetic Counseling or the American Board of Medical Genetics and Genomics.

658.5(1) The applicant shall submit a provisional license application form, proof of active candidate status, and supporting documentation prescribed by the board.

658.5(2) A provisional license expires and becomes inactive upon the earliest of the following:

- a. Issuance of a license as a genetic counselor by the board.
- b. Loss of active candidate status.

(1) A person holding a provisional license that is inactive due to loss of active candidate status may submit an application for reactivation of the provisional license upon demonstrating that active candidate status has been reestablished.

(2) An application for extension of a provisional license shall be signed by a qualified supervisor.

c. The date printed on the provisional license.

658.5(3) A person with a provisional license shall work at all times under the supervision of a qualified supervisor.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.6(147,148H) Application requirements.

658.6(1) *Application for licensure.* To apply for a license to practice genetic counseling, an applicant shall:

a. Submit the completed application, including required credentials and documents, a completed fingerprint packet, and a sworn statement by the applicant attesting to the truth of all information provided by the applicant;

b. Pay the nonrefundable initial application fee identified in 481—subrule 651.13(1) and pay the fee identified in 481—subrule 651.13(6) for the evaluation of the fingerprint packet and the national criminal history background checks by the division of criminal investigation (DCI) and the Federal Bureau of Investigation (FBI).

658.6(2) *Contents of the application form.* Each applicant shall submit the following information on the application form provided by the board:

a. The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board;

b. A chronology accounting for all time periods from the date the applicant entered a genetic counseling training program or educational institution to the date of the application;

c. The other jurisdictions in the United States or other nations or territories in which the applicant is authorized to practice genetic counseling, including license, certificate of registration or certification number and date of issuance;

d. Full disclosure of the applicant's involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process;

e. A statement disclosing and explaining any informal or nonpublic actions, such as letters of warning, letters of education, any confidential retraining, or any kind of confidential action taken toward a genetic counselor's certification or license that is not public discipline; warnings issued, investigations conducted, or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority, an educational institution, a training or research program, or a health facility in any jurisdiction;

f. A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside;

g. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure;

h. A completed fingerprint packet to facilitate a national criminal history background check. The fee for evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

658.6(3) *Application cycle.* If the applicant does not submit all materials within 90 days of the board's initial request for further information, the application is inactive.

a. To reactivate the application, an applicant shall submit a nonrefundable reactivation of application fee identified in 481—subrule 651.13(2) and shall update application materials if requested by the board. The period for requesting reactivation is limited to 30 days from the date the applicant is notified that the application is inactive, unless the applicant is granted an extension in writing by the committee or the board.

b. Once the application reactivation period is expired, an applicant must reapply and submit a new, nonrefundable initial application fee and a new application, including required documents and credentials.

658.6(4) *Applicant responsibilities.* An applicant for licensure to practice genetic counseling bears full responsibility for each of the following:

a. Paying all fees charged by regulatory authorities, national certifying organizations, health facilities, and educational institutions providing the information specified in subrule 658.6(2);

b. Providing accurate, up-to-date, and truthful information on the application form including but not limited to that specified under subrule 658.6(2) related to prior professional experience, education, training, active certification, licensure, and disciplinary history.

658.6(5) *Licensure application review process.* Licensure applications will be reviewed pursuant to the process outlined in rule 481—652.7(147,148).

658.6(6) *Grounds for denial of licensure.* The board, on the recommendation of the committee, and after consultation with an Iowa-licensed genetic counselor, may deny an application for licensure for any of the following reasons:

a. Failure to meet the requirements for licensure specified in this chapter pursuant to Iowa Code section 148H.3.

b. Pursuant to Iowa Code section 147.4, upon any of the grounds for which licensure may be revoked or suspended as specified in Iowa Code sections 147.55 and 148H.7 or in rule 481—658.20(147,148H,272C).

658.6(7) *Preliminary notice of denial.* Prior to the denial of licensure to an applicant, the board issues a preliminary notice of denial that is sent to the applicant by regular, first-class mail at the address provided by the applicant. The preliminary notice of denial is a public record and cites the factual and legal basis for denying the application, notifies the applicant of the appeal process, and specifies the date upon which the denial will become final if it is not appealed.

658.6(8) *Appeal procedure.* An applicant who has received a preliminary notice of denial may appeal the denial and request a hearing on the issues related to the preliminary notice of denial by serving a request for hearing upon the executive director not more than 30 calendar days following the date when the preliminary notice of denial was mailed. The applicant's current address shall be provided in the request for hearing. The request is deemed filed on the date it is received in the board office. If the request is received with a USPS nonmetered postmark, the board considers the postmark date as the date the request is filed. The request shall specify the factual or legal errors and that the applicant desires an evidentiary hearing and may provide additional written information or documents in support of licensure.

658.6(9) *Hearing.* If an applicant appeals the preliminary notice of denial and requests a hearing, the hearing will be a contested case open to the public and conducted in accordance with 481—Chapter 506.

658.6(10) *Finality.* If an applicant does not appeal a preliminary notice of denial in accordance with subrule 658.6(8), the preliminary notice of denial automatically becomes final. A final denial of an application for licensure is a public record.

658.6(11) *Failure to pursue appeal.* If an applicant appeals a preliminary notice of denial in accordance with subrule 658.6(8) but the applicant fails to pursue that appeal to a final decision within one year from the date of the preliminary notice of denial, the board may dismiss the appeal. The appeal may be dismissed only after the board sends a written notice by first-class mail to the applicant at the applicant's last-known address. The notice will state that the appeal will be dismissed and the preliminary notice of denial will become final if the applicant does not contact the board to schedule the appeal hearing within 30 days of the date the letter is mailed from the board office. Upon dismissal of an appeal, the preliminary notice of denial becomes final. A final denial of an application for licensure under this rule is a public record.

658.6(12) *Waiver prohibited.* Provisions of this rule are not subject to waiver pursuant to 481—Chapter 6 or any other provision of law.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.7(147,148H) Display of license and notification required to change the board's data system.

658.7(1) *Display of license.* Licensed genetic counselors shall display the license issued by the board in a conspicuous place in their primary place of business.

658.7(2) *Change of contact information.* Licensees shall notify the board within one month of a change in home address, address of the place of practice, home or practice telephone number, or personal email address regularly used by the applicant or licensee for correspondence with the board.

658.7(3) *Change of full legal name.* A licensee shall notify the board of any change in the licensee's full legal name within one month of making the name change. Notification requires a notarized copy of a marriage license or a notarized copy of court documents.

658.7(4) *Deceased.* A licensee's file will be closed and labeled "deceased" when the board receives a copy of the licensee's death certificate or other reliable information of the licensee's death.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.8(147,148H,272C) Biennial renewal of license required. Pursuant to Iowa Code section 148H.3, a license expires on October 31 of odd-numbered years and can be renewed for the fee identified in 481—paragraph 651.14(2)"c."

658.8(1) *Application.* The applicant for renewal shall provide:

- a. A renewal application.
- b. A letter sent directly from the ABGC or ABMGG to the board verifying that the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.
- c. Satisfactory evidence to the board that in the period since the license was issued or last renewed, the applicant has completed 30 hours of National Society of Genetic Counselors or ABMGG continuing education units as approved by the board.

658.8(2) *Expiration date.* Certificates of licensure to practice genetic counseling expire on October 31 in odd years.

658.8(3) *Prorated fees.* The first renewal fee for a license will be prorated on a monthly basis according to the date of issue.

658.8(4) *Renewal requirements and penalties for late renewal.* The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice does not relieve the licensee of responsibility for renewing that license.

- a. Upon receipt of the completed renewal application, staff will administratively issue a license that expires on October 31 of odd-numbered years. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration.
- b. Every renewal shall be displayed in connection with the original certificate of licensure.

c. If the licensee fails to submit the renewal application and renewal fee prior to the expiration date on the current license, a penalty fee identified in 481—subrule 651.13(4) will be assessed for renewal in the grace period, a period up until January 1.

658.8(5) *Inactive license.* Failure of a licensee to renew by January 1 will result in inactivation of the license, and the license will become invalid.

a. Licensees are prohibited from engaging in the practice of genetic counseling with an inactive or lapsed license.

b. Having a genetic counselor license in inactive or lapsed status does not preclude the board from taking disciplinary actions authorized in Iowa Code section 147.55 or 148H.7.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.9(147,272C) Reactivation of an inactive license.

658.9(1) *Reactivation requirements.* Licensees who allow their licenses to go inactive by failing to renew may apply for reactivation of a license. Pursuant to Iowa Code section 147.11, applicants for reactivation shall:

a. Submit a completed application for reactivation of a license to practice genetic counseling. The application shall include the following information:

(1) The applicant's full legal name, date and place of birth, home address, mailing address, principal business address, and personal email address regularly used by the applicant or licensee for correspondence with the board.

(2) Every jurisdiction in which the applicant is or has been authorized to practice, including license numbers and dates of issuance.

(3) Full disclosure of the applicant's involvement in civil litigation related to the practice of genetic counseling in any jurisdiction of the United States or other nations or territories. Copies of the legal documents may be requested if needed during the review process.

(4) A statement disclosing and explaining any warnings issued, investigations conducted or disciplinary actions taken, whether by voluntary agreement or formal action, by a medical, genetic counseling or professional regulatory authority; an educational institution; a training or research program; or a health facility in any jurisdiction.

(5) Verification of an applicant's hospital and clinical staff privileges and other professional experience for the past five years if requested by the board.

(6) A chronology accounting for all time periods from the date of initial licensure.

(7) A statement disclosing and explaining any charge of a misdemeanor or felony involving the applicant filed in any jurisdiction, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

b. Submit a completed fingerprint packet to facilitate a national criminal history background check. The fee identified in 481—subrule 651.13(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks will be assessed to the applicant.

c. Pay the reactivation fee identified in 481—subrule 651.13(7) plus the fee identified in 481—subrule 651.13(6) for the evaluation of the fingerprint packet and the DCI and FBI criminal history background checks.

d. A letter sent directly from the ABGC or ABMGG to the board verifying the applicant holds active certification in genetic counseling by the ABGC or ABMGG for genetic counselor licensure or a letter sent directly from the ABGC or ABMGG to the board verifying the applicant has been granted active candidate status for provisional licensure.

e. Meet any new requirements instituted since the license lapsed.

658.9(2) *Reactivation for an applicant who has been out of practice for three years.* If an applicant for reactivation has not engaged in the field of genetic counseling or precision medicine in the past three years in any jurisdiction of the United States, the board may, after consultation with an Iowa-licensed genetic counselor, require an applicant to:

a. Successfully complete board-approved continuing education or remediation.

b. Successfully complete a board-approved employment-based monitoring program developed by the genetic counselor's employer, an Iowa-licensed genetic counselor and the board.

c. Successfully complete any other pathway as agreed upon by the board.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25; Editorial change: IAC Supplement 6/11/25]

481—658.10(272C) Code of ethics. The NSGC Code of Ethics prepared and approved by the National Society of Genetic Counselors shall be utilized by the board as guiding principles in the practice of genetic counseling in this state.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—658.11(148H,272C) Surrender of license to the board.

658.11(1) A genetic counselor whose ABGC certification has lapsed or whose certification has been revoked by the ABGC shall surrender the genetic counselor's license to the board.

658.11(2) A provisional licensee who loses active candidate status with the ABGC must immediately cease the practice of genetic counseling until the provisional licensee obtains an extension of the provisional license or obtains a new provisional license.

[ARC 9118C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

These rules are intended to implement Iowa Code chapters 147, 148, 148H, and 272C.

[Filed ARC 4339C (Notice ARC 4095C, IAB 10/24/18), IAB 3/13/19, effective 4/17/19]¹

[Filed Emergency ARC 4468C, IAB 6/5/19, effective 5/15/19]

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[Editorial change: IAC Supplement 6/11/25]

[Editorial change: IAC Supplement 6/10/26]

¹ April 17, 2019, effective date of Chapter 20 [ARC 4339C] delayed 70 days by the Administrative Rules Review Committee at its meeting held April 5, 2019; delay lifted at the meeting held May 14, 2019.

CHAPTER 659
PHYSICIAN SUPERVISION OF A PHYSICIAN ASSOCIATE
PURSUANT TO IOWA CODE CHAPTER 148C
[Prior to 2/4/26, see Medicine Board[653] Ch 21]

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/17/30

481—659.1(148,272C) Ineligibility determinants. A physician with an active permanent, special, or temporary Iowa license who is actively engaged in the practice of medicine in Iowa may supervise a physician associate. A physician is ineligible to supervise a physician associate for any of the following reasons:

659.1(1) The physician does not hold an active, permanent, special or temporary Iowa medical license.

659.1(2) The physician is subject to a disciplinary order of the board that restricts or rescinds the physician's authority to supervise a physician associate. The physician may supervise a physician associate to the extent that the order allows.

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26; Editorial change: IAC Supplement 6/10/26]

481—659.2(148,272C) Exemptions from this chapter. This chapter does not apply to the following:

659.2(1) A physician working in a federal facility or under federal authority when the provisions of this chapter conflict with federal regulations.

659.2(2) A physician who supervises a physician associate providing medical care created by an emergency or a state or local disaster pursuant to Iowa Code section 148C.4.

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26; Editorial change: IAC Supplement 6/10/26]

481—659.3(148) Board notification. A physician who supervises a physician associate shall notify the board of the supervisory relationship within 60 days of the provision of initial supervision and at the time of the physician's license renewal.

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26; Editorial change: IAC Supplement 6/10/26]

481—659.4(148,272C) Requirements for supervising. More information regarding requirements for supervising can be found in rules 481—780.4(148C) through 481—780.6(148C).

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26]

481—659.5(148,272C) Grounds for discipline. A physician may be subject to disciplinary action for supervising a physician associate in violation of these rules, 481—Chapter 661, or 481—Chapter 780, which relate to duties and responsibilities for physician supervision of physician associates. Grounds for discipline also include:

659.5(1) The physician supervises a physician associate when the physician does not have sufficient training or experience to supervise a physician associate in the area of medical practice in which a physician associate is to be utilized.

659.5(2) The physician fails to ensure that the physician associate is adequately supervised, including being available in person or by telecommunication to respond to the physician associate.

659.5(3) The physician fails to adequately direct and supervise a physician associate or fails to comply with the minimum standards of supervision in accordance with this chapter, 481—Chapters 780 through 784, and Iowa Code chapters 148 and 148C.

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26; Editorial change: IAC Supplement 6/10/26]

481—659.6(148,272C) Disciplinary sanction. The board may restrict or rescind a physician's authority to supervise a physician associate as part of a disciplinary sanction following a contested

case proceeding if the reason for the disciplinary action impacts the ability of the physician to supervise a physician associate. The board shall notify the board of physician associates when it takes a disciplinary action against a physician's license that affects the physician's authority to supervise a physician associate.

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26; Editorial change: IAC Supplement 6/10/26]

481—659.7(148,272C) Communication with physician associate supervisees. The physician shall notify all physician associate supervisees within one workday upon receiving disciplinary action from the board or any other change in status that affects the physician's eligibility to supervise a physician associate.

[ARC 9703C, IAB 11/12/25, effective 12/17/25; Editorial change: IAC Supplement 2/4/26; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 148C and section 272C.3.

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[Editorial change: IAC Supplement 2/4/26]

[Editorial change: IAC Supplement 6/10/26]

¹ Effective date of 3/1/89 delayed 70 days by Administrative Rules Review Committee at its February 13, 1989, meeting.

² Effective date of 3/1/89 delayed until adjournment of the 1990 Session of the General Assembly at its May 9, 1989, meeting.

³ Delay until adjournment of the 1990 G.A. lifted by the Administrative Rules Review Committee at its August 3, 1989, meeting which allowed the rules to become effective August 4, 1989.

⁴ Effective date of 4/17/96 delayed 70 days by the Administrative Rules Review Committee at its meeting held April 16, 1996. Effective date delayed until adjournment of the 1997 General Assembly by the Administrative Rules Review Committee at its meeting held June 11, 1996.

⁵ Effective date of 1/28/04 delayed 70 days by the Administrative Rules Review Committee at its January 6, 2004, meeting; at its meeting held March 8, 2004, the Committee lifted the delay, effective March 9, 2004.

⁶ Amendments to ch 21 in ARC 2532C, which included the renumbering of 21.4 to 21.7 as 21.5 to 21.8 (Item 1), the adoption of new 21.4 (Item 2), and the amendment to the implementation sentence (Item 3), rescinded by 2017 Iowa Acts, House File 591, section 2, paragraph "a," on 4/12/17 and, pursuant to paragraph "b," prior language restored IAC Supplement 5/10/17.

CHAPTER 662
COMPLAINTS AND INVESTIGATIONS

[Prior to 7/19/06, see Medical Examiners Board [653] Ch 12]

[Prior to 6/11/25, see Medicine Board[653] Ch 24]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

481—662.1(17A,147,148,272C) Complaints.

662.1(1) *Form and content of the complaint.* A complaint will be made in the form deemed acceptable by the board. The complaint will contain the following information:

a. The full name, address and telephone number of the complainant, except in instances in which the identity of the complainant is unknown.

b. The full name, address and telephone number, if known, of the licensee.

c. A clear and accurate statement of the facts that appraises the board of the allegations against the licensee.

662.1(2) *Place and time of filing of the complaint.* A written complaint may be delivered in person, by mail or electronically to the board office. The office address is Iowa Board of Medicine, 6200 Park Avenue, Suite 100, Des Moines, Iowa 50321.

662.1(3) *Immunity.* A person is not civilly liable as a result of filing a report or complaint with the board or peer review committee, or for the disclosure to the board or its agents or employees, whether or not pursuant to a subpoena of records, documents, testimony or other forms of information that constitute privileged matter concerning a recipient of health care services or some other person, in connection with proceedings of a peer review committee, or in connection with duties of the board. However, such immunity from civil liability is not applicable if such act is done with malice.

[ARC 9121C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—662.2(17A,147,148,272C) Processing complaints and investigations.

662.2(1) *Complaint and investigative files.* Board staff shall open a complaint file upon receiving a complaint or other appropriate information or upon a motion of the board. A complaint file becomes an investigative file once an investigation is ordered.

a. If the board does not have legal jurisdiction over a matter or the complaint does not allege a violation of rule or law, staff may close the complaint file administratively without investigation or review by the board. All other complaints will be sent to the complaint review committee.

b. A complaint file will be labeled as such and is not a public record. A complaint file will become part of the licensee's history with the board.

c. Any time an investigation is ordered, a complaint file will be relabeled as an investigative file. An investigative file is not a public record. The investigative file will become part of the licensee's history with the board and may be shared with another licensing authority upon request.

662.2(2) *Complaint review committee.*

a. The complaint review committee includes the medical advisor, executive director, general counsel for the board, and chief investigator.

b. The complaint review committee reviews each complaint the board has received and takes one of the following four actions:

(1) Close a complaint file administratively for any of these reasons:

1. The board does not have legal jurisdiction over the matter;
2. The case involves a matter that the board is already addressing; or
3. The case is appropriate for referral to the board's Iowa physician health program, and investigation is not warranted.

(2) Recommend to the board's screening committee that the board close the complaint file without investigation.

(3) Request a letter of explanation from the physician, medical records, or both.

(4) Request a full investigation.

- c. The complaint review committee uses the following to guide its decision making:
 - (1) Serious public safety issues include but are not limited to the following:
 - 1. A clear violation of the laws and rules governing the practice of medicine, genetic counseling, or acupuncture, as applicable;
 - 2. Significant investigative history that raises serious concerns about the licensee's ability to practice in a competent and safe manner;
 - 3. Significant investigative history that raises serious concerns that the licensee has engaged in a pattern of unprofessional conduct or disruptive behavior that interferes with, or has the potential to interfere with, patient care or the effective functioning of health care staff;
 - 4. Serious quality of care cases that include severe patient harm, a pattern of inappropriate treatment, or serious medical errors;
 - 5. Serious criminal conduct;
 - 6. Substance abuse or other impairment that significantly impacts the licensee's ability to practice the licensee's respective practice in a competent and safe manner;
 - 7. Sexual misconduct;
 - 8. Severe unprofessional conduct or disruptive behavior;
 - 9. Disciplinary action by another regulatory authority; or
 - 10. Unlicensed practice of medicine, genetic counseling, or acupuncture.
 - (2) Less serious public safety issues include but are not limited to the following:
 - 1. Less serious quality of care cases that do not involve serious patient harm and are isolated occurrences rather than a part of a pattern of inappropriate treatment or serious medical errors;
 - 2. A single incident involving a billing dispute;
 - 3. A single incident involving rude behavior or personality conflicts;
 - 4. A single incident of communication problems; or
 - 5. Poor recordkeeping practices that are not repeated or ongoing in nature and do not significantly affect patient care.
- d. The board may at any time reopen for review and reconsideration any complaint or investigative file that has been closed administratively.
- e. The complaint review committee will indicate high-priority cases when they are assigned for investigation. The committee may provide recommendations to investigators regarding the nature of investigation to be completed. The medical advisor will provide medical advice to the investigators as part of the investigative process.

662.2(3) Screening committee. The screening committee will review the recommendations of the complaint review committee and take one of the following actions:

- a. Recommend to the board that the complaint file be closed without investigation.
- b. Request a letter of explanation from the physician, medical records, or both.
- c. Review the materials acquired pursuant to paragraph 662.2(3)"b" and recommend to the board that the investigative file be closed, with or without issuing an informal letter.
- d. Request an investigation for board review.

662.2(4) Board action.

- a. The board will review the screening committee's recommendations and take one of the following actions:
 - (1) Close the complaint file without investigation. The board will notify the complainant.
 - (2) Close the investigative file that has been partially or fully investigated, with or without issuing an informal letter. The board will notify the complainant and the licensee of the decision.
 - (3) Request further investigation.
- b. The board may reconsider and reopen a closed complaint or investigative file at a later date should it be deemed appropriate.

662.2(5) Investigations.

- a. *Complainants.* At the time an investigation is opened, the complainant will be sent a letter with the name of the investigator assigned to the case and the investigator's contact information

and a statement encouraging the complainant to submit any further information that would assist the investigator with the case.

(1) The complainant may request a meeting with the investigator prior to the completion of the investigation.

(2) The complainant will be informed of the confidentiality of the investigative information as provided in subrule 662.2(8).

(3) The complainant may contact the chief investigator with questions or concerns about the investigation.

b. Investigative subpoenas.

(1) Issuance of an investigative subpoena. The executive director or a designee may, upon the written request of a board investigator or upon the executive director's own initiative, subpoena books, papers, records, and other real evidence necessary for a board investigation.

(2) Request for subpoena. A written request for a subpoena will contain the following:

1. The name and address of the person to whom the subpoena will be directed;
2. A specific description of the books, papers, records or other real evidence requested;
3. An explanation of why the evidence sought to be subpoenaed is necessary for the board to determine whether it should institute a contested case proceeding; and
4. In the case of a subpoena request for mental health records, confirmation that the conditions described in subparagraph 662.2(5) "b"(4) have been satisfied.

(3) Contents of subpoena. Each subpoena will contain the following:

1. The name and address of the person to whom the subpoena is directed;
 2. A description of the books, papers, records or other real evidence requested;
 3. The date, time and location for production or inspection and copying;
 4. The time within which a motion to quash or modify the subpoena must be filed;
 5. The signature, address and telephone number of the executive director or designee;
 6. The date of issuance; and
 7. A return of service attached to the subpoena.
- (4) Subpoena for mental health records. A subpoena for mental health records shall meet the requirements of subparagraph 662.2(5) "b"(3). The board shall document the following prior to the issuance of a subpoena for mental health records:
1. The nature of the complaint reasonably justifies the issuance of a subpoena;
 2. Adequate safeguards have been established to prevent unauthorized disclosure;
 3. An express statutory mandate, articulated public policy, or other recognizable public interest favors access; and
 4. An attempt was made to notify the patient and to secure an authorization from the patient for release of the records at issue.

(5) Motion to quash or modify subpoena.

1. Any person who is adversely affected by compliance with the subpoena and desires to challenge the subpoena must file with the board a motion to quash or modify the subpoena within 14 days of service, or before if the time specified is less than 14 days. The motion shall describe the legal reasons why the subpoena should be quashed or modified and may be accompanied by legal briefs or factual affidavits.

2. Hearing on motion. Upon receipt of a timely motion to quash or modify a subpoena, the board may request an administrative law judge to hold a hearing and issue a decision, or the board may conduct a hearing and issue a decision. Oral argument may be scheduled at the discretion of the administrative law judge or the board. The administrative law judge or the board may quash or modify the subpoena, deny the motion, or issue an appropriate protective order.

3. Appeal of decision on motion. A person who is aggrieved by a ruling of an administrative law judge and who desires to challenge that ruling must appeal the ruling to the board by serving on the board's executive director, either in person or by certified mail, a notice of appeal within ten days after service of the decision of the administrative law judge.

4. Final agency action. If the person contesting the subpoena is not the person under investigation, the board's decision is final for purposes of judicial review. If the person contesting the subpoena is the person under investigation, the board's decision is not final for purposes of judicial review until either the person is notified that the investigation has been concluded with no formal action or there is a final decision in the contested case.

c. Licensee response. Before a contested case begins, the investigator will attempt to reach the licensee at the licensee's listed address to allow the licensee to respond to the allegations. If the licensee cannot be found there, reasonable efforts to locate the licensee will be made. If the licensee cannot be located, the investigation will proceed without the licensee's response, and the findings will be sent to the board. Contact and response from the licensee can be in writing or through a personal interview.

d. Investigative report. Upon completion of an investigation, the investigator will prepare a report for the board's consideration. The report will set forth the information obtained in the course of the investigation and the response, if any, of the licensee.

e. Board review. The board will review the investigative record, discuss the case, and take one of the following actions:

(1) Close the investigative file without action. The board will notify the complainant and the licensee of the decision. The board may reconsider and reopen a closed complaint or investigative file at a later date should it be deemed appropriate.

(2) Request further investigation, including peer review.

(3) Meet with the licensee. The board or the licensee may request that the licensee appear before the board to discuss a pending investigation. The board has discretion on whether to grant a licensee's request for an appearance. By electing to participate in the appearance, the licensee waives any objection to a board member's both participating in the appearance and later participating as a decision maker in a contested case proceeding on the grounds that:

1. Board members have personally investigated the case, and

2. Board members have combined investigative and adjudicative functions.

If the executive director or director of legal affairs participates in the appearance, the licensee further waives any objection to having the executive director or director of legal affairs assist the board in the contested case proceeding.

(4) Issue an informal letter of warning or education. If the board concludes that there is not probable cause to file disciplinary charges, the board may issue the licensee an informal letter of warning or education. A letter of warning or education is an informal communication between the board and the licensee and is not formal disciplinary action or a public document.

(5) File a statement of charges. If the board determines that there is probable cause for taking formal disciplinary action against a licensee, the board shall file a statement of charges, thereby commencing a contested case proceeding.

Prior to the initiation of formal disciplinary charges in a case involving the supervision of a physician associate, the board shall forward a copy of the investigative report to the board of physician associates for its advice and recommendation. The board of physician associates shall respond within six weeks or sooner if requested by the board of medicine. The board of medicine shall consider the advice and recommendation of the board of physician associates.

(6) Request a combined statement of charges and settlement agreement. At the board's discretion, the board and the licensee may enter into a combined statement of charges and settlement agreement to resolve a contested case proceeding.

662.2(6) *Licensee-patient privileged communications.* The privilege of confidential communication between the recipient and the provider of health care services do not extend to afford confidentiality to medical records maintained by or on behalf of the subject of an investigation by the board, or records maintained by any public or private agency or organization, which relate to a matter under investigation by the board. No provision of Iowa Code section 622.10, except as it relates to an attorney of the licensee, or the stenographer or confidential clerk of the licensee's attorney,

shall be interpreted to restrict access by the board or its staff or agents to information sought in an investigation being conducted by the board.

662.2(7) *Investigation of malpractice lawsuits, judgments and settlements.* The board will review reports received from insurance carriers and licensees involving malpractice lawsuits, adverse judgments, and settlements. The board may choose to investigate such reports in the same manner as is prescribed in these rules for the review and investigation of other complaints to determine whether there is probable cause under applicable statutes or administrative rules for licensee discipline.

662.2(8) *Confidentiality of investigative information.* All investigative information gathered by the board or its employees or agents, including peer reviewers, is confidential and privileged. The information cannot be obtained through discovery, subpoena, or other legal means except by the licensee and the board. This information is not admissible in any judicial or administrative proceeding, except in cases involving licensee discipline. However, the board's statement of charges, settlement agreements, or decisions in disciplinary proceedings are public records.

[ARC 9121C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25; Editorial change: IAC Supplement 6/10/26]

481—662.3(272C) Peer review. The board may assign any case to peer review for evaluation of the professional services rendered by the licensee and report to the board.

662.3(1) *Registration of peer reviewers.* The board may register peer reviewers by maintaining a list of peer reviewers in the board office. The board will enter into a contract with peer reviewers to provide peer review services.

662.3(2) *Case referral for peer review.* The board or board staff will determine which peer reviewer(s) will review a case and what investigative information is referred to a peer reviewer.

662.3(3) *Board assistance to peer reviewers.* The board may provide investigatory and related services to assist the peer reviewer(s).

662.3(4) *Confidentiality.* Peer reviewers shall observe the confidentiality requirements imposed by Iowa Code section 272C.6(4).

662.3(5) *Liability, defense and indemnity.* Peer reviewers are not liable for acts, omissions or decisions made in connection with service on the peer review committee. However, such immunity from civil liability does not apply if such act is done with malice. Peer reviewers are to be provided a defense by the state for civil lawsuits related to board peer review and will be indemnified for all such judgments or settlements as provided by applicable law and administrative rules.

662.3(6) *Written peer review report.* Peer reviewers will review the information provided by the board and provide a written report to the board.

a. The written report will contain a statement of facts, an opinion of the peer reviewers whether the licensee violated the standard of care, and the rationale supporting the opinion.

b. The written report shall be signed by all peer reviewers concurring in the report.

c. If the peer reviewers find that they are unable to review the case, the investigative information shall be returned to the board.

[ARC 9121C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/11/25]

481—662.4(272C) Order for physical, mental, or clinical competency evaluation. All licensees will undergo a physical, mental, or clinical evaluation as directed by the board. This evaluation may be ordered if there is probable cause of a mental, physical, or behavioral condition, including professional misconduct, disruptive behavior, or substance abuse. The evaluation may include various assessments for disruptive behavior or neuropsychological, psychiatric, sexual misconduct, or substance abuse evaluations. Clinical competency evaluations can be ordered if there is probable cause of professional incompetence. All evaluation orders and related information are confidential according to Iowa Code section 272C.6(4). The licensee will bear the cost, and orders will be delivered via personal service or certified mail, return receipt requested.

662.4(1) *Content of order.* A board order shall include the following items:

a. Probable cause. A showing by the board that there is probable cause to order the licensee to complete an evaluation.

b. Nature of evaluation or screening. A description of the type of evaluation or screening that the licensee needs to complete.

c. Evaluation facility. The name and address of the examiner or evaluation or treatment or screening facility that the board has identified to perform the evaluation.

d. Scheduling the evaluation. The amount of time in which the licensee must schedule the required evaluation.

e. Completion of the evaluation. The amount of time in which the licensee must complete the evaluation.

f. Board release. A requirement that the licensee sign all necessary releases for the board to communicate with the evaluator or the evaluation or treatment program and to obtain any reports generated by the program.

662.4(2) Alternatives. Following issuance of the evaluation order, the licensee may request additional time to schedule or complete the evaluation or to request the board to approve an alternative evaluator or treatment facility. The board will determine whether to grant such a request.

662.4(3) Objection to order. A licensee who is the subject of a board evaluation order and who objects to the order may file a request for hearing. The request shall be filed within 14 days of issuance of the evaluation order. A licensee who fails to timely file a request for hearing to object to an evaluation order waives any future objection to the evaluation order in the event formal disciplinary charges are filed for failure to comply with the evaluation order or on any other grounds. The request for hearing shall specifically identify the factual and legal issues upon which the licensee bases the objection. The hearing will be considered a contested case proceeding and will be governed by the provisions of 481—Chapter 506.

662.4(4) Closed hearing. Any hearing on an objection to the board order will be closed pursuant to Iowa Code section 272C.6(1).

662.4(5) Order and reports confidential. An evaluation order and any subsequent evaluation reports issued in the course of a board investigation are confidential investigative information pursuant to Iowa Code section 272C.6(4). However, all investigative information related to an evaluation order will be provided to the licensee in the event the licensee files an objection under subrule 24.4(3), in order to allow the licensee an opportunity to prepare for hearing.

662.4(6) Admissibility. In the event the licensee submits to evaluation and subsequent proceedings are held before the board, all objections will be waived as to the admissibility of the licensee's testimony or evaluation reports on the grounds that they constitute privileged communication. The medical testimony or examination reports will not be used against the licensee in any proceeding other than one relating to licensee discipline by the board.

662.4(7) Failure to submit. Failure of a licensee to submit to a board-ordered mental, physical, clinical competency or substance abuse evaluation or alcohol or drug screening constitutes a violation of the rules of the board and is grounds for disciplinary action.

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¹ Effective date of subrule 135.204(10) [renumbered 12/4(10), IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from November 2, 1983.

² Effective date of rules 135.206, 135.207 and 135.208 [renumbered 12.6, 12.7 and 12.8, IAC 5/4/88] delayed by the Administrative Rules Review Committee 70 days from December 12, 1984. Delay lifted by committee on January 9, 1985.

BOARD OF PHYSICIAN ASSISTANTS

CHAPTER 780

LICENSURE OF PHYSICIAN ASSOCIATES

[Prior to 8/7/02, see 645—325.2(148C) to 645—325.5(148C) and 645—325.16(148C)]

[Prior to 9/18/24, see Professional Licensure Division[645] Ch 326]

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/8/30

481—780.1(148C) Definitions. In addition to the definitions herein, and unless otherwise stated, the board adopts by reference the definitions found in Iowa Code section 148C.1.

“Active license” means a license that is current and has not expired.

“Approved program” means a program for the education of physician associates that has been accredited by the Accreditation Review Commission on Education for the Physician Assistant, or its successor, or, if accredited prior to 2001, either by the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.

“CME” means continuing medical education.

“Collaboration” means consultation with or referral to the appropriate physician or other health care professional by a physician associate as indicated by the patient’s condition; the education, competencies, and experience of the physician associate; and the best practice guidelines.

“Direction” means authoritative policy or procedural guidance for the accomplishment of a function or activity.

“Grace period” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, PL 104-191, August 21, 1996, 110 Stat 1936.

“Inactive license” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“Licensee” means a person licensed by the board as a physician associate.

“Licensure by endorsement” means the issuance of an Iowa license to practice as a physician associate to an applicant who is or has been licensed in another state.

“Locum tenens” means the temporary substitution of one licensed physician associate for another.

“Mandatory training” means training on identifying and reporting child abuse or dependent adult abuse required of physician associates who are mandatory reporters. The full requirements on mandatory reporting of child abuse and the training requirements are found in Iowa Code section 232.69. The full requirements on mandatory reporting of dependent adult abuse and the training requirements are found in Iowa Code section 235B.16.

“NCCPA” means the National Commission on Certification of Physician Assistants.

“Opioid” means a drug that produces an agonist effect on opioid receptors and is indicated or used for the treatment of pain or opioid use disorder.

“Other health care provider” means a person licensed as a physician associate under Iowa Code chapter 148C or an advanced registered nurse practitioner licensed under Iowa Code chapter 152.

“Physician” means a person who is currently licensed in Iowa to practice medicine and surgery or osteopathic medicine and surgery. A physician supervising a physician associate practicing in a federal facility or under federal authority will not be required to obtain licensure beyond licensure requirements mandated by the federal government for supervising physicians.

“Prescription monitoring program database” or *“PMP database”* means the Iowa prescription monitoring program database administered by the board of pharmacy pursuant to Iowa Code chapter 124, subchapter VI, and 481—Chapter 556.

“Reactivate” or *“reactivation”* means the process as outlined in rule 481—780.9(17A,147,272C) by which an inactive license is restored to active status.

“Reinstatement” means the process as outlined in rule 481—506.31(272C) by which a licensee who has had a license suspended or revoked or who has voluntarily surrendered a license may apply to have the license reinstated, with or without conditions. Once the license is reinstated, the licensee may apply for active status.

“Supervising physician” means a physician who supervises the medical services provided by the physician associate engaged in independent practice consistent with the physician associate’s education, training, or experience. Supervision shall not be construed as a requirement to be applied to those physician associates who (1) are not engaged in an independent practice arrangement, (2) have already met the requirements to practice independently, or (3) are not required by law to be supervised. Supervision shall not be construed as requiring the personal presence of a supervising physician at the place where such services are rendered, except insofar as the personal presence is expressly required by these rules or by Iowa Code chapter 148C.

“Supply prescription drugs” means to deliver to a patient or the patient’s representative a quantity of prescription drugs or devices that are properly packaged and labeled.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.2(148C) Initial licensure.

780.2(1) The following criteria shall apply to the initial licensure of physician associates:

a. The applicant for licensure will complete an online application packet and pay the nonrefundable application fee.

b. The applicant for licensure will successfully pass the certifying examination conducted by the NCCPA or a successor examination approved by the board. The applicant will request the NCCPA, or its successor agency, to send a copy of the initial certification to the board office.

c. The applicant for licensure will request the approved program for education of physician associates to submit official copies of the applicant’s transcript to the board office.

EXCEPTION: An applicant who is not a graduate of an approved program but who passed the NCCPA initial certification examination prior to 1986 is exempt from the graduation requirement.

d. In lieu of paragraphs 780.2(1)“*b*” and “*c*,” an applicant for licensure may provide documentation from the Federation Credentials Verification Service (FCVS) of the Federation of State Medical Boards as primary source verification for identity, education and national certification information.

780.2(2) If licensed in another jurisdiction, an applicant for licensure will:

a. Complete the licensure by endorsement application;

b. Submit a license verification document that discloses any disciplinary action taken in all jurisdictions where the applicant was previously licensed; and

c. Submit proof of completion of 100 CME hours for each biennium since the licensee was initially certified.

780.2(3) An applicant for licensure who is licensed in another jurisdiction who cannot satisfy the requirements of licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 481—501.1(272C).

780.2(4) An application not completed according to guidelines will not be reviewed by the board.

780.2(5) Incomplete applications that have been on file in the board office for more than two years will be:

a. Considered invalid and destroyed; or

b. Maintained upon written request from the applicant for licensure.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.3(148C) Temporary licensure.

780.3(1) A temporary license may be issued for an applicant for licensure who has not taken the NCCPA initial certification examination or successor agency examination or is waiting for the results of the examination.

780.3(2) An applicant for licensure must comply with subrule 780.2(1), with the exception of paragraphs 780.2(1) “b” and “c.”

780.3(3) A temporary license will be valid for one year from the date of issuance.

780.3(4) The temporary license will be renewed only once upon an applicant for licensure’s showing proof that, through no fault of the applicant, the applicant was unable to take the certification examination recognized by the board. Proof of inability to take the certification examination will be submitted to the board office with written request for renewal of a temporary license, accompanied by the temporary license renewal fee.

780.3(5) If the temporary licensee fails the certification examination, the temporary licensee must cease practice immediately and surrender the temporary license by the next business day.

780.3(6) There is no additional fee for converting temporary licensure to permanent licensure.

780.3(7) An applicant for licensure will ensure that certification of completion is sent to the board directly from an approved program for the education of physician associates. The certification of completion must be signed by a designee from the approved program.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.4(148C) Physician supervision not required. A physician associate is not required to be supervised by a physician when:

780.4(1) The physician associate is licensed in the state of Iowa or eligible to become licensed in the state of Iowa; and

780.4(2) The physician associate has previously practiced under a supervising physician or in collaboration with an Iowa-licensed physician or other licensed health care professional for a period of at least two years; or

780.4(3) The physician associate is not practicing in an independent practice arrangement as defined in Iowa Code section 148C.1(5).

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.5(148C) Physician supervision required.

780.5(1) A physician associate is required to be supervised by a physician when the physician associate is practicing in an independent practice arrangement as defined in Iowa Code section 148C.1(5) and the physician associate has not previously practiced under a supervising physician or in collaboration with the appropriate physician or other health care professional for a period of at least two years.

780.5(2) Requirements for a physician associate and supervising physician.

a. A physician associate will use the jointly approved board forms to notify the board of the identity of the physician associate’s supervising physician prior to beginning practice in Iowa. The physician associate will notify the board of the identity of each of the physician associate’s supervising physicians and of any change in the status of the supervisory relationships during the physician associate’s required supervisory biennium.

b. A physician associate and a supervising physician will utilize the board form to show a mutual understanding of the physician associate’s scope of practice, identified medical procedures and the areas of medicine performed.

c. A physician associate will maintain documentation of current supervising physicians, which will be made available to the board upon request.

d. It shall be the joint responsibility of a physician associate and a supervising physician to ensure the physician associate is adequately supervised. Upon agreeing to supervise the physician associate, the supervising physician will be advised that the physician’s name will be listed with the board as a supervising physician. The physician associate and the supervising physician are each responsible for knowing and complying with the supervision provisions of these rules.

e. Patient care provided by a physician associate will be reviewed with a supervising physician determined at the practice level, ensuring each patient has received the appropriate medical care.

f. Patient care provided by a physician associate may be reviewed with a supervising physician in person, by telephone or by other means of telecommunication and determined at the practice level.
[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.6(148C) Physician eligibility to supervise physician associates. Information on physician eligibility to supervise physician associates is contained in 653—subrules 21.1(1) through 21.1(4).
[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.7(148C) Collaborative practice.

780.7(1) After the conclusion of two years of practice under a supervising physician as required by rule 481—780.5(148C), a physician associate will continue collaboration with a physician or other health care provider as defined in rule 481—780.1(148C), which will be determined at the practice level. This rule shall not be construed to apply to physician associates in independent practice who did not previously meet the criteria of rule 481—780.5(148C).

780.7(2) A collaborating physician or other health care provider defined in rule 481—780.1(148C) and a physician associate should follow best practice guidelines and discuss cases as determined at the practice level. If there are any deficiencies in care noted, the collaborating health care provider will educate the physician associate on best practice guidelines.

780.7(3) The scope of practice for a physician associate shall be limited to medical care that is within the physician associate's education, training, and experience.

780.7(4) Documentation of the collaboration between a physician associate and a physician or other health care provider shall be kept by the physician associate and provided to the board upon request.

780.7(5) Eligibility of other health care provider for collaboration. During the two-year period of collaboration, the other health care provider as defined in rule 481—780.1(148C) shall be a provider who has been in practice for a minimum of five years and is not subject to discipline by the provider's respective licensing authority.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.8(148C) License renewal.

780.8(1) The license renewal period for a license to practice will begin on October 1 and end on September 30 two years later. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

780.8(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal date two years later.

780.8(3) A licensee applying for renewal will:

a. Meet the continuing education requirements of 481—Chapter 782 and the mandatory reporting requirements of subrule 780.8(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Complete the online renewal application, pay the fee, and attach certificate of completion of continuing education hours before the expiration date.

780.8(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa will indicate on the renewal application completion of training in child abuse identification and reporting as required by Iowa Code section 232.69(3)“*b*” in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 780.8(4)“*e*.”

b. A licensee who, in the course of employment responsibilities, examines, attends, counsels or treats adults in Iowa will indicate on the renewal application completion of training in dependent adult

abuse identification and reporting as required by Iowa Code section 235B.16(5) “b” in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 780.8(4) “e.”

c. The course(s) will be the curriculum provided by the department of health and human services.

d. The licensee will maintain written documentation for three years after mandatory training as identified in paragraphs 780.8(4) “a” through “c,” including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse will be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements.

f. The board may select licensees for audit of compliance with the requirements in paragraphs 780.8(4) “a” through “e.”

780.8(5) Upon receiving the information required by this rule and the required fee, a two-year license will be issued. In the event the board receives adverse information on the renewal application, the board will issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

780.8(6) A person licensed to practice as a physician associate will keep the license certificate and renewal displayed in a conspicuous public place at the primary site of practice.

780.8(7) Late renewal. The license will become late when the license has not been renewed by the expiration date on the renewal. A licensee will be assessed a late fee as specified in 481—subrule 507.14(4). To renew a late license, the licensee will complete the renewal requirements and submit the late fee within the grace period.

780.8(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa but may not practice as a physician associate in Iowa until the license is reactivated. A licensee who practices as a physician associate in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.9(17A,147,272C) Requirements for reactivation. To apply for reactivation, a licensee will:

780.9(1) Complete an online reactivation application and pay the nonrefundable reactivation fee.

780.9(2) Provide verification of current competence to practice as a physician associate by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must:

(1) Submit a license verification document that discloses if disciplinary action was taken in the jurisdiction where the applicant was most recently licensed.

(2) Submit proof of completing 100 hours of continuing education within two years of application for reactivation or NCCPA or successor agency certification.

b. If the license has been on inactive status for more than five years, an applicant must:

(1) Submit a license verification document that discloses if disciplinary action was taken against the applicant from every jurisdiction in which the applicant has been licensed.

(2) Submit proof of completing 200 hours of continuing education within two years of application for reactivation, of which at least 40 percent of the hours completed will be in Category I, or NCCPA or successor agency certification.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.10(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with rule 481—506.31(272C) and must apply for and be granted reactivation of the license in accordance with rule 481—780.9(17A,147,272C) prior to practicing as a physician associate in this state.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.11(148C) Use of title. A physician associate licensed under Iowa Code chapter 148C may use the words “physician associate” after the person’s name or signify the same by the use of the letters “PA.” A person who meets the qualifications for licensure under Iowa Code chapter 148C but does not possess a current license may use the title “PA” or “physician associate” but may not act or practice as a physician associate unless licensed under Iowa Code chapter 148C.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

481—780.12(148C) Address change. A physician associate will notify the board of any change in permanent address within 30 days of its occurrence.

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481—780.13(148C) Student physician associate.

780.13(1) Any person who is enrolled as a student in an approved program will comply with the rules set forth in this chapter. A student is exempted from licensure requirements.

780.13(2) Notwithstanding any other provisions of these rules, a student may perform medical services when the medical services are rendered within the scope of an approved program.

[ARC 9536C, IAB 9/3/25, effective 10/8/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A, 147, 148C and 272C.

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[Editorial change: IAC Supplement 6/10/26]

◇ Two or more ARCs

¹ Effective date of 326.1, “remote medical site,” delayed 70 days by the Administrative Rules Review Committee at its meeting held June 7, 2004.

CHAPTER 781
PRACTICE OF PHYSICIAN ASSOCIATES

[Prior to 8/7/02, see 645—325.6(148C) to 645—325.9(148C) and 645—325.18(148C)]

[Prior to 9/18/24, see Professional Licensure Division[645] Ch 327]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/3/29

481—781.1(148C,88GA,ch1020) Duties. The medical services to be provided by the physician associate are those for which the physician associate has been prepared by education, training, or experience and is competent to perform. The ultimate role of the physician associate cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician associate may assume requires that, at the conclusion of the formal education, the physician associate possess the knowledge, skills, and abilities necessary to provide those services appropriate to the practice setting. The physician associate's services may be utilized in any clinical settings including but not limited to offices, ambulatory clinics, hospitals, patient's homes, extended care facilities, and nursing homes.

781.1(1) A physician associate's duties relating to prescribing, dispensing, ordering, administering, and procuring drugs and medical devices include all of the following:

a. Administering any drug.

b. Prescribing, dispensing, ordering, administering, and procuring drugs and medical devices. A physician associate may plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including but not limited to durable medical equipment, nutrition, blood and blood products, and diagnostic support services, including but not limited to home health care, hospice, and physical and occupational therapy. The prescribing and dispensing of drugs may include Schedule II through V substances, as described in Iowa Code chapter 124, and all legend drugs.

c. A physician associate may prescribe drugs and medical devices subject to all of the following conditions:

(1) The physician associate will have passed the national certifying examination conducted by the National Commission on Certification of Physician Assistants or its successor examination approved by the board.

(2) The physician associate must comply with appropriate federal and state regulations.

(3) If a physician associate prescribes or dispenses controlled substances, the physician assistant must register with the federal Drug Enforcement Administration.

(4) The physician associate may prescribe or order Schedule II controlled substances that are listed as depressants in Iowa Code chapter 124.

(5) The physician associate may prescribe, supply, and administer drugs and medical devices in all settings, including but not limited to hospitals, health care facilities, health care institutions, hospice, clinics, offices, health maintenance organizations, and outpatient and emergency care settings.

(6) A physician associate may request, receive, and supply sample drugs and medical devices.

d. Supplying properly packaged and labeled prescription drugs, controlled substances, or medical devices when pharmacist services are not reasonably available or when it is in the best interest of the patient.

(1) If the physician associate is the prescriber of the medications supplied pursuant to this paragraph, the medications supplied will be for the purpose of accommodating the patient and will not be sold for more than the cost of the drug and reasonable overhead costs as they relate to supplying prescription drugs to the patient and not at a profit to the physician associate.

(2) A nurse or staff assistant may assist the physician associate in supplying medications.

781.1(2) The medical services to be provided by the physician associate also include but are not limited to the following:

- a.* Initial approach to a patient of any age group in any setting to elicit a medical history and perform a physical examination.
- b.* Assessment, diagnosis and treatment of medical or surgical problems and recording the findings.
- c.* Order, interpret, or perform laboratory tests, X-rays or other medical procedures or studies.
- d.* Performance of therapeutic procedures such as injections, immunizations, suturing and care of wounds, removal of foreign bodies, ear and eye irrigation and other clinical procedures.
- e.* Performance of office surgical procedures including, but not limited to, skin biopsy, mole or wart removal, toenail removal, removal of a foreign body, arthrocentesis, incision and drainage of abscesses.
- f.* Assisting in surgery.
- g.* Prenatal and postnatal care and assisting a physician in obstetrical care.
- h.* Care of orthopedic problems.
- i.* Performing and screening the results of special medical examinations including, but not limited to, electrocardiogram or Holter monitoring, radiography, audiometric and vision screening, tonometry, and pulmonary function screening tests.
- j.* Instruction and counseling of patients regarding physical and mental health on matters such as diets, disease, therapy, and normal growth and development.
- k.* Function in the hospital setting by performing medical histories and physical examinations, making patient rounds, recording patient progress notes and other appropriate medical records, assisting in surgery, performing or assisting with medical procedures, providing emergency medical services and issuing, transmitting and executing patient care orders.
- l.* Providing services to patients requiring continuing care (i.e., home, nursing home, extended care facilities).
- m.* Referring patients to specialty or subspecialty physicians, medical facilities or social agencies as indicated by the patients' problems.
- n.* Immediate evaluation, treatment and institution of procedures essential to providing an appropriate response to emergency medical problems.
- o.* Order drugs and supplies in the office, and assist in keeping records and in the upkeep of equipment.
- p.* Admit patients to a hospital or health care facility as defined in Iowa Code section 135C.1.
- q.* Order diets, physical therapy, inhalation therapy, or other rehabilitative services as indicated by the patient's problems.
- r.* At the request of the peace officer, withdraw a specimen of blood from a patient for the purpose of determining the alcohol concentration or the presence of drugs.
- s.* Direct medical personnel, health professionals, and others involved in caring for patients and the execution of patient care.
- t.* Authenticate a medical form by signing the form.
- u.* Perform other duties appropriate to a physician associate's practice.
- v.* Health care providers will consider the instructions of a physician associate to be authoritative.

781.1(3) Emergency medicine duties.

- a.* A physician associate may be a member of the staff of an ambulance or rescue squad pursuant to Iowa Code chapter 147A.
- b.* A physician associate will document skills, training and education equivalent to that required of a certified advanced emergency medical technician or a paramedic.
- c.* A physician associate must apply for approval of advanced care training equivalency on forms supplied by the board of physician associates.
- d.* Exceptions to this subrule include:
 - (1) A physician associate who accompanies and is responsible for a transfer patient;
 - (2) A physician associate who serves on a basic ambulance or rescue squad service; and

(3) A physician associate who renders aid within the physician associate's skills during an emergency.

[ARC 8038C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—781.2(148C) Prohibition. No physician associate engaged in independent practice, as defined in Iowa Code section 148C.1(5), will be permitted to measure the visual power and visual efficiency of the human eye, as distinguished from routine visual screening, except in the personal presence of a supervising physician at the place where these services are rendered.

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481—781.3(147,88GA,ch1020) Identification as a physician associate. The physician associate will be identified as a physician associate to patients and to the public, regardless of the physician associate's educational degree.

[ARC 8038C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—781.4(147) Prescription requirements.

781.4(1) Each written outpatient prescription drug order issued by a physician assistant will contain the following:

- a. The date of issuance.
- b. The name and address of the patient for whom the drug is prescribed.
- c. The name, strength, and quantity of the drug, medicine, or device prescribed and directions for use.
- d. The physician associate's name and the practice address.
- e. The signature of the physician associate followed by the initials "PA."
- f. The Drug Enforcement Administration (DEA) number of the physician associate if the prescription is for a controlled substance.

781.4(2) Each oral prescription drug order issued by a physician associate will include the same information required for a written prescription, except for the written signature of the physician associate and the physician associate's practice address.

781.4(3) Prior to prescribing an opioid, a physician associate will review the patient's information contained in the prescription monitoring program database, unless the patient is receiving inpatient hospice care or long-term residential facility patient care.

781.4(4) Beginning January 1, 2020, every prescription issued for a prescription drug will be transmitted electronically unless exempted pursuant to Iowa Code section 124.308 or 155A.27. Beginning January 1, 2020, a licensee who fails to comply with the electronic prescription mandate may be subject to a nondisciplinary administrative penalty of \$250 per violation, up to a maximum of \$5,000 per calendar year.

[ARC 8038C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—781.5(147) Supplying—requirements for containers, labeling, and records.

781.5(1) Containers. A prescription drug will be supplied in a container that meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. §1471-1476 (1976), which relate to childproof closure, unless otherwise requested by the patient. The containers must also meet the requirements of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §301 et seq. (1976), which pertain to light resistance and moisture resistance needs of the drug supplied.

781.5(2) Labeling. A label bearing the following information will be affixed to a container in which a prescription drug is supplied:

- a. The name and practice address of the supervising physician and physician associate.
- b. The name of the patient.
- c. The date supplied.
- d. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician associate.

- e.* The name, strength and quantity of the prescription drug in the container.
- f.* When supplying Schedule II, III, or IV controlled substances, the federal transfer warning statement must appear on the label as follows: "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."

781.5(3) *Samples.* Prescription sample drugs will be provided without additional charge to the patient. Prescription sample drugs supplied in the original container or package will be deemed to conform to labeling and packaging requirements.

781.5(4) *Records.* A record of prescription drugs supplied by the physician associate to a patient will be kept that contains the label information required by paragraphs 781.7(2) "*b*" through "*e*." Noting such information on the patient's chart or record is sufficient.

[ARC 8038C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—781.6(147,148C,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the provision of telemedicine services.

781.6(1) *Telemedicine, generally.*

a. Technological advances have made it possible for licensees in one location to provide medical care to patients in another location with or without an intervening health care provider.

b. Telemedicine is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential cost savings.

c. Licensees using telemedicine will be held to the same standards of care and professional ethics as licensees using traditional in-person medical care.

d. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may subject the licensee to potential discipline by the board.

781.6(2) *Definitions.* For the purposes of this rule:

"*Asynchronous store-and-forward transmission*" means the collection of a patient's relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

"*Board*" means the Iowa board of physician associates.

"*HIPAA*" means the Health Insurance Portability and Accountability Act of 1996, PL 104-191, August 21, 1996, 110 Stat. 1936.

"*In-person encounter*" means that the physician associate and the patient are in the physical presence of each other and are in the same physical location during the physician associate-patient encounter.

"*Licensee*" means a physician associate licensed by the board.

"*Telemedicine*" means the practice of medicine using electronic audiovisual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine, for the purposes of this rule establishing standards of practice, does not include the provision of medical services only through an audio-only telephone, email messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

"*Telemedicine technologies*" means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

781.6(3) *Practice guidelines.* A licensee who uses telemedicine will utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice

guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

781.6(4) *License required.* A physician associate who uses telemedicine in the diagnosis and treatment of a patient located in Iowa will hold an active Iowa physician associate license consistent with state and federal laws. Nothing in this rule will be construed to supersede the exceptions to licensure contained in rule 481—780.17(148C).

781.6(5) *Standards of care and professional ethics.* A licensee who uses telemedicine will be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

781.6(6) *Scope of practice.* A licensee who uses telemedicine will ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

781.6(7) *Identification of patient and physician associate.* A licensee who uses telemedicine will verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

781.6(8) *Physician associate-patient relationship.*

a. A licensee who uses telemedicine will establish a valid physician associate-patient relationship with the person who receives telemedicine services. The physician associate-patient relationship begins when:

- (1) The person with a health-related matter seeks assistance from a licensee;
- (2) The licensee agrees to undertake diagnosis and treatment of the person; and
- (3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician associate and the person.

b. A valid physician associate-patient relationship may be established by:

- (1) In-person encounter. Through an in-person medical interview and physical examination where the standard of care would require an in-person encounter;
- (2) Consultation with another licensee. Through consultation with another licensee (or other health care provider) who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care; or
- (3) Telemedicine encounter. Through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

781.6(9) *Medical history and physical examination.* Generally, a licensee will perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine will interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

781.6(10) *Non-physician associate health care providers.* If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a non-physician associate health care provider, the licensee will:

a. Ensure that systems are in place to ensure that the non-physician associate health care provider is qualified and trained to provide that service within the scope of the non-physician associate health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the non-physician associate health care provider, particularly in the case of injury or an emergency.

781.6(11) *Informed consent.* A licensee who uses telemedicine will ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

781.6(12) *Coordination of care.* A licensee who uses telemedicine will, when medically appropriate, identify the medical home or treating clinician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee will provide a copy of the medical record to the patient's medical home or treating clinician(s).

781.6(13) *Follow-up care.* A licensee who uses telemedicine will have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

781.6(14) *Emergency services.* A licensee who uses telemedicine will refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

781.6(15) *Medical records.* A licensee who uses telemedicine will ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician associate-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee will note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee will ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee will ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

781.6(16) *Privacy and security.* A licensee who uses telemedicine will ensure that all telemedicine encounters comply with the privacy and security measures of HIPAA to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols will be established that address the following:

- (1) Privacy;
- (2) Health care personnel who will process messages;
- (3) Hours of operation;
- (4) Types of transactions that will be permitted electronically;
- (5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;
- (6) Archiving and retrieval; and
- (7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols will include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

781.6(17) *Technology and equipment.* Broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine will comply with the following requirements:

a. The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities;

b. The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services; and

c. The technology and equipment utilized in the provision of telemedicine services must be compliant with HIPAA.

781.6(18) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine will ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

e. Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter;

f. Financial interests, other than fees charged, in any information, products, or services provided by the licensee(s);

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for emails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

781.6(19) *Patient access and feedback.* A licensee who uses telemedicine will ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism will include information regarding the filing of complaints with the board.

781.6(20) *Financial interests.* Advertising or promotion of goods or products from which the licensee receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, internet services may provide links to general health information sites to enhance education; however, the licensee should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees will not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

781.6(21) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

a. Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient;

b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;

- c. Call situations in which a licensee is taking calls for another health care provider who has an established provider-patient relationship with the patient;
- d. Cross-coverage situations in which a licensee is taking calls for another health care provider who has an established provider-patient relationship with the patient;
- e. Emergency situations in which the life or health of the patient is in imminent danger;
- f. Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak;
- g. Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partner(s) for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention; and
- h. For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities, hospice settings, and correctional facilities.

781.6(22) *Prescribing based solely on an internet request, internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an internet request or internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician associate-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 781.9(21).

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These rules are intended to implement Iowa Code sections 147.10 and 147.107 and chapters 148C and 272C.

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¹ June 16, 2004, effective date of amendments published in ARC 3345B delayed 70 days by the Administrative Rules Review Committee at its meeting held June 7, 2004.

² April 22, 2015, effective date of ARC 1909C [327.4(2)] delayed until the adjournment of the 2016 General Assembly by the Administrative Rules Review Committee at a special meeting held April 20, 2015. At its meeting held February 5, 2016, the Committee extended the delay 70 days beyond the adjournment of the 2016 General Assembly.

CHAPTER 782
CONTINUING EDUCATION FOR PHYSICIAN ASSOCIATES
[Prior to 9/18/24, see Professional Licensure Division[645] Ch 328]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/3/29

481—782.1(148C) Definitions. For the purpose of these rules, the following definitions will apply:

“*Active license*” means a license that is current and has not expired.

“*Approved program/activity*” means a continuing education program/activity meeting the standards set forth in these rules.

“*Audit*” means the selection of licensees for verification of satisfactory completion of continuing education requirements during a specified time period.

“*Board*” means the board of physician associates.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensee’s knowledge and skills in order for the licensee to develop new knowledge and skills relevant to the enhancement of practice, education, or theory development to improve the safety and welfare of the public.

“*Hour of continuing education*” means at least 50 minutes spent by a licensee in actual attendance at and completion of an approved continuing education activity.

“*Inactive license*” means a license that has expired because it was not renewed by the end of the grace period. The category of “inactive license” may include licenses formerly known as lapsed, inactive, delinquent, closed, or retired.

“*License*” means license to practice.

“*Licensee*” means any person licensed to practice as a physician associate in the state of Iowa.

[ARC 8039C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—782.2(148C) Continuing education requirements.

782.2(1) The biennial continuing education compliance period will extend for a two-year period beginning on October 1 of each year and ending on September 30 two years later. Each biennium, each licensee will be required to complete a minimum of 100 hours of continuing education approved by the board. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 50 hours from the previous renewal period.

782.2(2) Requirements of new licensees. Those persons licensed for the first time will not be required to complete continuing education as a prerequisite for the first renewal of their licenses. The new licensee will be required to complete a minimum of 100 hours of continuing education per biennium for each subsequent license renewal.

782.2(3) A licensee whose license was reactivated during the current renewal compliance period may use continuing education earned during the compliance period for the first renewal following reactivation.

[ARC 8039C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 9/18/24; ARC 9262C, IAB 5/14/25, effective 6/18/25]

481—782.3(148C,272C) Standards.

782.3(1) General criteria. A continuing education activity is appropriate for continuing education credit if the continuing education activity:

- a. Constitutes an organized program of learning that contributes directly to the professional competency of the licensee;
- b. Pertains to subject matters that integrally relate to the practice of the profession;
- c. Is conducted by individuals who have specialized education, training and experience by reason of which said individuals should be considered qualified concerning the subject matter of the program;

- d. Fulfills stated program goals, objectives, or both; and
- e. Provides an individual certificate of completion or evidence of successful completion of the course provided by the course sponsor. This documentation must contain the course title, date(s), contact hours, sponsor and licensee's name.

782.3(2) *Specific criteria.* Continuing education requirements are as follows:

a. The licensee will complete a minimum of 50 hours of credit designated as Category I by the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association Council on Continuing Medical Education, the American Academy of Family Physicians or other organizations accredited by the Accreditation Council for Continuing Medical Education (ACCME).

b. For the remaining 50 hours of required continuing medical education (CME), Category I or Category II credit, as accepted by the National Commission on Certification of Physician Assistants (NCCPA), will satisfy the CME requirements. In case of audit, licensees will provide evidence of NCCPA certification during the time period being audited or an activity log for all Category II credits for which a certificate of completion is not available. The activity log will list for each activity the date and type of activity and number of hours claimed per activity.

c. Licensees who maintain certification by the NCCPA may show proof of meeting the board's CME requirements by providing proof of current certification by the NCCPA for the time period being reviewed or audited.

d. A licensee who has prescribed opioids to a patient during the renewal cycle will complete a minimum of two hours of continuing education regarding the guidelines for prescribing opioids for chronic pain, as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, including recommendations on limitations on dosages and the length of prescriptions, risk factors for abuse, and nonopioid and nonpharmacologic therapy options, as a condition of license renewal. These hours may count toward the 100 hours of continuing education required for license renewal. The licensee will maintain documentation of these hours, which may be subject to audit.

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CHAPTER 783
DISCIPLINE FOR PHYSICIAN ASSOCIATES

[Prior to 8/7/02, see 645—325.11(148C,272C)]

[Prior to 9/18/24, see Professional Licensure Division[645] Ch 329]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/3/29

481—783.1(148C) Definitions.

“*Board*” means the board of physician associates.

“*Discipline*” means any sanction the board may impose upon licensees.

“*Licensee*” means a person licensed to practice as a physician associate in Iowa.

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481—783.2(147,272C) Grounds for discipline. The board may impose any of the disciplinary sanctions provided in Iowa Code section 272C.3 when the board determines that the licensee is guilty of any of the following acts or offenses or those listed in 481—Chapter 504:

783.2(1) Professional incompetency. Professional incompetency includes but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other physician associates in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care that is ordinarily exercised by the average physician associate acting in the same or similar circumstances.

d. Failure to conform to the minimal standard of acceptable and prevailing practice of a physician associate in this state.

e. Inability to practice with reasonable skill and safety by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or other type of material or as a result of a mental or physical condition.

f. Being adjudged mentally incompetent by a court of competent jurisdiction.

783.2(2) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

783.2(3) Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes but is not limited to an action by a licensee in making information or intention known to the public that is false, deceptive, misleading or promoted through fraud or misrepresentation.

783.2(4) Representing oneself as a physician associate when one’s license has been suspended or revoked, or when one’s license is on inactive status, except as provided by rule 481—780.15(148C).

783.2(5) Failure to comply with universal precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

783.2(6) The performance of a medical function without approved supervision, if supervision is required pursuant to rules 481—780.7(148C) and 481—780.8(148C), except in cases requiring performance of evaluation and treatment procedures essential to providing an appropriate response to an emergency situation.

783.2(7) Prescribing opioids in dosage amounts that exceed what would be prescribed by a reasonably prudent licensee.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 784
ADOPTION OF UNIFORM AND MODEL RULES
[Prior to 9/18/24, see Professional Licensure Division[645] Ch 330]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/28/29

481—784.1(17A,272C) Board of physician associates adoption of uniform and model rules. The board hereby adopts by reference the following:

784.1(1) to **784.1(9)** Reserved.

784.1(10) Model rules for licensee review committee, 481—Chapter 505.

This rule is intended to implement Iowa Code chapter 272C.

[ARC 8148C, IAB 7/24/24, effective 8/28/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

[Filed ARC 8148C (Notice ARC 7296C, IAB 1/24/24), IAB 7/24/24, effective 8/28/24]

[Editorial change: IAC Supplement 9/18/24]

[Editorial change: IAC Supplement 6/10/26]

BOARD OF ATHLETIC TRAINING

CHAPTER 861

LICENSURE OF ATHLETIC TRAINERS

[Prior to 4/17/02, see rules 645—350.6(147,152D) to 645—350.10(147,152D)]

[Prior to 9/18/24, see Professional Licensure Division[645] Ch 351]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/5/29

481—861.1(152D) Definitions. In addition to the definitions included in Iowa Code section 152D.1, the following definitions shall apply:

“*Active license*” means a license that is current and has not expired.

“*Board*” means the board of athletic training created under Iowa Code chapter 147.

“*BOC*” means the Board of Certification or its successor organization.

“*Directing physician*” means a physician who supervises the athletic training services provided by a licensed athletic trainer.

“*Direction*” means that a physician directs the performance of a licensed athletic trainer in the development, implementation, and evaluation of an athletic training service plan as set out in rule 481—861.6(152D). Direction shall not be construed as requiring the personal presence of that physician at each activity of the licensed athletic trainer. It is the responsibility of the licensed athletic trainer to ensure that the practice of athletic training is carried out only under the direction of a licensed physician.

“*Endorsement*” means the issuance of an Iowa license to practice athletic training to an applicant who is currently licensed in another state that has the same or similar qualifications to those required in Iowa.

“*Grace period*” means the 30-day period following expiration of a license when the license is still considered to be active. In order to renew a license during the grace period, a licensee is required to pay a late fee.

“*Licensee*” means any person licensed to practice as an athletic trainer in the state of Iowa.

“*License expiration date*” means February 28 of each odd-numbered year.

“*Mandatory reporter training*” means the training on identifying and reporting child abuse or dependent adult abuse as required in Iowa Code sections 323.69 and 235B.16.

“*Physical reconditioning*” means the part of the practice of athletic training that combines physical treatment, rehabilitation and exercise and is carried out under the orders of a physician or physician associate. Physical treatment is part of a service plan that includes but is not limited to the continued use of any of the following: cryotherapy, thermotherapy, hydrotherapy, electrotherapy, or the use of mechanical devices.

“*Physician*” means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, osteopathy, chiropractic, or podiatry under the laws of this state.

“*Reactivate*” or “*reactivation*” means the process as outlined in rule 481—861.8(17A,147,272C) by which an inactive license is restored to active status.

“*Reinstatement*” means the process as outlined in rule 481—506.31(272C). Once the license is reinstated, the licensee may apply for active status.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 1/22/25; Editorial change: IAC Supplement 6/10/26]

481—861.2(152D) Initial licensure.

861.2(1) Requirements for licensure. The applicant shall:

a. Submit a complete online application and pay the nonrefundable fee specified in rule 481—507.1(147,152D). If the application is not completed according to the instructions, the application will not be reviewed by the board.

b. Submit official copies of academic transcripts directly from the school to the board of athletic training. No application will be considered by the board until official copies of academic transcripts have been received.

c. Have successfully completed the BOC examination. It is the responsibility of the applicant to make arrangements to take the examination and have the official results submitted to the Iowa board of athletic training.

d. Provide verification of license from the jurisdiction in which the applicant has been most recently licensed, sent directly from the jurisdiction to the board office. The applicant must also disclose any public or pending complaints against the applicant in any other jurisdiction.

861.2(2) Web-based verification may be substituted for verification direct from the jurisdiction's board office if the verification provides:

- a.* Licensee's name;
- b.* Date of initial licensure;
- c.* Current licensure status; and
- d.* Any disciplinary actions taken against the license.

861.2(3) Licensure by endorsement. An athletic trainer applicant who holds a license from the District of Columbia or another state, territory, province or foreign country may be eligible for licensure by endorsement and may direct the BOC to submit:

- a.* A current certification status, or
- b.* A passing score on the examination of the BOCs.

861.2(4) Licensure by verification. A person who is licensed in another jurisdiction but who is unable to satisfy the requirements for licensure by endorsement may apply for licensure by verification, if eligible, in accordance with rule 481—501.1(272C).

861.2(5) Incomplete applications that have been on file in the board office for more than two years shall be:

- a.* Considered invalid and shall be destroyed; or
- b.* Maintained upon written request of the candidate. The candidate is responsible for requesting that the file be maintained.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

481—861.3(152D) Educational qualifications.

861.3(1) An applicant for licensure to practice as an athletic trainer shall possess a baccalaureate degree or postbaccalaureate degree from a U.S. regionally accredited college or university.

861.3(2) Foreign-trained athletic trainers shall:

a. Provide an equivalency evaluation of their educational credentials by International Education Research Foundation, Inc., Credentials Evaluation Service, P.O. Box 3665, Culver City, CA 90231-3665; telephone 310.258.9451; website www.ierf.org or email at info@ierf.org. The professional curriculum must be equivalent to that stated in these rules. A candidate shall bear the expense of the curriculum evaluation. An applicant who has passed the BOC examination is exempt from this requirement.

b. Provide a copy of the certificate or diploma awarded to the applicant from an athletic training program in the country in which the applicant was educated. An applicant who has passed the BOC examination is exempt from this requirement.

c. Receive a final determination from the board regarding the application for licensure.

d. Pass the BOC examination. Official results are to be submitted directly to the board from the BOC.

861.3(3) An applicant who has relocated to Iowa from a state that did not require licensure to practice the profession may submit proof of work experience in lieu of educational and training requirements, if eligible, in accordance with rule 481—501.2(272C).

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

481—861.4(152D) Examination requirements.

861.4(1) The examination required by the board shall be the BOC examination. Application and information may be obtained from the BOC Offices, 1411 Harney Street, Suite 200, Omaha, NE 68102; telephone 402.559.0091; website www.bocatc.org or email at BOC@bocatc.org.

861.4(2) The applicant has responsibility for:

- a. Making arrangements to take the national examination; and
- b. Arranging to have the examination scores sent directly to the board from BOC.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

481—861.5(152D) Documentation of physician direction. Each licensee must maintain documentation of physician direction. It is the responsibility of the licensee to ensure that documentation of physician direction is obtained and maintained, including the following:

1. Athletic training service plan as set out in rule 481—861.6(152D);
2. Dates and names of physician and physician associate orders or referrals;
3. Initial evaluations and assessments;
4. Treatments and services rendered, with dates; and
5. Dates of subsequent follow-up care.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24; Editorial change: IAC Supplement 6/10/26]

481—861.6(152D) Athletic training standards of professional practice. Athletic training service plans shall be composed of the following components as taken from the Board of Certification Standards of Professional Practice (January 2018):

861.6(1) Practice Standards.

861.6(2) Code of Professional Responsibility.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

481—861.7(147) License renewal.

861.7(1) The biennial license renewal period for a license to practice athletic training shall begin on March 1 of each odd-numbered year and end on February 28 of the next odd-numbered year. The licensee is responsible for renewing the license prior to its expiration. Failure of the licensee to receive notice from the board does not relieve the licensee of the responsibility for renewing the license.

861.7(2) An individual who was issued a license within six months of the license renewal date will not be required to renew the license until the subsequent renewal two years later.

861.7(3) A licensee seeking renewal shall:

a. Meet the continuing education requirements of rule 481—862.2(152D) and the mandatory reporting requirements of subrule 861.9(4). A licensee whose license was reactivated during the current renewal compliance period may use continuing education credit earned during the compliance period for the first renewal following reactivation; and

b. Submit the completed renewal application and renewal fee before the license expiration date.

861.7(4) Mandatory reporter training requirements.

a. A licensee who, in the scope of professional practice or in the licensee's employment responsibilities, examines, attends, counsels or treats children in Iowa shall indicate on the renewal application completion of training in child abuse identification and reporting as required by Iowa Code section 232.69(3) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 861.7(4) "e."

b. A licensee who, in the course of employment, examines, attends, counsels or treats adults in Iowa shall indicate on the renewal application completion of training in dependent adult abuse identification and reporting as required by Iowa Code section 235B.16(5) "b" in the previous three years or condition(s) for waiver of this requirement as identified in paragraph 861.7(4) "e."

c. The course(s) shall be the curriculum provided by the Iowa department of health and human services.

d. The licensee shall maintain written documentation for three years after mandatory training as identified in paragraphs 861.7(4) “a” through “c,” including program date(s), content, duration, and proof of participation.

e. The requirement for mandatory training for identifying and reporting child and dependent adult abuse shall be suspended if the board determines that suspension is in the public interest or that a person at the time of license renewal:

(1) Is engaged in active duty in the military service of this state or the United States.

(2) Holds a current waiver by the board based on evidence of significant hardship in complying with training requirements.

f. The board may select licensees for audit of compliance with the requirements in paragraphs 861.7(4) “a” through “e.”

861.7(5) Upon receiving the information required by this rule and the required fee, board staff shall administratively issue a two-year license. In the event the board receives adverse information on the renewal application, the board shall issue the renewal license but may refer the adverse information for further consideration or disciplinary investigation.

861.7(6) A person licensed to practice as an athletic trainer shall keep the license certificate and renewal displayed in a conspicuous public place at the primary site of practice.

861.7(7) Late renewal. The license shall become late when the license has not been renewed by the expiration date on the renewal. The licensee shall be assessed a late fee as specified in 481—subrule 507.1(4). To renew a late license, the licensee shall complete the renewal requirements and submit the late fee within the grace period.

861.7(8) Inactive license. A licensee who fails to renew the license by the end of the grace period has an inactive license. A licensee whose license is inactive continues to hold the privilege of licensure in Iowa, but may not practice as an athletic trainer in Iowa until the license is reactivated. A licensee who practices as an athletic trainer in the state of Iowa with an inactive license may be subject to disciplinary action by the board, injunctive action pursuant to Iowa Code section 147.83, criminal sanctions pursuant to Iowa Code section 147.86, and other available legal remedies.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

481—861.8(17A,147,272C) License reactivation. To apply for reactivation of an inactive license, a licensee shall:

861.8(1) Submit a reactivation application on a form provided by the board.

861.8(2) Pay the reactivation fee that is due as specified in 481—Chapter 507.

861.8(3) Provide verification of current competence to practice as an athletic trainer by satisfying one of the following criteria:

a. If the license has been on inactive status for five years or less, an applicant must provide the following:

(1) Verification of the license from the jurisdiction in which the applicant has most recently been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction to the board office. Web-based verification may be substituted for verification from a jurisdiction’s board office if the verification includes:

1. Licensee’s name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 50 hours of continuing education within two years of the application for reactivation or verification of active practice, consisting of a minimum of 2,080 hours, in another state or jurisdiction during the two years preceding an application for reactivation.

b. If the license has been on inactive status for more than five years, an applicant must provide the following:

(1) Verification of the license from the jurisdiction in which the applicant has most recently been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction to the board office. Web-based verification may be substituted for verification from a jurisdiction's board office if the verification includes:

1. Licensee's name;
2. Date of initial licensure;
3. Current licensure status; and
4. Any disciplinary action taken against the license; and

(2) Verification of completion of 40 hours of continuing education within two years of application for reactivation; and

(3) Verification of current BOC certification.

861.8(4) Submit a sworn statement of previous practice from an employer or professional associate, detailing places and dates of employment and verifying that the applicant worked as an athletic trainer for at least 2,080 hours or taught as the equivalent of a full-time faculty member for at least one of the immediately preceding years during the last two-year time period.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

481—861.9(17A,147,272C) License reinstatement. A licensee whose license has been revoked, suspended, or voluntarily surrendered must apply for and receive reinstatement of the license in accordance with rule 481—506.31(272C) and must apply for and be granted reactivation of the license in accordance with rule 481—861.15(17A,147,272C) prior to practicing as an athletic trainer in this state.

[ARC 7928C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/18/24]

These rules are intended to implement Iowa Code chapters 17A, 147, 152D and 272C.

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[Editorial change: IAC Supplement 1/22/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTERS 984 to 1020
Reserved

CHAPTER 1021 DEFINITIONS

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 1]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1021.1(542) Definitions. The following definitions apply to the rules of the board of accountancy.

“*Act*” means the Accountancy Act of 2001 as amended by 2008 Iowa Acts, chapter 1106.

“*AICPA*” means the American Institute of Certified Public Accountants.

“*AICPA Code of Professional Conduct*” means the AICPA code of professional conduct as amended through January 1, 2024.

“*Attest*” or “*attest service*” means the same as defined in Iowa Code section 542.3(1).

“*Attest engagement team*” means the team of individuals participating in attest service, including those who perform concurring and second partner reviews. The attest engagement team includes all employees and contractors retained by the firm who participate in attest service, irrespective of their functional classification.

“*Audit*” means the procedures performed in accordance with applicable auditing standards for the purpose of expressing or disclaiming an opinion on the fairness with which the historical financial or other information is presented in conformity with generally accepted accounting principles, another comprehensive basis of accounting, or a basis of accounting described in the report.

“*Board*” means the same as defined in Iowa Code section 542.3(2).

“*Certificate*” means the same as defined in Iowa Code section 542.3(3).

“*Client*” means the same as defined in Iowa Code section 542.3(6).

“*Commission*” means the same as defined in Iowa Code section 542.3(7) and includes any form of compensation in a fixed or variable amount or percentage received for selling, recommending or referring any product or service of another, including a referral fee.

“*Compensation*” means anything of value received by a CPA or LPA while practicing public accounting for selling, recommending or referring a product or service of another.

“*Compilation*” means the same as defined in Iowa Code section 542.3(8).

“*Contingent fee*” means the same as defined in Iowa Code section 542.3(9).

“*Certified public accountant*” or “*CPA*” means the same as defined in Iowa Code section 542.3(4).

“*Examination of prospective financial information*” means an evaluation by a CPA of a forecast or projection, the support underlying the assumptions in the forecast or projection, whether the presentation of the forecast or projection is in conformity with AICPA presentation guidelines, and whether the assumptions in the forecast or projection provide a reasonable basis for the projection or forecast.

“*FASB*” means the Financial Accounting Standards Board.

“*Financial statement*” means a presentation of financial data, including accompanying notes derived from accounting records and intended to communicate an entity’s economic resources or obligations at a point in time or the changes therein for a period of time in conformity with a comprehensive basis of accounting, but does not include incidental financial data included in management advisory services reports to support recommendations to a client, nor does it include tax returns and supporting documents.

“*Firm*” means a sole proprietorship, partnership, corporation, professional corporation, professional limited liability company, limited liability partnership or any other form of organization issued a permit to practice as a firm under Iowa Code section 542.7 or 542.8 or the office of the auditor of state, state of Iowa, when the auditor of state is a certified public accountant.

“*Forecast*” means prospective financial statements that present, to the best of the responsible party’s knowledge and belief, an entity’s expected financial position, results of operations, and

changes in financial position or cash flows that are based on the responsible party's assumptions reflecting conditions it expects to exist and the course of action it expects to take.

"GASB" means the Governmental Accounting Standards Board.

"Home office" means the same as defined in Iowa Code section 542.3(10).

"IASB" means International Accounting Standards Board.

"IFRS" means International Financial Reporting Standards.

"IRS" means the Internal Revenue Service, United States Department of the Treasury.

"License" means the same as defined in Iowa Code section 542.3(11).

"Licensed public accountant" or *"LPA"* means the same as defined in Iowa Code section 542.3(12).

"Licensed public accounting firm" means the same as defined in Iowa Code section 542.3(13).

"Licensee" means the same as defined in Iowa Code section 542.3(14).

"Managing partner," "managing shareholder," or *"managing member"* means the designated individual with ultimate responsibility for the operation of a firm's practice.

"NASBA" means the same as defined in Iowa Code section 542.3(17).

"NSA" means the National Society of Accountants.

"Office" means the same as defined in Iowa Code section 542.3(18).

"Owner" means any person who has equity ownership interest in a CPA or LPA firm.

"PCAOB" means the Public Company Accounting Oversight Board created by the Sarbanes-Oxley Act of 2002.

"Peer review," as used in 193A—Chapters 11 and 12, means the same as defined in Iowa Code section 542.3(19).

"Person," unless the context indicates otherwise, means individuals, sole proprietorships, partnerships, corporations, limited liability companies, limited liability partnerships or other forms of entities.

"Person associated with a CPA or LPA" means any owner, partner, shareholder, member, employee, assistant, or independent contractor of a CPA or LPA firm.

"Practice of public accounting" means the same as defined in Iowa Code section 542.3(24).

"Practice privilege" means the same as defined in Iowa Code section 542.3(25).

"Principal place of business" means the same as defined in Iowa Code section 542.3(26).

"Projection" means prospective financial statements that present, to the best of the responsible party's knowledge and belief given one or more hypothetical assumptions, an entity's expected financial position, results of operations, and changes in financial position or cash flows that are based on the responsible party's assumptions reflecting conditions it expects would exist and the course of action it expects would be taken given such hypothetical assumptions.

"Report" means the same as defined in Iowa Code section 542.3(27).

"Respondent" means any person against whom a formal statement of charges has been filed.

"Review" means the same as Iowa Code section 542.3(1)"a"(2).

"SAS" means statements on auditing standards.

"SEC" means the United States Securities and Exchange Commission.

"SSARS" means the statements on standards for accounting and review services.

"State" means the same as defined in Iowa Code section 542.3(28).

"Substantial equivalency" means the same as defined in Iowa Code section 542.3(29).

"Year," when used in the context as a time measurement of experience in accounting work, means a period of 365 days.

[ARC 7677C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

This rule is intended to implement Iowa Code chapter 542.

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CHAPTER 1022
ORGANIZATION AND ADMINISTRATION

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 2]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1022.1(542) Description.

1022.1(1) The accountancy examining board administers and enforces the provisions of Iowa Code chapter 542 with regard to the practice of accountancy in the state.

1022.1(2) The primary mission of the board is to protect the public interest.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1022.2(542) Advisory committees. The board chair may appoint advisory committees composed of board members to make recommendations on matters within the board's jurisdiction.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1022.3(542) Annual meeting. At the first board meeting scheduled after April 30 of each year (the annual meeting), the board will elect a chair and vice-chair to serve until their successors are elected.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1022.4(542) Other meetings. Other meetings throughout the year may be established by the chairperson, by board resolution, or by a request of a majority of board members.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1022.5(542) Board administrator's duties. The board administrator's duties include the following:

1022.5(1) Ensuring that complete records are kept of all applications for examination and registration; all certificates, licenses and permits granted; and all necessary information in regard thereto. The board administrator is the lawful custodian of the board records.

1022.5(2) Determining when the prerequisites for licensure have been satisfied with regard to issuance of certificates, licenses or registrations.

1022.5(3) Submitting to the board any questionable application.

1022.5(4) Keeping accurate minutes of board meetings.

1022.5(5) Keeping a list of persons issued certificates as certified public accountants, persons issued licenses as licensed public accountants, and all firms issued permits to practice.

1022.5(6) Performing such additional administrative duties as assigned.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1022.6(542) Disclosure of confidential information.

1022.6(1) Persons who take the examination may consent to the publication of their names on a list of passing candidates.

1022.6(2) Information relating to the examination results, including the specific grades by subject matter, may only be given to the person who took the examination, except that the board may:

a. Disclose the specific grades by subject matter to the regulatory authority of any other state or foreign country in connection with the candidate's application for a reciprocal certificate or license from the other state or foreign country, but only if requested by the applicant.

b. Disclose the specific grades by subject matter to educational institutions, professional organizations, or others, provided the names of the persons taking the examination are not provided in conjunction with the scores.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1022.7(17A,21,22,272C,542) Uniform rules. Administrative and procedural rules can be found in rules of the model rules governing professional licensing division programs 481—Chapters 500 through 507.

[ARC 7678C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A, 21, 22, 272C and 542.

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CHAPTER 1023
CERTIFICATION OF CPAs

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 3]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1023.1(542) Qualifications for a certificate as a certified public accountant.

1023.1(1) A person who meets the qualifications of Iowa Code section 542.5 and this chapter and applies pursuant to Iowa Code section 542.6 may be granted a certificate as a certified public accountant.

1023.1(2) An application may be denied if the applicant is in violation of any of the requirements of Iowa Code chapter 542, prior enforcement proceedings under 481—Chapter 1037, or Iowa Code section 272C.15.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.2(542) Colleges or universities recognized by the board. Pursuant to Iowa Code section 542.5(7), the board recognizes educational institutions accredited by the Association to Advance Collegiate Schools of Business and the regional accrediting bodies listed in the Accredited Institutions of Postsecondary Education as published on January 1, 2024.

This rule is intended to implement Iowa Code section 542.5.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.3(542) Accounting concentration.

1023.3(1) A candidate will be deemed to have met the educational requirement if, as part of the 150 semester hours of education as outlined in Iowa Code section 542.5, the candidate has met one of the following four conditions:

a. Earned a graduate degree with a concentration in accounting from a program that is accredited in accounting by an accrediting agency recognized by the board.

b. Earned a graduate degree in business from a program that is accredited in business by an accrediting agency recognized by the board and completed at least 24 semester hours in accounting, including courses covering the subjects of financial accounting, auditing, taxation, and management accounting. Such accounting hours exclude elementary accounting or principles of accounting, internships or life experience.

c. Earned a baccalaureate degree in business or accounting from a program that is accredited in business by an accrediting agency recognized by the board and completed at least 24 semester hours in accounting courses covering the subjects of financial accounting, auditing, taxation, and management accounting. Such accounting hours exclude elementary accounting or principles of accounting, internships or life experience.

d. Earned a baccalaureate or higher degree and completed the following hours from an accredited institution recognized by the board:

(1) At least 24 semester hours in accounting courses above elementary accounting or principles of accounting covering the subjects of financial accounting, auditing, taxation, and management accounting, not including internships or life experience; and

(2) At least 24 additional semester hours in business-related courses, not including internships or life experience. Elementary accounting hours that do not qualify under subparagraph 1023.3(1) “d”(1) may apply toward business-related courses.

Quarter hours will be accepted in lieu of semester hours at a 3:2 ratio; that is, three quarter hours are equivalent to two semester hours. Internships and life experience hours may apply toward the total required 150 hours.

1023.3(2) The board will consider correspondence study and study in other schools not meeting the above requirements on an individual basis if the candidate can provide evidence that such study

would be acceptable for credit by a college or university recognized by the board; provided, however, that at least 18 of the required hours in accounting and at least 16 of the required hours in business-related subjects are obtained from a college or university recognized by the board.

1023.3(3) The applicant needs to have an official transcript of credit issued by a recognized institution sent by the institution to the board's test administrator at the time of application in order for the applicant's claimed college or university credits to be confirmed.

1023.3(4) Graduates of foreign colleges or universities will have their education evaluated by a foreign credentials evaluation advisory service specified by the board.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.4(542) Examination applications.

1023.4(1) An individual desiring to take the certified public accountant examination as an initial candidate should apply to the board's test administrator. Only a complete application will be considered. A complete application includes a completed application form, the designated fee, and all applicable college transcripts.

1023.4(2) To be eligible to apply for the examination, a candidate needs to fulfill the requirements of rule 481—1023.3(542). A candidate may apply for the examination before the educational requirements are met pursuant to Iowa Code section 542.5(9).

1023.4(3) A candidate whose application is denied under subrule 1023.1(2) may be denied admittance to the examination by the board.

1023.4(4) A candidate may be considered as a reexamination applicant regardless of whether or not the candidate sat for the examination once initially approved. Reexamination applicants may apply to the board's test administrator.

1023.4(5) A nonrefundable proctoring fee will be collected from a candidate who wishes to be proctored in Iowa.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.5(542) Content and grading of the examination.

1023.5(1) The board may use the Uniform Certified Public Accountant Examination prepared by the American Institute of Certified Public Accountants or another nationally recognized organization under a plan of cooperation with the boards of all states and territories of the United States.

1023.5(2) The board may also make use of the advisory grading service provided by the American Institute of Certified Public Accountants or another nationally recognized organization under a plan of cooperation with the boards of all states and territories of the United States.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.6(542) Conditional requirements.

1023.6(1) Effective with the implementation of the computer-based examination, a candidate may take the test subjects individually and in any order. Except as provided in rule 481—1023.7(542), credit for any subjects passed will be valid for 30 months from the actual date initial credit is earned, without the candidate having to attain a minimum score on any failed subject(s) and without regard to whether the candidate sat for any other subjects. The candidate needs to pass all four subjects of the examination within a rolling 30-month period that begins on the date initial credit is earned, which is calculated on the date the examination administrator provides scores to the boards, the candidate, or both. If all four subjects are not passed within the 30-month period, credit for any subject taken outside the 30-month period will expire.

1023.6(2) A candidate will be deemed to have passed the examination once the candidate holds, at the same time, valid credit for passing each of the four subjects of the examination. For purposes of this rule, credit for passing a subject of the examination is valid from the actual date of the testing event for that subject, regardless of the date the candidate actually received notice of the passing score.

This rule is intended to implement Iowa Code section 542.5.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.7(542) Extension of conditional status.

1023.7(1) The time limit within which a candidate needs to pass all subjects under these rules will not include any period during which the candidate was serving in the armed forces of the United States. This exception does not apply if the candidate takes an examination while so serving. The board may extend the time limit in particular instances on a case-by-case basis.

1023.7(2) The time limit within which a candidate needs to pass all subjects under these rules may be extended for hardship cases, such as when the applicant for the examination is prevented from attending for such reasons as unexpected illness, verified by a medical doctor, or a death in the family, verified in writing.

1023.7(3) The time limit within which a candidate needs to pass all subjects under these rules may be extended if circumstances occur that prevent the score from an examination from reaching the candidate in a reasonable period of time. Such circumstances would allow the candidate the opportunity to retake a failed subject.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.8(542) Transfer of credit from another jurisdiction. A candidate requesting transfer of grades from any other jurisdiction will be subject to the same provisions of these rules as an Iowa candidate, provided that the examination given by the licensing authority in the other state was an examination approved by the Iowa board.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.9(542) Examination procedures. At the examination, a candidate needs to provide evidence of identification and comply with the requirements of the examination administrator.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.10(542) Conduct of the examination.

1023.10(1) Any individual who subverts or attempts to subvert the examination process may, at the discretion of the board, have the individual's examination scores declared invalid for the purpose of certification in Iowa, be barred from accountancy licensing and certification examinations in Iowa, or be subject to the imposition of other sanctions the board deems appropriate.

1023.10(2) Individuals are subject to the conduct rules and regulations of the examination administrator.

1023.10(3) Any examination candidate who wishes to appeal a decision of the board under this rule may request a contested case hearing. The request for hearing needs to be in writing, briefly describe the basis for the appeal, and be filed in the board's office within 30 days of the date of the board decision being appealed. Any hearing requested under this subrule will be governed by the rules applicable to contested case hearings under 481—Chapter 506.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.11(542) Refunding of examination fees. Examination fees will not be refunded except in hardship cases, such as when the candidate for the examination is prevented from attending for such reasons as unexpected illness, verified by a medical doctor, a death in the family, or a call to active military service, in which case 50 percent of the fee may be returned. Written documentation including evidence of the hardship will be provided to the board's test administrator.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.12(542) Experience for certificate.

1023.12(1) One year of experience will consist of full- or part-time employment that extends over a period of no less than one year and no more than three years and includes no fewer than 2,000 hours of performance of services outlined in Iowa Code section 542.5(12). Experience may be gained in more than one employment situation, including an internship.

1023.12(2) An applicant seeking qualification as an attest CPA will have, at a minimum, two years of experience, as described in 481—subrule 1026.2(1).

1023.12(3) All experience will be verified by a licensee with direct supervisory control over the applicant or by a licensee who can attest that the experience gained by the applicant meets the requirements of Iowa Code section 542.5(12) if the applicant is not supervised by a licensee.

1023.12(4) Teaching experience will be in the employment of an institution of higher education and will include teaching a minimum of 24 semester hours of accounting courses for which the course participants receive credit on an official transcript. Teaching of noncredit continuing education courses will not qualify under this rule.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.13(542) Ethics course and examination. A successful candidate will need to pass an examination covering the code of ethical conduct prior to issuance of the certificate.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.14(542) Obtaining the certificate.

1023.14(1) A candidate who successfully passes the examination, completes the ethics course and examination and meets the obligations of rule 481—1023.1(542) needs to apply for the certificate on the board's website. An applicant for a certificate may be denied the certificate for reasons outlined in subrule 1023.4(3) regardless of when the incident occurred.

1023.14(2) If the candidate does not file an application for a certificate within three years of passing the examination, the candidate needs to comply with the basic continuing education obligations outlined in rule 481—1030.5(542) prior to filing an application. The continuing education hours need to include a minimum of eight hours of continuing education every three years devoted to financial statement presentation, such as courses covering the statements on standards for accounting and review services (SSARS) and accounting and auditing updates.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1023.15(542) Use of title.

1023.15(1) Only a person who holds an active, unexpired certificate and who complies with the requirements of 481—Chapters 1025 and 1030 or a person lawfully exercising a practice privilege under Iowa Code section 542.20 may use or assume the title “certified public accountant” or the abbreviation “CPA” or any other title, designation, words, letters, abbreviation, sign, card, or device tending to indicate that such person is a certified public accountant.

1023.15(2) Rules regarding the use of the title “CPA” in a firm name are found in the AICPA Code of Professional Conduct as adopted by reference in 481—Chapter 1033.

[ARC 7679C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 542 and section 10A.506.

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CHAPTER 1024
LICENSURE OF LPAs

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 4]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1024.1(542) Qualifications for a license as a licensed public accountant.

1024.1(1) A person who meets the qualifications and applies subject to Iowa Code section 542.8 may be granted a license as a licensed public accountant.

1024.1(2) An application may be denied if the applicant is in violation of any of the requirements of Iowa Code chapter 542, prior enforcement proceedings under 481—Chapter 1037, or Iowa Code section 272C.15.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.2(542) Examination application.

1024.2(1) An individual desiring to take the examination to qualify for a license as a licensed public accountant should apply to the board's test administrator.

1024.2(2) To be eligible to take the examination, the applicant needs to meet the conditions of Iowa Code section 542.8(1) "b" at the time of filing the application.

1024.2(3) A candidate whose application is denied under subrule 1024.1(2) may be denied admittance to the examination by the board.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.3(542) Major in accounting. In determining whether the conditions in Iowa Code section 542.8(1) "b"(2) as to a major in accounting have been met, the board will follow the provisions associated with a concentration in accounting outlined in rule 481—1023.3(542).

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.4(542) Transcripts needed. In order for an applicant's claim to college or university credits to be confirmed, the applicant needs to have an official transcript of credit issued by a recognized institution sent by the institution to the board's test administrator at the time of application.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.5 Reserved.

481—1024.6(542) Content and grading of the examination.

1024.6(1) The board may use the examination prepared by the Accreditation Council for Accountancy and Taxation, without questions regarding auditing or attest functions.

1024.6(2) The board may use the grading services provided by the Accreditation Council for Accountancy and Taxation.

1024.6(3) Absent a showing of good cause, the board will accept the passing grade established by the Accreditation Council for Accountancy and Taxation.

1024.6(4) Alternatively, an applicant may satisfy the examination obligations of this rule by passing the Financial Accounting and Reporting and Regulation sections of the CPA examination provided by the AICPA.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.7(542) Conditional requirements. Effective with the implementation of the computer-based examination, a candidate may take the required test subjects individually and in any order. Except as provided in rule 481—1023.7(542), credit for any subjects passed will be valid for 18 months from the actual date the candidate sat for the subject, without the candidate having to attain a minimum score on any failed subject(s) and without regard to whether the candidate sat for any other subjects. The candidate needs to pass both subjects of the examination within a rolling 18-month

period that begins on the date that the first subject is passed. If both subjects are not passed within the 18-month period, credit for any subject taken outside the 18-month period will expire.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.8(542) Examination procedures. The examination procedures to be followed by a candidate for the certified public accountants' examination as outlined in rule 481—1023.8(542) apply to a licensed public accountant examination candidate.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.9(542) Refunding of examination fees. Examination fees will not be refunded except as provided by the rules concerning the refunding of examination fees to an examination candidate for a certified public accountant certificate outlined in rule 481—1023.10(542).

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.10(542) Credit for an examination taken in another state. A candidate who has partially passed an examination in another state will be given credit for the part or parts passed, provided the candidate meets the conditioning requirements of the board and further provided the examination given by the licensing authority in the other state was an examination that complies with rule 481—1024.7(542).

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.11(542) Experience for license.

1024.11(1) One year of experience will consist of full- or part-time employment that extends over a period of no less than one year and no more than three years and includes no fewer than 2,000 hours of performance of services outlined in Iowa Code section 542.8(8). Experience may be gained in more than one employment situation, including an internship.

1024.11(2) All experience will be verified by a licensee with direct supervisory control over the applicant or by a licensee who can attest that the experience gained by the applicant meets the conditions of subrule 1024.12(1) if the applicant is not supervised by a licensee.

1024.11(3) Teaching experience needs to be in the employment of an institution of higher education and needs to include teaching a minimum of 24 semester hours of accounting courses for which the course participants will receive credit on an official transcript. Teaching of noncredit continuing education courses will not qualify under this rule.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.12(542) Ethics course and examination. A successful candidate will need to pass an examination covering the code of ethical conduct prior to issuance of the license.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.13(542) Statements on standards for accounting and review services (SSARS) education. An LPA license applicant needs to complete a minimum of eight hours of continuing education devoted to statements on standards for accounting and review services (SSARS) prior to issuance of the license.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.14(542) Obtaining the license. A candidate who successfully passes the examination and completes conditions outlined in rules 481—1024.12(542), 481—1024.13(542), and 481—1024.14(542) may apply for licensure on the board's website. An applicant is obligated to list on the application all states in which the applicant has applied for or holds a certificate, license or permit and will also list any past denial, revocation, suspension, refusal to renew, or voluntary surrender to avoid disciplinary action of a certificate, license or permit. An applicant will notify the board in writing within 30 days after the occurrence of any issuance, denial, revocation, suspension, refusal to renew, or voluntary surrender to avoid disciplinary action of a certificate, license or permit.

by another state. An applicant for licensure may be denied the license for reasons outlined in subrule 1024.1(2) regardless of when the incident occurred.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.15(542) Licensure by reciprocity.

1024.15(1) Iowa Code section 542.8 examination obligations will be waived for an applicant who has passed a comparable examination administered by another state if the examination was prepared and graded by the Board of Examiners of the American Institute of Certified Public Accountants or the Accreditation Council for Accountancy and Taxation.

1024.15(2) A person desiring a license as a licensed public accountant in this state on the basis of a licensed public accountant license issued by another state needs to apply on the board's website. The burden is on the applicant to obtain information satisfactory to the board that the applicant's license in such other state is in full force and effect and that the conditions for obtaining such license were substantially equivalent to those of this state to obtain a license as a licensed public accountant.

1024.15(3) An applicant needs to list on the application all states in which the applicant has applied for or holds a certificate, license or permit and needs to also list any past denial, revocation, suspension, refusal to renew or voluntary surrender to avoid disciplinary action of a certificate, license, or permit. An applicant needs to notify the board in writing within 30 days after the occurrence of any issuance, denial, revocation, suspension, refusal to renew or voluntary surrender to avoid disciplinary action of a certificate, license or permit by another state.

1024.15(4) An applicant needs to affirm that all information provided on the form is accurate. Providing false information will be considered prima facie evidence of a violation of Iowa Code chapter 542. A nonrefundable application fee will be charged to each applicant.

[ARC 7680C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1024.16(542) Use of title. Only a person holding a license as a licensed public accountant may use or assume the title "licensed public accountant" or the abbreviation "LPA" or any other title, designation, words, letters, abbreviation, sign, card, or device tending to indicate that such person is a licensed public accountant.

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CHAPTER 1025
LICENSURE STATUS AND RENEWAL OF CERTIFICATES AND LICENSES

[Prior to 7/13/88, see Accountancy, Board of[10]]

[Prior to 5/1/02, see 193A—Chapter 6]

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 5]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1025.1(542) Licensure status and practice privilege.

1025.1(1) Licenses issued by the board pursuant to Iowa Code section 542.6, 542.8, or 542.19, or any other applicable law or rule, may be in active, inactive, or lapsed status, as follows:

a. An initial license is issued in active status with an expiration date. Maintaining active status is conditioned on periodic renewal as provided in rule 481—1025.3(542). Completion of sufficient continuing education as provided in 481—Chapter 1030 is a prerequisite to renewal in active status.

b. A license may be renewed in inactive status as provided in rule 481—1025.7(272C,542) if the licensee does not satisfy the continuing education obligations for renewal in active status. A renewal license issued in inactive status lapses if not timely renewed pursuant to rule 481—1025.3(542). An inactive license may be reinstated to active status at any time pursuant to subrule 1025.7(7).

c. An active or inactive license that is not timely renewed lapses. A lapsed license may be reinstated to active or inactive status at any time pursuant to subrule 1025.4(3).

1025.1(2) Practicing public accounting in Iowa or for a client with a home office in Iowa while holding an inactive or lapsed license is a ground for discipline under Iowa Code section 542.10 and may also or alternatively provide grounds for the regulatory actions described in Iowa Code section 542.14.

1025.1(3) Out-of-state individuals holding an inactive or lapsed Iowa CPA certificate and out-of-state individuals to whom an Iowa CPA certificate has never been issued under Iowa Code chapter 542 or prior law may exercise a practice privilege under Iowa Code section 542.20 if they hold an active CPA certificate in the jurisdiction in which they maintain their principal place of business and otherwise satisfy all of the conditions described in Iowa Code section 542.20 and 481—Chapter 1039.

1025.1(4) Exercising a practice privilege in Iowa or for a client with a home office in Iowa while holding an inactive or lapsed Iowa CPA certificate places a special burden on the individual to ensure that the public is informed about the individual's licensure status in Iowa and in the jurisdiction of active licensure, as provided in 481—paragraphs 1039.8(2)“*b*” and 1039.8(3)“*b*.” As a practical matter, an individual's failure to clarify licensure status in Iowa and in the jurisdiction of the individual's principal place of business may confuse the public. However, the public may consult CPAverify, a comprehensive national data bank, to verify an individual's licensure in another jurisdiction. CPAverify may be accessed at www.cpaverify.org. A client contacting the board or consulting the board's website will be informed of the individual's licensure status in Iowa.

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1025.2(542) Notices.

1025.2(1) The board typically sends, by electronic means, a notice to licensees in the May preceding license expiration, but neither the failure of the board to send nor a licensee's failure to receive a renewal notice excuses the obligation to timely renew a license.

1025.2(2) A licensee needs to notify the board within 30 days of any change of address or firm affiliation.

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1025.3(542) Renewal procedures.

1025.3(1) Licenses expire on June 30 of each year. Licensees will submit electronic online renewal application by the deadline in the renewal year. An application is deemed filed on the date of electronic renewal. An annual renewal fee will be charged.

1025.3(2) Applicants for renewal are obligated to disclose on the application all background and character information requested by the board including, but not limited to:

- a.* All states or foreign jurisdictions in which the applicant has applied for or holds a CPA certificate or license, an LPA license, or a substantially equivalent designation from a foreign country;
- b.* Any past denial, revocation, suspension, or refusal to renew a CPA certificate, license or permit to practice or LPA license; voluntary surrender of a CPA certificate, license or permit or LPA license to resolve or avoid disciplinary action; or similar actions concerning a substantially equivalent foreign designation;
- c.* Any other form of discipline or other penalty imposed against a CPA certificate, license or permit, LPA license, or a substantially equivalent foreign designation, or a practice privilege;
- d.* The conviction of any crime; and
- e.* The revocation of a professional license of any kind in this or any other jurisdiction.

1025.3(3) A licensee who performs compilation services for the public other than through a certified public accounting or licensed public accounting firm needs to submit a certification of completion of a peer review conducted in accordance with 481—Chapter 1031 no less often than once every three years.

1025.3(4) Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application needs to be:

- a.* Received by the board in electronic form on or before the date the license is set to expire or lapse;
- b.* Certified as accurate through the online renewal process;
- c.* Fully completed, including continuing education, if applicable; and
- d.* Accompanied with the proper fee. Attempted financial transactions that result in payment of anything less than the proper fee will result in application rejection.

1025.3(5) The administrative processing of an application to renew an existing license does not prevent the board from subsequently commencing a contested case to challenge the licensee's qualifications for continued licensure if grounds exist to do so.

1025.3(6) If grounds exist to deny a timely and sufficient application to renew, the board will send written notification to the applicant by certified mail, return receipt requested. Grounds may exist to deny an application to renew if, for instance, the licensee failed to meet the continuing education obligations. If the basis for denial is pending disciplinary action or disciplinary investigation, which is reasonably expected to culminate in disciplinary action, the board shall proceed as provided in 481—Chapter 506. 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 481—Chapter 506. The board shall proceed as provided in 481—Chapter 506.

1025.3(7) When a licensee appears to be in violation of mandatory continuing education under 481—Chapter 1030, the board may, in lieu of proceeding to a contested case hearing on the denial of a renewal application as provided in rule 481—506.33(17A,272C), offer a licensee the opportunity to renew in inactive status or 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, depending on the severity of the violation; establish deadlines for compliance; and may impose additional educational obligations on the licensee. A licensee is free to accept or reject the offer. If the offer of settlement is accepted, the licensee will be issued a renewed license 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 applicant pursuant to 481—Chapter 506. A licensee who falsely reports continuing education to the board may be subject to additional sanctions including, when appropriate, suspension or revocation.

1025.3(8) A certificate or license holder who continues to practice public accounting as a CPA or an LPA in Iowa after the certificate or license has expired may be subject to disciplinary action. Such unauthorized activity may also be grounds to deny a licensee's application for reinstatement.

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1025.4(542) Failure to renew.

1025.4(1) A license or certificate holder who fails to renew the certificate or license by the expiration date, but does so within 30 days following its expiration date, will be assessed a penalty as provided in rule 481—1032.1(542).

1025.4(2) If the holder fails to renew the certificate or license within the 30-day grace period, the certificate or license will lapse. The licensee is not authorized to practice during the period of time that the certificate or license is lapsed, including the 30-day grace period.

1025.4(3) The board may reinstate a lapsed certificate or license upon the applicant's submission of an application to reinstate and completion of all of the following:

- a. Paying a penalty as provided in rule 481—1032.1(542);
- b. Paying the current renewal fee;
- c. Providing evidence of completed continuing education outlined in rule 481—1030.5(542), if the licensee wishes to reinstate to active status; and
- d. Providing a written statement outlining the professional activities of the applicant during the period in which the applicant's license was lapsed describing all services performed that constitute the practice of accounting including, but not limited to, those professional practice activities described in subrule 1025.9(2). The applicant will also be obligated to state whether the applicant exercised a practice privilege in the period during which the license was lapsed and, if so, the jurisdiction of the applicant's principal place of business and status of out-of-state licensure.

1025.4(4) A licensee holding a lapsed CPA certificate is not authorized to perform attest or compilation services or to otherwise practice public accounting using the title "CPA" in Iowa or for a client with a home office in Iowa. A licensee holding a lapsed LPA license is not authorized to perform compilation services or to otherwise practice public accounting in Iowa using the title "LPA." A licensee holding a lapsed CPA certificate or LPA license may not use the title "CPA" or "LPA" in any context unless the licensee discloses that the certificate or license has lapsed. Additionally, a person holding a lapsed Iowa CPA certificate and who is actively licensed as a CPA in another jurisdiction in which the person maintains the principal place of business may be eligible to exercise a practice privilege pursuant to Iowa Code section 542.20 and 481—Chapter 1039.

1025.4(5) Practicing public accounting on a lapsed license is a ground for discipline. The board may find probable cause to file charges if the individual continues to offer services defined as the practice of public accounting while using the title "CPA" or "LPA" during the period of lapsed licensure. In addition to the disciplinary sanctions described in rule 481—1036.3(272C,542), individuals found to have practiced public accounting on a lapsed license will be obligated to notify clients upon such terms as the board orders.

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1025.5(272C,542) Certificates and licenses—property of the board. Every certificate or license granted by the board will, while it remains in the possession of the holder, be preserved by the holder but always remain the property of the board. In the event that the certificate or license is revoked or suspended, or is not renewed in the manner prescribed by Iowa Code chapter 542 or 272C, the licensee will, on demand, deliver the certificate or license by the holder to the board. However, a person is entitled to retain possession of a lapsed certificate or license that has not been revoked, suspended or voluntarily surrendered in a disciplinary action as long as the person complies with all provisions of Iowa Code sections 542.10 and 542.13. A lapsed certificate or license may be reinstated to active or inactive status at any time pursuant to subrule 1025.4(3).

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1025.6(542) Licensee's continuing duty to report. An active or inactive licensee has a duty to notify the board in writing of the licensee's conviction of a crime within 30 days of the date of conviction. "Conviction" is defined in Iowa Code section 542.5(2). Licensees also have a duty to notify the board in writing within 30 days of the date of any issuance, denial, revocation, or suspension of a certificate, license or permit by another state.

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1025.7(272C,542) Inactive status.

1025.7(1) *General purpose.* This rule establishes a procedure under which a person issued a certificate as a certified public accountant or a license as a licensed public accountant may apply to the board for licensure in inactive status. Inactive licensure under this rule is available to a certificate or license holder who is not engaged in Iowa or for a client with a home office in Iowa in any practice of public accounting. A person eligible for inactive status may, as an alternative, allow the person's certificate or license to lapse.

1025.7(2) *Eligibility.* A person holding a lapsed or active certificate or license that has not been revoked or suspended may apply to renew in inactive status through the online application process if the person is not engaged in the state of Iowa or for clients with a home office in Iowa in any practice regulated by the board, including:

a. Supervising or performing any attest services, such as audits, reviews or agreed-upon procedures (which may only be performed by a CPA within a CPA firm that holds a permit to practice);

b. Supervising or performing compilation services or otherwise issuing compilation reports (which may only be performed by a CPA or LPA); or

c. Performing any accounting, tax, consulting, or financial or managerial advisory services for any client, business, employer, government body, or other entity while holding oneself out as a CPA or an LPA or otherwise using titles regulated by Iowa Code section 542.13.

1025.7(3) *Affirmation.* The application form will contain a statement in which the applicant affirms that the applicant will not engage in any of the practices in Iowa listed in subrule 1025.7(2) 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 subrule 1025.7(7).

1025.7(4) *Renewal.* A person licensed in inactive status may renew the person's certificate or license on the schedule described in rule 481—1025.1(542). Such person is exempt from the continuing education provisions under 481—Chapter 1030 and will be charged a reduced renewal fee as provided in rule 481—1032.1(542). An inactive certificate or license lapses if not timely renewed.

1025.7(5) *Permitted practices.* A person may, while registered as inactive, perform for a client, business, employer, government body, or other entity those accounting, tax, consulting, or financial or managerial advisory services that may lawfully be performed by a person to whom a certificate or license has never been issued as long as the person does not in connection with such services use the title "CPA" or "LPA," or any other title regulated under Iowa law for use only by CPAs or LPAs in Iowa Code section 542.13 (with or without additional designations such as "inactive"). Regulated titles may only be used by active CPAs or LPAs who are subject to continuing education under 481—Chapter 1030 to ensure that the use of such titles is consistently associated with the maintenance of competency through continuing education. Additionally, individuals who are actively licensed as CPAs in another jurisdiction in which they maintain their principal place of business may be eligible to exercise a practice privilege pursuant to Iowa Code section 542.20 and 481—Chapter 1039.

1025.7(6) *Unauthorized practices.* A person who, while licensed in inactive status, engages in any of the practices described in subrule 1025.7(2) or violates any provision of rule 481—1034.2(17A,272C,542) is subject to disciplinary action. A person in inactive status is not authorized to verify the experience of an applicant for a CPA certificate under Iowa Code section 542.5(12) or an applicant for an LPA license under Iowa Code section 542.8(8).

1025.7(7) *Reinstatement to active status.* A person licensed in inactive status needs to, prior to engaging in any of the practices in Iowa listed in subrule 1025.7(2) or for a client with a home office in Iowa, apply to the board to reinstate to active status. Such person will be obligated to pay the applicable renewal fee for active status, but is given credit for renewal fees previously paid for inactive status if the person applies for reinstatement at a date other than the person's regular renewal date. Such person will be obligated to demonstrate compliance with all applicable continuing

education and peer review obligations. A person who has engaged in the practice of public accounting as an active licensee of another jurisdiction while licensed as inactive in Iowa will be deemed to have satisfied the continuing education obligations for reinstatement if the person demonstrates that the person has satisfied substantially equivalent continuing education in the other jurisdiction.

1025.7(8) *Retired status.* A person holding an inactive license who does not reasonably expect to return to the workforce in the practice of public accounting due to bona fide retirement or disability may use the title “CPA, retired” or “LPA, retired,” as applicable, in the context of non-income-producing personal activities. These designations may only be used during a period of bona fide retirement or disability.

[ARC 7681C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 272C and 542 and section 10A.506.

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CHAPTER 1026
ATTEST AND COMPILATION SERVICES
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 6]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1026.1(542) Who may perform attest services.

1026.1(1) Only a CPA may perform audit, review, or other attest services as defined in Iowa Code section 542.3(1).

1026.1(2) Only an actively licensed attest-certified Iowa CPA or an out-of-state licensee exercising a practice privilege under Iowa Code section 542.20 may perform attest services in Iowa or for a client with a home office in Iowa. CPAs are cautioned, however, that a government body or a client may obligate that an individual be licensed in Iowa as a condition of performing attest services in Iowa or for a client with a home office in Iowa, whether or not the individual may otherwise satisfy the conditions for a practice privilege. Iowa licensure as a certified public accountant is a precondition, for example, to perform certain audit services described in Iowa Code chapter 11.

1026.1(3) CPAs performing attest services, whether the CPAs are certified in Iowa or exercising a practice privilege, may only do so in a CPA firm that holds a permit to practice pursuant to Iowa Code section 542.7 or in an out-of-state CPA firm exercising a practice privilege in compliance with Iowa Code section 542.20(5) and 542.20(6) and associated rules and the peer review and ownership provisions of Iowa Code section 542.7.

1026.1(4) CPAs who are responsible for supervising attest services for a CPA firm or who sign or authorize someone to sign the accountant's report on behalf of a CPA firm are obligated to satisfy the experience or competency obligations established by nationally recognized professional standards that are applicable to the attest services performed.

[ARC 7682C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1026.2(542) Necessary attest experience.

1026.2(1) A CPA who is responsible for supervising attest services or who signs or authorizes someone to sign the accountant's report on behalf of a firm is obligated to have two years of full-time or part-time equivalent experience that extends over a period of no less than two years and includes no fewer than 4,000 hours, including at least 2,000 hours providing attest services under the supervision of one or more CPAs responsible for supervising attest services on behalf of a CPA firm that holds a permit to practice in Iowa or an equivalent form of CPA firm licensure in another jurisdiction.

1026.2(2) Experience needs to include all of the following:

- a. Experience in applying a variety of attest procedures and techniques to the usual and customary financial transactions recorded in accounting records.
- b. Experience in the preparation of attest working papers covering the examination of the accounts usually found in accounting records.
- c. Experience in the planning of the program of attest work, including the selection of the procedures to be followed.
- d. Experience in the preparation of written explanations and comments on the findings of the examinations and on the content of the accounting records.
- e. Experience in the preparation and analysis of reports and financial statements together with explanations and notes thereon.

1026.2(3) Attest experience is verified by the applicant and by a CPA who supervised the applicant or, if a supervising CPA is unavailable, by a CPA or CPA firm with sufficient factual documentation to verify the applicant's attest qualification.

1026.2(4) Any applicant or CPA who has been requested to submit to the board evidence of an applicant's attest experience and has refused to do so will, upon request by the board, explain in writing or in person the basis for the refusal. The board may obligate any applicant or CPA who furnished the evidence of an applicant's experience to substantiate the information provided. An

applicant may be obligated to appear before the board to supplement or verify evidence of experience. The board may inspect documentation relating to an applicant's claimed experience.

[ARC 7682C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1026.3(542) Attest qualification.

1026.3(1) Attest qualification is necessary before a CPA may perform attest services in Iowa or for a client with a home office in Iowa. "Attest qualification" or "attest qualified" means that the CPA has satisfied the experience obligations of rule 481—1026.2(542).

1026.3(2) All CPAs who held an individual permit to practice in Iowa at any point prior to July 1, 2002, are deemed to be attest qualified. Under Iowa law prior to July 1, 2002, CPAs were only issued an individual permit to practice if they verified their qualification to perform attest services. Individual permits to practice were discontinued under Iowa law effective July 1, 2002.

1026.3(3) CPAs who did not hold a permit to practice prior to July 1, 2002, may attain or establish attest qualification as follows:

a. Applicants may apply for attest qualification when initially applying for a certificate as an Iowa CPA under Iowa Code section 542.6 or when applying for reciprocal Iowa certification under Iowa Code section 542.19 or any other applicable law or rule.

b. Iowa CPA certificate holders may apply for attest qualification at any time at which they are qualified to do so.

c. Out-of-state CPAs performing attest services while exercising a practice privilege under Iowa Code section 542.20 do not have to individually apply to the board for attest qualification. However, if:

(1) CPAs perform attest services in an Iowa CPA firm, the Iowa CPA firm will affirm when applying for an initial or renewal firm permit to practice that the CPAs who supervise attest services for the firm or who sign or authorize someone to sign the accountant's report on behalf of the firm, as such attest services are or will in the following year be performed in Iowa or for a client with a home office in Iowa, have been qualified to perform attest services in Iowa or another jurisdiction.

(2) CPAs perform attest services through an out-of-state CPA firm exercising a practice privilege, the out-of-state CPA firm will affirm upon request from the board that the CPAs who supervise attest services for the firm or who sign or authorize someone to sign the accountant's report on behalf of the firm, as such attest services are or will in the following year be performed in Iowa or for a client with a home office in Iowa, have been qualified to perform attest services in Iowa or another jurisdiction.

[ARC 7682C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1026.4(542) Compilation services.

1026.4(1) Only a CPA licensed by the board under Iowa Code section 542.6 or 542.19 or any other applicable law or rule; an LPA licensed by the board under Iowa Code section 542.8 or any other applicable law or rule; or a person exercising a practice privilege under Iowa Code section 542.20 may issue a report in standard form upon a compilation of financial information or otherwise provide compilation services in Iowa or for a client with a home office in Iowa.

1026.4(2) An individual described in subrule 1026.4(1) may perform compilation services through a CPA firm that holds a permit to practice under Iowa Code section 542.7, an LPA firm that holds a permit to practice under Iowa Code section 542.8, a CPA firm exercising a practice privilege under Iowa Code section 542.20, or, if both the individual and business comply with Iowa Code section 542.13(13), through any other form of business.

1026.4(3) All individuals described in subrule 1026.4(1) who are responsible for supervising compilation services or who will sign or authorize someone to sign the accountant's compilation report on financial statements, as such compilation services will be performed in Iowa or for a client with a home office in Iowa, are obligated to comply with the nationally recognized professional standards that are applicable to compilation services, including SSARS.

1026.4(4) All individuals described in subrule 1026.4(1) will satisfy peer review obligations individually or through the peer review of a CPA or LPA firm holding a permit to practice pursuant

to Iowa Code section 542.7 or 542.8 or a CPA firm exercising a practice privilege under Iowa Code section 542.20.

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CHAPTER 1027
CERTIFIED PUBLIC ACCOUNTING FIRMS

[Prior to 5/1/02, see 193A—Chapter 8]

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 7]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1027.1(542) When licensure is needed.

1027.1(1) Except as provided in 481—Chapter 1040, a sole proprietorship, corporation, partnership, limited liability company, or any other form of organization is obligated to apply for a permit to practice as a firm of certified public accountants pursuant to Iowa Code section 542.7.

1027.1(2) A firm that is not subject to subrule 1027.1(1) may practice public accounting in Iowa in accordance with Iowa Code section 542.7(1) “b.”

1027.1(3) Unless individual Iowa licensure is needed by a government body or a client, the public accounting services provided by a CPA firm holding an Iowa permit to practice may be performed in Iowa or for a client with a home office in Iowa by Iowa CPAs or wholly by persons exercising a practice privilege under Iowa Code section 542.20.

1027.1(4) A CPA firm issued a permit to practice by the board is accountable to the board and subject to discipline by the board for the acts of its owners or other agents, pursuant to 481—subrule 1034.2(4), whether or not such persons are individually licensed by the board.

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1027.2(542) Application process.

1027.2(1) All applications are submitted through the board’s online application process. The board will only process fully completed applications accompanied by the proper fee. Each application fee is nonrefundable.

1027.2(2) An initial or renewal application for a firm permit to practice may be denied:

- a. Pursuant to Iowa Code section 542.7(3) “f”;
- b. Based on the firm’s failure to comply with Iowa Code section 542.7 or a failure to sustain the simple majority of ownership obligations of Iowa Code section 542.7(3); or
- c. Based on a regulatory or disciplinary action or, to the extent applicable and subject to the limitations and processes set forth at Iowa Code section 272C.15 and corresponding implementing rules located at 481—Chapter 502, a criminal conviction described in subrules 1027.3(14) and 1027.3(15) against any of the firm’s licensed or unlicensed owners.

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1027.3(542) Application contents. Applicants for a firm permit to practice will provide information requested by the board, including:

1027.3(1) The lawful name of the firm.

1027.3(2) The legal form and jurisdiction of the firm’s organization.

1027.3(3) Contact information for the principal place of business of the firm and each Iowa office.

1027.3(4) All jurisdictions in which the firm is licensed or has applied for licensure.

1027.3(5) The names, licensure, and contact information for all persons responsible for supervising attest and compilation service or responsible for the proper licensure of the firm.

1027.3(6) The highest level of public accounting services offered by the firm, such as compilation or attest.

1027.3(7) Evidence of satisfactory completion of the last firm peer review, when applicable.

1027.3(8) Sufficient information from which the board can determine that a simple majority of owners hold a CPA certificate under Iowa Code section 542.6 or 542.19 or hold a CPA certificate in another state and are eligible to exercise a practice privilege under Iowa Code section 542.20. The board reserves the right to request at any time a full list of owners, or a targeted sublist, such as a list

of those persons who perform services from an Iowa office or those who perform attest or compilation services in Iowa or for a client with a home office in Iowa.

1027.3(9) The affirmation described in 481—paragraph 1026.3(3) “c.”

1027.3(10) Affirmation that all CPAs who are responsible for supervising attest services for the CPA firm or who sign or authorize someone to sign the accountant’s report on behalf of the CPA firm satisfy the experience or competency standards established by nationally recognized professional standards.

1027.3(11) Affirmation that all CPAs or LPAs who are responsible for supervising compilation services or who sign or authorize someone to sign the accountant’s compilation report on behalf of the firm comply with nationally recognized professional standards that are applicable to the compilation services performed in Iowa or for a client with a home office in Iowa.

1027.3(12) Affirmation that all nonlicensee owners are active participants in the firm or affiliated entity.

1027.3(13) Affirmation that the firm and its licensed or unlicensed owners will comply with all applicable Iowa laws and rules, including rules of professional conduct, when practicing in Iowa or for a client with a home office in Iowa.

1027.3(14) Details of any past denial, cancellation, revocation, suspension, refusal to renew, or voluntary surrender of a professional license of any kind, authority to practice, or practice privilege by the board or another state agency in any jurisdiction, a federal agency, or the PCAOB, regarding the firm and the firm’s current owners (e.g., partners, shareholders, or members).

1027.3(15) Details of any past felony conviction or the conviction of any crime, any element of which is dishonesty or fraud, as provided in Iowa Code section 542.5(2), under the laws of any state or the United States, regarding the firm and the firm’s current owners (e.g., partners, shareholders, or members).

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1027.4(542) Renewal procedures.

1027.4(1) The permit holder will submit an electronic online renewal by the June 30 deadline each year. Applications are deemed filed on the date of electronic renewal.

1027.4(2) The permit holder will list on the renewal application all states in which the applicant has applied for or holds a permit as a certified public accounting firm and list any past denial, revocation, suspension, refusal to renew or voluntary surrender to avoid disciplinary action of a permit to practice or practice privilege. Renewal applications include such additional information as the board needs, including all of the information described in rule 481—1027.3(542).

1027.4(3) Within the meaning of Iowa Code chapters 17A, 272C and 542, a timely and sufficient renewal application will be:

- a. Received by the board in electronic form on or before June 30;
- b. Certified as accurate through the online renewal process;
- c. Fully completed and accompanied with the proper fee. The fee will be deemed improper if, for instance, the amount is incorrect, the fee was not included with the application, the credit card number provided by the applicant is incorrect, the date of expiration of a credit card is omitted or incorrect, the attempted credit card transaction is rejected, or the applicant’s check is returned for insufficient funds or a closed account.

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1027.5(542) Failure to renew permit.

1027.5(1) A firm that fails to renew the permit by the expiration date, but does so within 30 days following the expiration date, will be assessed a penalty as provided in rule 481—1032.1(542).

1027.5(2) If the firm fails to renew the permit within the 30-day grace period outlined in rule 481—1027.6(542), the permit will lapse and the firm will need to reinstate in accordance with rule 481—1027.7(542). The firm is not authorized to practice during the period of time that the permit is lapsed, including the 30-day grace period.

1027.5(3) The board may reinstate the permit upon payment of the proper renewal fee and a penalty as provided in rule 481—1032.1(542). A written statement outlining the firm's professional activities during the period of lapsed licensure, including a list of Iowa clients and the services performed, is also needed.

1027.5(4) The board may find probable cause to file charges for unlicensed practice if the firm engaged in any activity that obligates licensure pursuant to subrule 1027.1(1) during the period of lapsed licensure. In addition to the disciplinary sanctions described in rule 481—1036.3(272C,542), firms found to have practiced public accounting in violation of subrule 1027.1(1) on a lapsed license will notify clients upon such terms as the board orders.

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1027.6(542) Notice to the board. A holder of or applicant for a permit shall notify the board in writing within 30 days of an occurrence described in Iowa Code section 542.7(6).

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1027.7(542) Noncompliance. The board may grant a reasonable period of time, usually 90 days, for a firm to take such corrective action pursuant to Iowa Code section 542.7(7).

[ARC 7683C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A, 272C and 542 and section 10A.506.

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CHAPTER 1028
LICENSED PUBLIC ACCOUNTING FIRMS

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 8]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1028.1(542) Initial permit to practice.

1028.1(1) A sole proprietorship, corporation, partnership, limited liability company, or any other form of organization may apply for a permit to practice under Iowa Code section 542.8.

1028.1(2) The application may be completed and submitted through the online application process and provide sufficient information pursuant to Iowa Code section 542.8(12) or certificates issued by the board under Iowa Code section 542.6 or 542.19 or are eligible to practice under practice privilege pursuant to Iowa Code section 542.20, or otherwise hold a license or certificate to practice public accounting in another state. At least one owner has to be licensed under Iowa Code section 542.8.

1028.1(3) The application will list the physical location and contact information for all offices within this state and the licensee in charge of each such office.

1028.1(4) Fraud or deceit, by commission or omission, in obtaining a firm permit to practice is a ground for discipline, including permanent revocation of the firm's permit to practice, the individual certificate of an Iowa LPA or CPA, or an individual's practice privilege, as applicable to the entity or persons responsible.

1028.1(5) An initial or renewal application for a firm permit to practice may be denied pursuant to Iowa Code section 542.8(12) "e."

[ARC 7684C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1028.2(542) Renewal procedures. The permit holder will submit an online renewal with the board by the June 30 deadline each year. Applications are deemed filed on the date of renewal.

[ARC 7684C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1028.3(542) Failure to renew permit.

1028.3(1) A firm that fails to renew the permit by the expiration date, but does so within 30 days following the expiration date, will be assessed a penalty of 25 percent of the annual renewal fee.

1028.3(2) If the firm fails to renew the permit within the 30-day grace period outlined in subrule 1028.3(1), the permit will lapse and the firm may then apply for reinstatement in accordance with subrule 1028.3(3). The firm is not authorized to practice as an LPA firm during the period of time that the permit is lapsed, including the 30-day grace period.

1028.3(3) The board may reinstate the permit upon payment of the proper renewal fee and a penalty as provided in rule 481—1032.1(542). A written statement outlining the firm's professional activities during the period of lapsed licensure is needed in this context.

1028.3(4) The board may find probable cause to file charges for unlicensed practice if the firm continues to offer services defined as the practice of accounting while using the title "LPAs" or "LPA firm" during the period of lapsed licensure.

[ARC 7684C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1028.4(542) Notice to the board. A holder of or an applicant for a permit will notify the board in writing within 30 days in compliance with Iowa Code section 542.8(15).

[ARC 7684C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1028.5(542) Noncompliance. A firm which, after receiving or renewing a permit, is not in compliance with Iowa Code section 542.8 as a result of a change in firm ownership or personnel will take corrective action to bring the firm back into compliance as quickly as possible or apply to modify or amend the permit. The board may grant a reasonable period of time, usually 90 days, for a firm to

take such corrective action. Failure to comply within a reasonable period as deemed by the board will result in the suspension or revocation of the firm permit.

[ARC 7684C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1028.6(542) Peer review obligations. Firm peer review is necessary pursuant to Iowa Code section 542.7(8).

[ARC 7684C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A, 272C and 542 and section 10A.506.

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CHAPTER 1029
RECIPROCITY AND SUBSTANTIAL EQUIVALENCY

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 9]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1029.1(542) Iowa CPA certificate necessary. A person who holds a certificate or license to practice as a CPA in another state or a substantially equivalent designation from a foreign jurisdiction may apply to the board for an Iowa CPA certificate and has to do so if the person plans to establish the person's principal place of business as a CPA in Iowa.

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1029.2(542) Application forms. Application forms may only be completed and submitted through the online application process. An applicant will attest that all information provided on the form is true and accurate. An application may be denied based on a false statement of material fact. A nonrefundable fee will be charged to each applicant as provided in 481—Chapter 1032.

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1029.3(542) Background and character.

1029.3(1) An applicant for a CPA certificate under this chapter will disclose on the application all background and character information requested by the board including, but not limited to:

- a.* All states or foreign jurisdictions in which the applicant has applied for or holds a CPA certificate or license, or a substantially equivalent designation from a foreign country;
- b.* Any past denial, revocation, suspension, or refusal to renew a CPA certificate, license or permit to practice, or voluntary surrender of a CPA certificate, license or permit to resolve or avoid disciplinary action, or similar actions concerning a substantially equivalent foreign designation;
- c.* Any other form of discipline imposed against the holder of a CPA certificate, license or permit, or a substantially equivalent foreign designation;
- d.* The conviction of any felony or any crime described in Iowa Code section 542.5(2);
- e.* The revocation of a professional license of any kind in this or any other jurisdiction; and
- f.* Such additional information as the board may request to determine if grounds exist to deny certification under 481—subrule 1023.1(2).

1029.3(2) The board may deny an application based on prior discipline imposed against the holder of a CPA certificate, license or permit, or a substantially equivalent foreign designation, or on any of the grounds listed in 481—subrule 1023.1(2).

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1029.4(542) Verification of state licensure. An applicant holding a CPA certificate or license from another state or states will submit verification that the applicant's CPA certificate or license is valid and in good standing in the state in which the applicant's principal place of business is located. An applicant applying for a CPA certificate under the substantial equivalency provisions of Iowa Code section 542.19(1) "a" and paragraph 1029.5(1) "a" may attach a letter of good standing to the application. Such letter of good standing will be prepared by the state in which the applicant's principal place of business is located and be dated within six months of the date of the application. To expedite the application process, the board will accept verification from another state's board by facsimile or email. The board reserves the right to request an original verification document directly from another state board.

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1029.5(542) Qualifications for a CPA certificate.

1029.5(1) A person who holds in good standing a valid CPA certificate or license from another state is deemed qualified for an Iowa CPA certificate if the person satisfies one of the following three conditions:

a. Substantially equivalent state. The licensing standards on education, examination and experience of the state that issued the applicant's CPA certificate or license were, at the time of licensure, comparable or superior to the education, examination and experience obligations of Iowa Code chapter 542 in effect at the time the application is filed in Iowa. The board may accept the determination of substantial equivalency made by the National Association of State Boards of Accountancy or may make an independent determination of substantial equivalency.

b. Individual substantial equivalency. The applicant's individual qualifications on education, examination and experience are comparable or superior to the education, examination and experience obligations of Iowa Code chapter 542 in effect at the time the application is filed in Iowa.

c. "Four-in-ten rule." The applicant satisfies all of the following:

(1) The applicant passed the examination necessary for issuance of the applicant's certificate or license with grades that would have been passing grades at the time in this state.

(2) The applicant has had at least four years of experience within the ten years immediately preceding the application that occurred after the applicant passed the examination upon which the CPA certificate or license was based and that in the board's opinion is substantially equivalent to the obligations set forth in Iowa Code section 542.5(12).

(3) If the applicant's CPA certificate or license was issued more than four years prior to the filing of the application in this state, the applicant has fulfilled the continuing professional education mandates as described in Iowa Code section 542.6(3) and 481—Chapter 1030.

1029.5(2) A person who holds in good standing a certificate, license or designation from a foreign authority that is substantially equivalent to an Iowa CPA certificate is deemed qualified for an Iowa CPA certificate if the person satisfies all of the provisions of Iowa Code section 542.19(3). The burden is on the applicant to demonstrate that such certificate, license or foreign designation is in full force and effect and that the prerequisites for that certificate, license or foreign designation are comparable or superior to those needed for a CPA certificate in this state. Original verification from the foreign authority that issued the certificate, license or designation is needed to demonstrate that such certificate, license or designation is valid and in good standing. If the applicant cannot establish comparable or superior qualifications, the applicant will need to pass the Uniform Certified Public Accountant Examination designed to test the applicant's knowledge of practice in this state and country. If the applicant is a Canadian Chartered Accountant, Australian Chartered Accountant, Ireland Chartered Accountant, Mexico Contador Público Certificado (CPC), New Zealand Chartered Accountant, Scottish Chartered Accountant, or South African Chartered Accountant, the applicant may be obligated to take the International Qualification Examination (IQEX) in lieu of the uniform certified public accountant examination.

1029.5(3) An applicant seeking an Iowa CPA certificate based on the provisions of paragraph 1029.5(1) "b," paragraph 1029.5(1) "c," or subrule 1029.5(2) will submit such supporting information on education, examination or experience as the board deems reasonable to determine whether the applicant qualifies for licensure in Iowa.

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1029.6(542) Continuing obligations. A person issued a CPA certificate under this chapter is subject to all laws and rules governing persons holding CPA certificates issued in this state including, without limitation, those concerning continuing education, peer review, and notification of crimes and professional discipline. However, a person issued a CPA certificate under this chapter who maintains the principal place of business in a different state and who maintains in good standing a valid CPA certificate or license in that state is deemed to have satisfied the continuing education and peer review obligations described in 481—Chapters 1030 and 1031 if the person satisfies similar obligations in the state in which the principal place of business is located.

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1029.7(542) Expedited application processing. A person applying for a CPA certificate under the substantial equivalency provisions of Iowa Code section 542.19(1) "a" often desires

expedited application processing to facilitate cross-border practice. Applications by such persons are especially suitable for rapid processing given the substantially equivalent standards previously enforced in another state. Unless such application reveals grounds to deny the application under subrule 1029.3(2), the board is otherwise aware of such grounds, or the application is unaccompanied by the proper fee, the board's administrator will approve an application that qualifies under Iowa Code section 542.19(1) "a" as rapidly as feasible and deem the effective date of approval to practice in Iowa to be the date the board received the completed application with timely letter of good standing in a substantially equivalent state.

[ARC 7685C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 542.19.

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CHAPTER 1030 CONTINUING EDUCATION

[Prior to 7/13/88, see Accountancy, Board of[10]]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 10]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1030.1(542) Scope. The right to use the title “Certified Public Accountant” and “Licensed Public Accountant” is regulated in the public interest and imposes a duty on accounting professionals to maintain public confidence and current knowledge, skills, and abilities in all areas of services. CPAs and LPAs have to accept and fulfill their ethical responsibilities to the public and the profession regardless of their fields of employment.

1030.1(1) The development of professional competence involves a continued commitment to learning and professional improvement. A CPA and an LPA performing professional services need to have a broad range of knowledge, skills and abilities. A program that promotes professional competence in the practice of accountancy is defined as one that refers to the process, methods, or principles of accounting or is directly related to the CPA’s and LPA’s employment and is above the level of the CPA’s and LPA’s current knowledge.

1030.1(2) Acceptable subjects for continuing professional education include accounting, assurance/auditing, consulting services, specialized knowledge and applications, management, taxation, and ethics. Other subjects, including nontechnical professional skills, may be approved by the board if they maintain or improve CPAs’ and LPAs’ competence in their current employment.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.2(542) Definitions. The following definitions apply to the rules of this chapter.

“*Continuing professional education (CPE)*” means education that is acquired by a licensee in order to maintain, improve, or expand skills and knowledge present at initial licensure or to develop new and relevant skills and knowledge.

“*Firm meeting*” means a formally arranged gathering/assembly of staff or management groups or both to inform them of administrative matters.

“*Formal program*” means a structured learning activity based on clearly defined learning objectives and outcomes that articulate achievable knowledge, skills and abilities.

“*In-house or on-site training*” means a formally organized professional educational program sponsored by the employer.

“*Live instruction*” means an educational program delivered in a classroom setting or through videoconferencing whereby the instructor and student carry out essential tasks while together. Examples include distance learning and webcasts.

“*Nontechnical professional skills*” means formal programs of learning that contribute to the professional competence of a certificate holder or license holder in fields of study that indirectly relate to the holder’s field of business. “Nontechnical professional skills” includes, but is not limited to, the following programs or courses:

1. Communication;
2. Interpersonal management;
3. Leadership and personal development;
4. Client and public relations;
5. Practice development;
6. Marketing;
7. Motivational and behavioral; and
8. Speed reading and memory building.

“*Qualified instructor*” means an individual whose training and experience adequately prepares the individual to carry out specified training assignments.

“*Self-study*” means a computer-generated program or written materials or exercises intended for self-study that do not include simultaneous interaction with an instructor but do include tests transmitted to the provider for review and grading.

“*Technical professional skills*” means formal programs of learning that contribute to the professional competence of a certificate holder or license holder in fields of study that directly relate to the holder’s field of business. “Technical professional skills” includes, but is not limited to, the following programs or courses:

1. Auditing standards or procedures;
2. Compilation and review of financial statements;
3. Financial statement preparation and disclosures;
4. Attestation standards and procedures;
5. Projection and forecast standards or procedures;
6. Accounting and auditing;
7. Management advisory services;
8. Personal financial planning;
9. Taxation;
10. Management information systems;
11. Budgeting and cost analysis;
12. Asset management;
13. Professional ethics;
14. Specialized areas of industry;
15. Human resource management;
16. Economics;
17. Business law;
18. Mathematics, statistics and quantitative applications in business;
19. Business management and organization;
20. General computer skills, computer software training, information technology planning and management;
21. Operations management, inventory, and production; and
22. Negotiation or dispute resolution.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.3(542) Applicability. Completion of continuing professional education is a condition precedent to the renewal of the certificate or license.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.4(542) Cost of continuing professional education. All costs of completing continuing professional education are the responsibility of the certificate holder or license holder wishing to maintain registration in this state.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.5(542) Basic continuing professional education.

1030.5(1) Except as provided in subrules 1030.5(2) through 1030.5(7), an applicant for renewal will have completed 120 hours of qualifying continuing professional education during the three-year period ending on the December 31 or June 30 preceding the July 1 renewal date of the certificate or license. The following conditions apply:

- a. On each renewal, a CPA or LPA self-selects December 31 or June 30 as the date by which continuing education will be completed in order to be eligible to renew the certificate or license.
- b. A CPA or LPA applying to renew a certificate or license may declare a continuing education deadline of December 31 in one renewal cycle and a continuing education deadline of June 30 in a subsequent renewal cycle, and vice versa.

c. Licensees need to maintain continuing education records in a manner that corresponds with the self-selected continuing education deadline of December 31 or June 30.

d. When declaring a June 30 continuing education deadline, licensees should be cautious to ensure that the continuing education is fully completed on or prior to the date the renewal application is submitted to the board.

e. Licensees who renew with penalty during the 30-day grace period following June 30 need to declare either December 31 or June 30 as the continuing education deadline. The deadline cannot be extended beyond June 30.

1030.5(2) At the first annual renewal date of July 1 that is less than 12 months from the date of filing of the initial application for the certificate or license, the certificate holder or license holder is not required to report continuing professional education.

1030.5(3) At the annual renewal date of July 1 that is 12 months or more than 12 months, but less than 24 months, from the date of filing of the initial application for the certificate or license, the certificate holder or license holder will report 40 hours of continuing professional education earned in the one-year period ending December 31 or June 30 prior to the July 1 renewal date.

1030.5(4) At the annual renewal date of July 1 that is 24 months or more than 24 months, but less than 36 months, from the date of filing of the initial application for the certificate or license, the certificate holder or license holder will report 80 hours of continuing professional education earned in the two-year period ending December 31 or June 30 prior to the July 1 renewal date.

1030.5(5) A licensee is deemed to have completed continuing education under this rule if, for the period that the licensee is a resident of another state or district having a continuing professional education obligation, the licensee met the resident state's mandatory continuing professional education.

1030.5(6) The board may make exceptions for reasons of individual hardship including health, certified by a medical doctor, military service, foreign residency, retirement, or other good cause. No exceptions may be made solely because of age. Applicants entitled to a full or partial exception under the provisions of Iowa Code section 272C.2(4) for active military service or government service outside of the United States may request an exception by submitting acceptable documentation as applicable to the exception requested. Applicants seeking an exception on other grounds of undue hardship can submit an application for waiver as provided in 7—Chapter 2504.

1030.5(7) Licensees who apply to reinstate a lapsed or inactive certificate or license to active status pursuant to 481—subrule 1025.6(3) or 1025.9(7) need to satisfy 120 hours of continuing professional education earned in the preceding three-year period prior to the date of the application, including all mandatory education described in rule 481—1030.7(542). Once the certificate or license is reinstated, the continuing education obligations apply at each subsequent renewal. The 120-hour obligation described in this subrule is modified as needed to incorporate the phase-in schedule for initial licensees described in subrules 1030.5(2) through 1030.5(4).

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.6(542) Measurement standards. The following standards will be used to measure the hours of credit to be given for qualifying continuing professional education programs completed by individual applicants:

1030.6(1) Credit is measured with one 50-minute period equaling one contact hour of credit. Half-hour credits may be allowed (equal to not less than 25 minutes) after the first hour of credit has been earned.

1030.6(2) Only class hours or the equivalent, and not student hours devoted to preparation, will be counted.

1030.6(3) Credit expressed as continuing education units (CEUs) will be counted as ten contact hours for each continuing professional education unit. (0.1 CEU = 1 CPE)

1030.6(4) Service as lecturer or discussion leader of continuing professional education programs will be counted to the extent that this service contributes to the applicant's professional competence.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.7(542) Mandatory education.

1030.7(1) Every CPA certificate holder or LPA license holder who is responsible for supervising compilation services or who signs or authorizes someone to sign the accountant's compilation report on behalf of a firm will complete, as a condition of certificate or license renewal, a minimum of eight hours of continuing professional education devoted to financial statement presentation, such as courses covering the statements on standards for accounting and review services (SSARS) and accounting and auditing updates. The financial statement presentation continuing education has to be completed within the three-year period ending on the December 31 or June 30 preceding the application for certificate or license renewal. For credit to be claimed for a course covering multiple topics, a minimum of one hour as outlined in subrule 1030.6(1) has to be devoted to financial statement presentation. For example, if a seminar or presentation is conducted for a total of four hours and only one hour is devoted to financial statement presentation, then only one hour may be claimed toward satisfaction of this subrule.

1030.7(2) Every CPA certificate holder or LPA license holder needs to complete a minimum of four hours of continuing education devoted to ethics and rules of professional conduct during the three-year period ending December 31 or June 30, prior to the July 1 annual renewal date. For a course to qualify to satisfy this subrule, the course description will clearly outline the subject matter covered as professional or business ethics. If credit is to be claimed for a course covering multiple topics, a minimum of one hour as outlined in rule 481—1030.6(542), measurement standards, specifically in subrule 1030.6(1), needs to be devoted to business or professional ethics. For example, if a seminar or presentation is conducted for a total of four hours and only one hour is devoted to business or professional ethics, then only one hour may be claimed toward satisfaction of this subrule. Ethics courses, which are defined as courses dealing with regulatory and behavioral ethics, are limited to courses on the following:

- a. Professional standards;
- b. Licenses and renewals;
- c. SEC oversight;
- d. Competence;
- e. Acts discreditable;
- f. Advertising and other forms of solicitation;
- g. Independence;
- h. Integrity and objectivity;
- i. Confidential client information;
- j. Contingent fees;
- k. Commissions;
- l. Conflicts of interest;
- m. Full disclosure;
- n. Malpractice;
- o. Record retention;
- p. Professional conduct;
- q. Ethical practice in business;
- r. Personal ethics;
- s. Ethical decision making; and
- t. Corporate ethics and risk management as these topics relate to malpractice and relate solely to the practice of certified public accounting.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.8(542) Programs that qualify and CPE limitations.

1030.8(1) The overriding consideration in determining whether a specific program qualifies as acceptable continuing education is that it be a formal program of learning that contributes directly to

the professional competence of an individual certified or licensed in this state. It will be left to each individual certificate holder or license holder to determine the technical or nontechnical professional skills courses of study to be pursued. Thus, the auditor may study accounting and auditing, the tax practitioner may study taxes, and the management advisory services practitioner may study subjects related to such practice. Job-related continuing professional education qualifies as acceptable provided the courses selected from nontechnical professional skills contribute to the professional competence of the certificate holder or license holder.

1030.8(2) Program standards have to include the following:

- a.* Learning activities based on clearly defined, relevant learning objectives and outcomes that clearly articulate the knowledge, skills, and abilities that can be achieved by participants.
- b.* Learning activities developed in a manner consistent with the prerequisite education, experience, and advanced preparation of the participants.
- c.* Activities, materials, and delivery systems that are current, technically accurate, and effectively designed. Providers, sponsors, or contractors that are competent in the subject matter. Competence may be demonstrated through practical experience or education.
- d.* Learning programs that are reviewed by qualified persons other than those who develop the program to ensure that the program is technically accurate and current and addresses the stated learning objectives. This standard is waived for single presentations such as lectures that are given once.

1030.8(3) Continuing professional education programs will qualify only if:

- a.* An outline of the program is prepared in advance and preserved.
- b.* The program is at least one hour (50-minute period) in length.
- c.* The program is conducted by a qualified instructor, discussion leader or lecturer. A qualified instructor, discussion leader or lecturer is anyone whose background, training, education or experience makes it appropriate for that person to lead a discussion on the subject matter of the particular program.
- d.* A record of attendance or certification of completion or transcript is maintained.

1030.8(4) The following programs are deemed to qualify provided all other criteria of this rule are met:

- a.* Professional development programs of recognized national and state accounting organizations.
- b.* Technical sessions at meetings of recognized national and state accounting organizations and their chapters.
- c.* Formally organized in-house or on-site educational programs provided by the certificate holder's or license holder's employer.
- d.* Distance learning programs or group study webcast programs.
- e.* University or college courses meet the continuing professional education obligations of those attending. Each semester hour is equal to 15 contact hours of credit. Each quarter hour is equal to 10 contact hours of credit.
- f.* Technical or nontechnical sessions offered by employers in business and industry, as well as firms of certified public accountants.

1030.8(5) Formal correspondence and formal self-study programs contributing directly to the professional competence of an individual that obligate the licensee to register and provide evidence of satisfactory completion will be considered for credit. The amount of credit to be allowed for correspondence and formal self-study programs (including tested study programs) will be recommended by the program sponsor and based upon appropriate "field tests" and will not exceed 50 percent of the renewal obligation. A licensee claiming credit for correspondence or formal self-study courses will obtain evidence of satisfactory completion of the course from the program sponsor. Credit will be allowed in the renewal period in which the course is completed.

1030.8(6) Credit may be allowed for self-study programs on the basis of one hour of credit for each 50 minutes spent on the self-study program if the developer of such programs is approved by

either the national continuing professional education registry or by the NASBA continuing education registry and the program sponsor has not designated the amount of credit to be claimed for completing the course of study. The licensee has to estimate the equivalent number of hours and justify the amount of hours claimed. The maximum credit will not exceed 50 percent of the renewal obligation. Credit will be allowed in the renewal period in which the course is completed.

1030.8(7) The credit allowed an instructor, discussion leader, or speaker will be on the basis of two hours for subject preparation for each hour of teaching. Credit for teaching college or university coursework may be claimed for courses taught above the elementary accounting or principles of accounting level. Repetitious presentations will not be considered. The maximum credit for such preparation and teaching will not exceed 50 percent of the renewal period obligation.

1030.8(8) Credit may be awarded for published articles and books. The amount of credit so awarded will be determined by the board. Credit may be allowed for published articles and books provided they contribute to the professional competence of the licensee. Credit for preparation of such publications may be given on a self-declaration basis up to 25 percent of the renewal period obligation. In exceptional circumstances, a licensee may request additional credit by submitting the article(s) or book(s) to the board with an explanation of the circumstances that the licensee believes justify additional credit.

1030.8(9) Credit may be allowed for the successful completion of professional examinations as detailed below. Credit is calculated at the rate of five times the length of each examination, which is presumed to include all preparation time, claimed in the calendar year of the examination, and limited to 50 percent of the total renewal obligation.

- a.* Certified Management Accountant/CMA.
- b.* Certified Information Systems Auditor/CISA.
- c.* Certified Information Technology Professional/CITP.
- d.* Certified Financial Planner/CFP.
- e.* Enrolled Agent/EA.
- f.* Certified Governmental Financial Manager/CGFM.
- g.* Certified Government Auditing Professional/CGAP.
- h.* Certified Internal Auditor/CIA.
- i.* Accredited Business Valuation/ABV.
- j.* Certified Financial Forensics/CFF.
- k.* Certified Valuation Analyst/CVA.
- l.* Certified Insolvency & Restructuring Advisor/CIRA.
- m.* Forensic Certified Public Accountant/FCPA.
- n.* Certified Fraud Examiner/CFE.
- o.* Certified Business Analyst/CBA.
- p.* Certified Trust and Financial Advisor/CTFA.
- q.* Chartered Financial Analyst/CFA.
- r.* Registered Representative, Series 6 and 7 and other examinations.
- s.* Registered Investment Advisor/RIA.
- t.* Certified Forensic Accountant/CrFA.
- u.* Personal Financial Specialist/PFS.
- v.* Chartered Life Underwriter/CLU.
- w.* Fellow of the Society of Actuaries/FSA.
- x.* Chartered Property & Casualty Underwriter/CPCU.
- y.* Fellow Life Management Institute/FLMI.
- z.* Other similar examinations approved by the board.

1030.8(10) Firm meetings for staff or management groups for the purpose of administrative and firm matters do not meet the standards set forth in subrule 1030.8(1).

1030.8(11) Dinner, luncheon and breakfast meetings of recognized organizations may qualify if they meet the appropriate provisions and are limited to 25 percent of the total renewal criteria if the individual meeting is no more than two hours long.

1030.8(12) Continuing professional education taken in nontechnical skills area as defined in rule 481—1030.2(542) is limited to 50 percent of the total renewal obligation.

1030.8(13) The board may look to recognized state or national accounting organizations for assistance in interpreting the acceptability of and credit to be allowed for individual courses.

1030.8(14) The right is specifically reserved to the board to approve or deny credit for continuing professional education claimed under these rules.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.9(542) Controls and reporting.

1030.9(1) An applicant for renewal may be requested to provide, in such manner, including but not limited to the online renewal process, and at such time as set forth by the board, verification and documentation setting forth the continuing professional education in which the licensee has participated. The board may allow for attestation that the licensee has completed continuing education in lieu of providing a listing. If the applicant for renewal is requested to provide a listing of the continuing professional education completed, the documentation will include:

- a.* School, firm or organization conducting the course and contact information.
- b.* Location of course.
- c.* Title of course or description of content.
- d.* Principal instructor.
- e.* Dates attended.
- f.* Hours claimed.
- g.* Certificate of completion.
- h.* Name of participant.
- i.* Course field of study.
- j.* Type of instruction or delivery method.
- k.* Amount of CPE recommended.
- l.* Verification by CPE program sponsor representative.

Canceled checks and registration forms are not proof of attendance.

1030.9(2) The board may request sponsors of courses to furnish an attendance record, a certification of completion or any other information the board deems essential for administration of these continuing professional education rules.

1030.9(3) The board will verify, on a test basis, information submitted by licensees. If an application for renewal is not approved, the applicant will be so notified and may be granted a period of time by the board in which to correct the deficiencies noted.

1030.9(4) Primary responsibilities for documenting the continuing education compliance is with the licensee, and such documentation has to be retained for a period of three years subsequent to submission of the report claiming the credit. (More information can be found in 481—subrule 1034.3(1) and Iowa Code section 542.10(1)“a,” which provides for permanent revocation based on fraud or deceit in procuring a license.) Satisfaction of the obligations, including retention of attendance records, certification of completion records, and written outlines, may be accomplished as follows:

a. For courses taken for scholastic credit in accredited universities and colleges (state, community, or private) or high school districts, evidence of satisfactory completion of the course will be sufficient; for noncredit courses taken, a statement of the hours of attendance, signed by the instructor, will be obtained by the licensee.

b. For correspondence and formal independent self-study courses, written evidence or a certificate of completion from the sponsor or course provider will be obtained by the licensee.

c. In all other instances, the licensee will maintain a record of the information as listed in subrule 1030.8(3).

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.10(542) Grounds for discipline. A licensee or an applicant is subject to discipline, including permanent revocation, if the licensee or applicant provides false information to the board in connection with an application to renew or reinstate a certificate or license. A licensee or an applicant is also subject to discipline if the licensee or applicant is unable to document the continuing professional education hours reported to the board in connection with an audit or other request for documentation. False information of this nature will subject the licensee or applicant to discipline whether the false information was supplied intentionally or with reckless disregard for the truth or accuracy of the number of hours claimed. Licensees and applicants are accordingly cautioned to supply the board with accurate continuing professional education information.

[ARC 7686C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1030.11(272C,542) Alternative continuing education cycles authorized.

1030.11(1) Purpose. For a variety of reasons, some CPAs and LPAs may wish to complete their continuing education on a three-year cycle ending on a date other than December 31. By way of illustration, some licensees may prefer to take courses on particular substantive topics that are not always offered at the same time each year. Some licensees may wish to schedule continuing education to comply with the differing obligations of multiple jurisdictions. This rule is intended to authorize a more flexible time frame within which continuing education may be satisfied. This rule does not alter any other requirement of this chapter.

1030.11(2) Declaration may vary by renewal cycle. A CPA or LPA applying to renew a certificate or license may declare a continuing education deadline of December 31 in one renewal cycle and a continuing education deadline of June 30 in a subsequent renewal cycle, and vice versa. Licensees are expected to maintain continuing education records in a manner that complies with the self-selected declaration in any particular renewal cycle.

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These rules are intended to implement Iowa Code chapters 272C and 542.

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CHAPTER 1031

PEER REVIEW

[Prior to 5/1/02, see 193A—Chapter 17]

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 11]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1031.1(542) Peer review obligations. As a condition of renewal for a CPA or an LPA who issues compilation reports other than through a CPA or an LPA firm that holds a permit to practice, and as a condition of permit renewal for LPA firms that issue compilation reports or CPA firms that provide attest services or issue compilation reports, the applicant shall submit certification of completion of a peer review issued pursuant to this chapter. Such review needs to be completed at the highest level of service provided by the firm or licensee. The performance of preparation services under SSARS 21 does not alone subject a firm or individual to peer review, although if a firm or individual is otherwise subject to peer review, the reviewer may include preparation services in the scope of practices reviewed.

[ARC 7687C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1031.2(542) Three-year cycle. During the three-year period ending December 31 preceding the application for renewal of a certificate, license, or permit to practice, the individual licensee or firm shall have completed a peer review in accordance with this chapter. A peer review shall be completed no less often than once every three years.

[ARC 7687C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1031.3(542) System of internal quality control. If the firm has not performed any attest or compilation services prior to the application for renewal, the firm will have in place a system of internal quality control prior to the commencement of an engagement including attest or compilation services and come into compliance with the peer review obligations within 18 months of completion of an engagement including attest or compilation services.

[ARC 7687C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1031.4(542) Peer review programs that qualify. A firm's completion of a peer review program endorsed or supported by the AICPA, the National Society of Accountants or other substantially similar review programs in Iowa or other states approved by the board satisfies this chapter.

[ARC 7687C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1031.5(542) Waiver of peer review. At the time of renewal, a licensee or firm may request a waiver from this chapter, as provided in Iowa Code sections 542.7(9) and 542.8(18).

[ARC 7687C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1031.6(542) Submission of peer review reports. Unless the subject of a peer review timely objects in writing to the administering entity of the peer review program, the administering entity will make available to the board, within 30 days of the issuance of the peer review acceptance letter, the final peer review report or such peer review records as are designated by the peer review program in which the administering entity participates. The subject of a peer review may voluntarily submit the final peer review report directly to the board.

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CHAPTER 1032

FEES

[Prior to 7/13/88, see Accountancy, Board of[10]]

[Prior to 5/1/02, see 193A—Chapter 14]

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1032.1(542) Fees. The following is a schedule of the fees for examinations, certificates, licenses, permits and renewals adopted by the board:

Initial CPA examination application:		
Paid directly to CPA examination services		not to exceed \$1,500
Reexamination:		
Paid directly to CPA examination services		not to exceed \$1,500
Original issuance of CPA certificate or LPA license by examination (fee includes wall certificate)		\$100
Original issuance of CPA certificate by reciprocity or substantial equivalency		\$100
CPA wall certificate or LPA license issued by reciprocity or substantial equivalency		\$50
Replacement of lost or destroyed wall CPA certificate or LPA license		\$50
Original issuance of attest qualification		\$100
Annual renewal of CPA certificate or LPA license—active status		\$100
Late renewal of CPA certificate or LPA license within 30-day grace period (July 1 to July 30)—active status		\$25
Annual renewal of CPA certificate or LPA license—inactive status		\$50
Late renewal of CPA certificate or LPA license within 30-day grace period (July 1 to July 30)—inactive status		\$10
Original issuance of firm permit to practice		\$100
Annual renewal of firm permit to practice		\$100
Reinstatement of lapsed CPA certificate or LPA license		\$100 + renewal fee + \$25 per month of expired registration
Reinstatement of lapsed firm permit to practice		\$100 + renewal fee + \$25 per month of expired registration
Interstate Transfer Form		\$25
License predetermination fee		\$25

[ARC 7688C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1032.2(542) Reinstatement.

1032.2(1) *Reinstatement of a lapsed CPA certificate or LPA license.* The fee for the reinstatement of a lapsed CPA certificate or LPA license is \$100 plus the renewal fee plus \$25 per month of expired registration up to a maximum of \$1,000.

1032.2(2) *Reinstatement of lapsed firm permit to practice.* The fee for the reinstatement of a lapsed CPA or LPA firm permit to practice for applications is \$100 plus the renewal fee plus \$25 per month of expired registration up to a maximum of \$1,000.

1032.2(3) *Applicants for reinstatement.* All applicants for reinstatement will be assessed the \$100 reinstatement fee. The \$25 per month penalty fee described in subrules 1032.2(1) and 1032.2(2) will 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 CPA certificate, LPA license, or firm permit to practice as a CPA or LPA firm is necessary in Iowa. Falsely claiming an exemption from the monthly penalty 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.

[ARC 7688C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1032.3(542) Prorating of certain fees. Fees for the issuance of an original CPA certificate or LPA license, pursuant to rule 481—1025.3(542), or the issuance of an initial permit to practice to a CPA or LPA firm, pursuant to rule 481—1027.1(542), will not be prorated.

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CHAPTER 1033
RULES OF PROFESSIONAL ETHICS AND CONDUCT

[Prior to 5/1/02, see 193A—Chapter 11]

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 13]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1033.1(542) Applicability.

1033.1(1) The AICPA Code of Professional Conduct is based upon the premise that the reliance of the public in general and of the business community in particular on sound financial reporting and on the implication of professional competence inherent in the authorized use of a board-regulated title relating to the practice of public accountancy imposes on persons engaged in such practice certain obligations both to their clients and to the public. These obligations, which the rules of professional ethics and conduct are intended to enforce where necessary, include the obligation to maintain independence of thought and action and a continued commitment to learning and professional improvement, to observe applicable generally accepted accounting principles and generally accepted auditing standards, to promote the public interest through sound and informative financial reporting, to hold the affairs of clients in confidence, and to maintain high standards of personal conduct in all professional activities in whatever capacity performed.

1033.1(2) In addition to the rules specifically enumerated herein, and only to the extent applicable to certificate holders' and licensees' respective scope of practice, all certificate holders and licensees are obligated to comply with the AICPA Code of Professional Conduct. In the event of a conflict or inconsistency between the AICPA Code of Professional Conduct and rules specifically enumerated herein, the rules specifically enumerated herein prevail.

1033.1(3) The rules of professional ethics and conduct apply to all professional services performed by all CPAs and LPAs, whether or not they are engaged in the practice of public accountancy, except where the wording of a rule clearly indicates that the applicability is specifically limited to the practice of public accountancy.

1033.1(4) A CPA or an LPA engaged in the practice of public accountancy outside the United States will not be subject to discipline by the board for departing, with respect to such foreign practice, from any of the board's rules of professional ethics and conduct, so long as the CPA's or LPA's conduct is in accordance with the standards of professional conduct applicable to the practice of public accountancy in the country in which the CPA or LPA is practicing. However, even in such a case, if a CPA's or an LPA's name is associated with financial statements in such manner as to imply that the CPA or LPA is acting as an independent public accountant and under circumstances that would entitle the reader of the financial statement to assume that United States practices are followed, the CPA or LPA will comply with applicable generally accepted engagement standards and applicable generally accepted accounting principles.

1033.1(5) A CPA or an LPA may be held responsible for compliance with the rules of professional ethics and conduct by all persons associated with the accountant in the practice of public accounting who are either under the accountant's supervision or are licensees, partners or shareholders in the accountant's practice.

1033.1(6) CPAs and CPA firms exercising a practice privilege in Iowa or for a client with a home office in Iowa are subject to the professional standards set forth in this chapter.

1033.1(7) These rules complement the grounds for discipline set out in 481—Chapter 1034.

[ARC 7689C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1033.2(542) Rules applicable to all CPAs and LPAs.

1033.2(1) *Cooperation with board inquiry.* A CPA or an LPA will, when requested, respond to communications from the board within 30 days.

1033.2(2) *Reporting convictions, judgments, and disciplinary actions.* In addition to any other reporting obligations in Iowa Code chapter 542 or these rules, a CPA or an LPA needs to notify the board within 30 days of:

a. Imposition upon the CPA or LPA of discipline including, but not limited to, censure, reprimand, sanction, probation, civil penalty, fine, consent decree or order, or suspension, revocation or modification of a license, certificate, permit or practice rights by:

(1) The SEC, PCAOB, or IRS (by the Director of Practice); or

(2) Another state board of accountancy for cause other than failure to pay a professional fee by the due date or failure to complete continuing education obligations by another state board of accountancy; or

(3) Any other federal or state agency regarding the CPA's or LPA's conduct while rendering professional services; or

(4) Any foreign authority or credentialing body that regulates the practice of accountancy;

b. Occurrence of any matter reportable by the CPA or LPA to the PCAOB pursuant to the Sarbanes-Oxley Act, Section 102(b)(2)(f) as amended to December 29, 2022, and PCAOB rules and forms adopted pursuant thereto;

c. Any judgment, award or settlement of a civil action or arbitration proceeding in which the CPA or LPA was a party if the matter included allegations of gross negligence, violation of specific standards of practice, fraud, or misappropriation of funds in the practice of accounting; provided, however, licensed firms will notify the board regarding civil judgments, settlements or arbitration awards directly involving the firm's practice of public accounting in this state; or

d. Criminal charges, deferred prosecution or conviction or plea of no contest to which the CPA or LPA is a defendant if the crime is:

(1) Any felony under the laws of the United States or any state of the United States or any foreign jurisdiction; or

(2) Any crime, including a misdemeanor, if an essential element of the offense is dishonesty, deceit or fraud, as more fully described in Iowa Code section 542.5(2).

1033.2(3) *Firm's duty to report.* Each firm will designate a CPA or an LPA as responsible for firm licensure or office registration and responsible for reporting any matter reportable under this rule.

1033.2(4) *Solicitation or disclosure of CPA examination questions and answers.* A CPA or an LPA who solicits or knowingly discloses a Uniform Certified Public Accountant Examination question(s) or answer(s) without the written authorization of the AICPA has committed an act discreditable to the profession.

1033.2(5) *Falsely reporting continuing professional education (CPE).* A CPA or an LPA has committed an act discreditable to the profession when the CPA or LPA falsely reports CPE credits to the board.

[ARC 7689C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1033.3(542) Rules applicable to CPAs and LPAs who use the titles in offering or rendering products or services to clients.

1033.3(1) *Use of title.*

a. Certified public accountant. Only a person who holds an active, unexpired certificate and who complies with 481—Chapter 1025, Licensure Status and Renewal of Certificates and Licenses, and 481—Chapter 1030, Continuing Education, or a person lawfully exercising a practice privilege under Iowa Code section 542.20 may use or assume the title “certified public accountant” or the abbreviation “CPA” or any other title, designation, word(s), letter(s), abbreviation(s), sign, card, or device indicating that such person is a certified public accountant.

b. Licensed public accountant. Only a person holding a license as a licensed public accountant may use or assume the title “licensed public accountant” or the abbreviation “LPA” or any other title, designation, word(s), letter(s), abbreviation(s), sign, card, or device indicating that such person is a licensed public accountant.

1033.3(2) Forms of practice.

a. Certified public accountant firms. A sole proprietorship, corporation, partnership, limited liability company, or any other form of organization has to apply for a permit to practice under Iowa Code section 542.7 and these rules as a firm of certified public accountants in order to use the title “CPAs” or “CPA firm,” as more fully described in 481—Chapter 1027.

b. Licensed public accounting firms. A sole proprietorship, corporation, partnership, limited liability company, or any other form of organization has to apply for a permit to practice under Iowa Code section 542.8 and these rules as a firm of licensed public accountants in order to use the title “LPAs” or “LPA firm,” as more fully described in 481—Chapter 1028.

1033.3(3) Acting through others. A CPA or an LPA is obligated to not allow others to carry out on the CPA’s or LPA’s behalf, either with or without compensation, acts which, if carried out by the CPA or LPA, would violate the rules of professional ethics and conduct.

[ARC 7689C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1033.4(542) Audit, review and other attest services.

1033.4(1) Practice privilege. All audit, review, and other attest services performed in Iowa or for a client with a home office in Iowa has to be performed through a CPA firm that holds an active Iowa firm permit to practice or through an out-of-state CPA firm exercising a practice privilege in compliance with Iowa Code section 542.20(5) and 542.20(6) and associated rules and the peer review and ownership provisions of Iowa Code section 542.7. Unless Iowa certification is specifically mandated by a governmental body or client, the individual CPAs performing such attest services may either hold an active Iowa CPA certificate or exercise a practice privilege as more fully described in Iowa Code section 542.20. LPAs and LPA firms are not authorized to perform attest services.

1033.4(2) Reserved.

[ARC 7689C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1033.5(542) Compilation.

1033.5(1) Who can perform. Only a CPA licensed under Iowa Code section 542.6 or 542.19, or any other applicable law or rule; an LPA licensed under Iowa Code section 542.8, or any other applicable law or rule; or a CPA exercising a practice privilege under Iowa Code section 542.20 may issue a report in standard form upon a compilation of financial information or otherwise provide compilation services in Iowa or for a client with a home office in Iowa. (More information can be found in rule 481—1026.4(542).)

1033.5(2) Peer review. All individuals described in 481—subrule 1026.4(1) will satisfy peer review obligations, individually or through a peer review of a CPA or an LPA firm holding a permit to practice pursuant to Iowa Code section 542.7 or 542.8 or a CPA firm exercising a practice privilege under Iowa Code section 542.20.

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481—1033.6(542) Rules applicable to tax practice. CPAs, LPAs, and persons who are not CPAs or LPAs may perform tax services in Iowa. The rules of professional ethics and conduct in this chapter apply to any CPA or LPA who is licensed in Iowa and to any CPA exercising a practice privilege in Iowa whenever such person informs the client or prospective client that the person is a CPA or an LPA. Clients may be so informed in a number of ways, including oral or written representations, the display of a CPA certificate or LPA license, or use of the CPA or LPA title in advertising, telephone or Internet directories, letterhead, business cards or email.

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These rules are intended to implement Iowa Code chapters 272C and 542.

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CHAPTER 1034
DISCIPLINARY AUTHORITY AND GROUNDS FOR DISCIPLINE
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 14]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1034.1(17A,272C,542) Disciplinary authority. The board exercises disciplinary authority for the protection and well-being of those persons who rely on licensed individuals and firms for the performance of public accounting services within this state or for clients in this state. To perform these functions, the board is broadly vested with authority to review and investigate alleged acts or omissions of licensees, determine whether disciplinary proceedings are warranted, initiate and prosecute disciplinary proceedings, establish standards of professional conduct, and impose discipline, as authorized under Iowa law.

[ARC 7690C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1034.2(17A,272C,542) Disciplinary policy.

1034.2(1) The board's disciplinary policy rests upon the premise that the reliance of the public in general and of the business community in particular on sound financial reporting, and on the implication of professional competence inherent in the authorized use of a licensee's regulated title relating to the practice of public accountancy, imposes on persons and firms engaged in such practice certain obligations both to their clients and to the public. These obligations include the obligation to maintain independence of thought and action; to strive continuously to improve one's professional skills; to observe, where applicable, generally accepted accounting principles, generally accepted auditing standards, and similar principles and standards; to promote sound and informative financial reporting; to hold the affairs of clients in confidence; and to maintain high standards of personal conduct in all matters affecting one's fitness to practice public accountancy.

1034.2(2) The public interest dictates that persons professing special competence in accountancy have demonstrated their qualifications to do so, and that persons who have not demonstrated and maintained such qualifications not be permitted to represent themselves as having such special competence; that the conduct of persons licensed as having special competence in accountancy be regulated in all aspects of their professional work; and that the use of titles that have a capacity or tendency to deceive the public as to the status or competence of the persons using such titles not be permitted.

1034.2(3) A CPA or LPA firm is subject to discipline for its own violations of Iowa Code chapter 542 and administrative rules and the violations of the firm's CPAs, LPAs, nonlicensee owners, persons acting or purporting to act under a practice privilege, and others performing professional services on the firm's behalf. Whether a CPA or LPA firm will be charged based on the acts of such individuals will depend on the circumstances. Among the factors the board will consider are whether the firm took reasonable steps to prevent the violation, whether the violation was or could have been discovered by the firm upon reasonable inquiry, what steps the firm took upon discovering the violation, whether the acts or omissions involved licensees of the board or were committed by persons who are not individually licensed by the board, the nature of the services at issue, and whether the violations are isolated matters or more systemic to the firm's performance.

[ARC 7690C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1034.3(17A,272C,542) Grounds for discipline. The board may initiate disciplinary action against a CPA, an LPA, or a firm of CPAs or LPAs that holds an active, inactive or lapsed certificate, license or permit to practice on any of the following grounds:

1034.3(1) *Fraud or deceit in procuring a license.* Fraud or deceit in procuring or attempting to procure an initial, reciprocal, renewal, or reinstated certificate, license, or permit to practice includes any intentional perversion of the truth when submitting an application to the board, or when submitting information in support of another's application to the board, including:

a. False representation of a material fact, whether by word or by conduct, by false or misleading allegation, or by concealment of that which should have been disclosed.

b. Attempting to file or filing with the board any false or forged record or document, such as a college transcript, diploma or degree, examination report, verification of licensure, continuing education certificate, or verification of peer review.

c. Failing or refusing to provide complete information in response to a question on an application.

d. Reporting information, such as satisfaction of continuing education, peer review, or attest qualification, in a false manner through overt deceit or with reckless disregard for the truth or accuracy of the information asserted.

e. Otherwise participating in any form of fraud or misrepresentation by act or omission.

1034.3(2) Professional incompetence. Professional incompetence includes, but is not limited to:

a. A substantial lack of knowledge or ability to discharge professional obligations within the practice of public accounting.

b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.

c. A failure to exercise the degree of care ordinarily exercised by the average practitioner acting in the same or similar circumstances.

d. Failure to conform to the minimum standards of acceptable and prevailing practice of public accounting in this state.

e. A willful, repeated, or material deviation from generally accepted engagement standards, generally accepted accounting standards, generally accepted auditing standards, or any other nationally recognized standard applicable to the public accounting services at issue.

f. Any other act or omission that demonstrates an inability to safely practice in a manner protective of the public's interest.

1034.3(3) Deceptive practices. Deceptive practices are grounds for discipline, whether or not actual injury is established, and include:

a. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of public accounting.

b. Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a licensee in making information or intention known to the public that is false, deceptive, misleading or promoted through fraud or misrepresentation.

c. Acceptance of any fee by fraud or misrepresentation.

d. Falsification of business or client records.

e. Submission of false or misleading reports or information to the board including information supplied in an audit of continuing education, reports submitted as a condition of probation, or any reports identified in this rule or 481—Chapter 1038.

f. Knowingly presenting as one's own a certificate or certificate number, license or license number, permit or permit number, or signature, when the above belongs to another or a fictitious licensee; or otherwise falsely impersonating a person holding a CPA certificate, an LPA license, or a permit to practice as a firm of CPAs or LPAs.

g. Representing oneself as a CPA, LPA, CPA firm, or LPA firm when the certificate, license, or permit to practice has been suspended, revoked, surrendered, or placed on inactive status, or has lapsed, except as allowed under Iowa Code section 542.20.

h. Fraud in representations as to skill or ability.

1034.3(4) Unethical, harmful or detrimental conduct. Licensees engaging in unethical conduct or practices harmful or detrimental to the public may be disciplined whether or not injury is established. Behaviors and conduct that are unethical, harmful or detrimental to the public may include, but are not limited to, the following actions:

a. Verbal or physical abuse, or improper sexual contact, if such behavior occurs within the practice of public accounting or if such behavior otherwise provides a reasonable basis for the board to conclude that such behavior within the practice of public accounting would place the public at risk.

b. A violation of a rule of professional conduct relating to improper conflicts of interest, or lack of integrity, objectivity or independence, as provided in the AICPA Code of Professional Conduct.

c. A violation of a provision of Iowa Code section 542.13, or aiding or abetting any unlawful activity for which a civil penalty can be imposed under Iowa Code sections 542.13 and 542.14.

1034.3(5) *Lack of proper qualifications.* Lack of proper qualifications includes, but is not limited to:

a. Continuing to practice as a CPA or LPA without satisfying the continuing education necessary for certificate or license renewal.

b. Continuing to perform attest services or compilation services without timely completion of peer review.

c. Performing attest services as an individual without proper certification or attest qualification, or without acting through a CPA firm holding a permit to practice pursuant to Iowa Code section 542.7 or exercising a practice privilege pursuant to Iowa Code section 542.20.

d. Performing attest services as a firm without holding a permit to practice pursuant to Iowa Code section 542.7 or exercising a practice privilege pursuant to Iowa Code section 542.20, or without ensuring that the individuals responsible for supervising attest services or signing or authorizing someone to sign the accountant's report are attest-qualified, hold the necessary certification or are eligible to exercise a practice privilege, or otherwise performing attest services in a manner inconsistent with Iowa Code chapter 542 or the rules of the board.

e. Habitual intoxication or addiction to the use of drugs, or impairment that adversely affects the CPA's or LPA's ability to practice in a safe and competent manner.

f. Any act, conduct, or condition, including lack of education or experience and careless or intentional acts or omissions, that demonstrates a lack of qualifications that are necessary to ensure a high standard of professional care as provided in Iowa Code section 272C.3(2) "b," or that impairs a practitioner's ability to safely and skillfully practice the profession.

1034.3(6) *Negligence in the practice of public accounting.* Negligence in the practice of public accounting includes the following acts, practices, or omissions, whether or not injury results:

a. Failure or refusal without good cause to exercise reasonable diligence in the practice of public accounting.

b. Failure to exercise due care including negligent delegation of duties in the practice of public accounting.

c. Neglect of contractual or other duties to a client.

1034.3(7) *Professional misconduct.* Professional misconduct includes, but is not limited to, the following:

a. Violation of a generally accepted engagement standard, generally accepted accounting standard, generally accepted auditing standard, or any other nationally recognized standard applicable to the public accounting services at issue, as provided in rule 481—1033.4(542), or any other violation of a provision of the AICPA Code of Professional Conduct.

b. Violation of a regulation or law of this state, another state, the United States, or the PCAOB in the practice of public accounting.

c. Engaging in any conduct that subverts or attempts to subvert a board investigation of a licensed or unlicensed firm, individual, or other entity, or failure to fully cooperate with a disciplinary investigation of a licensee or with an investigation of firms, individuals or other entities that are not licensed by the board, including, without limitation, failure to comply with a subpoena issued by the board or to respond to a board inquiry within 30 days.

d. Revocation, suspension, or other disciplinary action taken against a licensee or person or firm exercising a practice privilege by a licensing authority of this state or another state, territory, or country. A stay by an appellate court does not negate the obligation to report such incidents to

the board; however, if such disciplinary action is overturned or reversed by a court of last resort, discipline by the board based solely on such action will be vacated.

e. Suspension or revocation of the right to practice before any state or federal agency, or the PCAOB.

f. Violating Iowa Code section 542.17.

g. Violating Iowa Code section 542.18.

h. Violating or aiding and abetting another's violation of Iowa Code section 542.13 or 542.20.

i. Violating the terms of an initial agreement with the Iowa professionals review committee or violation of the terms of an impaired practitioner recovery contract with the Iowa professionals review committee.

j. Violating a practice privilege afforded to an Iowa licensee in another state.

k. Engaging in the practice of public accounting on a lapsed or inactive certificate, license or permit when the acts or practices obligate active Iowa licensure and, in the case of a firm, allowing such acts or practices by firm CPAs or LPAs.

1034.3(8) *Willful or repeated violations.* The willful or repeated violation or disregard of any provision of Iowa Code chapter 272C or 542 or any administrative rule adopted by the board in the administration or enforcement of such chapters.

1034.3(9) *Failure to report.*

a. Failure by a CPA firm to timely report as provided in rule 481—1027.7(542).

b. Failure of an LPA firm to timely report as provided in rule 481—1028.5(542).

c. Failure to timely report judgments and settlements and reportable violations by others as provided in 481—Chapter 1038.

d. Failure to report in writing to the board any issuance, denial, revocation, or suspension of a license by another state, or the voluntary surrender of a license to resolve a pending disciplinary investigation or action, within 30 calendar days of the licensing authority's final action.

e. Failure to report the conviction of any felony, or a crime described in Iowa Code section 542.5(2), within 30 calendar days of the conviction.

f. Failure to report to the board a change in the licensee's physical or mailing address within 30 calendar days of the change.

g. Failure to report as provided in 481—subrule 1033.4(3) or as otherwise required in the AICPA Code of Professional Conduct.

1034.3(10) *Failure to comply with board order.* Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order, or other decision imposing discipline.

1034.3(11) *Conviction of a crime.* Conviction of any crime described in Iowa Code section 542.5(2) and as limited by Iowa Code section 272C.10(5) is grounds for denial, revocation, or suspension of a license. "Conviction" includes any plea of guilty or nolo contendere, including Alford pleas, or finding of guilt whether or not judgment or sentence is deferred, withheld, not entered, or suspended, and whether or not the conviction is on appeal. If such conviction is overturned or reversed by a court of last resort, discipline by the board based solely on the conviction is vacated.

1034.3(12) *Conduct discreditable to the accounting profession.* Conduct discreditable to the accounting profession includes any act or practice that diminishes the public's confidence in the profession, impairs the credibility of the profession, or otherwise compromises the public's trust. While it is not possible to list all conduct that is discreditable to the accounting profession, the following list provides an illustrative range of acts or practices that are implicated:

a. Dishonesty in business or financial affairs, or a pattern of fiscal irresponsibility.

b. Placement on the sex offender registry.

c. Securities fraud or violation of the Iowa consumer fraud Act.

d. Willful or repeated failure to timely file tax returns or other tax documents.

e. False testimony in a court or administrative proceeding, or affidavit, or otherwise under oath.

f. Providing false or misleading information to a financial institution or governmental body or official.

- g. Stating or implying an ability to improperly influence a government agency or official, or attempting to do so through deception, bribery or other unlawful means.
- h. Violation of a breach of fiduciary duty when acting in the capacity of a trustee, conservator, or other fiduciary, or as the professional advisor to a fiduciary.
- i. Any violation of Iowa Code chapter 542 or administrative rules that involves dishonesty, bad faith, or unethical behavior.

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These rules are intended to implement Iowa Code chapters 17A, 272C and 542 and section 546.10.

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CHAPTER 1035
DISCIPLINARY INVESTIGATIONS
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 15]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1035.1(17A,272C,542) Initiation of disciplinary investigations. The board may initiate a licensee disciplinary investigation upon the board's receipt of information suggesting that a licensee may have violated a law or rule enforced by the board which, if true, would constitute grounds for licensee discipline. The board may also review the publicly available work product of licensees on a general or random basis to determine whether reasonable grounds exist to initiate disciplinary proceedings or to conduct a more specific investigation.

[ARC 7691C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1035.2(17A,272C,542) Conflict of interest. If the subject of a complaint is a member of the board, or if a member of the board has a conflict of interest in any disciplinary matter before the board, that member will abstain from participation in any consideration of the complaint and from participation in any disciplinary hearing that may result from the complaint.

[ARC 7691C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1035.3(272C,542) Complaints. Written complaints may be submitted by any means and by anyone.

1035.3(1) Contents of a written complaint. Written complaints may be submitted through the online complaint process. Written complaints, whether submitted on a board complaint form or in other written medium, will contain the following information:

- a. The full name, address, and telephone number of the complainant (person complaining).
- b. The full name, address, and telephone number of the respondent (licensee against whom the complaint is filed).
- c. A statement of the facts and circumstances giving rise to the complaint, including a description of the alleged acts or omissions that the complainant believes demonstrate that the respondent has violated or is violating laws or rules enforced by the board.
- d. If known, citations to the laws or rules allegedly violated by the respondent.
- e. Evidentiary supporting documentation.
- f. Steps, if any, taken by the complainant to resolve the dispute with the respondent prior to filing a complaint.

1035.3(2) Immunity. As provided by Iowa Code section 272C.8, a person is not civilly liable as a result of filing a report or complaint with the board unless such act is done with malice, nor may an employee be dismissed from employment or discriminated against by an employer for filing such a report or complaint.

1035.3(3) Role of complainant. The role of the complainant in the disciplinary process is limited to providing the board with factual information relative to the complaint. A complainant is not party to any disciplinary proceeding that may be initiated by the board.

1035.3(4) Role of the board. The board does not act as an arbiter of disputes between private parties, nor does the board initiate disciplinary proceedings to advance the private interest of any person or party. The role of the board in the disciplinary process is to protect the public by investigating complaints and initiating disciplinary proceedings in appropriate cases. The board possesses sole decision-making authority throughout the disciplinary process, including the authority to determine whether a case will be investigated, the manner of the investigation, whether a disciplinary proceeding will be initiated, and the appropriate licensee discipline to be imposed, if any.

1035.3(5) Initial complaint review. All written complaints received by the board are initially reviewed by the board's administrator to determine whether the complaint allegations fall within the

board's investigatory jurisdiction and whether the facts presented, if true, would constitute a basis for licensee disciplinary action. Complaints that are clearly outside the board's jurisdiction, which clearly do not allege facts upon which disciplinary action would be based, or which are frivolous, will be referred by the board administrator to the board for closure at the next scheduled board meeting.

[ARC 7691C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1035.4(272C,542) Case numbers. Complaint files are tracked by a case numbering system. Once a case file number is assigned to a complaint, all persons communicating with the board regarding that complaint are encouraged to include the case file number to facilitate accurate records and prompt response.

[ARC 7691C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1035.5(272C,542) Confidentiality of complaint and investigative information.

1035.5(1) General provisions. All complaint and investigative information received or created by the board is privileged and confidential pursuant to Iowa Code section 272C.6(4). Such information will not be released to any person except as provided in that section and this rule.

1035.5(2) Confidentiality of PCAOB information and records.

a. The PCAOB was created by the Sarbanes-Oxley Act of 2002 (the Act) as a nonprofit corporation under the laws of the District of Columbia. The duties of the PCAOB include the registration of public accounting firms that prepare audit reports for public companies; the promulgation of rules (as approved by the SEC) for auditing, quality control, ethics, independence and other standards relating to the preparation of audit reports; the inspection of registered public accounting firms; the investigation of alleged standards violations; and the imposition of appropriate sanctions following disciplinary proceedings.

b. Pursuant to Section 105(b)(5)(A) of the Act and PCAOB rules, PCAOB investigatory information and records are confidential and privileged and are exempt from disclosure under the federal Freedom of Information Act. PCAOB, in its discretion, may share such information and records, along with the nonpublic sections of inspection reports, with state regulatory authorities as necessary to accomplish the purposes of the Act or to protect investors. As provided in Section 105(b)(5)(B) of the Act, state regulatory authorities also maintain such information and records as confidential and privileged, and the board will maintain that information as confidential.

1035.5(3) Disclosure to the subject of the investigation.

a. Legal authority. Pursuant to Iowa Code section 10A.506, the board may supply to a licensee who is the subject of a disciplinary complaint or investigation, prior to the initiation of a disciplinary proceeding, all or such parts of a disciplinary complaint, disciplinary or investigatory file, report, or other information as the board in its sole discretion believes would aid the investigation or resolution of the matter.

b. General rule. As a matter of general policy, the board will not disclose confidential complaint and investigative information to a licensee except as permitted by Iowa Code section 272C.6(4). Disclosure of a complainant's identity in advance of the filing of formal disciplinary charges, for instance, may adversely affect a complainant's willingness to file a complaint with the board.

c. Exceptions to general rule. The board may exercise its discretion to release information to a licensee that would otherwise be confidential under Iowa Code section 272C.6(4) under narrow circumstances, including but not limited to the following:

(1) Following a board determination that probable cause exists to file disciplinary charges against a licensee and prior to the issuance of the notice of hearing, the board may provide the licensee with a peer review or investigative report or expert opinions, as reasonably needed for the licensee to assess the merits of a settlement proposal.

(2) The board may release to a licensee who is the subject of a board-initiated investigation, including investigations initiated following the board's receipt of an anonymous complaint, such records or information as may aid the investigation or resolution of the matter.

(3) The board may release information from a peer review or consultant's report when the soliciting of the licensee's position will aid in making the probable cause determination and such disclosure can be made to the licensee without revealing identifying information regarding the complainant, peer reviewer or consultant.

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481—1035.6(17A,272C,542) Subpoena authority. Pursuant to Iowa Code sections 17A.13(1), 272C.6(3) and 542.11(1), the board is authorized in connection with a disciplinary investigation to issue subpoenas to compel witnesses to testify or persons to produce books, papers, records and any other real evidence, whether or not privileged or confidential under law, which the board deems necessary as evidence in connection with a disciplinary proceeding or relevant to the decision of whether to initiate a disciplinary proceeding. Board procedures concerning investigative subpoenas are set forth in 7—Chapter 2504.

[ARC 7691C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1035.7(17A,272C,542) Informal discussion. If the board considers it advisable, or if requested by the affected licensee, the board may grant the licensee an opportunity to appear for a voluntary informal discussion of the facts and circumstances of an alleged violation, subject to the provisions of this rule.

1035.7(1) An informal discussion is intended to provide a licensee an opportunity to share the licensee's side of a complaint in an informal setting before the board determines whether probable cause exists to initiate a disciplinary proceeding. A licensee may attend an informal discussion but is not compelled to do so. Because disciplinary investigations are confidential, a licensee is not permitted to bring persons other than legal counsel to an informal discussion. Where an allegation is made against a firm, the firm may be represented by a managing partner, member or other firm representative.

1035.7(2) 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 waives 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 be waiving 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.

1035.7(3) 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.

1035.7(4) The board may propose a consent order at the time of the informal discussion. If the licensee agrees to a consent order, a statement of charges is filed simultaneously with the consent order as provided in rule 481—506.35(17A,272C).

[ARC 7691C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1035.8(17A,272C,542) Closing complaint files.

1035.8(1) Grounds for closing. The board may close a complaint file, with or without prior investigation. Given the broad scope of matters about which members of the public may have complaints, it is not possible to catalog all possible reasons why the board may close a complaint file.

1035.8(2) *Closing orders.* The board's administrator may enter an order stating the basis for the board's decision to close a complaint file. If entered, the order will not contain the identity of the complainant or the respondent and will not disclose confidential complaint or investigative information.

If entered, a closing order will be indexed by case number and is a public record pursuant to Iowa Code section 17A.3(1) "d." A copy of the order may be mailed to the complainant, if any, and to the respondent. The board's decision whether or not to pursue an investigation, to institute disciplinary proceedings, or to close a file is not subject to judicial review.

1035.8(3) *Cautionary letters.* The board may issue a confidential letter of caution to a licensee when a complaint file is closed that informally cautions or educates the licensee about matters that could form the basis for disciplinary action in the future if corrective action is not taken by the licensee. Informal cautionary letters do not constitute disciplinary action, but the board may take such letters into consideration in the future if a licensee continues a practice about which the licensee has been cautioned.

1035.8(4) *Reopening closed complaint files.* The board may reopen a closed complaint file if additional information arises after closure that provides a basis to reassess the merits of the initial complaint.

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These rules are intended to implement Iowa Code chapters 17A, 272C and 542.

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CHAPTER 1036
DISCIPLINARY PROCEEDINGS

[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 16]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1036.1(17A,272C,542) Initiation of disciplinary proceedings. Disciplinary proceedings may be initiated only by the affirmative vote of a majority of a quorum of the board at a public meeting. Board members who are disqualified will be excluded in determining whether a quorum exists. If, for example, two members of the board are disqualified, four members of the board constitutes a quorum of the remaining six board members for purposes of voting on the case in which the two members are disqualified. When three or more members of the board are disqualified or otherwise unavailable for any reason, the administrator may request the special appointment of one or more substitute board members pursuant to Iowa Code section 17A.11(5).

[ARC 7692C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1036.2(17A,272C,542) Disciplinary contested case procedures. Unless in conflict with a provision of Iowa Code chapter 542 or board rules in this chapter, all of the procedures set forth in 481—Chapter 506 apply to disciplinary contested cases initiated by the board.

[ARC 7692C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1036.3(272C,542) Disciplinary sanctions.

1036.3(1) *Type of sanctions.* The board has the authority to impose the following disciplinary sanctions:

a. Revoke a license issued by the board. In the event of a revocation, the licensee is not allowed to remain a member, partner or shareholder of a business entity if the law dictates that all members, partners or shareholders of such an entity be actively involved.

b. Suspend a license issued by the board. A CPA or LPA who is under suspension will refrain, during the period of the suspension, from all facets of the ordinary practice of public accounting.

c. Revoke or suspend the privilege to engage in one or more areas of the practice of public accounting.

d. Impose a period of probation. As a condition to a period of probation, the board may impose terms and conditions deemed appropriate by the board, which may include, but are not limited to, the following:

(1) The board may order the licensee to undergo a quality review or desk review under the board's supervision. The licensee will select, subject to approval by the board, a CPA, an LPA, or a firm of CPAs or LPAs. The review cost will be paid by the licensee. The board will be furnished a copy of the report issued by the reviewing party and may order remedial actions or education as a result of the report findings.

(2) The board may order the licensee to enter into an agreement with a CPA, an LPA, or a firm of CPAs or LPAs to obtain a preissuance review of any audits, compilations, or reviews issued by the licensee or other public accounting services performed during the probationary period. The agreement will be preapproved by the board. The board may order the licensee to report regularly concerning the preissuance reviews conducted pursuant to the agreement. Any cost incurred in obtaining preissuance review will be paid by the licensee.

(3) The board may order the licensee to undergo a substance abuse evaluation and such care and treatment appropriate under the circumstances.

e. Specify that a designated amount of continuing education be taken in specific subjects and may specify the time period for completing these courses. The board may also specify whether that continuing education be in addition to the continuing education routinely necessary for license renewal. The board may also specify that additional continuing education be a condition for the

termination of any suspension or reinstatement of a certificate, permit, license, or registration. The board may also specify that current reference materials be obtained and maintained.

f. Obligate the licensee to undergo reexamination, using one or more parts of the CPA or LPA examination given to candidates for the CPA certificate or the LPA license.

g. Impose civil penalties pursuant to Iowa Code section 542.14(2).

h. Issue a reprimand.

i. Order the licensee to alter a professional practice or refrain from engaging in a particular act or practice in the future, notify clients of unlicensed or unprofessional conduct, or take such other remedial measures that are appropriate under the public interest and circumstances of the infraction.

j. Order such alternative discipline as is allowed by law.

1036.3(2) *Imposing discipline.* Discipline may be imposed against a licensee only by the affirmative vote of a majority of the members of the board who are not disqualified.

1036.3(3) *Voluntary surrender.* The board may accept the voluntary surrender of a license to resolve a pending disciplinary contested case or pending disciplinary investigation. The board will not accept a voluntary surrender of a license to resolve a pending disciplinary investigation unless a statement of charges is filed along with the order accepting the voluntary surrender. Such a voluntary surrender is considered disciplinary action and will be published in the same manner as is applicable to any other form of disciplinary order.

1036.3(4) *Client notification.* Whenever a license is revoked, suspended, under probation, or voluntarily surrendered under this chapter, the licensee will:

a. Within 30 days of receipt of the board's final order, notify in writing all clients of the fact that the license has been revoked, suspended or voluntarily surrendered or that the licensee is under probation and the subject of compliance terms imposed by the board; for example, the licensee may agree to discontinue governmental audits while the licensee's license is under probation. Such notice will advise the client to obtain alternative professional services, unless probationary compliance terms at issue would not impact the public accounting services provided for that client;

b. Within 30 days of receipt of the board's final order, file with the board copies of the notices sent pursuant to paragraph 1036.3(4) "*a.*" Compliance with this paragraph is a condition precedent for an application for reinstatement.

[ARC 7692C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1036.4(272C,542) Notification of decisions. The board will notify NASBA of disciplinary action taken against an Iowa licensee.

[ARC 7692C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1036.5(272C,542) Reinstatement.

1036.5(1) The term "reinstatement" as used in this rule and in rule 481—506.32(17A,272C) includes the reinstatement of a suspended license, the modification or removal of a probationary limitation on a licensee's practice, the issuance of a license following the denial of an application to renew a license, and the issuance of a new license following the revocation or voluntary surrender of a license.

1036.5(2) Any person whose license has been revoked, suspended or placed under probation by the board, or who has voluntarily surrendered a license to conclude a disciplinary investigation or proceeding, or whose application to renew a license has been denied may apply to the board to modify or terminate the suspension, issue or reissue the license, or modify or remove the probationary limitations of practice in accordance with Iowa Code section 542.12, rule 481—506.32(17A,272C), the provisions of this rule, and the terms of the order of revocation, suspension or probation, denial of license renewal, or acceptance of voluntary license surrender.

1036.5(3) If the applicable order did not establish terms upon which the licensee may apply for reinstatement, an initial application for reinstatement may be made after at least one year has elapsed from the date of the order that revoked, suspended or placed under probation the license, denied license renewal, or accepted a voluntary surrender.

1036.5(4) All proceedings for reinstatement are initiated by the respondent and subject to the procedures set forth in rule 481—506.32(17A,272C). In addition, the board may grant an applicant's request to appear informally before the board prior to the issuance of a notice of hearing on the application if the applicant requests an informal appearance in the application and agrees not to seek to disqualify on the ground of personal investigation the board members or staff before whom the applicant appears.

1036.5(5) An order granting an application for reinstatement may impose such terms and conditions as the board deems desirable, which may include one or more of the types of disciplinary sanctions described in rule 481—1036.3(272C,542).

1036.5(6) The board will not grant an application for reinstatement when the initial order that revoked, suspended or placed under probation the license; denied license renewal; or accepted a voluntary surrender was based on a criminal conviction and the applicant cannot demonstrate to the board's satisfaction that:

- a.* All the terms of the sentencing or other criminal order have been fully satisfied;
- b.* The applicant has been released from confinement and any applicable probation or parole; and
- c.* Restitution has been made or is reasonably in the process of being made to any victims of the crime.

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CHAPTER 1037
ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 17]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1037.1(542) Civil penalties against nonlicensees. The board may order compliance with Iowa Code chapter 542 and board rules, revoke a practice privilege, and impose civil penalties by order against a firm, other entity, or individual that is not licensed by the board pursuant to Iowa Code chapter 542 based on the unlawful practices specified in Iowa Code sections 542.13 and 542.20. In addition to the procedures set forth in Iowa Code section 542.14, this chapter applies.

[ARC 7693C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1037.2(17A,542) Investigations. The board is authorized by Iowa Code section 17A.13(1) and Iowa Code section 542.11 to conduct such investigations as are needed to determine whether grounds exist to impose civil penalties against a nonlicensee. Such investigations will conform to the procedures outlined in 481—Chapter 1035. Complaint and investigatory files concerning nonlicensees are not confidential except as may be provided in Iowa Code chapter 22.

[ARC 7693C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1037.3(17A,542) Notice of intent to impose civil penalties. The notice of the board's intent to issue an order to enforce compliance with Iowa Code chapter 542 and board rules and to impose a civil penalty will be served upon the nonlicensee by certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the nonlicensee may accept service personally or through authorized counsel. The notice will include the following:

1. A statement of the legal authority and jurisdiction under which the proposed civil penalty would be imposed.
2. Reference to the particular sections of the statutes and rules involved.
3. A short, plain statement of the alleged unlawful practices.
4. The dollar amount of the proposed civil penalty, the nature of the intended order to enforce compliance with Iowa Code chapter 542 and board rules, and whether a practice privilege will be revoked.
5. Notice of the nonlicensee's right to a hearing and the time frame in which hearing can be requested.
6. The address to send a written request for hearing.

[ARC 7693C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1037.4(17A,542) Request for hearing.

1037.4(1) Nonlicensees have 30 days to request a hearing. The 30-day time frame begins on the date the notice is mailed if served through certified mail to the last-known address, or 30 days from the date of service if service is accepted or made in accordance with Iowa Rule of Civil Procedure 1.305. A request for hearing has to be in writing and is deemed made on the date of the nonmetered United States Postal Service postmark or the date of personal service.

1037.4(2) If a request for hearing is not timely made, the board chairperson or the chairperson's designee may issue an order imposing the civil penalty, revoking the practice privilege, and requiring compliance with Iowa Code chapter 542 and board rules, as described in the notice. The order may be mailed by regular first-class mail or served in the same manner as the notice of intent to impose civil penalty.

1037.4(3) If a request for hearing is timely made, the board will issue a notice of hearing and conduct a hearing in the same manner as applicable to disciplinary cases against licensees.

1037.4(4) A nonlicensee may waive the right to hearing and all attendant rights and enter into a consent order imposing a civil penalty, revoking the practice privilege, and requiring compliance with Iowa Code chapter 542 and board rules at any stage of the proceeding upon mutual consent of the board.

1037.4(5) The notice of intent to issue an order and the order are public records available for inspection and copying in accordance with Iowa Code chapter 22. Hearings are open to the public.

[ARC 7693C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1037.5(542) “Safe harbor” language. Persons who do not hold a CPA certificate or LPA license, firms that do not hold a CPA or LPA firm permit to practice, or individuals or firms that are ineligible to exercise a practice privilege cannot use in any statement relating to the financial affairs of a person or entity language that is conventionally used by CPAs or LPAs in reports on financial statements. Pursuant to Iowa Code section 542.13(8), such persons or firms may use the following “safe harbor” language:

“I (we) have prepared the accompanying (financial statements) of (name of entity) as of (time period) for the (period) then ended. This presentation is limited to preparing in the form of financial statements information that is the representation of management (owners). I (we) have not audited, reviewed or compiled the accompanying financial statements and accordingly do not express an opinion or any other form of assurance on them.”

[ARC 7693C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1037.6(542) Enforcement options. The board may also pursue other enforcement as provided in Iowa Code sections 542.14(8), 542.14(9) and 542.15.

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CHAPTER 1038 LICENSEES' DUTY TO REPORT

[Prior to 5/1/02, see 193A—Chapter 15]
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 18]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1038.1(272C,542) Reporting acts or omissions committed by licensees.

1038.1(1) An individual or firm licensed by the board has a duty to report under Iowa Code section 272C.9(2). The failure to perform an engagement for a client in accordance with professional standards may demonstrate a lack of qualifications by a licensee or firm. These professional standards are set forth in 481—Chapter 1033.

1038.1(2) When a licensee observes an act or omission referenced in subrule 1038.1(1), the licensee is obligated to report the violation in writing to the board office, setting forth the name of the licensee alleged to have committed the violation and the rule(s) violated, together with a copy of all material that evidences the violation.

[ARC 7694C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1038.2(272C,542) Reporting judgments and settlements alleging malpractice.

1038.2(1) Licensees have a duty to report under Iowa Code section 272C.9(3). For the purposes of this rule, malpractice actions brought against a firm licensed by the board will be deemed to have been brought against both the firm and the firm's owners (e.g., partners, shareholders, or members) who performed the services that led to the malpractice action.

1038.2(2) When a licensee is a party to an adverse judgment resulting from a professional malpractice action or is a party to a settlement of a claim resulting from an allegation of malpractice, the licensee has an obligation to file a report in writing forwarded to the board office, setting forth the name and address of the client, the date the claim was originally made, a brief description of the circumstances precipitating the claim and a copy of the judgment or settlement agreement resulting from the claim.

[ARC 7694C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1038.3(272C,542) Timely reporting. The reports under this chapter are to be forwarded to the board within 30 days from the initial receipt of the information giving rise to the reporting obligation.

[ARC 7694C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1038.4(272C,542) Failure to make reports. The board may initiate a disciplinary proceeding against any licensee who fails to make a timely report under this chapter.

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CHAPTER 1039
PRACTICE PRIVILEGE FOR OUT-OF-STATE CERTIFIED PUBLIC ACCOUNTANTS
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 20]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1039.1(542) Overview and timing. Out-of-state certified public accountants who maintain their principal place of business in a jurisdiction other than Iowa may practice public accounting in Iowa or for clients with a home office in Iowa without Iowa licensure if all of the conditions of Iowa Code section 542.20 and this chapter are satisfied.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.2(542) Out-of-state licensure status. The practice privilege described in Iowa Code section 542.20 applies to individuals who are licensed to practice as certified public accountants in the jurisdiction in which their principal place of business is located for those periods of time in which all of the following conditions are satisfied:

1039.2(1) The out-of-state license is valid, in good standing, and active. The practice privilege ceases if the out-of-state license expires in the jurisdiction of the individual's principal place of business.

1039.2(2) The individual meets the criteria for substantial equivalency reciprocity, as provided in Iowa Code section 542.19(1) "a," "b," or "c" and rule 481—1029.5(542).

1039.2(3) The license authorizes in the individual's principal place of business all of the public accounting services the individual performs or offers to perform in Iowa or for clients with a home office in Iowa.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.3(542) When Iowa licensure may be necessary.

1039.3(1) The auditor of state, the department of agriculture and land stewardship, another governmental official or body, or a client may mandate that an individual be licensed in Iowa as a condition of performing public accounting services in Iowa or for a client with a home office in Iowa, whether or not the individual may otherwise satisfy the conditions for a practice privilege. Iowa licensure as a certified public accountant is necessary, for example, to perform certain audit services described in Iowa Code chapter 11.

1039.3(2) Iowa licensure is necessary if an individual has an office in Iowa at which the individual uses the title "CPA," unless the individual satisfies the conditions for a practice privilege and one of the following is true:

a. The Iowa office is the office of an Iowa CPA or LPA firm that holds a permit to practice under Iowa Code section 542.7 or 542.8, and the individual provides public accounting services through that firm.

b. The Iowa office is the office of a business entity that is not obligated to hold a firm permit to practice under Iowa Code section 542.7 or 542.8, and the individual provides public accounting services through that business entity.

1039.3(3) Iowa licensure is necessary if an individual moves the individual's principal place of business to Iowa and is otherwise obligated to be licensed under Iowa Code chapter 542. The board's streamlined application process for reciprocal licensure is described in Iowa Code section 542.19 and 481—Chapter 1029.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.4(542) Individuals ineligible for a practice privilege.

1039.4(1) The practice privilege described in Iowa Code section 542.20 is not applicable if:

a. The individual has been convicted of a felony under the laws of any jurisdiction.

b. The individual has been convicted of any crime under the laws of any jurisdiction if an element of the crime involves dishonesty or fraud, such as forgery, embezzlement, obtaining money under false pretenses, theft, extortion, conspiracy to defraud, or similar offense, as more fully described in Iowa Code section 542.5(2).

c. The individual's license to practice public accounting has been suspended, revoked, or otherwise disciplined by a licensing authority in this or another state, territory, or country, for any cause other than failure to pay appropriate fees. "Disciplined" includes the voluntary surrender of a license to resolve a pending disciplinary investigation or proceeding in Iowa or another jurisdiction.

d. The individual's right to practice public accounting before any state or federal agency, or the PCAOB, has been suspended or revoked.

e. The individual has applied for licensure as a certified public accountant in Iowa or another jurisdiction and the application has been denied.

f. Civil penalties have been imposed against the individual pursuant to Iowa Code section 542.14.

g. The individual's authority to exercise a practice privilege has been revoked in Iowa or another jurisdiction.

1039.4(2) Individuals precluded from exercising a practice privilege under this rule may apply for licensure in Iowa if otherwise qualified. The board will determine when an application is submitted whether the criminal or disciplinary history or other regulatory action provides a ground to deny licensure.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.5(542) Attest and compilation services. Individuals providing compilation services in Iowa or for a client with a home office in Iowa need to comply with the peer review provisions of Iowa Code section 542.6(6) or provide such services through a CPA or LPA firm, or a substantially equivalent firm that holds a valid license in the firm's principal place of business and that complies with the peer review and ownership provisions of Iowa Code section 542.7 or 542.8.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.6(542) Rights and duties.

1039.6(1) Individuals who satisfy the conditions for a practice privilege may practice public accounting in Iowa or for a client with a home office in Iowa in person or by telephone, mail, or electronic means without licensure under Iowa Code chapter 542 or notice to the board.

1039.6(2) Individuals lawfully practicing public accounting under a practice privilege may use the title "CPA" as long as they do not have an office in Iowa, except as provided in subrule 1039.3(2).

1039.6(3) Individuals practicing public accounting in Iowa or for a client with a home office in Iowa while exercising a practice privilege are subject to all of the following provisions:

a. Practice privilege practitioners are not allowed to make any representation tending to falsely indicate that the individuals are licensed under Iowa Code chapter 542. Such individuals may truthfully identify themselves as licensed in any jurisdiction in which they hold a valid, active, unexpired license to practice as a certified public accountant. For example, a practice privilege practitioner could not use the title "Iowa CPA" or otherwise state or imply licensure in Iowa, but, if true, the individual could use a title such as "CPA, licensed in Texas" or "Florida CPA." Such individuals could also truthfully state that they are CPAs practicing under a practice privilege.

b. Practice privilege practitioners will provide, upon a client's or prospective client's request, accurate information on the state or states of licensure, principal place of business, contact information, and manner in which licensure status can be verified.

c. Practice privilege practitioners will comply with all professional standards, laws, and rules that apply to licensees performing the same professional services.

1039.6(4) As a condition of exercising the practice privilege provided in Iowa Code section 542.20, the individual:

a. Consents to the personal and subject matter jurisdiction and regulatory authority of the board including, but not limited to, the board's jurisdiction to revoke the practice privilege or otherwise take action under Iowa Code section 542.14 for any violation of Iowa Code chapter 542 or board rules;

b. Appoints the regulatory body of the state that issued the license in the individual's principal place of business as the agent upon whom process may be served in any action or proceeding by the board against the individual;

c. Agrees to supply the board, upon the board's request and without subpoena, such information or records licensees are similarly obligated to provide the board under Iowa Code chapter 542, including but not limited to the information described in Iowa Code section 542.20(7) "c"; and

d. Agrees to promptly cease offering or providing public accounting services in Iowa or for a client with a home office in Iowa if the license in the individual's principal place of business expires or is otherwise no longer in good standing, or if any of the conditions for exercising the practice privilege are no longer satisfied, or if the board revokes the practice privilege.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.7(542) Penalties.

1039.7(1) Individuals purporting to practice public accounting under a practice privilege who are ineligible to exercise a practice privilege or who fail to satisfy the conditions for exercising a practice privilege are subject to all of the penalties that apply to unlicensed persons, including the criminal, administrative, and civil penalties described in Iowa Code sections 542.14 and 542.15.

1039.7(2) If an individual acting or purporting to act under a practice privilege engages in any act or practice that does or may in the future violate Iowa Code chapter 542 or board rules, the board may take any or all of the following actions, as applicable:

a. Apply to the district court for an injunction, restraining order, or other order, pursuant to Iowa Code section 542.14(1);

b. Issue an order to require compliance with Iowa Code chapter 542 or board rules and impose a civil penalty pursuant to Iowa Code section 542.14;

c. Deny the subsequent license application of the violator or the violator's firm, pursuant to Iowa Code section 542.20(4) "a" and "b";

d. Refer the complaint or other relevant information to the jurisdiction that issued a license to the alleged violator; and

e. Take disciplinary action against the individual pursuant to Iowa Code section 542.10 if the individual holds an inactive or lapsed Iowa license.

1039.7(3) Complaints filed with the board alleging violations by individuals who are not licensed by the board, including those acting or purporting to act under a practice privilege, are not confidential under Iowa Code section 272C.6(4) and will not be treated as confidential unless otherwise provided in Iowa Code chapter 22 or other applicable law.

1039.7(4) Persons filing complaints with the board against individuals acting or purporting to act under a practice privilege should provide as much information as possible to assist the board in locating the individual and in determining whether the individual is licensed in any jurisdiction.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1039.8(542) Relationship between Iowa licensure and the exercise of a practice privilege.

1039.8(1) *Active Iowa licensees.* An Iowa licensee holding an active CPA certificate is treated for all purposes as an Iowa licensee and is not subject to the provisions of Iowa Code section 542.20.

1039.8(2) *Inactive Iowa licensees.* An Iowa licensee holding an inactive CPA certificate is precluded by Iowa Code section 542.6(3) and rule 481—1025.9(272C,542) from performing attest or compilation services or using the title "CPA" while performing public accounting services in Iowa or for a client with a home office in Iowa. The practice of an inactive CPA is restricted because the continuing education necessary to renew in active status does not apply to those renewing in inactive status. Some individuals holding an inactive Iowa CPA certificate may, however, hold an active CPA certificate in another jurisdiction in which they maintain their principal place of business and

satisfy continuing education obligations. Such individuals may have maintained an inactive Iowa CPA certificate solely to facilitate reinstatement to active status when active Iowa licensure is necessary in their practice. The following provisions apply to inactive Iowa licensees who may wish to exercise a practice privilege:

a. In a disciplinary investigation or proceeding in which an inactive Iowa licensee is alleged to have improperly used the title “CPA” or otherwise practiced public accounting on an inactive license, the board will consider whether the inactive licensee, at the time of the events at issue, satisfied the conditions for a practice privilege under Iowa Code section 542.20 and complied with all rules applicable to the exercise of a practice privilege.

b. The individual will take care to avoid public confusion about licensure status as provided in 481—subrule 1025.1(6).

c. Violations of Iowa laws or rules by an individual holding an inactive Iowa CPA certificate will be prosecuted as disciplinary proceedings against a licensee under Iowa Code section 542.10 and, when appropriate under the factual circumstances, may also or alternatively be enforced under the provisions of Iowa Code sections 542.14 and 542.15.

1039.8(3) *Lapsed Iowa licensees.* An Iowa licensee holding a lapsed Iowa CPA certificate is not authorized to perform attest or compilation services or to otherwise practice public accounting using the title “CPA” in Iowa or for a client with a home office in Iowa. A lapsed licensee is subject to discipline for practicing on a lapsed license or representing oneself as a “CPA” in any context unless the licensee truthfully discloses that the certificate has lapsed. Some individuals holding lapsed Iowa CPA certificates may, however, hold active CPA certificates in another jurisdiction in which the individuals maintain their principal place of business. Such individuals may have intentionally allowed their Iowa CPA certificates to lapse because the individuals no longer need an active Iowa license in their practice. The following provisions apply to lapsed Iowa licensees who may wish to exercise a practice privilege:

a. In a disciplinary investigation or proceeding in which a lapsed Iowa licensee is alleged to have improperly used the title “CPA” or otherwise practiced public accounting on a lapsed license, the board will consider whether the lapsed licensee, at the time of the events at issue, satisfied the conditions for a practice privilege under Iowa Code section 542.20 and complied with all rules applicable to the exercise of a practice privilege.

b. The individual will take care to avoid public confusion about licensure status as provided in 481—subrule 1025.1(6).

c. Violations of Iowa laws or rules by an individual holding a lapsed Iowa CPA certificate will be prosecuted as disciplinary proceedings against a licensee under Iowa Code section 542.10 and, when appropriate under the factual circumstances, may also or alternatively be prosecuted under the provisions of Iowa Code sections 542.14 and 542.15.

1039.8(4) *Former Iowa licensees.* An individual who held an Iowa CPA certificate at one time whose Iowa CPA certificate has been revoked or surrendered in connection with a disciplinary investigation or proceeding is barred from performing attest or compilation services or using the title “CPA” whether or not such individual may otherwise qualify for a practice privilege.

a. The former Iowa licensees described in this subrule are ineligible to exercise the practice privilege described in Iowa Code section 542.20.

b. Violations of Iowa Code chapter 542 or board rules by former Iowa licensees are subject to the criminal, civil and administrative remedies described in Iowa Code sections 542.14 and 542.15, and may also be prosecuted as disciplinary proceedings under Iowa Code section 542.10 if the license remains subject to reinstatement under Iowa Code section 542.12.

[ARC 7695C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 542.20.

[Filed ARC 7715B (Notice ARC 7484B, IAB 1/14/09), IAB 4/22/09, effective 7/1/09]

[Filed ARC 0413C (Notice ARC 0254C, IAB 8/8/12), IAB 10/31/12, effective 12/5/12]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 1040
PRACTICE PRIVILEGE FOR OUT-OF-STATE CERTIFIED PUBLIC ACCOUNTING FIRMS
[Prior to 6/10/26, see Accountancy Examining Board[193A] Ch 21]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/10/29

481—1040.1(542) Overview and timing. Out-of-state certified public accounting firms that maintain their principal place of business in a jurisdiction other than Iowa may practice public accounting in Iowa or for clients with a home office in Iowa without Iowa licensure if all of the conditions of Iowa Code section 542.20 and this chapter are satisfied.

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.2(542) Out-of-state licensure status. The practice privilege described in Iowa Code section 542.20 applies to certified public accounting firms that are licensed to practice as certified public accounting firms in the jurisdiction in which their principal place of business is located for those periods of time in which all of the following conditions are satisfied:

1040.2(1) The out-of-state license is valid, in good standing, and active. The practice privilege ceases if the out-of-state license expires in the jurisdiction of the firm's principal place of business.

1040.2(2) The out-of-state license is substantially equivalent to a permit to practice issued under Iowa Code section 542.7.

1040.2(3) The license authorizes in the firm's principal place of business all of the public accounting services the firm performs or offers to perform in Iowa or for clients with a home office in Iowa.

1040.2(4) The public accounting services offered in Iowa or for clients with a home office in Iowa that are obligated under Iowa law to be performed by a CPA are performed by a person holding a certificate issued under Iowa Code section 542.6 or 542.19, or by a person exercising a practice privilege pursuant to Iowa Code section 542.20 and 481—Chapter 1039.

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.3(542) When Iowa licensure may be necessary.

1040.3(1) The auditor of state, the department of agriculture and land stewardship, another governmental official or body, or a client may mandate that a firm be licensed in Iowa as a condition of performing public accounting services in Iowa or for a client with a home office in Iowa, whether or not the firm may otherwise satisfy the conditions for a practice privilege. Iowa licensure as a certified public accounting firm is necessary, for example, to perform certain audit services described in Iowa Code chapter 11.

1040.3(2) Iowa licensure is necessary if the firm has one or more offices in Iowa at which the firm uses the title "CPAs," "CPA firm," "certified public accountants," or "certified public accounting firm."

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.4(542) CPA firms, revocation of practice privilege.

1040.4(1) The board may revoke the practice privilege in accordance with Iowa Code section 542.20.

1040.4(2) Firms precluded from exercising a practice privilege under this rule may apply for licensure in Iowa if otherwise qualified. The board will determine when an application is submitted whether the criminal or disciplinary history or other regulatory action against the firm or against any of the firm's owners (e.g., partners, shareholders, or members) provides a ground to deny licensure.

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.5(542) Attest and compilation services. Unless otherwise obligated by rule 481—1040.3(542), attest and compilation services may be performed by an out-of-state CPA firm exercising a practice privilege as long as the out-of-state firm is validly licensed in the state of its

principal place of business, complies with Iowa Code section 542.20(5) and 542.20(6) and associated rules, and complies with the peer review and ownership provisions of Iowa Code section 542.7.

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.6(542) Rights and duties.

1040.6(1) CPA firms that satisfy the conditions for a practice privilege may practice public accounting in Iowa or for a client with a home office in Iowa in person, or by telephone, mail, or electronic means without licensure under Iowa Code chapter 542 or notice to the board.

1040.6(2) CPA firms lawfully practicing public accounting under a practice privilege may use the title “CPAs,” “CPA firm,” “certified public accountants,” or “certified public accounting firm.”

1040.6(3) CPA firms practicing public accounting in Iowa or for a client with a home office in Iowa while exercising a practice privilege are subject to all of the following provisions:

a. Practice privilege firms are not allowed to make any representation tending to falsely indicate that the firm is licensed under Iowa Code chapter 542. Such firms may truthfully identify themselves as licensed in any jurisdiction in which the firm holds a valid, active, unexpired license to practice as a certified public accounting firm. For example, a practice privilege firm could not use the title “Iowa CPAs” or “Iowa CPA firm” or otherwise state or imply licensure in Iowa, but, if true, the firm could use a title such as “CPA firm, licensed in Texas” or “Florida CPAs.” Such firm could also truthfully state that the firm is practicing in Iowa under a practice privilege.

b. Practice privilege firms will provide, upon a client’s or prospective client’s request, accurate information on the state or states of licensure, principal place of business, contact information, and manner in which licensure status can be verified.

c. Practice privilege firms will comply with all professional standards, laws, and rules that apply to licensed firms performing the same professional services.

1040.6(4) As a condition of exercising the practice privilege provided in Iowa Code section 542.20, the firm:

a. Consents to the personal and subject matter jurisdiction and regulatory authority of the board including, but not limited to, the board’s jurisdiction to revoke the practice privilege or otherwise take action under Iowa Code section 542.14 for any violation of Iowa Code chapter 542 or board rules;

b. Appoints the regulatory body of the state that issued the license in the firm’s principal place of business as the agent upon whom process may be served in any action or proceeding by the board against the firm;

c. Agrees to supply the board, upon the board’s request and without subpoena, such information or records that licensed firms are similarly obligated to provide the board under Iowa Code chapter 542, including but not limited to the information described in Iowa Code section 542.20(7) “c,” and rule 481—1027.3(542); and

d. Agrees to promptly cease offering or providing public accounting services in Iowa or for a client with a home office in Iowa if the license in the firm’s principal place of business expires or is otherwise no longer in good standing, or if any of the conditions for exercising the practice privilege are no longer satisfied, or if the board revokes the practice privilege.

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.7(542) Penalties.

1040.7(1) Firms purporting to practice public accounting under a practice privilege that are ineligible to exercise a practice privilege or that fail to satisfy the conditions for exercising a practice privilege are subject to all of the penalties that apply to unlicensed firms, including the criminal, administrative, and civil penalties described in Iowa Code sections 542.14 and 542.15.

1040.7(2) If a firm acting or purporting to act under a practice privilege engages in any act or practice that does or may in the future violate Iowa Code chapter 542 or board rules, the board may take any or all of the following actions, as applicable:

a. Apply to the district court for an injunction, restraining order, or other order, pursuant to Iowa Code section 542.14(1);

b. Issue an order mandating compliance with Iowa Code chapter 542 or board rules and impose a civil penalty pursuant to Iowa Code section 542.14;

c. Deny the subsequent license application of the violator or, to the extent responsible for the violation, any of the firm's owners (e.g., partners, shareholders, or members), pursuant to Iowa Code section 542.20(4) "a" and "b";

d. Refer the complaint or other relevant information to a jurisdiction that issued a license to the alleged violator; and

e. Take disciplinary action against the firm or, to the extent responsible for the violation, any of the firm's owners (e.g., partners, shareholders, or members), pursuant to Iowa Code section 542.10, if the firm or individual holds an inactive or lapsed Iowa license.

1040.7(3) Complaints filed with the board alleging violations by firms that are not licensed by the board, including those acting or purporting to act under a practice privilege, are not confidential under Iowa Code section 272C.6(4) and will not be treated as confidential unless otherwise provided in Iowa Code chapter 22 or other applicable law.

1040.7(4) Persons filing complaints with the board against firms acting or purporting to act under a practice privilege should provide as much information as possible to assist the board in locating the firm and the individuals allegedly responsible for the acts or omissions causing the complaint, and in determining whether the firm or any responsible individual is licensed in any jurisdiction.

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

481—1040.8(542) Relationship between Iowa licensure and the exercise of a practice privilege.

1040.8(1) *Active Iowa licensees.* An Iowa CPA firm holding an active permit to practice under Iowa Code section 542.7 will be treated for all purposes as an Iowa licensee and is not subject to the provisions of Iowa Code section 542.20.

1040.8(2) *Lapsed Iowa licensees.* An Iowa CPA firm holding a lapsed permit to practice under Iowa Code section 542.7 is not authorized to perform attest or compilation services or to otherwise practice public accounting using the title "CPAs," "CPA firm," "certified public accountants," or "certified public accounting firm" unless the firm is eligible to exercise a practice privilege under Iowa Code section 542.20. The following provisions apply to firms holding a lapsed Iowa permit to practice when exercising a practice privilege:

a. In a disciplinary investigation or proceeding alleging unlicensed practice or improper use of title, the board will consider whether the lapsed licensee, at the time of the events at issue, satisfied the conditions for a practice privilege under Iowa Code section 542.20 and complied with all rules applicable to the exercise of a practice privilege.

b. The firm will take reasonable steps to avoid public confusion over licensure status.

c. Violations of Iowa laws or rules by a firm holding a lapsed permit to practice will be prosecuted as disciplinary proceedings against a licensee under Iowa Code section 542.10 and, when appropriate under the factual circumstances, may also or alternatively be prosecuted under the provisions of Iowa Code sections 542.14 and 542.15.

1040.8(3) *Former Iowa licensees.* A CPA firm that held an Iowa permit to practice at one time that has been revoked or surrendered in connection with a disciplinary investigation or proceeding is barred from performing any act or practice for which Iowa firm licensure is necessary and is further ineligible to exercise the practice privilege described in Iowa Code section 542.20. Violations of Iowa Code chapter 542 or board rules by such a firm are subject to the criminal, civil and administrative remedies described in Iowa Code sections 542.14 and 542.15, and may also be prosecuted as disciplinary proceedings under Iowa Code section 542.10 if the license remains subject to reinstatement under 481—subrule 1027.6(3).

[ARC 7696C, IAB 3/6/24, effective 4/10/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 542.20.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTERS 1041 to 1080
Reserved

CHAPTER 1081
DESCRIPTION OF ORGANIZATION

[Prior to 3/9/88, see Landscape Architectural Examiners Board[540] Ch 1]
[Prior to 6/10/26, see Landscape Architectural Examining Board[193D] Ch 1]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/4/30

481—1081.1(544B,17A) Definitions. As used in these rules, the following definitions of words and terms shall apply:

“*Board*” means the 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 is the responsibility of the applicant to satisfy the board as to the sufficiency of the record and the evidence.

“*Inactive*” means that a landscape architect is not engaged in Iowa in any practice for which a certificate of licensure is required.

“*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.

“*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 purposes of these rules, a professional landscape architect may be referred to as a landscape architect and may use the initials “P.L.A.”

“*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 9154C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1081.2(544B,17A) Organization and duties. The board consists of five licensed professional landscape architects and two members who are not licensed professional landscape architects and who represent the general public.

1081.2(1) *Qualifications of professional landscape architect board members.* Four of the five professional members will be actively engaged in the practice of landscape architecture or the teaching of landscape architecture in an accredited college or university and shall have been so engaged for five years preceding appointment, the last two of which shall have been in Iowa. One of the five professional members will be actively engaged in the practice of landscape architecture or the teaching of landscape architecture in an accredited college or university and may have been so engaged for fewer than five years preceding.

1081.2(2) *Election of chairperson and vice chairperson.* The board elects annually from its members a chairperson and a vice chairperson. A quorum of the board will be four members, and all final motions and actions must receive a vote by a majority of the members of the board.

1081.2(3) *Duties of board.* The board enforces the provisions of Iowa Code chapter 544B and makes rules for the examination of applications for licensure. The board keeps records of its proceedings. The board adopts an official seal that is affixed to all certificates of licensure granted. The board makes other rules, not inconsistent with law, as necessary for the proper performance of its duties. The board maintains a roster showing the name, place of business, residence, and date and number of the certificate of licensure of every professional landscape architect in the state.

1081.2(4) Duties of chairperson. The chairperson will, when present, preside at meetings, appoint committees, and perform all duties and powers of the chairperson.

1081.2(5) Duties of vice chairperson. The vice chairperson will, in the absence or incapacity of the chairperson, exercise the duties and powers of the chairperson.

[ARC 9154C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1081.3(544B,17A) Meetings. Calls for meetings are issued in accordance with Iowa Code section 21.4.

[ARC 9154C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1081.4(544B,17A) Order of business. The board executive will prepare an agenda listing all matters to be discussed at meetings. A copy of this agenda will be available to each member of the board.

[ARC 9154C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1081.5(17A) Interim waivers. In addition to the provisions of 481—Chapter 6, the following will apply for interim rulings:

1081.5(1) The board chairperson, or vice chairperson if the chairperson is not available, may rule on a petition for waiver when it would not be timely to wait for the next regularly scheduled board meeting for a ruling from the board.

1081.5(2) The board administrator, upon receipt of a petition that meets all applicable criteria established in 481—Chapter 6, will present the request to the board chairperson or vice chairperson along with all pertinent information regarding established precedent for granting or denying such requests.

1081.5(3) The chairperson or vice chairperson will 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.

1081.5(4) A waiver report will be placed on the agenda of the next regularly scheduled board meeting and recorded in the minutes of the meeting.

1081.5(5) This rule on interim rulings does not apply if the waiver was filed in a contested case.

[ARC 9154C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 1082 EXAMINATIONS AND LICENSING

[Prior to 3/9/88, see Landscape Architectural Examiners Board[540] Ch 2]
[Prior to 6/10/26, see Landscape Architectural Examining Board[193D] Ch 2]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/4/30

481—1082.1(544B,17A) Application for licensure by examination.

1082.1(1) Candidates will contact CLARB to start the examination licensure process by creating a council record. A candidate's council record will include verified history of the candidate's education, experience, examination and licensure history, and professional references and is used to apply for examination, licensure and certification.

1082.1(2) The candidate who successfully completes the LARE will complete an online application for certificate of licensure to the board after meeting one of the requirements listed below and requesting that the candidate's council record be transmitted to the board.

a. Graduation from a course in landscape architecture in a school, college, or university offering an accredited minimum four-year curriculum in landscape architecture, and a minimum of three years of practical experience in landscape architectural work that in the opinion of the board is of satisfactory character, at least one year of which must be under the supervision of a professional landscape architect or a person who becomes a professional landscape architect within one year after July 1, 2002.

b. Graduation from a nonaccredited course of landscape architecture of a minimum of four years in a school, college, or university and a minimum of four years of practical experience in landscape architectural work that in the opinion of the board is of satisfactory character, at least one year of which must be under the supervision of a professional landscape architect.

c. A minimum of ten years of practical experience in landscape architectural work that in the opinion of the board is of satisfactory character to properly prepare the applicant for the examination.

1082.1(3) A satisfactorily completed year of study in an accredited course of landscape architecture in an accredited school, college, or university may be accepted in lieu of one year of practical experience.

1082.1(4) A master's degree from an accredited school, college, or university may be accepted in lieu of one year of practical experience.

1082.1(5) Any four-year college or university degree may be accepted in lieu of two years of practical experience.

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.2(544B,17A) Procedure for processing applications. The board executive will determine when the legal requirements for licensure have been satisfied with regard to issuance of certificates, licenses or registrations, and the board executive will submit to the board any questionable application. An applicant's personal appearance before the board, if required, will 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 will be filed with the board in accordance with rule 481—506.26(17A). A judicial review can be filed in accordance with Iowa Code section 17A.19.

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.3(544B,17A) Registration of applicants. Applicants must meet the requirements of Iowa Code section 544B.9 for registration.

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.4(544B,17A) Written examination. The written examination will consist of the professional landscape architectural licensure examination published by CLARB and may include supplementary questions developed by the board.

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.5(544B,17A) Exemption from written examination. The board may exempt from written examination an applicant who meets one of the following criteria:

1082.5(1) The applicant holds a current CLARB certificate;

1082.5(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

1082.5(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 grandfathered 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 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.6(544B,17A) Certificate of licensure. When an applicant has qualified for licensure under this chapter and has paid the required license fee, board staff will enroll the applicant's name in the roster of professional landscape architects and issue to the applicant a certificate of licensure.

1082.6(1) *License number.* The certificate will indicate the license number of the landscape architect that must appear on the professional landscape architect's seal and on all works signed by the professional landscape architect.

1082.6(2) *Certificate.* Only one certificate of licensure will be issued to a professional landscape architect. The certificate will be displayed in a conspicuous place at the place of employment.

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.7(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 July 1 of the year of expiration. 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 481—1082.8(544B,17A).

1082.7(1) It is the policy of the board to email 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.

1082.7(2) If grounds exist to deny a timely and sufficient application to renew, the board will send notification to the applicant. 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 will proceed as provided in 481—Chapter 506. 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 rule 481—506.33(17A,272C).

1082.7(3) When a licensee appears to be in violation of mandatory continuing education requirements, and after or in lieu of giving the licensee an opportunity to come into compliance under 481—subrule 1083.3(3), the board may, in lieu of proceeding to a contested case hearing on the denial of a renewal application as provided in rule 481—Chapter 506, 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 481—Chapter 506.

1082.7(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 will not extend the date of expiration.

1082.7(5) A licensee who continues to practice landscape architecture in Iowa after licensure has expired will be subject to disciplinary action. Such unauthorized activity may also be grounds to deny a licensee's application for reinstatement.

1082.7(6) Licensees will notify the board within 30 days of any change of address or business connection.

1082.7(7) 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 will 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 licensed as inactive, including information that 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 will 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 on inactive status may reinstate to active status at any time pursuant to rule 481—1082.8(544B,17A).

b. Renewal. A person licensed as inactive may renew the person's certificate of licensure on the biennial schedule described in this rule. This person will be exempt from the continuing education requirements and will be charged a reduced renewal fee as provided in rule 481—1082.10(544B,17A). An inactive certificate of licensure will lapse if not timely renewed.

c. Permitted practices. A person may, while licensed as inactive, perform for a client, business, employer, government body, or other entity those services that 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.

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

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.8(544B,17A) Reinstatement.

1082.8(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 will 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 will 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, will be required to report 12 contact hours that 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 will 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 will be required to report 24 contact hours that 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 the requirements in 481—Chapter 1083. 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 will bear the seal of the licensing board. Out-of-state residents whose resident state has no mandatory continuing education will comply with the documented evidence requirements outlined in this subrule.

1082.8(2) An individual may reinstate an inactive license to an active license as follows:

a. The individual will 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 will be paid.

b. The individual will submit documented evidence of completion of 24 contact hours of continuing education in health, safety, and welfare subjects in compliance with the requirements in 481—Chapter 1083. The continuing education hours used for reinstatement to active status cannot be used again at the next renewal.

c. The individual will complete the appropriate 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 will 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 will report 12 hours of previously unreported continuing education.

d. The individual will 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.

1082.8(3) The board will 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 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.9(544B,17A) Responsibility for accuracy of applications. The landscape architect is responsible for verifying the accuracy of the information submitted on applications regardless of how the application is submitted or by whom it is submitted. For instance, if the office manager of a landscape architect's firm submits an application for renewal on behalf of the landscape architect and that information is incorrect, the landscape architect will be held responsible for the information and may be subject to disciplinary action.

[ARC 9155C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1082.10(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
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.)	
Prelicense determination fee	\$25

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 1083 CONTINUING EDUCATION

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

[Prior to 6/10/26, see Landscape Architectural Examining Board[193D] Ch 3]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/4/30

481—1083.1(544B,17A) Definitions. As used in these rules, the following definitions will apply:

“Distance learning” means any education process based on the geographical separation of student and instructor. “Distance learning” includes computer-generated programs, webinars, and home-study/correspondence programs.

“Health, safety, and welfare subjects” means technical and professional subjects that the board deems appropriate to directly safeguard the public’s health, safety, and welfare. Such subjects include design, environmental systems, site design, land use analyses, landscape architecture programming, grading and drainage, storm water management, erosion control, site and soil analyses, accessibility, building codes, review of state registration laws including the rules of professional conduct, evaluation and selection of products and materials, cost analysis, construction methods, contract documentation, construction contract administration, construction administration, construction-phase office procedures, project management, and the like.

“Hours of continuing education” means a contact hour spent in either structured educational activities or individually planned activities intended to increase the professional landscape architect’s knowledge and competence in public protection subjects and related practice subjects. “Contact hour” is defined as the typical 50-minute classroom instructional session or its equivalent.

“Structured educational activities” means educational activities in which the teaching methodology consists primarily of systematic presentation of public protection subjects or related practice subjects by qualified individuals or organizations including monographs, courses of study taught in person or by correspondence, organized lectures, presentations or workshops, and other means through which identifiable technical and professional subjects are presented in a planned manner.

[ARC 9156C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1083.2(544B,17A) Continuing education requirements. In order for professional landscape architects to provide competent, professional services to the public, continuing education will consist of learning experiences that enhance, expand and keep current the skills, knowledge, and abilities of practicing professionals. Professional landscape architects may pursue learning experiences in technical, nontechnical, regulatory, ethics and business practice areas, provided that the continuing education directly benefits the health, safety, and welfare of the public.

1083.2(1) Hours required. Each registrant will complete during each two-year licensing term a minimum of 24 hours of continuing education approved by the board. Compliance with the continuing education requirements is a prerequisite for license renewal.

1083.2(2) Within any biennial renewal period, 24 hours of continuing education must be acquired and will be in health, safety, and welfare subjects acquired in structured educational activities. A licensee may apply up to 12 continuing education hours obtained in excess of the requirement for a renewal period to the continuing education requirements for the following renewal period. Continuing education hours may be acquired in any location.

1083.2(3) A professional landscape architect who holds a license in Iowa for less than 12 months from the date of initial licensure will not be required to report continuing education at the first license renewal. 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 will be required to report 12 hours of continuing education in health, safety, and welfare subjects earned in the preceding 12 months at the first license renewal.

1083.2(4) Sources of continuing education. The following suggested list may be used by all licensees to determine the types of activities that may fulfill the continuing education requirements. All hours of continuing education must also comply with the directive in subrule 1083.2(2).

a. Hours of continuing education in attendance at short courses or seminars dealing with landscape architectural subjects and sponsored by colleges, universities or professional organizations.

b. Hours of continuing education in attendance at presentations on landscape architectural subjects that are held in conjunction with conventions or at seminars related to material use and function. Presentations such as those presented by CLARB, American Society of Landscape Architects, Construction Specification Institute, Construction Products Manufacturers Council or similar organizations devoted to landscape architecture education may qualify.

c. Hours of continuing education in attendance at short courses or seminars relating to business practice or new technology and offered by colleges, universities, professional organizations or system suppliers.

d. Hours of continuing education spent presenting or teaching courses or seminars in landscape architecture. Three preparation hours may be claimed for each class hour spent teaching landscape architectural courses or seminars. College or university faculty members may not claim credit for teaching regular curriculum courses.

e. Hours of continuing education spent learning through professional service to the public that draws upon the licensee's professional expertise on boards and commissions, such as serving on planning commissions, building code advisory boards, urban renewal boards, code study commissions or community boards. Hours of continuing education under this paragraph will be limited to six hours earned in any biennial renewal period.

f. Hours of continuing education spent in landscape architectural research that is published or formally presented to the profession or public. Credit may be claimed only following proof of publication or presentation. Hours of continuing education under this paragraph will be limited to 12 hours earned in any biennial renewal period.

g. Hours of continuing education spent in distance learning that concludes with an examination or other verification of course completion.

h. College or university courses dealing with landscape architectural subjects or business practices. Each semester hour equals 15 hours of continuing education. A quarter hour equals ten hours of continuing education.

i. Hours of continuing education spent in educational tours or tours in areas significant to landscape architecture when the tour is sponsored by college, university or professional organizations and verification of participation is provided by the tour sponsor. Self-guided tours do not qualify. Hours of continuing education under this paragraph will be limited to six hours earned in any biennial renewal period.

j. Hours of continuing education spent attending in-house educational programs, including dinner, luncheon, and breakfast meetings.

1083.2(5) Financing. It is the responsibility of each licensee to finance the costs for continuing education.

[ARC 9156C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1083.3(544B,17A) Compliance.

1083.3(1) Each professional landscape architect will file with the board a signed report, under penalty of perjury, on forms provided by the board or by online renewal, setting forth the continuing education activities in which the professional landscape architect has participated. The report will be filed with the renewal application for each two-year renewal period in which the claimed hours of continuing education were completed. The information in the report will include:

- a.* The school, firm or organization conducting the course.
- b.* The location of the course.
- c.* The title of the course and a description of the content.

- d. Names of the principal instructor(s).
- e. The dates attended.
- f. All hours claimed.
- g. In instances of service on a professional or community board, or other undocumented hours of continuing education (non-health, safety, and welfare documentation such as learning units or professional development hours), the licensee will provide a narrative description of the materials the licensee reviewed, the nature of the licensee's service, and a description as to how the licensee's claimed hours of continuing education have contributed to the health, safety, and welfare of the public.

This information shall be kept by the licensee for reported hours of continuing education for two years.

1083.3(2) A professional landscape architect's continuing education report forms or online renewal may be selected for review by the board for verification of compliance with these requirements. Evidence of compliance will be maintained by the professional landscape architect for two years after the period for which the form was submitted and will include written verification of attendance by someone other than the licensee. Examples of evidence may include but are not limited to a certificate of completion presented by the program sponsor, a letter from an employer verifying attendance at an in-firm training session, or copies of minutes from public service meetings. Canceled checks, slideshow presentations, email confirmation or receipts for payments of fees to attend a program are not evidence of actual attendance and are not acceptable.

1083.3(3) Any discrepancy between the number of continuing education hours reported and the number of continuing education hours actually supported by documentation may result in a disciplinary review. If, after the disciplinary review, the board disallows any continuing education hours, or the licensee has failed to complete the required continuing education hours, the landscape architect will have 60 days from board notice to either provide further evidence of having completed the continuing education hours disallowed or remedy the discrepancy by completing the required number of continuing education hours (provided that such continuing education hours will not again be used for the next renewal). Extension of time may be granted on an individual basis and will be requested by the licensee within 30 days of notification by the board. If the licensee fails to comply with the requirements of this subrule, the licensee may be subject to disciplinary action.

[ARC 9156C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1083.4(544B,17A) Hearings. In the event of denial, in whole or in part, of any application for approval of credit for continuing education activity, the licensee will have the right, within 20 days after the date of notification of the denial by mail, to request a hearing by the board. The hearing will be held within 60 days after receipt of the request for the hearing. The decision of the board will be final.

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481—1083.5(544B,17A) Physical disability, illness, hardship, or extenuating circumstances. The board may, in individual cases involving physical disability, illness (certified by a medical doctor), hardship, or extenuating circumstances, grant waivers of the continuing education requirements for a period of time not to exceed one year. No waiver or extension of time will be granted unless the licensee makes a written request to the board for such action.

[ARC 9156C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1083.6(544B,17A) Methods of compliance and exemptions.

1083.6(1) A licensee licensed to practice as a professional landscape architect will be deemed to have complied with the continuing education requirements during the continuing education compliance period that the licensee:

- a. Serves honorably on active duty in the military service; or
- b. Resides in another state or district having a continuing education requirement for the occupation or profession and meets all the requirements of that state or district for practice therein; or

c. Is a government employee working as a professional landscape architect and assigned to duty outside the United States; or

d. Is approved by the board for periods of active practice and absence from the state.

1083.6(2) If the licensee was not engaged in active practice as a professional landscape architect and will maintain inactive status during the period for which renewal is requested, the board may exempt the licensee from continuing education. No exemption will be granted without a written request from the licensee.

[ARC 9156C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1083.7(544B,17A) Grounds for denial of license renewal. Failure of a licensee to complete the continuing education requirements as set forth in this chapter, failure to file a report of completed continuing education, or failure to submit a written request for waiver or exemption will be grounds for the board to deny renewal of the license.

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CHAPTER 1084
RULES OF PROFESSIONAL CONDUCT AND DISCIPLINE PROCEDURES

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

[Prior to 6/10/26, see Landscape Architectural Examining Board[193D] Ch 4]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/4/30

481—1084.1(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 will be grounds for disciplinary action.

1084.1(1) Definition. 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.

1084.1(2) Competence.

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

b. When designing a project, a professional landscape architect will 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 will not knowingly design a project in violation of these laws and regulations.

c. A professional landscape architect will 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 will 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.

1084.1(3) Conflict of interest.

a. A professional landscape architect will 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 that is substantial enough to influence judgment in connection with the professional landscape architect’s performance of professional services, the professional landscape architect will 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 will 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.

1084.1(4) Full disclosure.

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

b. A professional landscape architect will 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 that violates applicable state or municipal building laws and regulations and that 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 will have no liability to the professional landscape architect's client or employer on account of such termination.

d. A professional landscape architect will 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 will 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 will report the knowledge to the board.

1084.1(5) *Compliance with laws.*

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

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

1084.1(6) *Professional conduct.*

a. Each office maintained for the preparation of drawings, specifications, reports or other professional work will 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 will 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 will 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 will not engage in conduct involving fraud or wanton disregard of the rights of others.

1084.1(7) *Seal and certificate of responsibility.*

a. Each professional landscape architect will 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 1¾ inches. The seal will include the name of the professional landscape architect and the words “Professional Landscape Architect, State of Iowa.” The professional landscape architect’s Iowa license number will 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, will 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 will 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 will 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	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. Printed or typed name or secure electronic signature Signature Pages or sheets covered by this seal: License Expires:

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 will 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 will be prima facie evidence that said technical submission was prepared by or under the responsible control of the individual named on that seal.

1084.1(8) Communications. A professional landscape architect will, 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 9157C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1084.2(544B,17A) Receipt of complaints. The board will receive and review all complaints that the board reasonably believes indicate that a licensee may have committed an act that is cause for disciplinary action.

1084.2(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 will 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 will 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 will receive immunities in accordance with Iowa Code section 272C.8.

1084.2(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 9157C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1084.3(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.

1084.3(1) Makeup of the peer review committee. The committee will 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.

1084.3(2) Authority. The committee's investigation will 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.

1084.3(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.

[ARC 9157C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1084.4(544B,272C) Investigation report of complaints.

1084.4(1) Board consideration of report to determine further action. Upon completion of the investigation, the investigator(s) will 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 that 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.

1084.4(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 cannot 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 9157C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

481—1084.5(544B,272C) Dispensation. The board will 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 will be set at the discretion of the board but will not exceed \$1,000. Civil penalties may be imposed for any of the disciplinary violations of Iowa Code sections 544B.15, 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 9157C, IAB 4/30/25, effective 6/4/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A and 544B and Executive Order 10.

[Filed 11/9/78, Notice 10/4/78—published 11/29/78, effective 1/3/79]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTERS 1085 to 2000
Reserved

CHAPTER 2001 ADMINISTRATION

[Prior to 6/15/88, see Real Estate Commission[700] Ch 1]

[Prior to 9/4/02, see 193E—Chs 2, 5, 7, 8]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 1]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2001.1(543B) Mission of the commission. The mission of the Iowa real estate commission is to protect the public through the examination, licensing, and regulation of real estate brokers, salespersons, and firms pursuant to Iowa Code chapter 543B, Real Estate Brokers and Salespersons; to administer Iowa Code chapter 543C, Sales of Subdivided Land Outside of Iowa; and to administer Iowa Code chapter 557A, Time-Shares.

The commission is a policymaking body with authority to promulgate rules for the regulation of the real estate industry consistent with all applicable statutes. Administrative support services are furnished by the professional licensing and regulation division of the department of inspections, appeals, and licensing. The commission or duly authorized representative may inspect subdivided land outside of Iowa pursuant to Iowa Code section 543C.4.

[ARC 7763C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2001.2(543B) Correspondence and communications. Correspondence and communications with the commission should be addressed or directed to the commission office.

[ARC 7763C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2001.3(543B) Meetings of the commission. Meetings of the commission are held at times scheduled by the commission in the offices of the commission or at a place designated by the commission. Special meetings may be called by the chairperson or executive officer of the commission, who sets the time and place of the meeting.

[ARC 7763C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2001.4(543B) Custodian of records, filings, and requests for public information. Unless otherwise specified by the rules of the department of inspections, appeals, and licensing or the professional licensing and regulation division, the commission is the principal custodian of its own agency orders, statements of law or policy issued by the commission, legal documents, and other public documents on file with the commission.

2001.4(1) Any person may examine public records promulgated or maintained by the commission at its office during regular business hours.

2001.4(2) Records, documents and other information may be gathered, stored, and available in electronic format. Information, various forms, documents, and the license law and rules may be reviewed or obtained at any time by the public from the commission's website.

2001.4(3) Deadlines. Unless the context dictates otherwise, any deadline for filing a document that falls on a Saturday, Sunday, or official state holiday will be extended to the next working day.

[ARC 7763C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2001.5(543B) Investigation and subpoena. Commission rules regarding investigations and investigatory subpoenas may be found in 481—Chapter 2018 and in the model rules governing professional licensing division programs at 481—Chapters 500 through 507.

[ARC 7763C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2001.6(543B) Impaired licensee review committees. Commission rules governing impaired licensee review committees may be found in the model rules governing professional licensing division programs at rule 481—505.5(272C).

[ARC 7763C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A, 252J, 261, 272C and 543B.

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[Filed ARC 6040C (Notice ARC 5736C, IAB 6/30/21), IAB 11/17/21, effective 12/22/21]

[Filed ARC 7763C (Notice ARC 7442C, IAB 1/10/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2002 DEFINITIONS

[Prior to 6/15/88, see Real Estate Commission[700] Ch 2]
[Prior to 9/4/02, see 193E—1.1(543B) and 193E—2.2(543B)]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 2]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2002.1(543B) Definitions.

“Additional license” means any officer or partner license(s) issued based upon and dependent or contingent upon the primary or main officer or partner license, but assigned to a different corporation or partnership.

“Advance fees” means any fees charged for services to be paid in advance of the rendering of such services including, without limitation, any fees charged for listing, advertising, or offering for sale or lease any real property, but excluding any fees paid solely for advertisement in a newspaper of general circulation.

“Affiliated licensee” means a broker associate or salesperson, as defined in Iowa Code section 543B.5(5) and 543B.5(19), who is under the supervision of a broker.

“Agency disclosure” means the same as defined in Iowa Code section 543B.5(2).

“Applicant” means a person who has applied for or intends to apply for a real estate salesperson or real estate broker license.

“Application form” means the form furnished by the commission to be completed and submitted to apply for an original license as a real estate salesperson, real estate broker, real estate firm or trade name.

“Branch office license” means the same as “duplicate license” as used in Iowa Code section 543B.31.

“Broker” means any person holding an Iowa real estate broker license as defined in Iowa Code section 543B.3.

“Brokerage agreement” means the same as defined in Iowa Code section 543B.5(7).

“Broker associate” means the same as defined in Iowa Code section 543B.5(5).

“Buyer” includes a purchaser, tenant, vendee, lessee, party to an exchange, or grantee of an option. Selected rules in these chapters will at times refer separately to “buyers” and “tenants” to clarify licensees’ duties and obligations.

“Client” means the same as defined in Iowa Code section 543B.5(9).

“Commercial” means property that is used exclusively for business purposes or to generate income and not intended for human inhabitants or property of more than four dwelling units.

“Commission” means the real estate commission.

“Common source information companies” means any individual, corporation, limited liability company, business trust, estate, trust, partnership, association, or any other legal entity (except any government or governmental subdivision or agency, or any officer or employee thereof acting in such individual’s official capacity) that is a source, compiler, or supplier of information regarding real estate for sale or lease and other data and includes, but is not limited to, multiple listing services.

“Compensation” means payment to a broker or licensee for real estate services performed.

“Completed application” means an original or renewal application timely received with all necessary information, documents, signatures, fees or penalties.

“Confidential information” means information made confidential by statute, regulation, or express instructions from the client. Confidential information does not include “material adverse facts” as defined in Iowa Code section 543B.5(14). Confidential information includes, but is not limited to, the following:

1. Information concerning the client that, if disclosed to the other party, could place the client at a disadvantage when bargaining;

2. That the seller or landlord is willing to accept less than the asking price or lease price for the property;

3. That the buyer or tenant is willing to pay more than the asking price or lease price for the property;

4. The motivating factors for the party selling or leasing the property;

5. The motivating factors for the party buying or leasing the property;

6. That the seller or landlord will agree to sale, lease, or financing terms other than those offered;

7. That the buyer or tenant will agree to sale, lease, or financing terms other than those offered;

8. The seller's or landlord's real estate needs;

9. The buyer's or tenant's real estate needs;

10. The seller's or landlord's financial information, except that the seller's ability to sell and the landlord's ability to lease are considered a material fact;

11. The buyer's or tenant's financial qualifications, except that the buyer's ability to buy and the tenant's ability to lease are considered a material fact.

Confidential information is not disclosable unless one of the following applies:

1. The client to whom the information pertains provides informed written consent to disclose the information;

2. The disclosure is mandated by statute or regulation, or failure to disclose the information would constitute fraudulent representation;

3. The information is made public or becomes public by the words or conduct of the client to whom the information pertains or from a source other than the licensee; or

4. The disclosure is necessary to defend the licensee against an accusation of wrongful conduct in an actual or threatened judicial proceeding, an administrative proceeding before the commission, or in a proceeding before a professional committee.

"Consumer" means a person seeking or receiving real estate brokerage services.

"Contract between the buyer and seller" means an offer to purchase, a sales contract, an option, a lease-purchase option, an offer to lease, or a lease.

"Conviction" means the same as defined in Iowa Code section 543B.15(3).

"Customer" means the same as defined in Iowa Code section 543B.5(11).

"Designated broker" means the broker or broker associate designated as the person in charge of and responsible for supervision of a main office or branch office as defined in Iowa Code section 543B.5(11).

"Dual agent" means a licensee who, with the written informed consent of all the parties to a contemplated real estate transaction, has entered into a brokerage agreement with and therefore represents the seller and buyer or both the landlord and tenant in the same in-house transaction.

"Duplicate license" or *"replacement license"* means a license reissued for the remainder of a license term, at the written request of the broker, to replace a lost or destroyed license.

"Electronic format" means a record generated, communicated, received, or stored by electronic means, and is in a format that has the continued capability to be retrieved and legibly printed upon request.

"Examination" means a licensure examination necessary before issuance of a license.

"Examinee" means a person who has registered or intends to register to take a licensure examination.

"Filed" means that documents or application and fees are considered filed with the commission on the date postmarked, not the date metered, or on the date personally delivered to the commission office.

"Firm" means a licensed partnership, association, limited liability company, or corporation.

"Licensee" means the same as defined in Iowa Code section 543B.5(13).

"Listing broker" means the real estate broker who obtains a listing of real estate or of an interest in a residential cooperative housing corporation.

“Ministerial acts” means those acts that a licensee may perform for a consumer that are informative in nature and do not rise to the level of specific assistance on behalf of a consumer. For purposes of these rules, ministerial acts include but are not limited to the following:

1. Providing responses to general consumer inquiries—whether made via telephone, in person, or through digital communication—regarding the availability and pricing of brokerage services, as well as the price, location, condition as reflected on the seller’s disclosure, and distinguishing features of specific properties;
2. Attending an open house and responding to general questions from a consumer about the facts and features of the property;
3. Setting an appointment to view property;
4. Accompanying an appraiser, inspector, contractor, or similar third party on a visit to a property;
5. Referring a person to another broker or service provider; or
6. A listing broker showing a property to a customer to which the listing broker has a brokerage agreement with a seller to the property.

“Moral turpitude” means an act of baseness, vileness, or depravity, in the private and social duties which a person owes to another person or to society in general, contrary to the accepted and customary rule of right and duty between person and person. It is conduct that is contrary to justice, honesty and good morals. Various factors may cause an offense which is generally not regarded as constituting moral turpitude to be regarded as such. A crime of moral turpitude as specified in Iowa Code section 543B.15(3) shall include without limitation forcible felonies as delineated in Iowa Code section 702.11.

“Original license” means the license of a salesperson, broker, or firm that covers the first term of licensure in Iowa. A license applied for and reissued after the final deadline for renewal of a license is also an original license.

“Primary license” or *“main license”* means the original license issued based upon examination, including any subsequent renewals or reinstatements of the license. Continuing education is necessary to renew to active status.

“Principal broker” means a broker who is either a real estate proprietor, a partner in a real estate partnership, or an officer in a real estate corporation.

“Real estate team” means two or more licensees assigned to the same broker, working together to provide real estate brokerage services and representing themselves to the public as a team.

“Renewal application form” means the form furnished by the commission to be completed and submitted to apply for renewal of a license as a real estate salesperson, real estate broker, real estate firm, branch office or trade name.

“Representative” means a person or entity representing the interests of the client, on the client’s behalf, but that is not the agent or broker of the client.

“Residential” means properties that are used primarily for living purposes rather than for business or industrial use.

“Salesperson” means any person holding an Iowa real estate salesperson license as defined in Iowa Code section 543B.5(19).

“Seller” includes an owner, landlord, vendor, lessor, party to an exchange, or grantor of an option. Selected rules in these chapters will at times refer separately to “sellers” and “landlords” to clarify licensees’ duties and obligations.

“Selling broker” means a real estate broker who finds and obtains a buyer in a transaction.

“Showing” means the act of a licensee providing a client physical or virtual access to a property that is being sold by a seller.

“Single agent” means a licensee who represents only one party in a real estate transaction. A single agent includes a broker and any affiliated broker associates or salespersons representing a party exclusively or nonexclusively, regardless of whether the single agent be all affiliated broker associates

or salespersons, or only the identified broker associates or salespersons, or a group of identified broker associates or salespersons. A single agent may be one of the following:

1. “Seller’s agent,” which means a licensee who represents the seller in a real estate transaction;
2. “Landlord’s agent,” which means a licensee who represents the landlord in a leasing transaction;
3. “Buyer’s agent,” which means a licensee who represents the buyer in a real estate transaction; and
4. “Tenant’s agent,” which means a licensee who represents the tenant in a leasing transaction.

“*Sole-proprietor broker*” means an individual or single license broker who privately owns and manages a real estate company.

“*Specific assistance*” means any communication beyond casual conversation concerning the facts and features of a property which occurs prior to the point of discussing price range or any specific, financial qualifications of the buyer or tenant, or selling or buying motives or objectives of the seller or buyer, or tenant or landlord, or eliciting or accepting information involving a proposed or preliminary offer associated with a specific property, in which the person may unknowingly divulge any confidential personal or financial information, which, if disclosed to the other party, could harm the party’s bargaining position. For the purposes of these rules, “specific assistance” does not include preliminary conversations or “small talk” concerning location and property styles, or responses to general factual questions from a potential buyer or tenant concerning facts and features of properties which have been advertised for sale or lease.

“*Status*” means the condition of a real estate license. A license may be active, inactive, expired, suspended, revoked or canceled. “Inactive license” is defined in Iowa Code section 543B.5(12).

“*Third party*” means a person or entity that is not a client, is not a party to the transaction, and has no agency relationship to a real estate brokerage.

“*Timely*” means done or occurring at a reasonable time under the circumstances.

“*Timely received*” means postmarked, not metered, not later than midnight on the last date of the deadline specified by the Iowa Code or commission rules.

“*Transaction*” means the sale, exchange, purchase, or rental of, or the granting or acceptance of, an option to sell, exchange, purchase, or rent an interest in real estate, but excluding the subleasing of an interest in a residential cooperative housing corporation, when the leases are for one year or less.

“*Type*” means the category to which a broker license or firm license is issued. A broker license may be issued as a sole-proprietor broker, broker officer, broker partner, or broker associate. A firm license may be issued as a corporation, partnership or association.

“*Undisclosed dual agent*” means a licensee representing two or more clients in the same transaction whose interests are adverse without the knowledge and informed consent of the clients.

This rule is intended to implement Iowa Code chapters 17A, 272C and 543B.

[ARC 7764C, IAB 4/17/24, effective 5/22/24; ARC 9481C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2003 BROKER LICENSE

[Prior to 6/15/88, see Real Estate Commission[700] Ch 3]

[Prior to 9/4/02, see 193E—2.10(543B) to 193E—2.12(543B) and 193E—3.3(543B)]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 3]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2003.1(543B) Broker licensure. An applicant is only eligible for a broker license by satisfying Iowa Code section 543B.15.

2003.1(1) An applicant for a real estate broker's license who has been convicted of a disqualifying criminal offense in a court of competent jurisdiction in this state or in any other state, territory, or district of the United States, or in any foreign jurisdiction, may be denied a license by the commission on the grounds of the conviction as provided by Iowa Code section 272C.15 and rule 481—502.2(272C).

2003.1(2) An applicant for a broker license may use active experience as a former Iowa salesperson or active salesperson experience in another state or jurisdiction, or a combination of both, to satisfy the experience requirement for a broker license under Iowa Code section 543B.15(7) only if the former Iowa salesperson or applicant from another state or jurisdiction was actively licensed for not less than 24 months and if the license on which the experience is based has not been expired for more than three years prior to the date the completed broker application with fee is filed with the commission.

[ARC 7765C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2003.2(543B) License examination. Examinations for licensure as a real estate broker are conducted by the commission's authorized representative.

2003.2(1) Testing service. The commission will negotiate an agreement with a testing service relating to examination development, test scheduling, examination sites, grade reporting and analysis. The commission approves the form, contract, and method of administration. The examination is conducted in accordance with approved procedures formulated by the testing agency. Applicants register and pay examination fees directly to the testing service.

2003.2(2) Requests for waiver. The commission will consider each request for a waiver of commission rules or of the qualifications for licensure on an individual basis. The commission may require additional supporting information. If the applicant's experience or prelicense education is found to be less than equivalent to the statutory requirement, the commission may suggest methods of satisfying the deficiency. If a waiver is granted, the applicable examination must be passed before the end of the sixth month following the date of the waiver.

2003.2(3) Eligibility to sit for examination. An individual may only sit for the examination after meeting the qualifications set out in Iowa Code section 543B.15. An examinee is obligated to show one of the following at the examination site:

- a. Evidence that prelicense education has been completed within the last two years.
- b. The letter from the commission granting a waiver of prelicense education.
- c. A written authorization from the commission for individuals planning to qualify under rule 481—2005.3(543B) or 481—2005.11(543B).
- d. A written authorization from the commission for individuals planning to seek reinstatement of an expired license.

2003.2(4) Failure to pass examination. An examinee who takes an examination and fails is eligible to apply to retake the examination at any time the examination is offered by filing a new registration form and paying the examination fee, unless the qualifying time period for the prelicense education or granted waiver has expired.

[ARC 7765C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2003.3(543B) Application for broker license. An applicant who applies for a broker's license will submit to the commission a completed application, license fee, proof of required education, and test score reports not later than the last working day of the sixth calendar month following the qualifying real estate examination. As required by Iowa Code section 543B.15(9), the completed application must be received within 210 calendar days of the completion of the criminal history check.

2003.3(1) Application contents. The applicant for licensure attests to the accuracy of the detailed personal, financial, and business information concerning the applicant included on the application.

2003.3(2) License terms. Real estate broker, salesperson, trade name, branch office, and firm licenses are issued for a three-year term, counting the remaining portion of the year issued as a full year. Licenses expire on December 31 of the third year of the license term. Branch office licenses and trade name licenses are issued for the remaining portion of the license term of the license to which each is assigned.

2003.3(3) Denial of application. An application may be denied on the grounds provided in Iowa Code chapter 543B and in 481—Chapter 506. The administrative processing of an application does not prevent the later initiation of a contested case to challenge a licensee's qualifications for licensure.

[ARC 7765C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2003.4(543B) Broker continuing education.

2003.4(1) To renew a license in active status, each broker or broker associate completes a minimum of 36 hours of approved programs, courses or activities. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 18 hours from the previous renewal period. Licensees cannot carry over any hours toward the mandatory eight-hour law update course or the four-hour ethics course.

2003.4(2) Brokers and broker associates complete approved courses in the following subjects to renew to active status, except in accordance with 481—Chapter 2016.

Law Update	8 hours
Ethics	4 hours
Electives	24 hours

2003.4(3) A license may be renewed in inactive status without the completion of continuing education. Prior to reactivating a license that has been issued inactive due to the licensee's failure to submit evidence of continuing education, the licensee submits an application to reactivate to active status with evidence that all deficient continuing education hours have been completed. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 18 hours from the previous renewal period. Licensees cannot carry over any hours toward the mandatory eight-hour law update course or the four-hour ethics course.

[ARC 7765C, IAB 4/17/24, effective 5/22/24; ARC 9245C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2003.5(17A,272C,543B) Renewing a broker license. To remain authorized to act as a real estate broker, a broker renews a real estate license before the expiration date of the license. Brokers who fail to renew a real estate license before expiration are not authorized to practice as real estate brokers in Iowa. Termination of a broker's authority to practice real estate in Iowa automatically terminates the authority of all salespersons employed by or assigned to the broker.

2003.5(1) Application forms. Applications for renewal of a broker's license may be found on the commission's website. Brokers renew electronically. While the commission generally mails reminders to brokers in the November preceding license expiration, the failure of the commission to mail a reminder does not excuse the broker from the requirement to renew prior to the expiration of the license.

2003.5(2) *Qualifications for renewal.* The commission grants an application to renew a broker's license if:

- a.* The application is timely received by the commission by December 31, or within the 30-day grace period after expiration as provided by Iowa Code section 543B.28.
- b.* The application is accompanied by the regular renewal fee and, if received by the commission after midnight December 31 but prior to midnight January 30, is accompanied by a penalty of \$25.
- c.* The application is fully completed with all necessary information, including proper disclosure of completed continuing education and errors and omissions insurance.
- d.* The application does not include grounds to deny a license, such as the revocation of a license in another jurisdiction or a criminal conviction.

2003.5(3) *Incomplete or untimely applications to renew.* Renewal applications received by the commission after midnight January 30 will be treated as applications to reinstate an expired license under rule 481—2003.6(272C,543B).

a. Applications to renew or reinstate a broker's license which are incomplete or which are not accompanied by the proper fee may be returned to the broker for additional information or fee.

b. Alternatively, the commission may retain the application, and notify the applicant that the application cannot be granted without further information or fee.

2003.5(4) *Insufficient continuing education.* Renewal applications which do not report completion of required continuing education, but which are otherwise timely and sufficient and accompanied with the proper fee, are renewed in inactive status. In the event of a factual dispute regarding the broker's intent to renew in inactive status or a broker's completion of continuing education, the commission may deny the application and provide the applicant with an opportunity for hearing according to the procedures set forth in 481—Chapter 506.

2003.5(5) *Denial of application to renew.* An application to renew may be denied on the grounds provided in Iowa Code chapter 543B and in 481—Chapter 506. The administrative processing of an application to renew does not prevent the later initiation of a contested case to challenge a licensee's qualifications for licensure.

2003.5(6) *Renewal of inactive or suspended license.* An inactive or suspended license expires if not timely renewed. The status of a license does not affect the requirement to renew.

[ARC 7765C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2003.6(272C,543B) Reinstatement of an expired broker license. A real estate broker who fails to renew or file a completed renewal application by midnight January 30 of the first year following expiration may reinstate the license within three years of expiration by submitting a complete and sufficient application accompanied by the regular renewal fee and an additional reinstatement fee of \$25 for each partial or full month following expiration. From the date of expiration to the date of reinstatement, the broker is not authorized to practice as a real estate broker in Iowa.

2003.6(1) *Continuing education.* A broker either fully satisfied all continuing education or has retaken and passed the broker examination to reinstate an expired broker license.

2003.6(2) *Starting over.* A broker who fails to reinstate an expired license by December 31 of the third year following expiration is treated as if the former broker had never been licensed in Iowa. Such a former broker starts over in the licensing process and must first qualify and apply for a salesperson license.

2003.6(3) *Denial of application.* An application may be denied on the grounds provided in Iowa Code chapter 543B and in 481—Chapter 506. The administrative processing of an application does not prevent the later initiation of a contested case to challenge a licensee's qualifications for licensure.

[ARC 7765C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2004
SALESPERSON LICENSE

[Prior to 9/4/02, see 193E—2.10(543B), 193E—2.11(543B), 193E—3.2(543B), and 193E—3.3(543B)]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 4]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2004.1(543B) General criteria for salesperson license. A person who is licensed under and employed by or otherwise associated with a real estate broker or firm is a “salesperson” as defined in Iowa Code section 543B.5(20) and rule 481—2002.1(543B).

2004.1(1) An original application for a salesperson license cannot be issued to inactive status.

2004.1(2) If the license is transferred, as provided in rule 481—2006.2(543B), the salesperson may work immediately for the new broker.

2004.1(3) A salesperson is assigned to a licensed broker or firm and cannot conduct business independently.

2004.1(4) Except as provided in Iowa Code section 543B.21, an applicant for a salesperson license must meet all qualifications under Iowa Code section 543B.15.

2004.1(5) An applicant for a real estate salesperson license who has been convicted of a disqualifying criminal offense in a court of competent jurisdiction in this state or in any other state, jurisdiction, territory, or district of the United States, or in any foreign jurisdiction, may be denied a license by the commission on the grounds of the conviction as provided by Iowa Code section 272C.15 and rule 481—502.2(272C).

2004.1(6) An applicant for a real estate salesperson license who has had a professional license of any kind revoked in this or any other jurisdiction may be denied a license by the commission on the grounds of the revocation.

2004.1(7) Salesperson prelicense education requirements. As required by Iowa Code section 543B.15(8) and 481—Chapter 2016, the required course of study for the salesperson licensing examination consists of 60 live instruction or online learning hours of real estate principles and practices. To be eligible to take the examination, the 60 live education or online learning hours of real estate principles and practices are completed during the 12 months prior to taking the examination. The applicant will also provide evidence of successful completion of the following courses: 12 hours of Developing Professionalism and Ethical Practices, 12 hours of Buying Practices and 12 hours of Listing Practices. The prelicense education will expire after 12 months.

[ARC 7766C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2004.2(543B) License examination. Examinations for licensure as a real estate salesperson are conducted by the commission or its authorized representative.

2004.2(1) *Testing service.* The commission will negotiate an agreement with a testing service relating to examination development, test scheduling, examination sites, grade reporting and analysis. The commission will approve the form, contract, and method of administration. The examination is conducted in accordance with approved procedures formulated by the testing service. Applicants register and pay examination fees directly to the testing service.

2004.2(2) *Requests for waiver.* The commission will consider each request for a waiver of commission rules or of the qualifications for licensure on an individual basis. The commission may require additional supporting information. If the applicant’s prelicense education is found to be less than equivalent to the statutory requirement, the commission may suggest methods of satisfying the deficiency. If a waiver is granted, the applicable examination must be passed before the end of the sixth month following the date of the waiver.

2004.2(3) *Eligibility to sit for examination.* An individual may only sit for the examination after meeting the qualifications set out in Iowa Code section 543B.15. An examinee is obligated to show one of the following at the examination site:

a. Evidence that 60 live education or online learning hours of real estate principles and practices have been completed.

b. A letter from the commission granting a waiver of prelicense education.

c. A written authorization from the commission for individuals planning to qualify under rule 481—2005.3(543B) or 481—2005.11(543B).

2004.2(4) *Failure to pass examination.* An examinee who takes an examination and fails is eligible to apply to retake the examination at any time the examination is offered by filing a new registration form and paying the examination fee, unless the qualifying time period for the prelicense education or waiver granted has expired.

[ARC 7766C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2004.3(543B) Application for salesperson license. An applicant who passes a qualifying examination and applies for a license must file with the commission a completed application with license fee, proof of required education, and test score report not later than the last working day of the sixth calendar month following the qualifying real estate examination. As required by Iowa Code section 543B.15(9), the completed application must be received within 210 calendar days of the completion of the criminal history check.

2004.3(1) *Application contents.* The application includes detailed personal, financial, and business information concerning the applicant, and the applicant for licensure attests to its accuracy.

2004.3(2) *License terms.* A salesperson license is issued for a three-year term, counting the remaining portion of the year issued as a full year. Licenses expire on December 31 of the third year of the license term.

2004.3(3) *Denial of application.* An application may be denied on the grounds provided in Iowa Code chapter 543B and in 481—Chapter 506. The administrative processing of an application does not prevent the later initiation of a contested case to challenge a licensee's qualifications for licensure.

[ARC 7766C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2004.4(543B) Salesperson continuing education requirements.

2004.4(1) As a requirement of license renewal in active status, each salesperson completes a minimum of 36 hours of approved programs, courses or activities. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 18 hours from the previous renewal period. Licensees cannot carry over any hours toward the mandatory eight-hour law update course or the four-hour ethics course.

2004.4(2) Salespersons renewing licenses shall complete approved courses in the following subjects to renew to active status, except in accordance with 481—Chapter 2016.

Law Update	8 hours
Ethics.	4 hours
Electives.	24 hours

2004.4(3) A salesperson license may be renewed to inactive status without completion of continuing education. Prior to reactivating a license that has been issued inactive due to failure to submit evidence of continuing education, the licensee must submit evidence that all deficient continuing education hours have been completed. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 18 hours from the previous renewal period. Licensees cannot carry over any hours toward the mandatory eight-hour law update course or the four-hour ethics course.

[ARC 7766C, IAB 4/17/24, effective 5/22/24; ARC 9246C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2004.5(543B) Renewing a license. To remain authorized to act as a real estate salesperson, a salesperson must renew a real estate license before the expiration date of the license. Salespersons

who fail to renew a real estate license before expiration are not authorized to practice as real estate salespersons in Iowa.

2004.5(1) *Application forms.* Applications for renewal of a salesperson license may be found on the commission's website. Salespersons will renew electronically. While the commission generally mails reminders to salespersons in the November preceding license expiration, the failure of the commission to mail a reminder does not excuse the salesperson from the requirement to timely renew.

2004.5(2) *Qualifications for renewal.* The commission shall grant an application to renew a salesperson license if:

a. The application is timely received by the commission by December 31, or within the 30-day grace period after expiration as provided by Iowa Code section 543B.28.

b. The application is accompanied by the regular renewal fee and, if received by the commission after midnight December 31, but prior to midnight January 30, is accompanied by a penalty of \$25.

c. The application is fully completed with all necessary information, including proper disclosure of required continuing education and errors and omissions insurance.

d. The application fails to reveal grounds to deny a license, such as a criminal conviction or the revocation of a license in another jurisdiction.

2004.5(3) *Incomplete or untimely applications to renew.* Renewal applications received by the commission, or postmarked, after midnight January 30 shall be treated as applications to reinstate an expired license under rule 481—2004.6(272C,543B).

a. Applications to renew or reinstate a salesperson license which are incomplete or which are not accompanied by the proper fee may be returned to the salesperson for additional information or fee.

b. Alternatively, the commission may retain the application and notify the applicant that the application cannot be granted without further information or fee.

2004.5(4) *Insufficient continuing education.* Renewal applications which do not report completion of required continuing education, but which are otherwise timely and sufficient and accompanied with proper fee, shall be renewed in inactive status. In the event of a factual dispute regarding the salesperson's intent to renew in inactive status or a salesperson's compliance with continuing education requirements, the commission may deny the application and provide the applicant with an opportunity for hearing according to the procedures set forth in 481—Chapter 506 and rule 481—2018.13(543B).

2004.5(5) *Denial of application to renew.* An application to renew may be denied on the grounds provided in Iowa Code chapter 543B and in 481—Chapter 506. The administrative processing of an application to renew shall not prevent the later initiation of a contested case to challenge a licensee's qualifications for licensure.

2004.5(6) *Renewal of inactive or suspended license.* An inactive or suspended license must be timely renewed or it shall expire. The status of a license does not affect the requirement to renew.

[ARC 7766C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2004.6(272C,543B) Reinstatement of an expired salesperson license. A real estate salesperson who fails to renew or fails to file a complete renewal application form by midnight January 30 of the first year following expiration may reinstate the license within three years of expiration by submitting a complete and sufficient application accompanied by the regular renewal fee and an additional reinstatement fee of \$25 for each partial or full month following expiration. From the date of expiration to the date of reinstatement, the salesperson is not authorized to practice as a real estate salesperson in Iowa.

2004.6(1) *Continuing education.* An application to reinstate an expired salesperson license must report that the salesperson either fully satisfied all required continuing education or has retaken and passed the salesperson examination. A salesperson holding an expired license who wishes to retake the salesperson examination must obtain written authorization from the commission to show at the examination site.

2004.6(2) *Deposit of reinstatement fees.* Reinstatement fees collected under this rule shall be transmitted to the treasurer's office and credited to the education fund established in Iowa Code section 543B.54.

2004.6(3) *Starting over.* A salesperson who fails to reinstate an expired license by December 31 of the third year following expiration shall be treated as if the former salesperson had never been licensed in Iowa. Such a former salesperson must start over in the licensing process and qualify and apply for a salesperson license.

2004.6(4) *Denial of application.* An application may be denied on the grounds provided in Iowa Code chapter 543B and in 481—Chapter 506. The administrative processing of an application shall not prevent the later initiation of a contested case to challenge a licensee's qualifications for licensure.

[ARC 7766C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2005
LICENSEES OF OTHER JURISDICTIONS AND RECIPROCITY

[Prior to 9/4/02, see 193E—2.3(543B)]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 5]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2005.1(543B) Licensees of other jurisdictions. As provided in Iowa Code section 543B.21, a nonresident of this state may be licensed as a real estate broker or a real estate salesperson upon complying with all the provisions and conditions of Iowa Code chapter 543B and commission rules relative to resident brokers or salespersons.

2005.1(1) A person licensed in another state or jurisdiction making application in Iowa by reciprocity or as provided in rule 481—2005.3(543B) or 481—2005.11(543B) may qualify for a salesperson license in Iowa.

2005.1(2) A person licensed as a broker or broker associate in another state or jurisdiction making application in Iowa by reciprocity or as provided in rule 481—2005.3(543B) or 481—2005.11(543B) may qualify for the same type of broker or broker associate license in Iowa. The person meets all criteria for an Iowa broker license as provided in rule 481—2003.1(543B). If the person does not meet the criteria, the person may qualify for a salesperson license if the person meets, at a minimum, the criteria for an Iowa salesperson license as provided in 481—Chapter 2004.

2005.1(3) A person may only perform activities in Iowa as provided by Iowa Code chapter 543B after qualifying for and being issued a real estate license.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.2(543B) Nonresident application. Each applicant under rule 481—2005.3(543B) or under a reciprocal licensing agreement or memorandum applies on forms provided by the commission under Iowa Code section 543B.16. The application includes but is not limited to a certification of license from the state of original licensure containing all information required by Iowa Code section 543B.21 and an affidavit certifying that the applicant has reviewed and is familiar with and will be bound by the Iowa real estate license law and the rules of the commission.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.3(543B) License by examination. A nonresident applicant licensed as a real estate salesperson or broker in a state or jurisdiction which does not have a reciprocal licensing agreement or memorandum with Iowa, or an applicant who does not qualify for reciprocal licensing, may be issued a comparable Iowa license by passing the real estate examination under the following circumstances:

2005.3(1) Broker. The person has been actively licensed as a broker or broker associate, the person meets all criteria for an Iowa broker's license as provided in rule 481—2003.1(543B), and the license has not been inactive or expired for more than six months immediately preceding the date of passage of the national portion and Iowa portion of the broker real estate examination.

2005.3(2) Salesperson. The person has been actively licensed as a salesperson and the license has not been inactive or expired for more than six months immediately preceding the date of passage of the Iowa portion of the salesperson real estate examination.

2005.3(3) The applicant submits a written request for authorization to sit for the appropriate examination.

2005.3(4) The applicant submits certification of the applicant's current qualifying license from the licensing authority that issued the license.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.4(543B) Licensure by reciprocity. The commission may, as provided in Iowa Code section 543B.21, enter into specific written reciprocal licensing agreements or memorandums with other individual states or jurisdictions having similar licensing criteria and grant an Iowa license to

licensees from those states or jurisdictions on the same basis as Iowa licensees are granted licenses by those states or jurisdictions.

2005.4(1) The applicant is not a resident of Iowa.

2005.4(2) A license issued pursuant to this rule is based upon a nonresident salesperson or broker license issued by examination.

2005.4(3) A license issued pursuant to this rule is assigned to the same broker or firm as the nonresident license upon which it is based.

2005.4(4) If an applicant establishes residency in Iowa, that person does not qualify for licensure by reciprocal licensing agreement or memorandum.

2005.4(5) An Iowa license issued by reciprocity is based upon the nonresident license issued by examination in that other state or jurisdiction and is issued to the same broker and location as the nonresident license. The nonresident broker and firm, if applicable, must also be licensed in Iowa.

2005.4(6) A reciprocity agreement or memorandum of understanding is only a method to apply for licensure and does not grant any exception to mandatory license laws of Iowa or the other state or jurisdiction.

2005.4(7) An Iowa licensee wishing to obtain a license in any other state or jurisdiction should contact that state's or jurisdiction's licensing board for information and applications.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.5(543B) Renewal of a license issued by reciprocity. All renewal criteria for a real estate broker or salesperson license issued by examination apply to a license issued by reciprocity.

Continuing education reciprocity is specifically provided for in the reciprocal license agreement or memorandum, or in a separate reciprocal continuing education agreement or memorandum.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.6(543B) Reinstatement of a license issued by reciprocity. All reinstatement criteria for a real estate broker license or salesperson license issued by examination apply to a license issued by reciprocity.

2005.6(1) Starting over. A broker or salesperson who fails to file a complete application to reinstate an expired license by midnight December 31 of the third year following expiration is treated as if the former broker or salesperson had never been licensed in Iowa.

2005.6(2) A broker or salesperson must qualify for reciprocity in order to reinstate an expired reciprocal broker or salesperson license.

2005.6(3) If the broker or salesperson has moved into Iowa and no longer qualifies for reciprocity, the expired license is reinstated in the same manner as a license issued by examination as provided in rule 481—2003.6(272C,543B) for brokers and rule 481—2004.6(272C,543B) for salespersons.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.7(543B) Nonresident real estate offices and licenses required. All nonresident applicants for licensure in Iowa shall qualify for and obtain a license pursuant to Iowa Code section 543B.2(2) and rule 481—2007.1(543B).

2005.7(1) If the applicant is a broker associate or salesperson of a nonresident broker, the nonresident employing broker must have an Iowa broker license.

2005.7(2) If the applicant is employed by or otherwise associated with a nonresident real estate firm as defined in rule 481—2002.1(543B), that firm must apply and qualify for an Iowa license.

a. No firm as defined in rule 481—2002.1(543B) may be granted an Iowa license unless at least one member or officer of the firm applies for and is granted an Iowa broker license.

b. Every member or officer of the firm and every employee or associated real estate licensee who acts as a real estate broker, broker associate, or salesperson in Iowa must apply for and be granted an Iowa license.

2005.7(3) As provided by Iowa Code section 543B.22, a nonresident broker or firm is not obligated to maintain a definite place of business in Iowa if that broker or firm maintains an active place of business within the resident state or jurisdiction.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.8(543B) Actions against nonresidents. The application for a nonresident license is accompanied by an executed irrevocable written consent to suits and actions at law or in equity as provided in Iowa Code section 543B.23.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.9(543B) Nonresident continuing education. Nonresident licensees shall fully comply with all continuing education unless a separate education agreement is in place between Iowa and the nonresident state or jurisdiction.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.10(543B) License discipline reporting. If an Iowa licensee has a real estate license disciplined, suspended or revoked by any other state or jurisdiction, that disciplinary action will be considered prima facie evidence of violation of Iowa Code section 543B.29 or 543B.34 or both, and a hearing may be held to determine whether similar disciplinary action should be taken against the Iowa licensee. Failure to notify the commission within 15 days of an adverse action taken by another state or jurisdiction is cause for disciplinary action.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2005.11(543B) Licensure by verification. A person licensed in another state or jurisdiction may qualify for an Iowa salesperson or broker license through verification by making application as provided in rule 481—501.1(272C). In addition to all requirements provided by rule 481—501.1(272C), an applicant for a license through verification shall also submit to the commission proof of passing the Iowa portion of the salesperson or broker real estate examination.

2005.11(1) License terms. Once the applicant submits an approved application and appropriate licensing fees, a license will be issued for a three-year term, counting the remaining portion of the year issued as a full year. Licenses expire on December 31 of the third year of the license term.

2005.11(2) Reserved.

[ARC 7767C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2006
TERMINATION AND TRANSFER
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 6]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2006.1(543B) Terminating employment or association. When a licensee is discharged by the affiliated broker or the licensee terminates the employment or association with the affiliated broker, the licensee immediately ceases all activities that need an active real estate license until such time as a new affiliated broker makes written request for the license and the license is reassigned to the new affiliated broker.

2006.1(1) When a broker discharges a salesperson or broker associate, the broker complies with all criteria of Iowa Code section 543B.33. The releasing broker makes a reasonable effort to ensure that an application to inactivate the licensee is submitted electronically to the commission within 72 hours of the discharge date.

2006.1(2) The licensee may terminate the employment or association by providing written notice to the affiliated broker advising the effective date of the termination and requesting that the license be immediately returned to the commission. The affiliated broker cannot refuse to comply with the request. The releasing broker makes every reasonable effort to ensure that the commission receives the electronic application within 72 hours of the termination date.

[ARC 7768C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2006.2(543B) Transfer of license and necessary transfer application. All requests for transfer of license are made on the necessary electronic application for license transfer available from the commission. The license transfer application is only used for transferring the license from the affiliated broker to a new affiliated broker. This transfer application is only to be used if the transferring licensee has obtained the necessary information from the new affiliating broker. The license transfer application cannot be used for licensees who are terminated or who quit prior to obtaining a new affiliating broker. The transfer application cannot be backdated to a new affiliated broker.

2006.2(1) The license transfer process involves three steps, and each step needs to be correctly completed to qualify as a valid transfer. The steps are as follows:

- a.* The transferring licensee submits the electronic transfer application available from the commission.
- b.* Both the new affiliating broker and releasing broker electronically approve the transfer request within 48 hours of receiving notification from the commission of the transfer request.
- c.* The electronic transfer application is approved and issued by the commission.

2006.2(2) Transfer effective date. The effective date of the transfer is the date of approval and issuance from the commission.

[ARC 7768C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2007
OFFICES AND MANAGEMENT

[Prior to 9/4/02, see 193E—Ch 1 and 193E—2.14(543B) to 193E—2.17(543B)]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 7]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2007.1(543B) Real estate offices and licenses needed.

2007.1(1) Every Iowa resident real estate firm or self-employed broker maintains an office as provided in Iowa Code section 543B.31.

A nonresident Iowa real estate broker or firm is not obligated to maintain a definite place of business within Iowa as provided in Iowa Code section 543B.22.

2007.1(2) Sharing office space. It is acceptable for more than one broker to operate in an office at the same address if each broker maintains all records and trust accounts separate from all the others. Each broker operates under a business name, which clearly identifies the broker as an individual within the group of brokers.

2007.1(3) Branch office. A licensed Iowa real estate firm or sole-proprietor broker maintaining a branch office displays a commission-issued branch office license in that location. The branch office license is issued in the name of the firm or sole-proprietor broker and includes the license number and the physical address of the branch office. The branch office license is issued at a reduced fee and has the same expiration date of the primary license.

2007.1(4) When a real estate brokerage firm closes, the principal broker or a designated representative follows procedures as provided in 481—Chapter 2008.

2007.1(5) A licensed officer of a corporation or partnership may be licensed as an officer or partner of more than one corporation or partnership. The main or primary license for which the full license fee was paid is maintained in active status to keep any additional licenses that were issued at a reduced fee active and in effect. A broker officer licensed to more than one corporation or partnership may be the designated broker of more than one corporation or partnership.

Continuing education is needed only for renewal of the main or primary license.

2007.1(6) When a branch office closes, notice in writing, electronically or otherwise, shall be given to the commission.

2007.1(7) Each actively licensed broker associate and salesperson is licensed under a broker.

2007.1(8) A broker associate or salesperson may not be licensed under more than one broker during the same period of time.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.2(543B) Notification needed.

2007.2(1) Partnerships, associations, and corporations are obligated to obtain a license before acting as a real estate broker. Failure of a broker to inform the commission in writing, electronic or otherwise, within five working days that the broker has formed a new partnership, association or corporation, or has changed the type of the business, is prima facie evidence of a violation of Iowa Code section 543B.1.

2007.2(2) Failure of a broker to inform the commission in writing, electronic or otherwise, within five working days of a change in type of license as sole-proprietor broker, partner, officer or broker associate is prima facie evidence of a violation of Iowa Code sections 543B.1 and 543B.29(1).

2007.2(3) Failure of a broker to inform the commission in writing, electronic or otherwise, within five working days of a change of address of a proprietorship, partnership, or corporation is prima facie evidence of a violation of Iowa Code section 543B.32.

2007.2(4) Failure of a broker to return a license electronically to the commission office to ensure that it is received within 72 hours after a salesperson or broker associate is discharged or terminates employment is prima facie evidence of a violation of Iowa Code section 543B.33.

2007.2(5) Failure of a licensee to inform the commission in writing, electronic or otherwise, within five working days of a change of residence address or mailing address is prima facie evidence of a violation of Iowa Code sections 543B.16 and 543B.18.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.3(543B) Suspended and revoked licenses.

2007.3(1) As of the effective date of a suspended or revoked license, the licensee cannot engage in any activity that needs a real estate license as defined in Iowa Code chapter 543B.

2007.3(2) When a sole-proprietor broker, corporation or partnership license is suspended or revoked, all licensees associated with or assigned to that sole-proprietor broker, corporation or partnership are automatically placed on inactive status for the duration of the suspension or revocation, unless transferred to another sole-proprietor broker, corporation or partnership.

a. When a suspension or revocation is determined, the commission also determines whether the corporation or partnership license is automatically canceled.

b. If the broker whose license is suspended or revoked is the only licensed broker officer of a corporation, the corporation license will automatically be canceled.

2007.3(3) A licensee whose license is suspended or revoked may receive compensation during the period of suspension or revocation only for those acts performed and for which compensation was earned when the person was actively licensed prior to the effective date of the suspension or revocation.

This rule does not determine if a licensee is entitled to compensation; such entitlement would depend upon the licensee's written employment or association agreement with the former affiliated broker and is a matter of contract law.

2007.3(4) All brokerage and property management agreements are canceled by the broker whose license is suspended or revoked upon receipt of the order of revocation or suspension and prior to the effective date of the order.

a. The seller or landlord, or buyer or tenant, are advised that the seller or landlord, or buyer or tenant, may enter into a brokerage agreement with another broker of choice.

b. A broker whose license is suspended or revoked cannot sell or assign brokerage or management agreements to another broker without the written consent of the client, and any sale or assignment of brokerage or management agreements are completed prior to the effective date of the order.

2007.3(5) A broker whose license is suspended or revoked cannot finalize any pending closings. This responsibility is given to another broker, an attorney, a financial institution, or an escrow company.

a. Transfer of this responsibility is done with the written approval of all parties to the transaction.

b. All parties to the transaction are advised of the facts concerning the situation and are provided the name, address, and telephone number of the responsible entity where all trust and escrow moneys will be held, with the written approval of all parties.

2007.3(6) A broker whose license is suspended or revoked is barred from advertising real estate in any manner as a broker. All advertising, including but not limited to signs, is removed or covered within ten calendar days after the effective date of the suspension or revocation.

The real estate brokerage telephone is not answered in any manner to indicate the broker is active in the real estate business.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.4(543B) Barred practices. For purposes of this rule, only the term “real estate licensee” means “real estate broker or real estate salesperson” as defined in Iowa Code chapter 543B. A licensee participating in any of the practices described in this rule is deemed to be engaging in unethical

conduct and a practice harmful or detrimental to the public within the meaning of Iowa Code section 543B.29(1).

2007.4(1) An arrangement in which a real estate licensee needs or conditions, in connection with the sale of a lot, that the real estate licensee receive from the homebuilder an exclusive right to sell or list the house to be constructed on the lot.

2007.4(2) An arrangement in which a real estate licensee agrees to sell lots on behalf of a developer on the condition that the developer obligates each homebuilder purchasing such a lot to list the house to be constructed with the real estate licensee.

2007.4(3) An arrangement in which a real estate licensee, in connection with the sale of a lot to a consumer or homebuilder, obligates the consumer or homebuilder to pay compensation on the value of the house to be constructed on the lot.

2007.4(4) Any arrangement pursuant to which the sale of real estate to a prospective purchaser is conditioned upon the listing of real estate owned by the prospective purchaser with the real estate licensee.

2007.4(5) An arrangement in which a real estate licensee, in connection with the sale of a lot to a consumer, obligates the consumer to use a specified homebuilder to build the house to be constructed on the lot.

2007.4(6) Any arrangement in which a real estate licensee enters into an agreement with a mortgage broker, bank, savings and loan, or other financial institution pursuant to which the making of a loan is directly or indirectly conditioned upon payment of compensation to the real estate licensee.

2007.4(7) Any arrangement pursuant to which a real estate licensee who is affiliated with a mortgage broker, bank, savings and loan association or other financial institution benefits from the practice by the affiliated financial institution of granting mortgage loans or any other loan or financial services or the availability of other benefits directly or indirectly conditioned upon the use of the real estate services of the affiliated licensee.

2007.4(8) Any arrangement barred by Iowa Code section 543B.60A.

This rule is intended only to regulate the licensing of real estate licensees in the state of Iowa. This rule is not intended nor should it be interpreted to supplant Iowa Code chapter 553 (Iowa Competition Law) or as authorizing or approving business practices which are not specifically barred in this rule. The commission, upon receipt of any formal written complaint filed against a licensee alleging a violation of this rule, in addition to evaluating such complaint for license revocation or suspension under Iowa Code chapter 543B, forwards a copy of such complaint to the attorney general of the state of Iowa and to the United States Attorney for investigation and appropriate action.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.5(543B) Loan finder fees. The acceptance of a fee or anything of value by a real estate licensee from a lender or financing company for the referral or steering of a client to the lender for a loan is considered not in the best interest of the public and constitutes a violation of Iowa Code sections 543B.29(3) and 543B.34(8).

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.6(543B) Lotteries barred. Licensees cannot engage in lotteries and schemes of sales involving selling of certificates, chances or other devices, whereby the purchaser is to receive property to be selected in an order to be determined by chance or by some means other than the order of prior sale, or whereby property more or less valuable will be secured according to chance or the amount of sales made, or whereby the price will depend upon chance or the amount of sales made, or whereby the buyer or tenant will not receive, rent, or lease any property. Such activities are declared to be methods by reason of which the public interests are endangered.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.7(543B) Broker needed to furnish progress report. After an offer to buy has been made by a buyer and accepted by a seller, either party may demand at reasonable intervals and the broker furnishes a detailed statement showing the current status of the transaction.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.8(543B) Disclosure of licensee interest, acting as a principal, and status as a licensee.

A licensee cannot act in a transaction on the licensee's own behalf, on behalf of the licensee's immediate family, or on behalf of the brokerage, or on behalf of an organization or business entity in which the licensee has an interest, unless the licensee provides written disclosure of that interest to all parties to the transaction in accordance with Iowa Code section 543B.56(3) "b." Disclosure obligated under this rule is made at the time of or prior to the licensee's providing specific assistance to the party or parties to the transaction. Copies of the disclosure may be provided in person, electronically or by mail, as soon as reasonably practical. If no specific assistance is provided, disclosure is provided prior to the parties' forming a legally binding contract, either prior to an offer made by the buyer or tenant or prior to an acceptance by the seller or landlord, whichever comes first.

2007.8(1) *Licensee acting as a principal.* A licensee cannot acquire any interest in any property, directly or indirectly, nor can the licensee sell any interest in which the licensee, directly or indirectly, has an interest without first making written disclosure of the licensee's true position clear to the other party. Satisfactory proof of this disclosure is produced by the licensee upon request of the commission. Whenever a licensee is in doubt as to whether an interest, relationship, association, or affiliation obligates disclosure under this rule, the safest course of action is to make the written disclosure.

2007.8(2) *Status as a licensee.* Before buying, selling, or leasing real estate as described above, the licensee discloses in writing any ownership, or other interest, which the licensee has or will have and the licensee's status to all parties to the transaction. An inactive status license does not exempt a licensee from providing the obligated disclosure.

2007.8(3) *Dual capacity.* The licensee does not act in a dual capacity of agent and undisclosed principal in any transaction.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.9(543B) Financial interest disclosure needed. A licensee who has any affiliated business arrangement or relationship with any provider of settlement services, as defined below, and directly or indirectly refers business to that provider or affirmatively influences the selection of that provider discloses the arrangement and any financial interest to the person whose business is being referred or influenced. The obligated disclosure is acknowledged by the separate signatures of the person or persons whose business is being referred or influenced. The disclosure is given and signed before or at substantially the same time that the business is referred or the provider is selected. If the disclosure is made on a separate form, the licensee retains a copy of the signed disclosure in the transaction file for a period of five years after the execution.

2007.9(1) An affiliated business arrangement means an arrangement in which a real estate licensee, or an associate of a real estate licensee, has either an affiliate relationship with or a direct or beneficial ownership interest of more than 1 percent in the business entity providing the service or product.

a. An associate means one who has one or more of the following relationships with a real estate licensee:

- (1) A spouse, parent, or child of a real estate licensee;
- (2) A corporation or business entity that controls, is controlled by, or is under common control with a real estate licensee;
- (3) An employee, officer, director, partner, franchiser or franchisee of a real estate licensee; or
- (4) Anyone who has an agreement, arrangement or understanding with a real estate licensee or brokerage, the purpose or substantial effect of which is to enable the real estate licensee to refer for any service, settlement service, or business or product related to the transaction and to benefit financially from the referral of that business.

b. Settlement services include services in connection with a real estate transaction including, but not limited to, the following: mortgage or other financing; title searches; title examinations; the provisions of title certificates, title insurance, hazard insurance; services rendered by an attorney; the preparation of documents; property surveys; the rendering of credit reports or appraisals; pest, fungus, mechanical or other inspections; services rendered by a real estate agent or broker; and the handling of the processing and closing of settlement.

c. An affiliated business arrangement does not include an arrangement in which a real estate licensee, or an associate of a real estate licensee, gives or pays undisclosed compensation in a transaction to any other licensee for a referral to provide real estate brokerage services, including franchise affiliates, if there is no direct or beneficial ownership interest of more than 1 percent in the business entity providing the service. Referral fees or compensation paid by a licensee to another licensee under these conditions are exempted from the disclosure criteria.

2007.9(2) No particular language is needed for the disclosure. To assist real estate licensees and the public, the commission recommends the following sample language:

DISCLOSURE OF REFERRAL OF BUSINESS	
I understand that _____ (name of real estate licensee) _____ has an affiliate relationship with or owns an interest in _____ (name of company to which business is being referred) _____ and is also recommending that I employ this company for _____ (type of service) _____.	
I understand that _____ (name of real estate licensee) _____ may earn financial benefits from my use of this company. I understand that I am not obligated to use this company, and may select a different company if I wish to do so. This form has been fully explained to me and I have received a copy.	
(Date)	(Signature of person whose business is being referred)

2007.9(3) The term “franchise” has the same meaning as set forth in 24 CFR Chapter XX, Section 3500.15(c) as of April 1995.

2007.9(4) The term “affiliate relationship” means the relationship among business entities where one entity has effective control over the other by virtue of a partnership or other agreement or is under common control with the other by a third entity or where an entity is a corporation related to another corporation as parent to subsidiary by an identity of stock ownership.

2007.9(5) The term “beneficial ownership” means the effective ownership of an interest in a provider of settlement services or the right to use and control the ownership interest involved even though legal ownership or title may be held in another person’s name.

2007.9(6) The term “direct ownership” means the holding of legal title to an interest in a provider of settlement services except where title is being held for the beneficial owner.

2007.9(7) The term “control” as used in the definition of “affiliate relationship” means that a person:

- a. Is a general partner, officer, director, or employer of another person;
 - b. Directly or indirectly or acting in concert with others, or through one or more subsidiaries, owns, holds with power to vote, or holds proxies representing more than 20 percent of the voting interests of another person;
 - c. Affirmatively influences in any manner the election of a majority of the directors of another person; or
 - d. Has contributed more than 20 percent of the capital of the other person.

[**ARC 7769C**, IAB 4/17/24, effective 5/22/24; **ARC 9247C**, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.10(543B) Agency-designated broker responsibilities. The following conditions and circumstances, together with the education and experience of licensed and unlicensed employees

and independent contractors, is considered when determining whether or not the designated broker has met the supervisory responsibilities as set forth by Iowa Code section 543B.62(3) “b.”

2007.10(1) When making a determination, the commission may consider, but is not limited to consideration of, the following:

- a. Availability of the designated broker/designee to assist and advise regarding brokerage-related activities;
- b. General knowledge of brokerage-related staff activities;
- c. Availability of quality training programs and materials to licensed and unlicensed employees and independent contractors;
- d. Supervisory policies and practices in the review of competitive market analysis, listing contracts, sales contracts and other contracts or information prepared for clients and customers;
- e. Frequency and content of staff meetings;
- f. Written company policy manuals for licensed and unlicensed employees and independent contractors;
- g. Ratio of supervisors to licensed employees and independent contractors; and
- h. Assignment of an experienced licensee to work with new licensees.

2007.10(2) The designated broker disseminates, in a timely manner, to licensed employees and independent contractors all regulatory information received by the brokerage pertaining to the practice of real estate brokerage.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2007.11(543B) Supervision needed. An employing or affiliated broker is responsible for providing supervision of any salesperson or broker associate employed by or otherwise associated with the broker as a representative of the broker. The existence of an independent contractor relationship or any other special compensation arrangement between the broker and the salesperson or broker associate does not relieve either the broker or the salesperson or broker associate of duties, obligations or responsibilities obligated by law.

2007.11(1) Each salesperson and broker associate keeps the broker fully informed of all activities being conducted on behalf of the broker in accordance with Iowa Code section 543B.62(3) “b.”

2007.11(2) The activities of a salesperson or broker associate acting as a principal in the sale, lease, rental, or exchange of property owned by the licensee could impact the salesperson’s or broker associate’s license and the license of the employing or affiliated broker.

a. When a licensee is acting as a principal, the licensee keeps the employing or affiliated broker fully informed of all activities.

b. While this rule does not obligate that a licensee list property owned by the licensee with the employing or affiliated broker, the broker may obligate as a condition of employment or affiliation that the licensee list the property with the employing or affiliated broker or pay compensation.

2007.11(3) A broker associate means the same as defined in Iowa Code section 543B.5(5) and rule 481—2002.1(543B). A broker associate is subject to the provisions of Iowa Code sections 543B.24 and 543B.33 and commission rules pertaining to salespersons during the time the broker remains a broker associate.

2007.11(4) A broker who sponsors a salesperson during the salesperson’s first year of licensure must be able to demonstrate that the broker has the time available and experience necessary to adequately supervise an inexperienced salesperson.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.12(543B) Compensation controversies. The commission will not and is not authorized by law to consider or conduct hearings involving disputes over fees or compensation between cooperating brokers, salespersons, and other brokers.

2007.12(1) A former employing or affiliated broker may pay compensation directly to a broker associate or salesperson who is presently assigned to another broker or firm, or whose license is inactive, expired, suspended or revoked, only if the compensation was earned while the broker associate or salesperson was actively licensed and assigned to the former broker. Whether or not compensation was earned while the broker associate or salesperson was licensed with the former broker depends upon the licensee's written agreement with the former broker. The commission will not determine whether compensation is earned or whether compensation is to be paid.

2007.12(2) If the licensee is presently assigned to another broker or firm, the former broker does not pay the compensation to the new employing or affiliated broker or firm.

2007.12(3) An Iowa real estate broker may pay compensation or a fee to or receive compensation or a fee from a nonresident broker who is actively licensed in the broker's resident state but not licensed in Iowa. The nonresident broker takes no part in the listing, showing, negotiating offers or any other functions of a broker in Iowa unless actively licensed in Iowa.

2007.12(4) Upon the termination of association or employment with the affiliated broker or firm, the broker associate or salesperson cannot take or use any written listing or brokerage agreements secured during the association or employment. Said listings and brokerage agreements remain the property of the broker or firm and may be canceled only by the broker and the seller, unless the terms of the listing or brokerage agreement state otherwise.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.13(543B) Support personnel for licensees; permitted and barred activities. Whenever a licensee affiliated with a broker engages support personnel to assist the affiliated licensee in the activities of the real estate brokerage business, both the firm or designated broker and the affiliated licensee are responsible for supervising the acts or activities of the support personnel; however, the affiliated licensee has the primary responsibility for supervision subject to Iowa Code section 543B.7A. Unless the support person holds a real estate license, the support person cannot perform any activities, duties, or tasks of a real estate licensee as identified in Iowa Code sections 543B.3 and 543B.6 and may perform only ministerial duties that do not need discretion or the exercise of the licensee's own judgment. Personal assistants are considered support personnel.

2007.13(1) Individuals actively licensed with one firm or broker cannot work as support personnel for a licensee affiliated with another firm or broker. Individuals with an inactive status license may work as support personnel for a licensee but cannot participate in any activity that needs a real estate license.

2007.13(2) Any real estate brokerage firm or broker that allows an affiliated licensee to employ, or engage under an independent contractor agreement, support personnel to assist the affiliated licensee in carrying out brokerage activities complies with the following:

- a. Implement a written company policy authorizing the use of support personnel by licensees;
- b. Specify in the written company policy, which may incorporate the duties listed in subrule 2007.13(4), any duties that the support personnel may perform on behalf of the affiliated licensee;
- c. Ensure that the affiliated licensee and the support personnel receive copies of the duties that support personnel may perform.

2007.13(3) Broker supervision and improper use of license and office. While individual and designated brokers are responsible for supervising the real estate-related activities of all support personnel, an affiliated licensee employing a personal assistant has the primary responsibility for supervision of that personal assistant. A broker is not held responsible for inadequate supervision if:

- a. The unlicensed person violated a provision of Iowa Code chapter 543B or of commission rules that is in conflict with the designated broker's specific written policies or instructions;
- b. Reasonable procedures have been established to verify that adequate supervision was being provided;
- c. The broker, upon hearing of the violation, attempted to prevent or mitigate the damage;

- d. The broker did not participate in the violation; and
- e. The broker did not attempt to avoid learning of the violation.

2007.13(4) In order to provide reasonable assistance to licensees and their support personnel, but without defining every permitted activity, the commission has identified certain tasks that unlicensed support personnel under the direct supervision of a licensee affiliated with a firm or broker may not perform.

- a. Permitted activities include but are not limited to the following:

(1)	Answer the telephone, provide information about a listing to licensees, and forward calls from the public to a licensee;
(2)	Submit data on listings to a multiple listing service;
(3)	Check on the status of loan commitments after a contract has been negotiated;
(4)	Assemble documents for closings;
(5)	Secure documents that are public information from the courthouse and other sources available to the public;
(6)	Have keys made for company listings;
(7)	Write advertisements and promotional materials for the approval of the licensee and designated broker;
(8)	Place advertisements in magazines, newspapers, websites, social media, and other media as directed by the designated broker;
(9)	Record and deposit earnest money, security deposits, and advance rents, and perform other bookkeeping duties;
(10)	Type contract forms as directed by the licensee or the designated broker;
(11)	Monitor personnel files;
(12)	Compute compensation checks;
(13)	Place signs on property;
(14)	Order items of routine repair as directed by a licensee;
(15)	Act as courier for such purposes as delivering documents or picking up keys. The licensee remains responsible for ensuring delivery of all executed documents obligated by Iowa law and commission rules;
(16)	Schedule appointments with the seller or the seller's agent in order for a licensee to show a listed property;
(17)	Arrange dates and times for inspections;
(18)	Arrange dates and times for the mortgage application, the preclosing walk-through, and the closing;
(19)	Schedule an open house;
(20)	Perform physical maintenance on a property;
(21)	Accompany a licensee to an open house or a showing and perform the following functions as a host or hostess: 1. Open the door and greet prospects as they arrive; 2. Hand out or distribute prepared printed material; 3. Have prospects sign a register or guest book to record names, addresses and telephone numbers; 4. Accompany prospects through the home for security purposes and not answer any questions pertaining to the material aspects of the house or its price and terms;
(22)	Independently host open houses for tours attended by licensed brokers and salespersons only;
(23)	Advertise and list property for rent;
(24)	Show property for rent;
(25)	Collect rent and deposits for the rental of property; or
(26)	Complete and execute form agreements for the rental of property.

- b. Barred activities include but are not limited to the following:

(1)	Making cold calls by telephone or in person or otherwise contacting the public for the purpose of securing prospects for listings, sale, or exchanges;
(2)	Independently hosting open houses, kiosks, home show booths, or fairs attended by the public;
(3)	Preparing promotion materials or advertisements without the review and approval of licensee and designated broker;
(4)	Showing property for sale independently;

(5)	Answering any questions on title, financing, or closings (other than time and place);
(6)	Answering any questions regarding a listing except for information on price and amenities expressly provided in writing by the licensee;
(7)	Discussing or explaining a contract, listing, agreement, or other real estate document with anyone outside the firm;
(8)	Negotiating or agreeing to any compensation, management fee, or referral fee on behalf of a licensee, seller, or buyer with another licensee, client, or customer;
(9)	Discussing with the owner of real property the terms and conditions of the real property offered for sale or lease;
(10)	Collecting or holding deposit moneys, other moneys or anything of value received from the owner of real property or from a prospective buyer;
(11)	Providing owners of real property or prospective buyers with any advice, recommendations or suggestions as to the sale, purchase, or exchange of real property that is listed, to be listed, or currently available for sale; or
(12)	Holding one's self out in any manner, orally or in writing, as being licensed or affiliated with a particular firm or real estate broker as a licensee.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.14(543B) Information provided by nonlicensed support personnel limited.

Nonlicensed support personnel may, on behalf of the employer licensee, provide information concerning the sale, exchange, purchase, or advertising of real estate only to another licensee. Support personnel provides information only to another licensee that has been provided to the personnel by the employer licensee either verbally or in writing.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2007.15(543B) Presenting purchase agreements. All written offers to purchase received by a listing broker or listing agent are promptly presented to the seller for formal acceptance or rejection. The formal acceptance or rejection of the offer is promptly communicated to the prospective buyers. Unless there is written agreement between the seller and the listing broker directing otherwise, the listing broker is obligated to present back-up offers until the transaction has closed.

2007.15(1) A client's broker seeking compensation from another broker will obtain authorization and agreement from the cooperating broker prior to closing of the real estate transaction.

2007.15(2) Immediately upon receiving an offer to purchase signed and dated by the buyer with consideration, if any, the listing agent provides a copy of the offer to purchase to the buyer as a receipt.

2007.15(3) A client's agent or representative cannot negotiate directly or indirectly with a seller or buyer, or landlord or tenant, if the agent knows, or acting in a reasonable manner should have known, that the seller or buyer, or landlord or tenant, has a written unexpired brokerage agreement for services on an exclusive basis.

2007.15(4) A listing agent cannot refuse to permit a client's agent or representative to be present at any step in a real estate transaction, including but not limited to viewing a property, seeking information about a property, or negotiating directly or indirectly with an agent about a property listed by such agent, and an agent cannot refuse to show a property listed by that agent or otherwise deal with a represented client who requests that the client's agent or representative be present at any step in the real estate transaction, except as provided in this subrule.

a. The client's agent or representative does not have the right to be present at any discussion of confidential matters or evaluation of the offer by the seller and the listing agent.

b. Unless the seller provides written instructions to the listing agent to exclude a client's agent or representative from being present when the offer is presented, it is not unlawful for the client's agent or representative to be present.

c. Compliance with this rule does not need or obligate a listing broker to split any compensation or to otherwise compensate a client's agent.

[ARC 7769C, IAB 4/17/24, effective 5/22/24; ARC 8102C, IAB 7/10/24, effective 8/14/24; ARC 9247C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

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

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¹ Effective date of amendment to rule 1.21 delayed 70 days by the Administrative Rules Review Committee.

² Effective date of 1.31(543B) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 8, 1993.

³ Effective date of 1.1, definition of “referral fee”; 1.41, introductory paragraph; and subrules 1.41(3) and 1.41(7) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 7, 2000; rescinded IAB 6/28/00, effective 6/9/00.

CHAPTER 2008
CLOSING A REAL ESTATE BUSINESS
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 8]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2008.1(543B) Closing a real estate firm. The following steps are necessary for the voluntary closing of a real estate brokerage firm. The individual broker or the designated broker:

2008.1(1) Notifies the commission via electronic application upon closing the firm. The following information may be included:

- a. The date the firm closed or will close;
- b. The location where records and files will be stored for a minimum of five years; and
- c. The name, address, and telephone number of the custodian who will be storing the records and files;

2008.1(2) Notifies all licensees associated with the firm in writing of the effective date of the closing. The former affiliated broker makes every reasonable effort to return the licenses of any licensees associated with the firm at the time of closing to the commission within 72 hours, with written notice that the firm is closed;

2008.1(3) Notifies all clients as well as parties and co-brokers to existing contracts, in writing, advising of the date the firm will close. All clients are advised in writing that they may enter into a new brokerage or management agreement with the broker of their choice;

2008.1(4) Removes advertising signs from all properties that were listed with or managed by the firm. Arranges to cancel advertising in the name of the firm, including office signs, Internet to include websites and social media, and telephone listing advertisements;

2008.1(5) Maintains all escrow or trust accounts until all moneys are transferred to the lending institution, an escrow company or an attorney for closing of the transaction, or are otherwise properly disbursed as agreed to in writing by the parties having an interest in the funds; and

2008.1(6) Arranges for pending contracts to be closed by a lending institution, an escrow company or an attorney. In the case of a sale, transfer or merger of an existing brokerage, the acquiring broker may close the pending transactions acquired from the selling broker after having first obtained the express written consent of all parties to the transactions. The broker notifies all parties involved in pending transactions as to the name, address, and telephone number of the closing agent.

[ARC 7770C, IAB 4/17/24, effective 5/22/24; ARC 9248C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2008.2(543B) Involuntary closing of a sole-proprietor brokerage. Upon the death or disability of a sole-proprietor broker in which the affairs of the broker cannot be carried on, the following steps are necessary for closing the real estate brokerage business:

2008.2(1) All licensees associated with the broker cease all brokerage activity until their licenses have been transferred to another broker;

2008.2(2) The executor or legal representative of the broker's estate, if an attorney or a broker, may conclude pending business; and

2008.2(3) The administrator or executor of the broker's estate or the legal representative of the broker may follow the procedures established in rule 481—2008.1(543B) for voluntary closing.

[ARC 7770C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2008.3(543B) Involuntary closing of a corporation, partnership, or association brokerage firm.

2008.3(1) In the event of an involuntary closing of a brokerage firm as a result of the death or incapacity of one or more of the licensed broker officers, broker partners or broker associates of a real estate corporation, partnership or association in which the affairs of the broker, partnership,

corporation or association cannot be carried on, the following steps are necessary for closing the real estate brokerage business:

- a.* All licensees associated with the firm cease all brokerage activity until their licenses have been transferred to another broker;
- b.* The executor of the broker's estate, if an attorney, or the legal representative of the firm may conclude pending business; and
- c.* The administrator or executor of the broker's estate or the legal representative of the broker may follow the procedures established in rule 481—2008.1(543B) for voluntary closing.

2008.3(2) In the event of the death or incapacity of a designated broker for a firm, the affairs of the firm may be carried on by naming a new designated broker. The commission is notified of the change within 72 hours.

[ARC 7770C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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CHAPTER 2009

FEES

[Prior to 9/4/02, see 193E—2.9(543B)]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 9]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2009.1(543B) Fees.**2009.1(1) Original license or renewal.**

Broker license	\$170
Additional officer or partner license	\$50
Firm license	\$170
Branch office license	\$50
Trade name license	\$50
Salesperson license	\$125

2009.1(2) Fee for renewal of broker and salesperson license between January 1 and January 30 following expiration of license is the regular renewal fee plus \$25 reinstatement fee.

Broker license	\$195
Salesperson license	\$150

Reinstatement fee is not applicable to a firm license, additional officer license, additional partner license, trade name license, or branch office license.

2009.1(3) Fee for certification of license is \$25.

[ARC 7771C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2009.2(543B) Refunds and bad payments.

2009.2(1) Fees remitted with an application for license will be refunded if the commission finds the applicant is not qualified for a license.

2009.2(2) Fees will not be refunded for the unexpired term of a license that has been issued and is in effect.

2009.2(3) A fee remitted in error will be refunded if it is received as a separate check. If not received as a separate check, a fee remitted in error will be refunded if a written request is received within 30 days of receipt of the fee.

2009.2(4) Payment of a fee with a bad payment is prima facie evidence of a violation of Iowa Code section 543B.29(1) or 543B.34(8) or both.

2009.2(5) If a bad payment is received for an original license, the application for license is deemed incomplete and the license null and void.

2009.2(6) If a bad payment is received for renewal of a license, the application is deemed incomplete and the license issued for the new term is deemed null and void. If a replacement payment is not received by the commission by the date of expiration of the license (December 31), the appropriate reinstatement fee is added to the unpaid renewal fee.

[ARC 7771C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2009.3(543B) Examination fee. The examination fee is paid directly to the testing service at the prevailing rate established by contract between the commission and the testing service.

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These rules are intended to implement Iowa Code section 543B.27.

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CHAPTER 2010

ADVERTISING

[Prior to 9/4/02, see 193E—Ch 1]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 10]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2010.1(543B) Advertising. A broker cannot advertise to sell, buy, exchange, rent, or lease property in a manner indicating that the offer is being made by a private party not engaged in the real estate business, and no real estate advertisement can show only a post office box number, telephone number or street address. Every licensee, when advertising real estate, will use the licensed business name or the name under which the broker is licensed and affirmatively and unmistakably indicate that the party is a real estate licensee and not a private party. Each broker when operating under a franchise or trade name other than the broker's own name may license the franchise or trade name with the commission or clearly reveal in all advertising that the broker is the licensed individual who owns the entity using the franchise or trade name. An individual licensee or real estate team that is not a principal broker or firm is not required to register a trade name. An individual licensee or real estate team shall conspicuously display the name of the brokerage immediately preceding or immediately following the individual licensee's name or real estate team name in any advertising or information made available to the public. For purposes of this rule, "conspicuously display" shall mean advertisement that, when presented, a reasonable person would be able to identify or observe.

2010.1(1) Advertising includes all forms of identification, representation, promotion and solicitation disseminated in any manner and by any means of communication to the public for any purpose related to licensed real estate activity. Forms of advertising include, but are not limited to, real estate brokerage checks, letterhead, email, signs, websites, social media and business cards.

2010.1(2) Real estate advertising cannot be misleading or deceptive or intentionally misrepresent any property, terms, values, or policies and services of the brokerage.

2010.1(3) All advertising is conducted under the supervision of the broker. The broker ensures the accuracy of the information and, upon becoming aware of a material error or an advertisement that is in violation of this chapter or Iowa Code chapter 543B, the broker promptly corrects the error or problem within ten calendar days.

2010.1(4) A licensed firm advertising or marketing on a website or social media account that is either owned by or controlled by the licensed firm includes the following data on each page of the site on which the firm's advertisement or information appears:

a. Conspicuously display, in a font size that is readable to a reasonably prudent person, the firm or tradename as registered with the commission (abbreviations are not permitted) immediately preceding or immediately following the individual licensee's name or real estate team name;

b. The city and state in which the firm's main office is located; and

c. The states in which the firm holds a real estate brokerage license.

2010.1(5) A licensee advertising or marketing on a website or social media account that is either owned by or controlled by the licensee includes the following data on each page of the site on which the licensee's advertisement or information appears:

a. The licensee's legal name;

b. Conspicuously display the name of the firm or trade name with which the licensee is affiliated as that firm name is registered with the commission (abbreviations are not permitted) immediately preceding or immediately following the individual licensee's name or real estate team name;

c. The city and state in which the licensee's office is located; and

d. The states in which the licensee holds a real estate broker or salesperson license.

2010.1(6) A firm using any Internet electronic communication for advertising or marketing, including but not limited to email, websites, and social media accounts, includes the information in 481—subrule 2010.1(4).

2010.1(7) A licensee using any Internet electronic communication for advertising or marketing, including but not limited to email, websites, and social media accounts, includes on the first or last page of all communications the information in subrule 2010.1(5).

[ARC 7772C, IAB 4/17/24, effective 5/22/24; ARC 9249C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2010.2(543B) Advertising under own name. Salespersons and broker associates are barred from advertising under their own names unless they are the owners of the property they are advertising for sale, rent, lease or exchange, and on which no brokerage fees are to be paid. The sale is completely a “for sale by owner” transaction. The property cannot be listed or advertised in any way that would make it appear to be listed with a brokerage. The affiliated licensee cannot function in any capacity that needs a real estate license, and the licensee is responsible for all advertising conducted on the licensee’s own behalf.

[ARC 7772C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2010.3(543B) Signs on property. Placing a sign on any property offering it for sale, rent, lease, or exchange without the written consent of the owner is not considered in the best interest of the general public.

2010.3(1) When a listing expires, unless a new written listing or extension is obtained, the licensee immediately ceases advertising and active marketing of the property. The licensee makes every reasonable effort to remove signs as quickly as possible.

2010.3(2) The licensee makes every reasonable effort to remove signs from the property after the transaction is closed. Sold signs and other signs are not left on properties without the written consent of the new owner of record.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2011
BROKERAGE AGREEMENTS AND LISTINGS

[Prior to 9/4/02, see 193E—Ch 1]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 11]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2011.1(543B) Brokerage agreements. All brokerage agreements will be in writing, including the amount of compensation to be paid with disclosure that states compensation is negotiable and not set by law, the signatures of all parties concerned and a definite expiration date not to exceed one calendar year in length from the effective date, for residential properties. An exclusive brokerage agreement or exclusive right to sell agreement clearly indicates that it is such an agreement. A legible copy of every written brokerage agreement or other written authorization is given to the client by a licensee as soon as the signature of the client is obtained.

1. A listing agreement should properly identify the property and contain the terms and conditions under which the property is to be sold, including but not limited to the list price and any compensation to be earned from the sale of the property.

2. A buyer representation agreement is required for all residential properties. Open houses, auctions, and commercial properties are exempt from usage of a buyer representation agreement.

2011.1(1) A licensee cannot solicit or enter into a brokerage agreement with a buyer or seller if the licensee knows or has reason to know that the buyer or seller has a written unexpired exclusive brokerage agreement or exclusive right to sell listing agreement to the property with another broker unless the buyer or seller initiates the discussion and the licensee has not directly or indirectly solicited the brokerage agreement.

a. However, if the buyer or seller initiates the discussion, the licensee may negotiate and enter into a brokerage agreement that will take effect after the expiration of the current brokerage agreement.

b. If the buyer or seller initiates the discussion, the licensee may inform the buyer or seller that the buyer or seller needs to allow the current brokerage agreement to expire or obtain a mutually acceptable cancellation from the broker before any further discussion can take place.

2011.1(2) A real estate licensee cannot negotiate a sale, exchange, or lease of real property directly with a seller if it is known that the seller has a written unexpired contract in connection with the property that grants an exclusive right to sell to another broker.

2011.1(3) A real estate licensee cannot negotiate a sale, purchase, exchange, or lease of real property directly with a buyer or seller if it is known that the buyer or seller has a written unexpired exclusive brokerage agreement with another broker.

2011.1(4) All brokerage agreements are written and cannot be assigned, sold, or otherwise transferred to another broker without the express written consent of all parties to the original agreement, unless the terms of the agreement state otherwise. Upon termination of association or employment with the principal broker, the affiliated broker associate or salesperson cannot solicit, take, or use any written brokerage agreements secured during the association or employment. Said brokerage agreements remain the property of the principal broker and may be canceled only by the broker and the client.

2011.1(5) Net listing barred. No licensee makes or enters into a net listing agreement for the sale of real property or any interest in real property. A net listing agreement is an agreement that specifies a net sale price to be received by the owner with the excess over that price to be received by the broker as compensation. The taking of a net listing is unprofessional conduct and constitutes a violation of Iowa Code sections 543B.29(3) and 543B.34(8).

[ARC 7773C, IAB 4/17/24, effective 5/22/24; ARC 8102C, IAB 7/10/24, effective 8/14/24; ARC 9477C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2011.2(543B) Cooperation, compensation, and compliance.

2011.2(1) Every written brokerage agreement includes, at a minimum, the criteria set forth in Iowa Code section 543B.56A and the following provisions:

a. Brokerage agreements will contain a statement disclosing the brokerage policy on cooperating with and compensating other brokerages or the other parties' agent in the sale, lease, rental, or purchase of real estate, including whether the brokerage intends to split the compensation with other brokerages and any other method for negotiating compensation for another party's broker. Such disclosure serves to inform the client of any policy that would limit the participation of any other brokerage; and

b. All brokerage agreements comply with Iowa real estate law and commission rules, including but not limited to rules 481—2011.1(543B) and 481—2011.4(543B) and 481—Chapter 2015.

2011.2(2) Duration of relationship. The relationships commence at the time of the brokerage agreement and continue until closing of the transaction or performance or completion of the agreement by which the broker was engaged within the term of the agreement and not exceeding 12 months. If the transaction does not close, or the agreement for which the broker was engaged is not performed or completed for any reason, the relationship ends at the earlier of the following:

a. The date of expiration agreed upon by the parties; or

b. Any termination by written agreement of the parties.

2011.2(3) Obligation terminated. In addition to any continuing duty or obligation provided in the written agreement or pursuant to Iowa law and commission rules, a broker or brokerage engaged as a seller's or landlord's agent, buyer's or tenant's agent, or dual agent and affiliated licensees have the duty after termination, expiration, completion, or performance of the brokerage agreement to:

a. Account for all moneys and property related to and received during the engagement; and

b. Keep confidential all information received during the course of the engagement which was made confidential by request or instructions from the engaging party or is otherwise confidential by statute or rule.

2011.2(4) Compensation. In any real estate transaction, the broker's compensation may be paid by the seller, the buyer, the landlord, the tenant, a third party, or splitting of compensation between brokers.

a. Payment of compensation is not to be construed to determine or establish an agency relationship. The payment of compensation to a broker does not determine whether a brokerage relationship has been created between any broker and a seller, landlord, buyer, or tenant paying such compensation.

b. Written permission of the client is needed as follows:

(1) A seller's or landlord's agent may split compensation paid by such seller or landlord with another broker, with the written consent of the seller or landlord.

(2) A buyer's or tenant's agent may split compensation paid by such buyer or tenant with another broker, with the written consent of the buyer or tenant.

(3) Without the written approval of the client, a seller's or landlord's agent cannot propose to the buyer's or tenant's agent that such seller's or landlord's agent may be compensated by splitting compensation paid by such buyer or tenant.

(4) Without the written approval of the client, a buyer's or tenant's agent cannot propose to the seller's or landlord's agent that such buyer's or tenant's agent may be compensated by splitting compensation paid by such seller or landlord.

c. A broker may be compensated by more than one party for services in a transaction.

d. A licensee cannot accept, receive or charge an undisclosed compensation for a transaction.

e. A licensee cannot give or pay an undisclosed compensation to any other licensee for a transaction, except payment for referrals to other licensees, including franchise affiliates, to provide real estate brokerage services, if there is no direct or beneficial ownership interest of more than 1 percent in the business entity providing the service.

f. A licensee cannot pay any undisclosed rebate to any party to a transaction.

g. A licensee cannot give any undisclosed credit against compensation due from a client or licensee to any party to a transaction.

h. A licensee cannot accept, receive or charge any undisclosed payments for any services provided by any third party to any party to a transaction including but not limited to payments for procuring insurance or for conducting a property inspection related to the transaction.

i. The provisions of these rules do not apply to a gratuitous gift, such as flowers or a door knocker, to a buyer or tenant subsequent to closing and not promised or offered as an inducement to buy or lease, as long as any client relationship has terminated.

j. The provisions of these rules do not apply to a free gift, such as prizes, money, or other valuable consideration, to a potential party to a transaction or lease prior to the parties' signing a contract to purchase or lease and not promised or offered as an inducement to sell, buy, or lease, as long as no client relationship has been established with the buyer or lessee.

k. The seller or landlord may authorize a portion of the proceeds of the sale of real property or other negotiated term of an agreement or contract to pay compensation to other brokers who are part of the same real estate transaction as the seller or landlord, including a buyer's or tenant's broker solely representing the buyer or tenant. The payment of compensation may be a direct payment from the seller or landlord to the other brokers who are part of the same real estate transaction as the seller or landlord, including a buyer's or tenant's broker solely representing the buyer or tenant.

2011.2(5) Any compensation or fee in any brokerage agreement is fully negotiable among the parties to that brokerage agreement. Once the parties to a brokerage agreement have agreed to a compensation or fee, no licensee other than a party to that brokerage agreement attempts to alter, modify, or change or induce another person to alter, modify, or change a compensation or fee that has previously been agreed upon without the prior written consent of the parties to that brokerage agreement.

2011.2(6) The seller or landlord may, in the brokerage agreement, authorize the seller's or landlord's broker to disburse part of the broker's compensation to other brokers, including a buyer's or tenant's broker solely representing the buyer or tenant.

2011.2(7) Nothing contained in this rule shall obligate any buyer or tenant or seller or landlord to pay compensation to a licensee representing the buyer or tenant or seller or landlord in a real estate transaction unless the buyer or tenant or seller or landlord has entered into a written brokerage agreement with the broker specifying the compensation terms and conditions, in accordance with Iowa real estate license law and commission rules.

[ARC 7773C, IAB 4/17/24, effective 5/22/24; ARC 8102C, IAB 7/10/24, effective 8/14/24; ARC 9477C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2011.3(543B) Terms or conditions. A licensee cannot write, prepare or otherwise use a contract containing terms or conditions that would violate real estate laws in Iowa Code chapter 543B or commission rules. The broker is responsible to ensure that all preprinted documents and forms used follow these rules.

[ARC 7773C, IAB 4/17/24, effective 5/22/24; ARC 9477C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2011.4(543B) Distribution of executed instruments. Upon execution of any instrument in connection with a real estate transaction, a licensee, as soon as practicable, delivers a legible copy of the original instrument to each of the parties thereto. It is the responsibility of the licensee to prepare sufficient copies of such instruments to satisfy this criteria. The broker retains copies for five years.

[ARC 7773C, IAB 4/17/24, effective 5/22/24; ARC 9477C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2011.5(543B) Enforcing a protective clause. To enforce a protective clause beyond the expiration of an exclusive brokerage agreement, there must be a provision for the protective clause in the brokerage agreement that establishes a definite protection period. In writing and prior to the

expiration of the brokerage agreement, the broker furnishes to the party the names and available contact information of persons to whom the property was presented or a list of each property that was shown during the active term of the brokerage agreement and for whom protection is sought. Delivery is by personal or electronic service with written acknowledgment of receipt, or by regular mail or certified mail postmarked prior to the expiration of the brokerage agreement, return receipt requested.

[ARC 9477C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2011.6(543B) Rebates and inducements.

2011.6(1) A licensee cannot pay compensation, any part of compensation, or valuable consideration to an unlicensed third party for performing brokerage functions or engaging in any activity that needs a real estate license. Referral fees or finder's fees paid to unlicensed third parties for performing brokerage activities, or engaging in any activity that needs a real estate license, are barred.

2011.6(2) In a brokerage agreement, the broker is principal party to the contract. The broker may, with proper disclosure, pay a portion of the compensation earned to an unlicensed seller, landlord, buyer, or tenant that is a principal party to the brokerage agreement. This will be deemed a reduction in the amount of the earned compensation.

2011.6(3) A licensee may present a gratuitous gift, such as flowers or a door knocker, to the buyer or tenant subsequent to closing and not promised or offered as an inducement to buy or lease. The permission and disclosure criteria of rule 481—2011.3(543B) do not apply as long as any client relationship has terminated.

2011.6(4) A licensee may present free gifts, such as prizes, money, or other valuable consideration, to a potential party to a transaction or lease, prior to that party's signing a contract to purchase or lease and not promised or offered as an inducement to buy or lease. It is the licensee's responsibility to ensure that the promotion is in compliance with other Iowa laws, such as gaming regulations. The permission and disclosure criteria of rule 481—2011.3(543B) do not apply as long as no client relationship has been established with the buyer or lessee.

2011.6(5) The offering by a licensee of a free gift, prize, money, or other valuable consideration as an inducement is free from deception and does not serve to distort the true value of the real estate service being promoted.

2011.6(6) A licensee may make donations to a charity, or other not-for-profit organization, for each listing or closing, or both, that the licensee has during a specific time period. The receiving entity may be selected by the licensee or by a party to the transaction. The contribution may be in the name of the licensee or in the name of a party to the transaction. Contributions are permissible only if the following conditions are met:

- a. There are no limitations placed on the payment;
- b. The donation is for a specific amount;
- c. The receiving entity does not act or participate in any manner that would need a license;
- d. The licensee exercises reasonable care to ensure that the organization or fund is a bona fide nonprofit;
- e. The licensee exercises reasonable care to ensure that the promotional materials clearly explain the terms under which the donation will be made; and
- f. All necessary disclosures are made.

[ARC 7773C, IAB 4/17/24, effective 5/22/24; ARC 8102C, IAB 7/10/24, effective 8/14/24; ARC 9477C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2011.7(543B) New construction. A contract with a builder to construct or attach personal property or other type of structure to land and thereby produce an improvement to real estate is a real estate transaction. A licensee makes written disclosure revealing that the licensee and the licensee's broker or brokerage firm will receive a commission, compensation, or valuable consideration for its efforts in the transaction, as obligated by paragraph 2011.3(6)"d." Written disclosure is necessary

regardless of the type of representation provided by the licensee or if the licensee provides no representation.

[ARC 7773C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2012
DISCLOSURE OF RELATIONSHIPS

[Prior to 9/4/02, see 193E—Ch 1]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2012.1(543B) Written company policy needed. Every licensed sole-proprietor single broker, firm, partnership, limited liability company, association, or corporation has a written company policy. Regardless of the type or types of agency relationships offered, a written company policy is needed.

2012.1(1) The written company policy identifies and describes the types of real estate brokerage relationships in which the broker and affiliated licensees may engage with seller, landlord, buyer, or tenant as a part of any real estate brokerage business activities.

2012.1(2) In addition, every real estate brokerage that offers representation to both buyers and sellers, and tenants and landlords, also specifically addresses the following:

- a.* The appointed agent's policy and brokerage procedures intended to prevent any mishandling of information through both formal and informal sharing of information within the brokerage; and
- b.* The arrangement of brokerage office space and the personal relationships of affiliated licensees who are representing clients with adverse interests.

2012.1(3) A broker is not obligated to offer or engage in more than one type of brokerage relationship as enumerated in rules 481—2012.3(543B) through 481—2012.5(543B).

[ARC 7774C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2012.2(543B) Disclosure of agency.

2012.2(1) A licensee cannot represent any party or parties to a real estate transaction or otherwise act as a real estate broker or salesperson unless that licensee makes disclosure to all obligated parties to the transaction identifying which party or parties, if any, that licensee represents in the transaction. Disclosure pursuant to this rule is made by the licensee at the time the licensee provides specific assistance to the client or nonrepresented customer.

2012.2(2) Verbal disclosure needed. The disclosure obligated by subrule 2012.2(1) is made verbally by the licensee prior to the licensee's providing specific assistance to the client or nonrepresented customer. A change in the licensee's representation that makes the initial verbal disclosure incomplete, misleading, or inaccurate obligates that a new verbal disclosure be made immediately.

2012.2(3) Written disclosure needed. The written disclosure obligated by subrule 2012.2(1) is made by the licensee to all parties to a real estate transaction identifying which party the licensee represents in the transaction.

a. The written disclosure is needed to be made to the buyer or tenant prior to any offer, lease, or rental agreement being made or signed by the buyer or tenant, and prior to any offer, lease, or rental agreement being signed or accepted by the seller or landlord.

b. The written disclosure is acknowledged by separate signatures. A change in the licensee's representation that makes the initial written disclosure incomplete, misleading, or inaccurate obligates that a new verbal disclosure be made that is followed by a new written disclosure signed by all parties to the transaction as soon as practical.

2012.2(4) A licensee representing a buyer or tenant informs the listing broker, the listing agent, or the seller or landlord of the agency relationship in accordance with Iowa Code section 543B.57(5). If the property is not listed, the obligated disclosure is made to the unrepresented seller or landlord.

2012.2(5) The obligation of either the seller or landlord or buyer or tenant to pay compensation to a broker does not establish an agency relationship or affect any agency relationship.

2012.2(6) Nothing contained in this rule bars a party from entering into a written brokerage agreement with a broker that contains duties, obligations, and responsibilities that are in addition to those specified in Iowa real estate license law and commission rules.

2012.2(7) A licensee cannot be the agent for both the buyer or tenant without following Iowa Code section 543B.58(1).

2012.2(8) A licensee may work with and establish different types of agency relationships with the same client, in separate transactions. Examples of different agency relationships with the same client in separate transactions include, but are not limited to, the following:

a. A common example includes a licensee acting as a listing or seller's agent selling a property in one transaction and also working with and representing this same person in another transaction as a buyer's agent in the purchase of a different property.

b. A licensee may act as a dual agent in either of the separate transactions, or both, with the written permission of the parties to the specific transaction and if the broker or brokerage has a written company policy that includes disclosed dual agency for in-house transactions or same agent transactions.

c. Regardless of the type of agency relationship provided in each transaction, the licensee complies with the criteria of Iowa Code chapter 543B and this rule in establishing the relationships for each separate transaction.

2012.2(9) An agency relationship disclosure is not needed when the licensee is acting solely as a principal and not as an agent for another or when a written communication from the licensee is a solicitation of business.

2012.2(10) If the seller, landlord, buyer, or tenant refuses to sign the agency disclosure document, or refuses to sign acknowledging receipt of the disclosure, the licensee notes that fact and includes the date, place, time, and the names of others in attendance on a copy of the agency disclosure document and obtains other documentation establishing delivery of the disclosure and maintains the written documentation, including but not limited to copies of facsimile, restricted delivery certified mail, and other communications, in the transaction file.

2012.2(11) A licensee who is offering real estate brokerage services as an auctioneer makes the written disclosure to the buyer and obtains the acknowledgment of receipt obligated by law and rules, prior to the buyer's entering into a written purchase agreement for the property. For the purposes of this rule, the identification of the successful bidder constitutes the first meaningful contact with a buyer when specific assistance is provided. After the first meaningful contact, the first practical opportunity to make the necessary disclosures to the buyer depends upon the circumstances. While it is not necessary, it is recommended that licensees disclose in all advertisements and flyers that they are licensed agents representing the seller and, prior to crying the auction, announce that they are licensed real estate agents representing the seller.

a. Disclosure under this rule applies only to the day of the auction.

b. If the licensee provides brokerage services prior to the auction, the disclosure is made either orally or in writing prior to or at the time of specific assistance being provided.

2012.2(12) The licensee retains a copy of the disclosure form signed by the prospective buyer, seller, landlord or tenant, or the documentation and copies as obligated in subrule 2012.2(10) as follows:

a. If an offer is accepted, the signed or noted copy is retained by the broker in the closed transaction file for a period of five years from the date of the signature or note.

b. If the offer is not accepted, a signed and noted copy is retained with the rejected offer for a period of five years.

2012.2(13) Failure of a licensee to comply with this rule is prima facie evidence of a violation of Iowa Code section 543B.34(4).

2012.2(14) Failure of a licensee to act consistent with disclosure representations made pursuant to this rule is prima facie evidence of a violation of Iowa Code section 543B.34(4).

2012.2(15) Nothing in this rule affects the validity of title to real property transferred based solely on the reason that any licensee failed to conform to the provisions of this rule.

2012.2(16) A sole-proprietor single broker or firm is not obligated to offer or engage in more than one type of brokerage relationship as enumerated in rules 481—2012.3(543B) through 481—2012.5(543B).

2012.2(17) The licensee offering brokerage services to a person as a buyer's or tenant's agent, or who is providing brokerage services to a person as a seller's or landlord's agent, discloses in writing to that person the type or types of brokerage relationships the broker and affiliated licensees are offering to that person before entering into a brokerage agreement with that person.

[ARC 7774C, IAB 4/17/24, effective 5/22/24; ARC 8102C, IAB 7/10/24, effective 8/14/24; ARC 9478C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2012.3(543B) Single agent representing a seller or landlord.

2012.3(1) *Duty to seller or landlord.* A licensee representing a seller or landlord as an exclusive seller's agent or an exclusive landlord's agent have the following duties and obligations:

- a. Perform the terms of the written agreement made with the seller or landlord;
- b. Exercise reasonable skill and care for the seller or landlord;
- c. Promote the interests of the seller or landlord with the utmost care, integrity, honesty, and loyalty, including but not limited to the following:

- (1) Seeking a price and terms which are acceptable to the seller or landlord, except that the licensee is not obligated to seek additional offers to purchase the property while the property is subject to a contract for sale or to seek additional offers to lease the property while the property is subject to a lease or letter of intent to lease;

- (2) Presenting all written offers to and from the seller or landlord in a timely manner regardless of whether the property is subject to a contract for sale or lease or a letter of intent to lease, unless it is provided for by the brokerage agreement;

- (3) Disclosing to the seller or landlord all material adverse facts pursuant to Iowa Code section 543B.56(1);

- (4) Advising the client to obtain expert advice as to material matters about which the licensee knows but the specifics of which are beyond the expertise of the licensee;

- (5) Preserving the seller's or landlord's confidential information as defined in rule 481—2002.1(543B), unless disclosure is mandated by law or unless failure to disclose such information would constitute fraud or dishonest dealing, including but not limited to the following:

1. Information concerning the seller or the landlord that, if disclosed to the other party, could place the seller or landlord at a disadvantage when bargaining;

2. That the seller or landlord is willing to accept less than the asking price or lease price for the property;

3. What the motivating factors are for the client's selling or leasing the property;

4. That the seller or landlord will agree to sale, lease, or financing terms other than those offered;

5. The seller's or landlord's real estate needs;

6. The seller's or landlord's financial information;

- (6) Accounting in a timely manner for all money and property received;

- (7) Providing brokerage services honestly and in good faith;

- (8) Complying with all criteria of Iowa Code chapter 543B and all commission rules and regulations;

- (9) Complying with any applicable federal, state, or local laws, rules, or ordinances, including fair housing and civil rights statutes and regulations.

2012.3(2) *Duty to a buyer or tenant.* A licensee acting as an exclusive seller's or exclusive landlord's agent discloses to any customer all material adverse facts actually known by the licensee pursuant to Iowa Code section 543B.56.

- a. The licensee owes no duty to conduct an independent inspection of the property for the benefit of the buyer or tenant and owes no duty to independently verify the accuracy or completeness

of any statement made by the seller or landlord or any independent inspector, unless the licensee knows or has reason to believe the information is not accurate.

b. Nothing in this rule precludes the obligation of a buyer or tenant from the responsibility of protecting the buyer's or the tenant's own interest by means of, but not limited to, inspecting the physical condition of the property and verifying important information.

c. A real estate brokerage engaged by a seller or landlord in a real estate transaction may provide assistance to an unrepresented buyer or tenant by providing information and assistance concerning professional services not related to real estate brokerage services.

2012.3(3) *Alternative properties.* The licensee may show alternative properties not owned by the seller or landlord to buyers or tenants and may list competing properties for sale or lease without breaching any duty or obligation to the seller or landlord.

[ARC 7774C, IAB 4/17/24, effective 5/22/24; ARC 9478C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2012.4(543B) Single agent representing a buyer or tenant.

2012.4(1) *Duty to buyer or tenant.* A licensee representing a buyer or tenant as an exclusive buyer's or an exclusive tenant's agent have the same duties and obligations as mentioned in subrule 2012.3(1).

a. Perform the terms of any written agreement made with the client;
b. Exercise reasonable skill and care for the client;
c. Promote the interests of the client with the utmost good faith, loyalty, and fidelity, including but not limited to the following:

(1) Seeking a property at a price and terms which are acceptable to the buyer or tenant, except that the licensee is not obligated to seek other properties while the client is a party to a contract to purchase property, or to a lease or letter of intent to lease, unless it is provided for by the brokerage agreement;

(2) Presenting all written offers to and from the client in a timely manner regardless of whether the client is already a party to a contract to purchase property or is already a party to a contract or letter of intent to lease;

(3) Disclosing to the buyer or tenant material adverse facts concerning the property and the transaction that are actually known by the licensee, pursuant to Iowa Code section 543B.56;

(4) Advising the buyer or tenant to obtain expert advice on material matters about which the licensee knows but the specifics of which are beyond the expertise of the licensee;

(5) Preserving the buyer's or tenant's confidential information as defined in rule 481—2002.1(543B), unless disclosure is mandated by law or unless failure to disclose such information would constitute fraud or dishonest dealing, including but not limited to the following:

1. Information concerning the buyer or the tenant that, if disclosed to the other party, could place the client at a disadvantage when bargaining;

2. That the buyer or tenant is willing to pay more than the asking price or lease price for the property;

3. What the motivating factors are for the party's buying or leasing the property;

4. That the buyer or tenant will agree to sale, lease, or financing terms other than those offered;

5. The buyer's or tenant's real estate needs;

6. The buyer's or tenant's financial qualifications;

(6) Accounting in a timely manner for all money and property received;

(7) Providing brokerage services honestly and in good faith;

(8) Complying with all criteria of Iowa Code chapter 543B and all commission rules;

(9) Complying with any applicable federal, state, or local laws, rules, and ordinances, including fair housing and civil rights statutes and regulations.

2012.4(2) *Duty to a seller or landlord.* A licensee acting as an exclusive buyer's or an exclusive tenant's agent discloses to any customer all material adverse facts actually known by the licensee, pursuant to Iowa Code section 543B.56.

a. The licensee owes no duty to conduct an independent investigation of the buyer's or tenant's financial condition for the benefit of the seller or landlord and owes no duty to verify the accuracy or completeness of any statement made by the buyer or tenant or any independent source, unless the licensee knows or has reason to believe the information is not accurate.

b. Nothing in this rule limits the obligation of a seller or landlord from the responsibility of protecting the seller's or landlord's own interest by means of, but not limited to, verifying information concerning or provided by the buyer or tenant.

c. A real estate brokerage engaged by a buyer or tenant in a real estate transaction may provide assistance to an unrepresented seller or landlord by providing information and assistance concerning professional services not related to real estate brokerage services.

2012.4(3) *Competing buyers or tenants.* The licensee may show properties in which the buyer or tenant is interested to other buyers or tenants, may assist other competing buyers or tenants, and may enter into brokerage agreements with other competing buyers or tenants without breaching any duty or obligation to the buyer or tenant.

[ARC 7774C, IAB 4/17/24, effective 5/22/24; ARC 9478C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2012.5(543B) Disclosed dual agent.

2012.5(1) A brokerage which has a company policy that permits disclosed dual agency for in-house transactions provides a disclosed dual agency consent agreement to the client or prospective client prior to engaging in any activities of a dual agent. If any seller, landlord, buyer, or tenant rejects dual agency, or refuses to sign consent to dual agency, the licensee cannot act as a dual agent. The dual agency consent agreement complies with Iowa law and commission rules including, but not limited to, the criteria to inform the prospective clients that they are not obligated to consent to dual agency representation as provided by subrule 2012.5(2).

a. A licensee may act as a dual agent only with the informed consent of all parties to the transaction. The informed consent is evidenced by a written agreement pursuant to Iowa law and commission rules.

b. A dual agent is an agent for both the seller and buyer or the landlord and tenant and has the duties and obligations needed for a single agent representing a seller or landlord and for a single agent representing a buyer or tenant, unless otherwise provided for in this rule.

c. A dual agent discloses to the client all material adverse facts concerning the property that are actually known by the licensee, pursuant to Iowa Code section 543B.56.

d. A dual agent cannot disclose to one client confidential information about the other client and preserves a seller's or a landlord's, or a buyer's or a tenant's, confidential information as defined in rule 481—2002.1(543B), unless disclosure is mandated by law, or failure to disclose such information would constitute fraud or dishonest dealing, or disclosure is authorized by express instruction. A dual agent does not terminate the dual agency relationship by making the disclosures mandatory or permitted by the dual agency consent agreement. Confidential information includes the same information as 481—subrule 2012.3(1) or 2012.4(1).

e. In any transaction, a licensee may withdraw from representing a client who has not consented to a disclosed dual agency at any time prior to the existence of the dual agency, which is prior to discussing any seller's or landlord's property with a potential buyer or tenant and prior to discussing any potential buyer or tenant with a seller or landlord, when both the seller or landlord and the buyer or tenant are represented by and are clients of the licensee.

(1) All withdrawals are made in writing and acknowledged by the separate signatures of the clients.

(2) Such withdrawal does not prejudice the ability of the licensee to continue to represent the other client in the transaction or limit the licensee from representing the client in other transactions not involving a dual agency.

2012.5(2) A dual agency consent agreement:

- a.* Fairly and accurately describes the type of representation the licensee will provide each client;
- b.* Contains a statement of the licensee's duties under Iowa Code section 543B.56(1);
- c.* Contains a statement of the licensee's duties under Iowa Code section 543B.56(2);
- d.* Informs the clients that representing more than one party to a transaction may present a conflict of interest;
- e.* Informs the clients that they are not obligated to consent to dual agency;
- f.* Provides additional information that the licensee determines is necessary to clarify the licensee's relationship with each client, including any changes from prior types of representation;
- g.* Describes the confidential information a dual agent will not disclose to one client about the other client; and
- h.* Includes a statement that the clients understand the licensee's duties and consent to the licensee's providing brokerage services to more than one client.

2012.5(3) No particular disclosure language is needed. The commission recommends use of the following sample language to satisfy the mandatory disclosure regarding conflict of interest:

Representing more than one party to a transaction can create a conflict of interest since both clients may rely upon the broker's advice and the clients' respective interests may be adverse to each other. Broker will endeavor to be impartial between seller and buyer and will not represent the interest of either the seller or buyer to the exclusion or detriment of the other.

2012.5(4) Potential dual agency agreement. A brokerage which has a company policy that permits disclosed dual agency for in-house transactions and that elects to use a potential dual agency agreement provides the agreement to the client or prospective client prior to engaging in any activities of a dual agent. Such consent agreement complies with Iowa law and commission rules.

- a.* The potential dual agency agreement should be provided to the seller or landlord prior to entering into a listing agreement or a contract for seller or landlord brokerage services.
- b.* The potential dual agency agreement should be provided to the buyer or tenant prior to entering into a buyer or tenant agreement.
- c.* If the parties to a proposed transaction or contract have agreed in writing to potential dual agency, a dual agency consent disclosure is presented to the buyer or tenant prior to the buyer's or tenant's signing an offer to purchase or a rental or lease agreement. The buyer or tenant may accept or reject dual agency at this point in the transaction.
- d.* If the parties to a proposed transaction or contract have agreed in writing to potential dual agency, a dual agency consent disclosure is presented to the seller or landlord prior to the seller's or landlord's signing or accepting an offer to purchase or a rental or lease agreement. The seller or landlord may accept or reject dual agency at this point in the transaction.
- e.* If the parties to a proposed transaction or contract have agreed in writing to potential dual agency, the obligated subsequent dual agency consent disclosure is property-specific and complies with Iowa law and commission rules.

[ARC 7774C, IAB 4/17/24, effective 5/22/24; ARC 9478C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2012.6(543B) Appointed agents within a brokerage. Iowa Code section 543B.59 authorizes a designated broker to elect to appoint in writing one or more different licensees affiliated with the broker to act as agent to represent exclusively different clients in the same transaction, to the exclusion of all other affiliated licensees within the real estate brokerage. A licensee cannot disclose, except to the licensee's designated broker, information made confidential by request or instructions of the client

the licensee is representing or otherwise confidential by statute or rule, except information allowed by this chapter or mandated to be disclosed by law.

2012.6(1) The designated broker may want to include in the written company policy some or all of the appointed agents within the brokerage and may want to include the procedure by which the appointment of the agent or agents is made.

2012.6(2) The designated broker may decide that since both seller and buyer, or landlord and tenant, brokerage relationships are being offered to consumers by the broker's company, only the affiliated licensee who, on behalf of the designated broker, entered into the listing agreement with the seller or leasing agreement with the landlord will represent the seller or landlord as that client's agent. In that scenario, other licensees affiliated with the designated broker may represent buyers or tenants as their agents in any transactions dealing with the subject property.

2012.6(3) The designated broker may decide that since both seller and buyer, or landlord and tenant, brokerage relationships are being offered to consumers by the broker's company, only the affiliated licensee who, on behalf of the designated broker, entered into the buyer representation agreement with the buyer or leasing agreement with the tenant will represent the buyer or tenant as that client's agent. In that scenario, other licensees affiliated with the designated broker may represent sellers or landlords as their agents in any transactions dealing with the subject property.

2012.6(4) If any seller, landlord, buyer, or tenant who is a client of the broker refuses to sign and consent to the appointed agent within the brokerage appointed by that same broker for the other party to the transaction, then the broker and licensees affiliated with the broker cannot act as an appointed agent for that other party.

[ARC 7774C, IAB 4/17/24, effective 5/22/24; ARC 9478C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2012.7(543B) Appointed agent procedures and disclosure.

2012.7(1) Prior to entering into a brokerage agreement, a real estate brokerage notifies a client in writing of the real estate brokerage's appointed agent policy and those affiliated licensees in accordance with Iowa Code section 543B.59(1). The appointed agent disclosure includes, at a minimum, the following provisions:

- a.* The name of the appointed agent(s);
- b.* A statement that the appointed agent will be representing the client as the client's agent and will owe the client duties as set forth in Iowa Code section 543B.56(1) and 543B.56(2);
- c.* A statement that the brokerage may be representing both the seller and the buyer in connection with the sale or purchase of real estate;
- d.* A statement that other affiliated licensees may be appointed during the term of the brokerage agreement should the appointed agent not be able to fulfill the terms of the brokerage agreement or as by agreement between the designated broker and the client. An appointment of another affiliated licensee or an additional affiliated licensee does not relieve the first appointed agent of any of the duties owed to the client. At any time of the appointment of the new or additional agents, the designated broker complies with the provisions of this rule; and
- e.* A provision for the client to consent or not consent in writing to the appointment.

2012.7(2) Implementation of the appointed agent within a brokerage relationship. Any broker may elect to offer the appointed agent relationship. The broker cannot implement the use of the relationship until such time as the broker has fully complied with all Iowa laws and commission rules.

a. The broker cannot, without the written consent of the clients, appoint an affiliated licensee to act as an appointed agent in any transaction involving a written exclusive single agent or dual agent brokerage agreement that was in effect prior to the broker's implementing the appointed agent relationship.

b. If the client of an appointed agent wants to consider a property on which the broker has a prior existing exclusive single agent or dual agent brokerage agreement, the broker cannot allow

the use of the appointed agent without first obtaining the written consent of that particular seller or landlord to the appointed agent relationship.

c. If the written consent of the client to allow the appointed agency relationship is not given or cannot be obtained, the broker refers the client of the appointed agent to another broker for representation at least for the purpose of considering such property.

2012.7(3) A designated broker cannot be considered to be a dual agent solely because the designated broker makes an appointment under this rule, except that any licensee who, with prior written consent of all parties, personally represents both the seller and buyer or both the landlord and tenant in a transaction is a dual agent and needs to comply with the rules governing dual agents.

2012.7(4) Appointed agent and designated broker responsibilities.

a. A designated broker appointing an affiliated licensee(s) to act as an agent of a client takes ordinary and necessary care to protect confidential information disclosed by the client to the appointed agent.

b. An appointed agent may disclose to the brokerage's designated broker, or a designee specified by the designated broker, confidential information of a client for the purpose of seeking advice or assistance for the benefit of the client in regard to a possible transaction, or to comply with the broker's supervisory duties. Confidential information is treated as such by the designated broker or other specified representative of the broker and is not disclosed unless otherwise obligated by Iowa law and related commission rules or requested or permitted in writing by the client who originally disclosed the confidential information.

c. If a designated broker elects to use the appointed agent within a firm authority set forth in Iowa Code section 543B.59, and when the affiliated licensee appointed also acts in a supervisory capacity under the designated broker, such as branch managers, sales managers and the like, these appointed licensees may be treated in the same manner as the designated broker for purposes of determining dual agency under Iowa Code section 543B.59(2), only if the designated broker authorizes and provides for such supervisory positions in the written company policy.

(1) A designated broker may elect to authorize and appoint an affiliated licensee in a supervisory capacity to supervise and assist licensees appointed to exclusively represent a seller or landlord in a transaction.

(2) A designated broker may elect to authorize and appoint an affiliated licensee in a supervisory capacity to supervise and assist licensees appointed to exclusively represent a buyer or tenant in a transaction.

(3) A licensee in a supervisory capacity that is authorized and appointed to supervise and assist licensees appointed to represent a seller or landlord, or buyer or tenant, exclusively, have the same duties, obligations, and responsibilities as the designated broker.

(4) The use of an authorized appointed agent does not relieve the designated broker of duties, obligations, and responsibilities mandated by law or rules.

2012.7(5) Licensee's duty to designated broker or designee. A licensee keeps the brokerage's designated broker or that broker's designee fully informed of all activities conducted on behalf of the brokerage and notifies the designated broker or that broker's designee of any other activities that might impact on the responsibility of the designated broker or that broker's designee.

[ARC 7774C, IAB 4/17/24, effective 5/22/24; ARC 9478C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

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

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[Filed ARC 7774C (Notice ARC 7453C, IAB 1/10/24), IAB 4/17/24, effective 5/22/24]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2013
TRUST ACCOUNTS AND CLOSINGS

[Prior to 9/4/02, see 193E—Ch 1]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 13]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2013.1(543B) Trust account. All earnest payments, all rents collected, property management funds, and other trust funds received by the broker in such capacity or broker associate or salesperson on behalf of the broker's client are deposited in a trust account maintained by the broker in an identified trust account, with the word "trust" in the name of the account, in a federally insured depository institution and, for the purposes of this rule, may be referred to as the "depository."

2013.1(1) All money belonging to others received by the broker, broker associate or salesperson on the sale, rental, purchase, or exchange of real property located in Iowa are trust funds and are deposited in a trust account as directed by the principals to a transaction constituting dealing in real estate. This includes, but is not limited to, receipts from property management contracts; rental or lease contracts; advance fee contracts; escrow contracts; collection contracts; earnest money contracts; or money received by a broker for future investment or other purpose, except a nonrefundable retainer need not be placed in an escrow account if specifically provided for in the written agreement between the broker and the broker's principal.

a. All trust funds are deposited into the trust account no later than five banking days after the date indicated on the document that the last signature of acceptance of the offer to purchase, rent, lease, exchange, or option is obtained unless otherwise specified in the contract.

b. Money belonging to others cannot be invested in any type of fixed-term maturity account, security or certificate without the written consent of the party or parties to whom the money belongs.

c. A broker cannot commingle personal funds in a trust account unless authorized by Iowa Code section 543B.46(4).

The broker ensures that personal funds are deposited to cover bank service charges as specified in Iowa Code section 543B.46 and that at no time are trust moneys used to cover any charges. Upon notification that the broker's personal funds are not sufficient to cover service charges initiated by the bank that are above the normal maintenance charges, the broker deposits personal funds to correct the deficiency within 15 calendar days of the closing date of that bank statement.

d. Money held in the trust account, which becomes due and payable to the broker, is promptly withdrawn by the broker.

e. The broker cannot use the trust account as a business operating account or for personal use. Commissions, salaries, related items and normal business expenses are not disbursed directly from the trust account.

2013.1(2) As authorized by Iowa Code section 543B.46(1), all interest earned on the trust account is transferred on a calendar quarter basis to the state. The amount to be remitted to the state will be the amount of interest earned less any service charges directly attributable to the criteria of maintaining an interest-bearing account and of remitting the interest to the state. The broker may have the depository remit the interest directly or the broker may remit the interest but, in either case, it is the responsibility of the broker to see that the interest is remitted.

a. If the interest is remitted by the broker, the broker should use the commission-approved Real Estate Interest Remittance Form and include a copy of the applicable bank statement(s) showing the interest paid and the service charges attributable to maintaining the account.

b. If the interest is remitted by the broker, the broker mails the interest remittance check and mandatory documentation to:

The State of Iowa
c/o Bankers Trust Company
P.O. Box 4686
Des Moines, Iowa 50306

c. The depository should use the name “Iowa Finance Authority” and the federal tax identification number (TIN) 52-1699886 on the 1099 reporting form when reporting interest to the IRS.

d. The depository should send the 1099 reporting form to:

Iowa Finance Authority
2015 Grand Avenue
Des Moines, Iowa 50312

e. If the property management or rental account is interest-bearing, the interest is transferred on a calendar quarter basis to the state unless there is a written agreement paying the interest to the property owner.

f. A broker enters into a written agreement to pay interest to a buyer or seller in a transaction, or to a third party if requested by the parties to the contract and agreed to by the broker, if the client’s trust funds can earn net interest. In determining whether a client can earn net interest on funds placed in trust, the broker takes into consideration all relevant factors including the following:

(1) The amount of interest that the funds would earn during the period in which they are reasonably expected to be deposited;

(2) The cost of establishing and administering an individual interest-bearing trust account in which the interest would be transmitted to the client, including any needed tax forms; and

(3) The capability of the financial institution to calculate and pay interest to individual clients through subaccounting or otherwise.

2013.1(3) With disclosure to and the written agreement of all parties, a trust account may bear interest to be disbursed to (1) the buyer or seller involved in a real estate purchase, sale or exchange transaction, or (2) the property owner, if the property management or rental contract contains this specific provision, or (3) as otherwise specifically allowed or provided in Iowa Code sections 562A.12(2) and 562B.13(2), or (4) a third party if requested by the parties to the contract and agreed to by the broker. Disbursements of interest on trust funds are subject to all provisions of law that obligate a broker to safeguard and account for the handling of funds of others.

2013.1(4) Receipts from property management and rental account transactions may be deposited in a trust account separate from real estate transaction funds. If separately maintained, this account does not need to be an interest-bearing account.

a. The broker provides to the broker’s client a complete accounting of all moneys received and disbursed from the trust account(s) not less often than annually.

b. A broker may only utilize a separate property management or rents trust account for those moneys received by a broker pursuant to a written property management or rental agreement.

2013.1(5) A broker is needed to open and maintain one or more trust accounts if the broker is in the practice of depositing funds in a trust account. For each separate trust account opened, the broker files with the commission a written Consent to Examine and Audit Trust Account form, which irrevocably authorizes the commission to examine and audit the trust account. The form of consent is prescribed by and available from the commission and includes the account names and number and the name and address of the depository.

a. If the broker is not in the practice of depositing trust funds in a trust account, the broker files an affidavit with the commission on a form prescribed by and available from the commission.

b. If trust funds are received by the broker after filing an affidavit, the broker immediately opens a trust account and files the appropriate Consent to Examine and Audit Trust Account form with the commission.

c. As provided by Iowa Code section 543B.46(3), a consent to examine is not necessary for a separate farm business operating account or a separate property management account.

2013.1(6) Each broker obligated to maintain a trust account maintains at all times a record of each account, as mandated by these rules, in the place of business, consisting of at least the following:

a. A record called a journal which records in chronological order all receipts and disbursements of moneys in the trust account.

(1) For receipts, the journal for each trust account includes the date, name of depositor, the check number and the amount deposited, and the name of principal or identify the property.

(2) For disbursements, the journal for each trust account includes the date, name of payee, name of principal or identify the property, the check number and the amount disbursed.

(3) The journal provides a means for monthly reconciliation on a written worksheet of the general ledger balance with the bank balance and with the individual ledger accounts to ensure agreement.

b. Real estate sales transactions additionally need an individual ledger account identified by the property or the principal, which records all receipts and disbursements of the transaction and clearly separates the transaction from all others. The individual ledger account includes the date, check number, amount, name of payee or depositor or explanation of activity with a running balance.

c. Property management trust account records additionally include an individual ledger account for each tenant, identifying the tenant's rental unit and security deposit and including all receipts and disbursements together with check number and date. The journal for each account is maintained as an owner's ledger account for all properties owned by each owner showing receipts and disbursements applicable to each property managed.

(1) All disbursements are documented by bids, contracts, invoices or other appropriate written documentation.

(2) The running balance may be determined at the time of monthly reconciliation.

d. Trust account supporting documents include, but are not limited to, the following:

(1) Bank statements;

(2) Canceled checks;

(3) Copies of contracts, listing, sales, rental and leasing;

(4) Closing statements;

(5) Pertinent correspondence; and

(6) Any additional items necessary to verify or explain an entry.

2013.1(7) Funds, including interest on trust funds, are only disbursed from the trust account as provided in Iowa Code section 543B.46(1) and by the terms and conditions of the contract or escrow agreement. No funds are disbursed from the trust account prior to the closing, or other than as provided by the terms of the escrow agreement, without the informed written consent of all the parties. In the event of a dispute over the return or forfeiture of an earnest money deposit or the disbursement of an escrow deposit held by a broker, the broker continues to hold the deposit in the trust account until one of the following conditions is met:

a. The broker is in receipt of a written release from all parties to the transaction consenting to the disposition of the deposit or escrow funds; or

b. The broker is in receipt of a final judgment of the court directing the disposition of the deposit or escrow funds; or

c. There is a final decision of a binding alternative dispute resolution process, or mediation directing the disposition of the deposit or escrow funds; or

d. A civil court action is filed by one or more of the parties to determine the disposition of the deposit or escrow funds, at which time the broker may seek court authorization to pay the deposit or escrow funds into court.

2013.1(8) No funds are disbursed from the trust account prior to the closing without the informed written consent of all the parties to the transaction as provided in subrule 2013.1(7), except in accordance with this rule. Nothing in this rule obligates a broker to remove money from the broker's trust account when the disposition of such money is disputed by the parties to the transaction. The commission will not take disciplinary action against a broker who in good faith disburses trust account moneys pursuant to this rule.

a. In the absence of a pending civil court action or written agreement, it is not grounds for disciplinary action when, upon passage of 30 days from the date of the dispute, a broker disburses the earnest money deposit to a buyer, renter, or lessee in a transaction based upon a good faith decision

that a contingency has not been met, but disbursement is made only after the broker has given 30 days' written notice by certified mail to all parties concerned at their last-known addresses, setting forth the broker's proposed action and the grounds for the decision.

b. In the absence of a pending civil action or written agreement, it is not grounds for disciplinary action when, upon passage of six months from the date of the dispute, a broker disburses the earnest money deposit to a seller or landlord in a transaction based upon a good faith decision that the buyer, renter, or lessee has failed to perform as agreed, but disbursement is made only after the broker has given 30 days' written notice by certified mail to all parties concerned at their last-known addresses, setting forth the broker's proposed action and grounds for the decision.

c. If a buyer or seller, or a landlord or lessee, or a renter demands the return of the earnest money deposit, the broker consults with the other party who may agree or disagree with the return.

2013.1(9) Under no circumstances is the broker entitled to withhold any portion of the earnest money when a transaction fails to consummate even if a commission is earned. The earnest money is disposed of as provided in subrule 2013.1(7), 2013.1(8), or 2013.1(10), and the broker pursues any claim for commission or compensation against the broker's client.

2013.1(10) Interpleader. Anytime the broker in good faith believes that the parties disputing the return of the deposit will not agree on the disposition of the deposit or file a civil court action to determine the disposition of the deposit, then the broker may elect to file an interpleader action with the appropriate court pursuant to Iowa Rules of Civil Procedure and pay the deposit into court. The broker may, in filing such an interpleader court action:

a. Attempt to claim a part of the deposit pursuant to the listing contract with the seller, if the seller is successful in the suit.

b. Disclaim any part of the deposit and request the court to restrain the buyer and the seller from naming the broker in the civil suit and order them to litigate their claims to the deposit.

2013.1(11) A trust account may bear interest to be disbursed to the buyers or sellers or to a third party if requested by the parties to the contract and agreed to by the broker with the written approval of all parties to the contract or to the owner if the trust account is for a property management account and the management contract so specifies, or as otherwise specifically allowed or provided in Iowa Code sections 562A.12(2) and 562B.13(2). The account is a separate account from the account(s) which is to accrue interest to the state. Interest is disbursed to the owner or owners of the funds at the time of settlement of the transaction or as agreed to in the management contract and is properly accounted for on closing statements. A broker does not disburse interest on trust funds except as provided in subrules 2013.1(3) and 2013.1(7). Service charges for the account are a business expense of the broker and are not deducted from the proceeds.

2013.1(12) Property management account funds may be withdrawn at any time for the purpose of returning the funds to the payee in accordance with the terms of the contract or receipt.

2013.1(13) Property management funds may be withdrawn when and if the broker reasonably believes, from evidence available, that the tenant has obtained a rental or lease through information supplied by or on behalf of the broker.

2013.1(14) Trust funds that are not traceable to any individual for disbursement from the trust account are unclaimed property. In accordance with Iowa Code chapter 556, after three years, unclaimed trust funds are reported and remitted to the Treasurer, State of Iowa, Unclaimed Property Division.

[ARC 7775C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2013.2(543B) Closing transactions. It is mandatory for every broker to deliver to the seller in every real estate transaction, at the time the transaction is consummated, a complete detailed statement, showing all of the receipts and disbursements handled by the broker. Also, the broker at the same time delivers to the buyer a complete statement showing all moneys received in the transaction from the buyer and how and for what the same were disbursed.

2013.2(1) In the event all funds being held by the broker for a transaction cannot be disbursed at the time of closing, the broker obtains an escrow agreement signed by both parties to the transaction which directs the broker regarding the future disbursement of the funds.

2013.2(2) The broker retains all trust account records and a complete file, which includes but is not limited to the records mandated by rule 481—2013.5(543B), on each transaction for a period of at least five years after the date of the closing. Records mandated by this rule may be retained as an electronic record as provided by rule 481—2013.5(543B).

2013.2(3) The listing broker is responsible for the closing even though the closing may be completed by another licensee.

2013.2(4) If the closing transaction is handled through an unlicensed escrow agent and the escrow agent renders a closing statement, the listing broker ensures that funds which the broker has received or paid as part of the transaction are accounted for properly.

2013.2(5) In the case of a cooperative sale between brokers, the listing broker may elect to close the transaction or, by prior agreement, authorize the selling broker to close.

a. If the listing broker so elects, the selling broker has the buyer make the earnest money check or money order payable to the listing broker and immediately delivers the earnest money check or money order along with the offer to purchase to the listing broker or listing agent.

b. Unless by prior agreement the listing broker has authorized the selling broker to close, the offer to purchase designates that the earnest money is held in trust by the listing broker.

c. Unless by prior agreement the listing broker has authorized the selling broker to close, when cash is accepted as earnest money by the selling agent, the selling agent deposits the money in the selling broker's trust account in accordance with commission rules, and then immediately transfers the earnest money deposit to the listing broker by issuing a check drawn on the selling broker's trust account.

2013.2(6) Any means other than cash or an immediately cashable check are not accepted as earnest money unless that fact is communicated to the seller prior to the acceptance of the offer to purchase, and is stated in the offer to purchase.

2013.2(7) Brokers acting as agents for the buyer in a specific real estate transaction have the same criteria for retention of copies as stated in this rule, except that a buyer's agent who is not a party to the listing contract is not obligated to retain a copy of the listing contract or the seller's settlement statement.

2013.2(8) Iowa Court Rule 37.5, limited real estate practice. All Iowa real estate licensees should be aware that Iowa Court Rule 37.5 authorizes nonlawyers to select, prepare, and complete certain legal documents incident to residential real estate transactions of four units or less. The preparation of documents beyond that authorized by this court rule may constitute the unauthorized practice of law.

[ARC 7775C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2013.3(543B) Salesperson cannot handle closing. A salesperson cannot handle the closing of any real estate transaction except under the direct supervision or with the consent of the employing broker.

[ARC 7775C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2013.4(543B) Consent to return earnest money not necessary. When an offer to purchase is withdrawn or the acceptance is revoked without liability pursuant to Iowa Code chapter 558A, any earnest money deposit is promptly returned to the buyer without delay. The seller's consent and agreement to release the funds is not necessary. A copy of the written revocation or withdrawal is retained with the trust account supporting documents.

[ARC 7775C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2013.5(543B) File recordkeeping. Every broker retains for a period of at least five years true copies of all business books; accounts, including voided checks; records; contracts; closing

statements; disclosures; signed documents; the listing; any offers to purchase; and all correspondence relating to each real estate transaction that the broker has handled and each property managed. The records are made available for reproduction and inspection by the commission, staff, and commission-authorized representatives at all times during usual business hours at the broker's regular place of business. If the brokerage closes, the records are made available for reproduction and inspection by the commission, staff, and commission-authorized representatives upon request.

2013.5(1) Contracts and other documents that have been changed or altered to the point where the language is unreadable and faxed contracts and documents in which the language is unreadable are not acceptable records and are redrafted and signed by the parties.

2013.5(2) Copies of unreadable documents are not acceptable as true copies of the originals regardless of the medium.

2013.5(3) Electronic records. The files, records, and other documents mandated by this chapter may be stored in electronic format for convenience and efficiency in a system for electronic record storage, analysis, and retrieval.

a. A record obligated by this chapter may be retained as an electronic record only if the record storage medium can be easily accessed and the records can be readily retrieved and transferred to a legible printed form upon request.

b. The scanning or electronic generation of a record is monitored to ensure that the copy is clear, legible and true before the original is shredded.

c. Once the original record is transferred to the appropriate electronic storage medium consistent with this rule, the commission will no longer need the retention of the record in its original medium. For the purposes of this chapter, electronic records are considered the same as originals.

[ARC 7775C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2013.6(543B) Licensee acting as a principal. When a licensee is acting in the capacity of a real estate broker, broker associate or salesperson and is also a principal in the sale, lease, rental or exchange of property owned by the licensee, all payments, rent, or security deposits received from the lessee, renter or buyer are deposited into the broker's trust account. The use of the broker's trust account is not needed if all of the following exist:

1. The sale, rental, or exchange is strictly, clearly and completely a "by owner" transaction and there is not a listing or brokerage agreement;
2. No commission or other compensation is paid to or received by the licensee; and
3. The licensee does not function throughout the transaction in any capacity requiring a real estate license.

[ARC 7775C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2014
SELLER PROPERTY CONDITION DISCLOSURE

[Prior to 9/4/02, see 193E—Ch 1]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 14]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2014.1(543B) Property condition disclosure. The criteria of this chapter applies to transfers of real estate subject to Iowa Code chapter 558A. For purposes of this chapter, “transfer” means the same as Iowa Code section 558A.1(5) and “agent” means the same as Iowa Code section 558A.1(1).

2014.1(1) Additional disclosure. Nothing in this rule is intended to prevent any additional disclosure or to relieve the parties or agents in the transaction from making any disclosure otherwise mandated by law or contract.

2014.1(2) Licensee responsibilities to seller. At the time a licensee obtains a listing, the listing licensee obtains a completed disclosure signed and dated by each seller represented by the licensee.

a. A licensee representing a seller delivers the executed statement to a potential buyer, a potential buyer’s agent, or any other third party who may be representing a potential buyer, prior to the seller’s making a written offer to sell or the seller’s accepting a written offer to buy.

b. The licensee representing a seller attempts to obtain the buyer’s signature and date of signature on the statement and provides the seller and the buyer with fully executed copies of the disclosure and maintains a copy of the written acknowledgment in the transaction file. If the licensee is unable to obtain the buyer’s signature, the licensee obtains other documentation establishing delivery of the disclosure and maintains the written documentation in the transaction file.

c. If the transaction closes, the listing broker maintains the completed disclosure statement for a minimum of five years.

d. The executed disclosure statement is delivered to the buyer(s) or the buyer’s agent in accordance with Iowa Code section 558A.2(2). If there is more than one buyer, any one buyer or buyer’s agent may accept delivery of the executed statement.

2014.1(3) Licensee responsibilities to buyer. A licensee representing a buyer in a transfer notifies the buyer of the seller’s obligation to deliver the property disclosure statement.

a. If the disclosure statement is not delivered when mandated, the licensee notifies the buyer that the buyer may revoke or withdraw the offer and follows Iowa Code section 558A.2(2).

b. Reserved.

2014.1(4) Inclusion of written reports. A written report or opinion prepared by a person qualified to render the report or opinion may be included in a disclosure statement. A report may be prepared by those authorized by Iowa Code section 558A.4(1) “b.”

a. The seller identifies the necessary disclosure items which are to be satisfied by the report.

b. If the report is prepared for the specific purpose of satisfying the disclosure criteria, the preparer of the report follows Iowa Code section 558A.4(1) “b.”

c. A licensee representing a seller provides the seller with information on the proper use of reports if reports are used as part of the disclosure statement.

2014.1(5) Amended disclosure statement. A licensee’s obligations with respect to any amended disclosure statement are the same as the licensee’s obligations with respect to the original disclosure statement. A disclosure statement is amended if authorized by Iowa Code section 558A.3(2).

2014.1(6) Acknowledgment of receipt of disclosure statement by electronic means. Whether or not a licensee assists in a real estate transaction, electronic delivery of any property disclosure statement mandated by Iowa Code chapter 558A is not deemed completed until written acknowledgment of receipt is provided to the transferor by the transferee or the transferee’s agent. Acceptable acknowledgment of receipt includes return of a fully executed copy of the property disclosure statement to the transferor by the transferee or the transferee’s agent; or a letter, electronic mail, text message, or other written correspondence to the transferor from the transferee or the transferee’s agent acknowledging receipt. A computer-generated read receipt, facsimile delivery

confirmation, or other automated return message is not deemed acknowledgment of receipt for purposes of this rule.

2014.1(7) Minimum disclosure statement contents for all transfers. All property disclosure statements, whether or not a licensee assists in the transaction, contain at a minimum the information mandated by the following sample statement. No particular language is necessary in the disclosure statement provided that the necessary disclosure items are included and the disclosure complies with Iowa Code chapter 558A. To assist real estate licensees and the public, the commission recommends use of the following sample language:

RESIDENTIAL PROPERTY SELLER DISCLOSURE STATEMENT

Property address: _____

PURPOSE:

Use this statement to disclose information as mandated by Iowa Code chapter 558A. This law obligates certain sellers of residential property that includes at least one and no more than four dwelling units to disclose information about the property to be sold. The following disclosures are made by the seller(s) and not by any agent acting on behalf of the seller(s).

INSTRUCTIONS TO SELLER(S):

1. Seller(s) completes this statement. Respond to all questions, or attach reports allowed by Iowa Code section 558A.4(2);
2. Disclose all known conditions materially affecting this property;
3. If an item does not apply to this property, indicate that it is not applicable (N/A);
4. Please provide information in good faith and make a reasonable effort to ascertain the necessary information. If the necessary information is **unknown** or is **unavailable** following a reasonable effort, use an **approximation** of the information, or indicate that the information is **unknown (UNK)**. All **approximations** are identified as **approximations (AP)**;
5. Additional pages may be attached as needed;
6. Keep a copy of this statement with your other important papers.

1. Basement/Foundation: Any known water or other problems?	Yes ☐	No ☐
2. Roof: Any known problems?	Yes ☐	No ☐
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
3. Sewer System: Any known problems?	Yes ☐	No ☐
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
4. Heating System(s): Any known problems?	Yes ☐	No ☐
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
5. Central Cooling System(s): Any known problems?	Yes ☐	No ☐
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
If N/A check here ☐		
6. Plumbing System(s): Any known problems?	Yes ☐	No ☐
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
7. Electrical System(s): Any known problems?	Yes ☐	No ☐
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
8. Pest Infestation (e.g., termites, carpenter ants): Any known problems?	Yes ☐	No ☐
If yes, date(s) of treatment: ____/____/____		
Any known structural damage?	Yes ☐	No ☐
If yes, date(s) of repairs/replacement: ____/____/____		
9. Asbestos: Any known to be present in the structure?	Yes ☐	No ☐
If yes, explain: _____		
10. Radon: Any known tests for the presence of radon gas?	Yes ☐	No ☐

If yes, date of last report: ____/____/____
and results: _____

11. Lead-Based Paint: Any known to be present in the structure?	Yes ☐	No ☐
12. Flood Plain: Do you know if the property is located in a flood plain?	Yes ☐	No ☐
13. Are there currently, or have there ever been, any lead water service lines present?	Yes ☐	No ☐
	Unknown ☐	

If yes, please provide more information: _____

14. Zoning: Do you know the zoning classification of the property?	Yes ☐	No ☐
If yes, what is the zoning classification? _____		
15. Covenants: Is the property subject to restrictive covenants?	Yes ☐	No ☐
If yes, attach a copy or state where a true, current copy of the covenants can be obtained: _____		

16. Shared or Co-Owned Features: Any features of the property known to be shared in common with adjoining landowners, such as walls, fences, roads, and driveways whose use or maintenance responsibility may have an effect on the property?	Yes ☐	No ☐
Any known "common areas" such as pools, tennis courts, walkways, or other areas co-owned with others, or a Homeowner's Association which has any authority over the property?		
	Yes ☐	No ☐
17. Physical Problems: Any known settling, flooding, drainage or grading problems?	Yes ☐	No ☐
18. Structural Damage: Any known structural damage?	Yes ☐	No ☐
19. Well and Pump: Any known problems?	Yes ☐	No ☐
If N/A check here ☐		
Any known repairs?	Yes ☐	No ☐
If yes, date of repairs/replacement: ____/____/____		
Any known water tests?	Yes ☐	No ☐
If yes, date of last report: ____/____/____		
and results: _____		
20. Septic Tanks/Drain Fields: Any known problems?	Yes ☐	No ☐
If N/A check here ☐		
Location of tank: _____		
Date tank last cleaned: ____/____/____		

You need to explain any "YES" response(s) above. Use the back of this statement or additional sheets as necessary: _____

SELLER(S) DISCLOSURE:

Seller(s) discloses the information regarding this property based on information known or reasonably available to the Seller(s).

The Seller(s) has owned the property since ____/____/____. The Seller(s) certifies that as of the date signed this information is true and accurate to the best of my/our knowledge.

Seller(s) acknowledges that Buyer(s) be provided with the "Iowa Radon Home-Buyers and Sellers Fact Sheet" prepared by the Iowa Department of Health and Human Services.

Seller _____	Seller _____
Date ____/____/____	Date ____/____/____

BUYER(S) ACKNOWLEDGMENT:

Buyer(s) acknowledges receipt of a copy of this Real Estate Disclosure Statement. This statement is not intended to be a warranty or to substitute for any inspection Buyer(s) may wish to obtain.

Buyer(s) acknowledges receipt of the "Iowa Radon Home-Buyers and Sellers Fact Sheet" prepared by the Iowa Department of Health and Human Services.

Buyer _____ Buyer _____
Date ____/____/____ Date ____/____/____

This rule is intended to implement Iowa Code chapters 17A, 272C, 543B, and 558A.

[ARC 7776C, IAB 4/17/24, effective 5/22/24; ARC 0027D, IAB 1/21/26, effective 4/22/26; Editorial change: IAC Supplement 6/10/26]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2015
PROPERTY MANAGEMENT

[Prior to 9/4/02, see 193E—Ch 1]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 15]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2015.1(543B) Property management. A licensee cannot rent or lease real estate, offer to rent or lease real estate, negotiate or offer or agree to negotiate the rental or leasing of real estate, list or offer to list real estate for the leasing or rental of real estate, assist or direct in the negotiation of any transaction calculated or intended to result in the leasing or rental of real estate or show property to prospective renters or lessees of real estate unless the licensee's broker holds a current written property management agreement or other written authorization signed by the owner of the real estate or the owner's authorized agent.

2015.1(1) Every property management agreement or other written authorization between a broker and an owner of real estate includes, but is not limited to, the following:

- a.* Proper identification of the property to be managed.
- b.* All terms and conditions under which the property is to be managed and the powers and authority given to the broker by the owner.
- c.* Terms and conditions under which the broker will remit property income to the owner and when the broker will provide periodic written statements of property income and expenses to the owner, which is done no less than annually.
- d.* Which payments of property-related expenses are to be made by the broker to third parties.
- e.* Amount of fee or commission to be paid to the broker and when it will be paid.
- f.* Amount of security deposits and prepaid rents to be held by the broker or the owner.
- g.* Effective date of the agreement.
- h.* Terms and conditions for termination of the property management agreement by the broker or the owner of the property.
- i.* Signatures of the broker and owner or the owner's authorized agent.

2015.1(2) The licensee gives the owner or the owner's authorized agent a legible copy of every written property management agreement or written authorization at the time the signature of the owner is obtained, and the licensee's broker retains a copy.

2015.1(3) A licensee who is managing the leasing or rental of real estate may act as an agent in the sale or exchange of that real estate only if the property management agreement clearly grants the specific authorization and contains all of the necessary elements for a listing as set forth in rule 481—2011.1(543B) or if a separate listing agreement is secured.

2015.1(4) The broker deposits all funds received on behalf of the owner, by no later than five banking days after receipt of the funds, into a trust account maintained by the broker, under the broker's control and in compliance with Iowa Code section 543B.46 and rule 481—2013.1(543B).

2015.1(5) If the property management agreement is terminated or transferred for any reason, the property manager:

- a.* Terminates the management activities of the property as provided in the agreement and except as otherwise provided by the agreement;
- b.* Notifies the owner and any tenants of the property of the termination;
- c.* Provides the owner, not later than 30 days after the effective date of the termination, with any unobligated funds due the owner under the agreement and not later than 60 days after the effective date of the termination, provides the owner with a final accounting of the owner's ledger account, the amount of any obligated funds held in the property manager's client trust account under the agreement, a statement that explains why obligated funds are being held by the property manager and a statement of when and to whom the obligated funds will be disbursed by the property manager;
- d.* May disburse any unobligated funds only to the owner or, with the proper written authorization of the owner, to another property manager designated in writing by the owner;

e. Immediately notifies each tenant that the conditionally refundable deposit will be transferred to the owner or to a new property manager and, at the same time, provides the name and address of the owner or the new property manager to whom these deposits will be transferred.

2015.1(6) If any of the unobligated funds held by the property manager under the terminated agreement represent tenants' conditionally refundable deposits received from current tenants, the property manager:

a. Cannot expend any tenant's conditionally refundable deposits for payment of any expenses or fees not otherwise allowed by the tenant's rental or lease agreements, and

b. If any tenant terminates tenancy at the same time as or prior to the termination of the management of the rented or leased property, the licensee completes any final accounting, inspection or other procedure obligated by the tenant's rental or lease agreement, by the Uniform Residential Landlord and Tenant Law, Mobile Home Parks Residential Landlord and Tenant Law, or by the property management agreement, unless the owner directs otherwise in writing.

2015.1(7) Financial dealings under a property management agreement are conducted subject to the following:

a. A check is not issued or presented for payment prior to sufficient funds being in the owner's account to cover the check.

b. Transfers of funds between two or more accounts maintained for the same owner may be made if proper entries are made on the ledgers of the accounts affected and the broker maintains the specific written authorization of the owner.

Transfers of funds between an individual owner's accounts are done by writing billings and receipts debiting and crediting the appropriate accounts. Transfers are not done by ledger entries alone.

c. The broker cannot withdraw, pay or transfer money from the owner's account in excess of the remaining credit balance at the time of withdrawal, payment or transfer.

d. Management fees are withdrawn from the owner's account at least once a month unless the agreement provides otherwise. The fees are identified by property name or account number for which the fees were earned and withdrawn by the broker and deposited into the broker's business operating account. Fees are not paid directly from the owner's trust account to the broker.

e. Conditionally refundable deposits are placed in a trust account until refund is made or until all or a portion of the deposit accrues to the owner under the tenant's agreement.

If refundable deposits are not maintained in a separate trust account, the running balance of the account does not, at any time, go below the total of the refundable deposits being held in the account.

f. The total of balances of the individual property management accounts of the broker equals the balance shown on the journal, the account ledgers, and the reconciled bank balance of the broker.

All accounts and records are in compliance with Iowa Code section 543B.46 and rule 481—2013.1(543B).

g. Except as otherwise specifically allowed or provided in Iowa Code sections 562A.12(2) and 562B.13(2), if refundable deposits and funds are received from others pursuant to a property management agreement, deposited in an interest-bearing trust account, and there is not a separate written agreement to pay the interest earned to the owner or tenant, the interest is paid to the state pursuant to Iowa Code section 543B.46. The property manager does not receive or benefit from the interest.

The written approval agreement is signed by each party having an interest in the funds, fully disclosing how the funds are to be handled by the property manager, who will benefit from the interest earnings, how and when interest earnings will be paid and any limitations that may be provided for on the withdrawal of the funds deposited in the interest-bearing trust account.

This rule is intended to implement Iowa Code chapters 17A, 272C, and 543B.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2016
PRELICENSE EDUCATION AND CONTINUING EDUCATION

[Prior to 9/4/02, see 193E—Ch 3]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 16]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2016.1(543B) Definitions. For the purpose of these rules, the following definitions apply:

“*Affirmative marketing*” means the entire scope of social laws and ethics that are concerned with civil rights as they apply especially to housing and to the activities of real estate licensees.

“*Approved program, course, or activity*” means a continuing education program, course, or activity meeting the standards set forth in these rules which has received advance approval by the commission pursuant to these rules.

“*Approved provider*” means a person or an organization that has been approved by the commission to conduct continuing education activities pursuant to these rules.

“*Broker*” means any person holding an Iowa real estate broker license as defined in Iowa Code section 543B.3.

“*Commission*” means the real estate commission.

“*Continuing education*” means education needed as a condition to license renewal.

“*Credit hour*” means the value assigned by the commission to a prelicense or continuing education program, course, or activity.

“*Distance learning*” or “*online learning*” means a planned teaching/learning experience with a geographic separation of student and instructor that utilizes a wide spectrum of technology-based systems, including computer-based instruction, to reach learners at a distance. Home-study courses that include written materials, exercises and tests mailed to the provider for review are included in this definition.

“*Guest speaker*” means an individual who teaches a real estate education course on a one-time-only or very limited basis and who possesses a unique depth of knowledge and experience in the subject matter the individual proposes to teach.

“*Hour*” means 50 minutes of instruction.

“*Inactive license*” means the same as defined in Iowa Code section 543B.5(12).

“*Licensee*” means the same as defined in Iowa Code section 543B.5(13).

“*Live instruction*” means an educational program delivered in a traditional classroom setting or by electronic means whereby the instructor and student have real-time visual and audio contact to carry out their essential tasks.

“*Prelicense course*” means instruction consisting of one or more courses meeting the criteria of Iowa Code section 543B.15.

“*Salesperson*” means any person holding an Iowa real estate salesperson license as defined in Iowa Code section 543B.5(3).

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.2(543B) Salesperson prelicense criteria.

2016.2(1) *Mandatory course of study.*

a. The mandatory course of study for the salesperson licensing examination consists of 60 live instruction or distance/online learning hours of real estate principles and practices to comply with the criteria of Iowa Code section 543B.15. The curriculum includes, but is not limited to, the following subjects:

Introduction to Real Estate and Iowa License Law.	12 hours
Ownership, Encumbrances, Legal Descriptions, Transfer of Title and Closing.	12 hours
Contracts, Agency and Antitrust.	12 hours
Valuation, Finance and Real Estate Math.	12 hours
Property Management/Leasing, Fair Housing, Environmental Risks	

and Health Issues. 12 hours

b. At the time of submission of an application, an applicant applying for an original salesperson license also provides evidence of the following live instruction courses: 12 hours of Developing Professionalism and Ethical Practices, 12 hours of Buying Practices and 12 hours of Listing Practices. All the necessary education is completed during the 12 months prior to the date the application is postmarked or received.

2016.2(2) *Completion of prelicense education.* Successful completion of the salesperson prelicense education includes passage of an examination(s) designed by the approved provider that is sufficiently comprehensive to measure the student's knowledge of all aspects of the course(s). Times allotted for examinations may be regarded as hours of instruction.

2016.2(3) *Substitution of courses.* Written requests for substitution of the salesperson prelicense education courses specified in subrule 2016.2(1) may be granted if the applicant submits evidence of successful completion of a course or courses which are substantially similar to the courses specified in subrule 2016.2(1). Courses completed more than 12 months prior to commission consideration for approval do not qualify for substitution.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.3(543B) Broker prelicense education criteria.

2016.3(1) *Mandatory course of study.* The mandatory course of study to take the broker examination consists of Iowa Code section 543B.15(7). Approved courses include the following subjects:

Contract Law and Contract Writing.	6 hours
Iowa Real Estate Trust Accounts.	6 hours
Principles of Appraising and Market Analysis.	6 hours
Real Estate Law and Agency Law.	6 hours
Real Estate Finance.	6 hours
Federal and State Laws Affecting Iowa Practice.	6 hours
Real Estate Office Organization, Administration and Human Resources.	12 hours
Real Estate Technology and Data Security.	6 hours
Ethics and Safety Issues for Brokers.	6 hours

2016.3(2) *Completion of prelicense education.* Successful completion of the broker prelicense education includes passage of an examination(s) designed by the approved provider that is sufficiently comprehensive to measure the student's knowledge of all aspects of the course(s). Times allotted for examinations may be regarded as hours of instruction.

2016.3(3) *Substitution of courses.* Written requests for substitution of the broker prelicense education courses specified in subrule 2016.3(1) may be granted if the applicant submits evidence of successful completion of a course or courses which are substantially similar to the courses specified in subrule 2016.3(1). Any course completed more than 24 months prior to commission consideration for approval does not qualify for substitution.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.4(543B) Continuing education criteria.

2016.4(1) All individual real estate licenses are issued for three-year terms, counting the remaining portion of the year of issue as a full year. All individual licenses expire on December 31 of the third year of the license term.

2016.4(2) As a criteria of license renewal in an active status, each real estate licensee completes a minimum of 36 hours of approved programs, courses or activities. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 18 hours from the previous renewal period. Licensees cannot carry over any hours toward the mandatory eight-hour law update course nor the four-hour ethics course. Approved courses in the following subjects are completed to renew a license to active status:

Law Update.	8 hours
Ethics.	4 hours
Electives.	24 hours

2016.4(3) During each three-year renewal period a course may be taken for credit only once. A course may be repeated for credit only if the course numbers and instructors are different.

2016.4(4) A maximum of 24 hours of continuing education may be taken by distance/online learning each three-year renewal period.

2016.4(5) A licensee unable to attend educational offerings because of a disability may make a written request to the commission setting forth an explanation and verification of the disability. Licensees making requests need to meet the definition of a person with a disability found in the Americans with Disabilities Act as amended by the ADA Amendments Act of 2008 (ADAAA).

2016.4(6) In addition to courses approved directly by the commission, the following will be deemed acceptable as continuing education:

a. Credits earned in a state which has a continuing education criteria for renewal of a license if the course is approved by the real estate licensing board of that state for credit for renewal. However, state-specific courses are not acceptable.

b. Courses sponsored by the National Association of Realtors (NAR) or its affiliates.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; ARC 9480C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2016.5(543B) Continuing education records. Applicants for license renewal pursuant to Iowa Code section 543B.15 certify that the number of hours of continuing education needed to renew a license was completed as described in rule 481—2016.4(543B).

2016.5(1) The commission will verify by random audit or on a test basis the education claimed by the licensee. It is the responsibility of the licensee to maintain records that support the continuing education claimed and the validity of the credits. Documentation is retained by the licensee for a period of six years after the effective date of the license renewal.

2016.5(2) It will not be acceptable for a licensee to include on a renewal application continuing education which has not yet been completed, is outside the renewal period, or for which prior approval or postapproval has not been previously granted.

2016.5(3) Failure to provide necessary evidence of completion of claimed education within 30 days of the written notice from the commission results in the license's being placed on inactive status. Prior to activating a license that has been placed on inactive status pursuant to this provision, the licensee submits to the commission satisfactory evidence that all necessary continuing education has been completed.

2016.5(4) Filing a false affirmation is prima facie evidence of a violation of Iowa Code section 543B.29(1).

[ARC 7778C, IAB 4/17/24, effective 5/22/24; ARC 9480C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2016.6(543B) Reactivating an inactive license. A license may be renewed without the necessary continuing education, but it is only renewed to an inactive status. Prior to reactivating a license that has been issued inactive due to failure to submit evidence of continuing education, the licensee submits evidence that all deficient continuing education hours have been completed. Licensees who complete continuing education hours in excess of the requirements for renewal may apply up to 50 percent of the required hours to the following renewal period. Licensees may apply a maximum of 18 hours from the previous renewal period. Licensees cannot carry over any hours toward the mandatory eight-hour law update course nor the four-hour ethics course.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; ARC 9480C, IAB 8/6/25, effective 9/10/25; Editorial change: IAC Supplement 6/10/26]

481—2016.7(543B) Full-time attendance. Successful completion of continuing education needs full-time attendance throughout the program, course or activity. A student who arrives late, leaves during class or leaves early does not receive a certificate.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.8(543B) Education criteria for out-of-state licensees. Subrule 2016.4(2) applies to every Iowa real estate licensee unless exempted by Iowa Code section 272C.2(5).

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.9(543B) Examination as a substitute for continuing education.

2016.9(1) A salesperson may satisfy all continuing education deficiencies by taking and passing the real estate salesperson examination. An authorization letter is obtained from the commission prior to scheduling the examination with the examination administrator.

a. If the salesperson takes and passes the salesperson examination within the six months immediately preceding the expiration of the license, the salesperson examination score report may be substituted for the necessary hours of continuing education credit for the current license term and will satisfy all previous deficiencies.

b. A salesperson who is otherwise qualified to be a broker and who passes the broker licensing examination is not needed to furnish evidence of credit for continuing education earned as a salesperson.

2016.9(2) A broker may satisfy all continuing education deficiencies by taking and passing the real estate broker examination. An authorization letter is obtained from the commission prior to scheduling the examination with the examination administrator. If the broker takes and passes the broker examination within the six months immediately preceding the expiration of the license, the broker examination score report may be substituted for the necessary hours of continuing education credits for the current license term and will satisfy all previous deficiencies.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.10(543B) Use of prelicense courses as continuing education.

2016.10(1) Salespersons and brokers may take up to 24 hours of the salesperson prelicense courses specified in subrule 2016.2(1) as continuing education. However, a newly licensed salesperson cannot use credits from the salesperson prelicense course(s) to meet the continuing education criteria of the first renewal term.

2016.10(2) Broker prelicense courses taken by a salesperson may be applied as continuing education for renewal of the salesperson license and also may be used as prelicense credit to qualify for a broker license.

2016.10(3) A broker may take broker prelicense courses as continuing education, but a newly licensed broker cannot use as continuing education credits from the prelicense courses taken to qualify for the broker license.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2016.11(543B) Requests for prior approval or postapproval of a course(s). A licensee seeking credit for attendance and participation in a course, program, or other continuing education activity that is to be conducted by a school not otherwise approved by the commission may apply for approval to the commission at least 21 days in advance of the beginning of the activity. The commission approves or denies the application in writing within 14 days of receipt of the application.

2016.11(1) The application for prior approval of a course or an activity includes the following information:

- a.* School or organization or person conducting the activity.
- b.* Location of the activity.
- c.* Title and brief description of the activity or title and course outline.
- d.* Credit hours requested.

- e.* Date of the activity.
- f.* Principal instructor(s).

2016.11(2) The application for postapproval of a course or an activity includes the following information:

- a.* School, firm, organization or person conducting the activity.
- b.* Location of the activity.
- c.* Title, description of activity, and course outline.
- d.* Credit hours requested for approval.
- e.* Date of the activity.
- f.* Principal instructor(s).
- g.* Verification of attendance.

[ARC 7778C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

[◇] Two or more ARCs

¹ Effective date (8/14/91) of amendments to 3.1, unnumbered paragraphs 3, 8; 3.2(1-4); 3.3(2-9); 3.4(1); 3.4(2) “o”; 3.4(5) “h”; and rules 3.5 and 3.6 delayed 70 days by the Administrative Rules Review Committee. Delay lifted 8/21/91, effective 8/22/91.

CHAPTER 2017
APPROVAL OF SCHOOLS, COURSES AND INSTRUCTORS

[Prior to 9/4/02, see 193E—3.5(543B)]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 17]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2017.1(543B) Administrative criteria for schools, courses and instructors. All schools, courses and instructors of prelicense and continuing education receive advance approval of the commission.

2017.1(1) Schools, courses and instructors are approved on forms prescribed by the commission for 24-month periods, including the month of approval. Approval is obtained for each course that an instructor proposes to teach.

2017.1(2) A course outline and all necessary forms are submitted for approval at least 30 days prior to the first offering of the program, course or activity.

2017.1(3) Evidence of compliance with or exemption from Iowa Code sections 714.18 through 714.25 is furnished to the commission.

2017.1(4) Potential participants of all approved courses are clearly informed of the hours to be credited, policies concerning registration, payment of fees, refunds and attendance criteria.

2017.1(5) School staff and instructors allow access to any classes conducted to any member of the commission or its duly appointed representatives.

2017.1(6) No part of any approved course is used to advertise or solicit orally or in writing any product or service.

2017.1(7) The school shows that procedures are in place to ensure that the student who completes an approved course is the student who enrolled in the course.

2017.1(8) School staff and instructors are available during normal business hours to answer student questions and provide assistance as necessary.

2017.1(9) The commission may at any time evaluate an approved school or instructor. If the commission finds there is a basis for consideration of revocation of the approval of the school or the instructor, the commission gives notice by ordinary mail or email to the coordinator of that school or to the instructor of a hearing on the possible revocation at least 20 days prior to the hearing.

2017.1(10) The commission may deny or withdraw approval of a program, course, or activity, but the decision to deny or withdraw approval may be appealed within 20 days of the date of mailing the notice of denial or withdrawal.

2017.1(11) Each application for approval designates an individual as coordinator for the school in responsible charge of its operation who is also the contact for the commission. The coordinator is responsible for complying with the commission's rules relating to schools and for submitting reports and information if needed by the commission.

2017.1(12) An approved school cannot apply to itself either as part of its name or in any other manner the designation of "college" or "university" in such a way as to give the impression that it is an educational institution conforming to the standards and qualifications prescribed for colleges and universities unless the school, in fact, meets those standards and qualifications.

2017.1(13) Advertising and prospectus information. No approved school provides any information to the public or to prospective students that is misleading.

2017.1(14) Maximum hours of instruction. There is no more than eight classroom hours in any single day of instruction.

2017.1(15) Each approved school establishes and maintains for each student a complete, accurate and detailed record of instruction undertaken and satisfactorily completed in the areas of study prescribed by these rules. The records are maintained for a period of not less than five years. The commission assigns a number to each approved school and assigns a number to each approved program, course or activity. The approved school includes these reference numbers in correspondence

with the commission and includes these numbers on certificates of attendance issued by the approved school.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.2(543B) Certificates of attendance.

2017.2(1) Each approved school under rule 481—2017.1(543B) provides an individual certificate of attendance to each licensee upon completion of the program, course, or activity. The certificate contains the following information:

- a. School name and number;
- b. Program, course or activity name and number;
- c. Name and address of licensee;
- d. Date on which the program, course or activity was completed;
- e. Number of approved credit hours;
- f. Instructor's name;
- g. Signature of coordinator or other person authorized by the commission; and
- h. A notation as to whether credit hours are to be used as distance learning or as live instruction.

2017.2(2) An attendance certificate is not issued to a licensee who is absent from a continuing education program, course, or activity. The program, course, or activity is completed in its entirety. A student who arrives late, leaves during class or leaves early does not receive an attendance certificate.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.3(543B) Instructors taking license examinations for auditing purposes.

2017.3(1) Instructors who take the salesperson or broker examination for auditing purposes first obtain written consent from the commission.

2017.3(2) Any instructor who wishes to retake an examination for auditing purposes may be granted permission after 12 months have passed.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.4(543B) Continuing education credit for instructors.

2017.4(1) Commission-approved instructors may receive up to six hours of continuing education credit toward renewal of a real estate license for verified attendance at an instructor development workshop approved by the commission. The instructor may use continuing education credit only once in each three-year renewal period.

2017.4(2) An instructor may receive continuing education credit for approved education courses that the instructor teaches, but not more than six hours of credit in any three-year license renewal period.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.5(543B) Acceptable course topics.

2017.5(1) The commission will consider courses in the following areas to be acceptable for approval:

- a. Real estate ethics;
- b. Legislative issues that influence real estate practice, including both pending and recent legislation;
- c. The administration of licensing provisions of real estate law and rules, including compliance and regulatory practices;
- d. Real estate financing, including mortgages and other financing techniques;
- e. Real estate market analysis and evaluation, including site evaluations, market data, and feasibility studies;
- f. Real estate brokerage administration, including office management, trust accounts, and employee contracts;
- g. Real estate mathematics;

- h.* Real property management, including leasing agreements, accounting procedures, and management contracts;
- i.* Real property exchange;
- j.* Land use planning and zoning;
- k.* Real estate securities and syndications;
- l.* Estate building and portfolio management;
- m.* Accounting and taxation as applied to real property;
- n.* Land development;
- o.* Market analysis;
- p.* Real estate market procedures;
- q.* Technology and the practice of real estate;
- r.* Safety;
- s.* Fair housing; and
- t.* Diversity, equity and inclusion.

2017.5(2) Other course topics. A course topic may be approved if it is determined that it includes such facts, concepts and current information about which licensees are knowledgeable to conduct real estate negotiations and transactions and better protect client, customer and public interest. The same criteria will be used to evaluate courses that do not otherwise qualify under rule 481—2017.5(543B).

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.6(543B) Nonqualifying courses. The following course offerings do not qualify as continuing education:

2017.6(1) Courses of instruction designed to prepare a student for passing the real estate salesperson examination;

2017.6(2) Sales promotion or other meetings held in conjunction with a licensee's general business;

2017.6(3) A course certified by the use of a challenge examination. All students complete the necessary number of classroom hours to receive certification;

2017.6(4) Meetings which are a normal part of in-house staff or employee training;

2017.6(5) Orientation courses for licensees, such as those offered through local real estate boards.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.7(543B) Standards for approval of courses of instruction. The commission may approve live classroom instruction, distance education programs and paper and pencil home-study courses, subject to the following conditions:

2017.7(1) The course pertains to real estate topics that are integrally related to the real estate industry; and

2017.7(2) The course allows the participants to achieve a high level of competence in serving the objectives of consumers who engage the services of licensees; and

2017.7(3) The course qualifies for at least one credit hour.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.8(543B) Responsibilities of instructors and course developers.

2017.8(1) Instructors are competent in the subject matter and skilled in the use of appropriate teaching methods that have been proven effective through educational research and development.

2017.8(2) Course content and materials are accurate and consistent with currently accepted standards relating to the program's subject matter.

2017.8(3) Instructor and student materials are updated no later than 30 days after the effective date of a change in standards, laws or rules. Course content will not be considered current and up-to-date unless the new standards have been incorporated into the course or the instructor informs the participants of the new standards.

2017.8(4) Instructors attend workshops or instructional programs, as reasonably requested by the commission, to ensure that effective teaching techniques are used and current, relevant and accurate information is taught.

2017.8(5) All courses have an appropriate means of written evaluation by the participants. Evaluations include but are not limited to relevance of material, effectiveness of presentation and course content.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.9(543B) Standards for approval of classroom courses.

2017.9(1) The commission may approve live classroom courses, subject to the following criteria.

2017.9(2) The course application is accompanied by a comprehensive course outline that includes:

- a.* Description of course.
- b.* Purpose of course.
- c.* Level of difficulty.
- d.* Detailed learning objectives for each major topic that specify the level of knowledge or competency the student should demonstrate upon completing the course.
- e.* Description of the instructional methods utilized to accomplish the learning objectives.
- f.* Copies of all instructor and student course materials.
- g.* Course examination(s) or the diagnostic assessment method(s) utilized to achieve the course learning objectives, when applicable.
- h.* A description of the plan in place to periodically review course material with regard to changing federal and state statutes.
- i.* A statement of any attendance make-up policy that the school has in place.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.10(543B) Standards for approval of distance learning courses. The commission may approve distance learning courses, subject to the following criteria:

2017.10(1) The provider's purpose or mission statement is available to the public.

2017.10(2) The course outline includes clearly stated learning objectives and desired student competencies for each module of instruction and a description of how the program promotes interaction between the learner and the program.

2017.10(3) The course content is accurate and up-to-date. The provider describes the plan in place to periodically review course material with regard to changing federal and state statutes.

2017.10(4) The course is designed to ensure that student progress is evaluated at appropriate intervals and mastery of the material is achieved before a student can progress through the course material.

a. Students completing distance learning continuing education complete a final examination containing 10 questions for a one-hour course, 20 questions for a two-hour course, 30 questions for a three-hour course, 40 questions for a four-hour course, and 60 questions for a six- or eight-hour course.

b. A passing score of 80 percent is needed for course credit to be granted. There is no limit to the number of times a final examination may be taken to achieve a passing score.

2017.10(5) The provider shows that qualified individuals are involved in the design of the course.

2017.10(6) The provider lists individuals who provide technical support to students and state the specific times when support is available.

2017.10(7) A manual is provided to each registered student. It includes, but is not limited to, faculty contact information, student assignments and course criteria, broadcast schedules, testing information, passing scores, resource information, fee schedule and refund policy.

2017.10(8) The provider retains a statement signed by the student that affirms that the student completed the necessary work and examinations.

2017.10(9) The provider states in the course materials that the information presented in the course should not be used as a substitute for competent legal advice.

2017.10(10) Courses submitted for approval are sufficient in scope and content to justify the hours requested by the provider.

2017.10(11) Courses that have obtained approval from the Association of Real Estate License Law Officials (ARELLO) are automatically approved in Iowa.

2017.10(12) All computer-based continuing education and prelicense courses are completed within six months of the date of purchase.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.11(543B) Standards for approval of paper and pencil home-study courses. The commission may approve paper and pencil home-study courses, subject to the following criteria:

2017.11(1) Courses are arranged in chapter format and include a table of contents.

2017.11(2) Overview statements that preview the content of the chapter are included for each chapter.

2017.11(3) Courses are designed to ensure that student progress is evaluated at appropriate intervals. The assessment process measures what each student has learned and not learned at regular intervals throughout each module of the course. The student completes and returns quizzes to the provider to receive credit for the course.

2017.11(4) Students completing paper and pencil home-study continuing education complete a final examination containing 10 questions for a one-hour course, 20 questions for a two-hour course, 30 questions for a three-hour course, 40 questions for a four-hour course, and 60 questions for a six- or eight-hour course.

2017.11(5) A passing score of 80 percent is needed for course credit to be granted. There is no limit to the number of times a final examination may be taken to achieve a passing score.

2017.11(6) A licensee has six months from the date of purchase to complete all quizzes and assignments and to pass the final examination.

2017.11(7) The provider includes information that clearly informs the licensee of the course completion deadline, passing score needed, chapter quiz completion criteria and any other relevant information regarding the course.

2017.11(8) The provider states in the course materials that the information presented in the course should not be used as a substitute for competent legal advice.

2017.11(9) The provider retains a statement signed by the student that affirms that the student completed the necessary work and examinations.

2017.11(10) The provider is available to answer student questions or provide assistance as necessary during normal business hours.

2017.11(11) Courses submitted for approval are sufficient in scope and content to justify the hours requested by the provider.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2017.12(543B) Qualifying as an instructor.

2017.12(1) Individuals may be approved to teach prelicense and continuing education when they have shown proof of attendance of six hours at an instructor development workshop approved by the commission within 12 months preceding approval and have met the instructor qualification criteria.

2017.12(2) Guest speakers and individuals currently certified by a nationally recognized organization, such as a DREI, that has similar instructor standards are exempt, with prior approval of the commission, from the instructor qualification criteria and the instructor development workshop criteria.

2017.12(3) An applicant may be approved as an instructor when it is determined that the applicant evidences the ability to teach and communicate and possesses in-depth knowledge of the subject matter to be taught.

a. The applicant demonstrates the ability to teach by meeting at least one of the following criteria:

- (1) Holds a bachelor's degree or higher in education from an accredited college (copy(ies) of transcript(s) to be attached); or
- (2) Holds a current teaching credential or certificate in any field (copy to be attached); or
- (3) Holds a certificate of completion from a real estate instructor institute, workshop or school approved by the real estate commission and has experience in the area of instruction (specific teaching experiences to be detailed); or
- (4) Holds a full-time current appointment to the faculty of an accredited college; or
- (5) Holds a current teaching designation from an organization approved by the real estate commission (evidence to be attached).

b. The applicant demonstrates in-depth knowledge of the subject matter by meeting at least one of the following criteria:

- (1) Holds a bachelor's degree or higher from an accredited college with a major in a field of study directly related to the subject matter of the course the applicant proposes to teach, such as business, economics, accounting, real estate or finance (copy of transcript to be attached); or
- (2) Holds a bachelor's degree or higher from an accredited college and five years of real estate experience directly related to the subject matter of the course the applicant proposes to teach (copy of transcript to be attached and documentation to explain how applicant's experience is directly related to the subject matter the applicant proposes to teach); or
- (3) Be a licensed attorney in practice for at least three years in an area directly related to the subject matter of the course the applicant proposes to teach; or
- (4) Be a highly qualified professional with a generally recognized professional designation such as, but not limited to, FLI, MAI, SIOR, SREA, CRB, CRS, CPM, but not including GRI, and two years of education from a postsecondary institution (evidence of both to be attached); or
- (5) Have extensive instructional background in real estate education and experience in real estate as evidenced by a valid broker's license or five years of active real estate experience as a salesperson (evidence to be provided). In addition, three recently written letters of recommendation that attest to the applicant's in-depth knowledge combined with the ability to teach and communicate the subject the applicant proposes to teach; or
- (6) Other, as the commission may determine.

[ARC 7779C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2018
INVESTIGATIONS AND DISCIPLINARY PROCEDURES

[Prior to 9/4/02, see 193E—Ch 4]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 18]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2018.1(17A,272C,543B) Disciplinary and investigative authority. The commission is empowered to administer Iowa Code chapters 17A, 272C, and 543B and related administrative rules for the protection and well-being of those persons who may rely upon licensed individuals for the performance of real estate services within this state or for clients in this state. To perform these functions, the commission is broadly vested with authority, pursuant to Iowa Code sections 17A.13, 272C.3 through 272C.6, 272C.10, 543B.9, 543B.29, 543B.34 to 543B.41, and 543B.61 to review and investigate alleged acts or omissions of licensees, determine whether disciplinary proceedings are warranted, initiate and prosecute disciplinary proceedings, establish standards of professional conduct, and impose discipline.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.2(17A,272C,543B) Grounds for discipline. The commission may initiate disciplinary action against a licensee on any of the following grounds:

1. All grounds set forth in Iowa Code sections 543B.29, 543B.34 and 543B.61.
2. A violation of the rules of professional and business conduct described in 481—Chapters 2006 through 2008, 2010 through 2015 and 2019.
3. Failure to comply with an order of the commission imposing discipline.
4. Violation of Iowa Code sections 272C.3(2) and 272C.10.
5. Continuing to practice real estate with an expired or inactive license, or without satisfying the continuing education mandated by 481—Chapter 2016 or the errors and omissions insurance mandated by 481—Chapter 2019.
6. Knowingly aiding or abetting a licensee, license applicant or unlicensed person in committing any act or omission which is a ground for discipline under this rule or otherwise knowingly aiding or abetting the unlicensed practice of real estate in Iowa.
7. Failure to fully cooperate with a licensee disciplinary investigation, including failure to respond to a commission inquiry within 14 calendar days of the date of mailing by certified mail of a written communication directed to the licensee's last address on file at the commission office.
8. A violation of one or more of the acts or omissions upon which civil penalties may be imposed, as described in subrule 2018.14(5).

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.3(17A,272C,543B) Initiation of disciplinary investigations. The commission may initiate a licensee disciplinary investigation upon the commission's receipt of information suggesting that a licensee may have violated a law or rule enforced by the commission which, if true, would constitute a ground for licensee discipline.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.4(272C,543B) Sources of information. Without limitation, the following nonexclusive list of information sources may form the basis for the initiation of a disciplinary investigation or proceeding:

1. News articles or other media sources.
2. Reports filed with the commission by the commissioner of insurance pursuant to Iowa Code section 272C.4(9).
3. Complaints filed with the commission by any member of the public.
4. License applications or other documents submitted to the commission.

5. Reports to the commission from any regulatory or law enforcement agency from any jurisdiction.

6. Commission audits of licensee compliance, such as those involving continuing education, trust accounts, or errors and omissions insurance.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.5(17A,272C,543B) Conflict of interest. If the subject of a complaint is a member of the commission, or if a member of the commission has a conflict of interest in any disciplinary matter before the commission, that member abstains from participation in any consideration of the complaint and from participation in any disciplinary hearing that may result from the complaint.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.6(272C,543B) Complaints. Written complaints may be submitted to the commission office by mail, email, online via the commission's website, or personal delivery by any member of the public with knowledge of possible law or rule violations by licensees. Timely filing is encouraged to ensure the availability of witnesses and to avoid initiation of an investigation under conditions which may become substantially altered during a period of delay.

2018.6(1) Contents of a written complaint. Written complaints may be submitted on forms provided by the commission which are available from the commission office and on the commission's website. Written complaints, whether submitted on a commission complaint form or in other written medium, contain the following information:

- a. The full name, address, and telephone number of the complainant (person complaining).
- b. The full name, address, and telephone number of the respondent (licensee against whom the complaint is filed).
- c. A statement of the facts and circumstances giving rise to the complaint, including a description of the alleged acts or omissions which the complainant believes demonstrates that the respondent has violated or is violating laws or rules enforced by the commission.
- d. If known, citations to the laws or rules allegedly violated by the respondent.
- e. Evidentiary supporting documentation.
- f. Steps, if any, taken by the complainant to resolve the dispute with the respondent prior to filing a complaint.
- g. The address of the property involved.

2018.6(2) Immunity. A person is not civilly liable for filing a complaint unless such act is done with malice as provided by Iowa Code section 272C.8(1) "a." Employees cannot be discriminated against as a result for filing a complaint as provided by Iowa Code section 272C.8(1) "c."

2018.6(3) Role of complainant. The role of the complainant in the disciplinary process is limited to providing the commission with factual information relative to the complaint. A complainant is not party to any disciplinary proceeding which may be initiated by the commission based in whole or in part on information provided by the complainant.

2018.6(4) Role of the commission. The commission does not act as an arbiter of disputes between private parties, nor does the commission initiate disciplinary proceedings to advance the private interests of any person or party. The role of the commission in the disciplinary process is to protect the public by investigating complaints and initiating disciplinary proceedings in appropriate cases. The commission possesses sole decision-making authority throughout the disciplinary process, including the authority to determine whether a case will be investigated, the manner of the investigation, whether a disciplinary proceeding will be initiated, and the appropriate licensee discipline to be imposed, if any.

2018.6(5) Initial complaint screening. All written complaints received by the commission are initially screened by the commission's administrator or designated staff to determine whether the allegations of the complaint fall within the commission's investigatory jurisdiction and whether the facts presented, if true, would constitute a basis for disciplinary action against a licensee. Complaints which are clearly outside the commission's jurisdiction, which clearly do not allege facts upon

which disciplinary action would be based, or which are frivolous may be closed by the commission administrator or may be referred by the commission administrator to the commission for closure at the next scheduled commission meeting. All other complaints are referred by the commission administrator to the commission's disciplinary committee for committee review as described in rule 481—2018.9(17A,272C,543B). If a complainant objects in writing to the closure of the complaint by the commission administrator, the administrator will refer the objection to the disciplinary committee or commission for reconsideration.

2018.6(6) *Withdrawal or amendment.* A complaint may be amended or withdrawn at any time prior to official notification of the respondent and thereafter at the sole discretion of the commission. The commission may choose to pursue a matter even after a complaint has been withdrawn.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.7(272C,543B) Case numbers. Whether based on a written complaint received by the commission or a complaint initiated by the commission, all complaint files are tracked by a case numbering system. Complaints are assigned case numbers in chronological order with the first two digits representing the year in which the complaint was received or initiated, and the second three digits representing the order in which the case file was opened (e.g., 01-001, 01-002, 01-003). The commission's administrator maintains a case file log noting the date each case file was opened, whether disciplinary proceedings were initiated in the case, and the final disposition of the case. Once a case file number is assigned to a complaint, all persons communicating with the commission regarding that complaint are encouraged to include the case file number to facilitate accurate records and prompt response.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.8(272C,543B) Confidentiality of complaint and investigative information. All complaint and investigative information received or created by the commission is privileged and confidential pursuant to Iowa Code section 272C.6(4) and as such is not subject to discovery, subpoena, or other means of legal compulsion for release to any person except as provided in Iowa Code section 272C.6.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.9(17A,272C,543B) Investigation procedures.

2018.9(1) *Disciplinary committee.* The commission chair may appoint two members of the commission to serve on a commission disciplinary committee. The chair may appoint a standing committee or may appoint different members to serve on the committee on an as-needed basis. The disciplinary committee is a purely advisory body which reviews complaint files referred by the commission's administrator, generally supervises the investigation of complaints, and makes recommendations to the full commission on the disposition of complaints. Except as provided by rule 481—2018.10(17A,272C,543B), members of the committee do not personally investigate complaints, but they may review the investigative work product of others in formulating recommendations to the commission.

2018.9(2) *Committee screening of complaints.* Upon the referral of a complaint from the commission's administrator or from the full commission, the committee determines whether the complaint presents facts which, if true, suggest that a licensee may have violated a law or rule enforced by the commission. If the committee concludes that the complaint does not present facts which suggest such a violation or that the complaint does not otherwise constitute an appropriate basis for disciplinary action, the committee refers the complaint to the full commission with the recommendation that it be closed with no further action. If the committee determines that the complaint does present a credible basis for disciplinary action, the committee may either immediately refer the complaint to the full commission recommending that a disciplinary proceeding be commenced or initiate a disciplinary investigation.

2018.9(3) *Committee procedures.* If the committee determines that additional information is necessary or desirable to evaluate the merits of a complaint, the committee may assign an investigator or expert consultant, appoint a peer review committee, provide the licensee an opportunity to appear before the disciplinary committee for an informal discussion as described in rule 481—2018.10(17A,272C,543B) or request commission staff to conduct further investigation. Upon completion of an investigation, the investigator, expert consultant, peer review committee or commission staff presents a report to the committee. The committee reviews the report and determines what further action is necessary. The committee may:

- a. Request further investigation.
- b. Determine there is not probable cause to believe a disciplinary violation has occurred and refer the case to the full commission with the recommendation of closure.
- c. Determine there is probable cause to believe that a law or rule enforced by the commission has been violated, but that disciplinary action is unwarranted on other grounds, and refer the case to the full commission with the recommendation of closure. The committee may also recommend that the licensee be informally cautioned or educated about matters which could form the basis for disciplinary action in the future.
- d. Determine there is probable cause to believe a disciplinary violation has occurred and either attempt informal settlement, subject to approval by the full commission, or refer the case to the full commission with the recommendation that the commission initiate a disciplinary proceeding (contested case).
- e. Stay further action on the complaint if, for instance, there is a pending criminal case or civil litigation and the committee feels it would be in the best interest of the public and respondent to await the final outcome of the litigation. Additionally, the committee may stay further action on a complaint when the respondent's license is expired or revoked.

2018.9(4) *Subpoena authority.* The commission is authorized in connection with a disciplinary investigation to issue subpoenas to compel witnesses to testify or persons to produce books, papers, records and any other real evidence, whether or not privileged or confidential under law, which the commission deems necessary as evidence in connection with a disciplinary proceeding or relevant to the decision of whether to initiate a disciplinary proceeding, pursuant to Iowa Code sections 17A.13(1), 272C.6(3) and 543B.36. Commission procedures concerning investigative subpoenas are set forth in rule 481—503.5(17A,272C).

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.10(17A,272C,543B) *Informal discussion.* If the disciplinary committee considers it advisable, or if requested by the affected licensee, the committee may grant the licensee an opportunity to appear before the committee for a voluntary informal discussion of the facts and circumstances of an alleged violation, subject to the provisions of this rule.

2018.10(1) An informal discussion is intended to provide a licensee an opportunity to share the licensee's side of a complaint in an informal setting before the commission determines whether probable cause exists to initiate a disciplinary proceeding. Licensees are not obligated to attend an informal discussion. Because disciplinary investigations are confidential, the licensee cannot bring other persons to an informal discussion, but licensees may be represented by legal counsel. When an allegation is made against a firm, the firm may be represented by the designated broker, a managing partner, member or other firm representative.

2018.10(2) Unless disqualification is waived by the licensee, commission 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 commission 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 commission members to participate in commission decision making and to receive the advice of staff, licensees who desire to attend

an informal discussion therefore waive their right to seek disqualification of a commission member or staff based solely on the commission member's or staff's participation in an informal discussion. Licensees would not be waiving their right to seek disqualification on any other ground. By electing to attend an informal discussion, a licensee accordingly agrees that a participating commission member or staff person is not disqualified from acting as a presiding officer in a later contested case proceeding or from advising the decision maker.

2018.10(3) Because an informal discussion constitutes a part of the commission's investigation of a pending disciplinary case, the facts discussed at the informal discussion may be considered by the commission in the event the matter proceeds to a contested case hearing and those facts are independently introduced into evidence.

2018.10(4) The disciplinary committee, subject to commission approval, may propose a consent order at the time of the informal discussion. If the licensee agrees to a consent order, a statement of charges is filed simultaneously with the consent order, as provided in rule 481—506.35(17A, 272C).

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.11(17A,272C,543B) Closing complaint files.

2018.11(1) *Grounds for closing.* Upon the recommendation of the administrator pursuant to subrule 2018.6(5), the recommendation of the disciplinary committee pursuant to rule 481—2018.9(17A,272C,543B), or on its own motion, the commission may close a complaint file, with or without prior investigation. Given the broad scope of matters about which members of the public may complain, it is not possible to catalog all possible reasons why the commission may close a complaint file. The commission will take into consideration the severity of the alleged violation, the sufficiency of the evidence, the possibility that the problem can be better resolved by other means available to the parties, whether the matter has been the subject of a local board proceeding, the clarity of the laws and rules which support the alleged violation, whether the alleged violation is likely to recur, the past record of the licensee, whether the licensee has previously received a cautionary letter concerning the act or omission at issue, and other factors relevant to the specific facts of the complaint. The following nonexclusive list illustrates the grounds upon which the commission may close a complaint file:

- a. The complaint alleges matters outside the commission's jurisdiction.
- b. The complaint does not allege a reasonable or credible basis to believe that the subject of the complaint violated a law or rule enforced by the commission.
- c. The complaint is frivolous or trivial.
- d. The complaint alleges matters more appropriately resolved in a different forum, such as civil litigation to resolve a contract dispute, or more appropriately addressed by alternative procedures, such as outreach education or rulemaking.
- e. The matters raised in the complaint are situational, isolated, or unrepresentative of a licensee's typical practice, and the licensee has taken appropriate steps to ensure future compliance and prevent public injury.
- f. Resources are unavailable or better directed to other complaints or commission initiatives in light of the commission's overall budget and mission.
- g. Extenuating factors exist which weigh against the imposition of public discipline.

2018.11(2) *Closing orders.* The commission's administrator may enter an order stating the basis for the commission's decision to close a complaint file. If entered, the order cannot contain the identity of the complainant or the respondent, and cannot disclose confidential complaint or investigative information. If entered, closing orders will be indexed by case number and are a public record pursuant to Iowa Code section 17A.3(1)"d." A copy of the order may be mailed to the complainant, if any, and to the respondent. The commission's decision whether or not to pursue an investigation, to institute disciplinary proceedings, or to close a file is not subject to judicial review.

2018.11(3) *Cautionary letters.* When a complaint file is closed, the commission may issue a confidential letter of caution to a licensee which informally cautions or educates the licensee about

matters which could form the basis for disciplinary action in the future if corrective action is not taken by the licensee. Informal cautionary letters do not constitute disciplinary action, but the commission may take such letters into consideration in the future if a licensee continues a practice about which the licensee has been cautioned.

2018.11(4) *Reopening closed complaint files.* The commission may reopen a closed complaint file if, after closure, additional information arises which provides a basis to reassess the merits of the initial complaint.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.12(17A,272C,543B) Initiation of disciplinary proceedings. Disciplinary proceedings may only be initiated by the affirmative vote of a majority of a quorum of the commission at a public meeting. Commission members who are disqualified are not included in determining whether a quorum exists. When two or more members of the commission are disqualified or otherwise unavailable for any reason, the administrator may request the special appointment of one or more substitute commission members pursuant to Iowa Code section 17A.11(5).

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.13(17A,272C,543B) Disciplinary contested case procedures. Unless in conflict with a provision of Iowa Code chapter 543B or commission rules in this chapter, all of the procedures set forth in 481—Chapter 506 applies to disciplinary contested cases initiated by the commission.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2018.14(272C,543B) Disciplinary sanctions.

2018.14(1) *Type of sanctions.* The commission has authority to impose, alone or in combination, the following disciplinary sanctions:

- a. Revocation of a license.
- b. Suspension of a license for a period of time or indefinitely.
- c. Nonrenewal of a license.
- d. Ban permanently, until further order of the commission, or for a specified period of time, the engagement in specified procedures, methods or acts.
- e. Probation. As a condition to a period of probation, the commission may impose terms and conditions deemed appropriate by the commission including, but not limited to, substance abuse evaluation and such care and treatment as recommended in the evaluation or otherwise appropriate under the circumstances.
- f. Mandate additional continuing education. The commission may specify that a designated amount of continuing education be taken in specific subjects and may specify the time period for completing these courses. The commission may also specify whether this continuing education be in addition to the continuing education routinely needed for license renewal. The commission may also specify that additional continuing education be a condition for the termination of any suspension or reinstatement of a license.
- g. Require reexamination.
- h. Impose a monitoring or supervision arrangement.
- i. Downgrade a license from a broker license to a salesperson license.
- j. Issue a reprimand.
- k. Order a physical or mental examination with periodic reports to the commission, if deemed necessary.
- l. Impose civil penalties, the amount of which is at the discretion of the commission, but does not exceed \$2,500 per violation as authorized by Iowa Code section 543B.48. Civil penalties may be imposed for any of the disciplinary violations specified in rule 481—2018.2(17A,272C,543B) and as listed in subrule 2018.14(5).

2018.14(2) *Imposing discipline.* Discipline may only be imposed against a licensee by the authorization of Iowa Code section 272C.6(5). When determining the nature and severity of the

sanction to be imposed against a particular licensee or groups of licensees, the commission may consider the following factors:

- a. The relative seriousness of the violation as it relates to assuring the citizens of this state professional competency.
- b. The facts of the particular violation.
- c. Number of prior violations.
- d. Seriousness of prior violations.
- e. Whether remedial action has been taken.
- f. The impact of the particular activity upon the public.
- g. Such other factors as may reflect upon the competency, ethical standards and professional conduct of the licensee, including those listed in subrule 2018.14(6).

2018.14(3) *Voluntary surrender.* The commission may accept the voluntary surrender of a license to resolve a pending disciplinary contested case or pending disciplinary investigation. The commission cannot accept a voluntary surrender of a license to resolve a pending disciplinary investigation unless a statement of charges is filed along with the order accepting the voluntary surrender. Such a voluntary surrender is considered disciplinary action and is published in the same manner as is applicable to any other form of disciplinary order.

2018.14(4) *Notification criteria.* Whenever a broker's license is revoked, suspended, limited, or voluntarily surrendered under this chapter, the licensee follows the procedures set forth in rule 481—2007.3(543B). Strict compliance with these procedures is a condition for an application for reinstatement. Whenever a salesperson's or broker associate's license is revoked, suspended, limited, or voluntarily surrendered under this chapter, the licensee immediately notifies the licensee's broker, and:

- a. Within seven days of receipt of the commission's final order, notifies in writing all clients of the fact that the license has been revoked, suspended, limited, or voluntarily surrendered. Such notice advises the client to immediately contact the broker, unless the limitation at issue would not impact the real estate services provided for that client.
- b. Within 30 days of receipt of the commission's final order, the licensee files with the commission copies of the notices sent pursuant to paragraph 2018.14(4) "a." Compliance with this criteria is a condition for an application for reinstatement.

2018.14(5) *Violations for which civil penalties may be imposed.* The following is a nonexclusive list of violations upon which civil penalties may be imposed:

- a. Engaging in activities requiring a license when license is inactive.
- b. Failing to maintain a place of business.
- c. Improper care and custody of license:
 - (1) Failing to properly display license(s).
 - (2) Failing to return license in a timely manner (received within 72 hours as provided by 481—subrules 2006.1(1) and 2006.1(2)).
 - (3) Failing to notify associate when license is returned.
 - (4) Failing to provide mailing address of associate when license is returned.
- d. Failing to inform commission and remit necessary fees if appropriate:
 - (1) When changing business address (five working days).
 - (2) When changing status (five working days).
 - (3) When changing form of firm (five working days).
 - (4) When opening a trust account by not filing a consent to examine for the account.
 - (5) When changing residence address or mailing address (five working days).
 - (6) When independently obtained errors and omissions insurance status, coverage or provider changes (five working days).
- e. Maintaining inadequate transaction records such as:
 - (1) Failing to maintain a general ledger.
 - (2) Failing to maintain individual account ledgers.

- (3) Failing to retain records on file.
- f.* Improper trust account and closing procedures:
 - (1) Failing to deposit funds as necessary.
 - (2) Disbursing trust funds prior to closing without written authorization.
 - (3) Withholding earnest money unlawfully when the transaction fails to consummate.
 - (4) Failing to obtain escrow agreement for undisbursed funds.
 - (5) Failing to remit and account for interest on closing statements.
 - (6) Computing closing statements improperly.
 - (7) Failing to provide closing statements.
 - (8) Retaining excess personal funds in the trust account.
 - (9) Failing as a salesperson or broker associate to immediately turn funds over to the broker.
 - (10) Failing to deposit trust funds in interest-bearing account in accordance with Iowa Code section 543B.46.
 - (11) Failing to account for and remit to the state accrued interest due in accordance with Iowa Code section 543B.46.
- g.* Failing to immediately present offer.
- h.* Advertising without identifying broker or clearly indicating advertisement is by a licensee.
- i.* Failing to provide information to the commission when requested relative to a complaint (14 calendar days).
- j.* Failing to obtain all signatures needed on contracts or to obtain signatures or initials of all parties to changes in a contract.
- k.* Placing a sign on property without consent, or failure to remove a sign when requested.
- l.* Failing to furnish a progress report when requested.
- m.* Failing by a broker to supervise salespersons or broker associates.
- n.* Failing by a broker associate or salesperson to keep the employing broker informed.
- o.* Issuing an insufficient funds check to the commission for any reason or to anyone else in the individual's capacity as a real estate licensee.
- p.* Issuing an insufficient funds check on the broker's trust account.
- q.* Engaging in conduct which constitutes a barred practice or tying arrangement as banned by these rules.
- r.* Failing to inform clients of real estate brokerage firm of the date the firm will cease to be in business and the effect upon sellers' listing agreements.
- s.* Failing to have a brokerage agreement signed as outlined in Iowa Code section 543B.56A.
- t.* Violating any of the remaining provisions in 481—Chapters 2001 through 2022 that have not heretofore been specified in this rule.

2018.14(6) *Amount of civil penalties.* Factors the commission may consider when determining whether to assess and the amount of civil penalties include:

- a.* Whether other forms of discipline are being imposed for the same violation.
- b.* Whether the amount imposed will be a substantial deterrent to the violation.
- c.* The circumstances leading to the violation.
- d.* The severity of the violation and the risk of harm to the public.
- e.* The economic benefits gained by the licensee as a result of the violation.
- f.* The interest of the public.
- g.* Evidence of reform or remedial action.
- h.* Time elapsed since the violation occurred.
- i.* Whether the violation is a repeat offense following a prior cautionary letter, disciplinary order, or other notice of the nature of the infraction.
- j.* The clarity of the issues involved.
- k.* Whether the violation was willful and intentional.
- l.* Whether the licensee acted in bad faith.
- m.* The extent to which the licensee cooperated with the commission.

n. Whether the licensee with a lapsed, inactive, suspended, limited or revoked license improperly engaged in practices which need licensure.

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481—2018.15(17A,272C,543B) Reinstatement. The term “reinstatement” as used in this rule includes both the reinstatement of a suspended license and the issuance of a new license following the revocation, voluntary revocation, or voluntary surrender of a license.

2018.15(1) Any person whose license has been revoked or suspended by the commission, or who has voluntarily surrendered a license to the commission or has agreed to a voluntary revocation of a license, may apply to the commission for reinstatement in accordance with the terms of the order of revocation, voluntary surrender, voluntary revocation, or suspension.

2018.15(2) Unless otherwise provided by law, if the order of revocation, voluntary revocation, voluntary surrender, or suspension did not establish terms upon which reinstatement might occur, initial application for reinstatement cannot be made until at least two years have elapsed from the date of the order or the date the commission accepted the order.

2018.15(3) Following the revocation or surrender of a broker or salesperson license, an applicant for reinstatement, as a condition of reinstatement, start over as an original applicant for a salesperson license, regardless of the type of license the applicant previously held. The applicant is obligated to satisfy all preconditions for licensure as a salesperson.

2018.15(4) In addition to the provisions of rule 481—506.32(272C), the following provisions apply to license reinstatement proceedings:

a. The commission may grant an applicant’s request to appear informally before the commission prior to the issuance of a notice of hearing on an application to reinstate if the applicant requests an informal appearance in the application and agrees not to seek to disqualify, on the ground of personal investigation, commission members or staff before whom the applicant appears.

b. An order granting an application for reinstatement may impose such terms and conditions as the commission deems desirable, which may include one or more of the types of disciplinary sanctions described in rule 481—2018.14(272C,543B).

c. The commission cannot grant an application for reinstatement when the initial order which revoked, suspended or limited the license; denied license renewal; or accepted a voluntary surrender was based on a criminal conviction and the applicant cannot demonstrate to the commission’s satisfaction that:

- (1) All terms of the sentencing or other criminal order have been fully satisfied;
- (2) The applicant has been released from confinement and any applicable probation or parole; and
- (3) Restitution has been made or is reasonably in the process of being made to any victims of the crime.

[ARC 7780C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

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¹ Effective date (8/14/91) of amendments to 4.40(4) “e,” “f”; and 4.40(17-19) delayed 70 days by the Administrative Rules Review Committee. Delay lifted 8/21/91, effective 8/22/91.

CHAPTER 2019
REQUIREMENTS FOR MANDATORY ERRORS AND OMISSIONS INSURANCE

[Prior to 9/4/02, see 193E—Ch 6]
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 19]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2019.1(543B) Insurance definitions.

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

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

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

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

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

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

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

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

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

[Editorial change: IAC Supplement 6/10/26]

481—2019.2(543B) Insurance criteria—general. The group coverage insurance policy selected by the commission is approved by the Iowa insurance division. As a condition of licensure, all active real estate licensees follow Iowa Code section 543B.47(1) regarding mandatory errors and omissions insurance.

2019.2(1) Who submits plan of coverage. The following persons submit proof of insurance when needed or when requested:

- a. Any active individual broker, broker associate, broker sole proprietor or salesperson.
- b. Any active firm.

2019.2(2) Inactive status. Individuals whose licenses are on inactive status as defined in Iowa Code section 543B.5(12) do not need to carry errors and omissions insurance as authorized by Iowa Code section 543B.47(1).

2019.2(3) Territory. All resident Iowa licensees are covered for activities contemplated under Iowa Code chapter 543B both in and out of the state of Iowa. Nonresident licensees participating under the state plan are not covered both in and out of the state of Iowa unless the state plan selected by the commission will cover participating nonresidents when involved in real estate activities in the nonresident state.

2019.2(4) Insurance form. Licensees may obtain errors and omissions coverage through the insurance carrier selected by the commission to provide the group policy coverage. The following are minimum criteria of the group policy to be issued to the Iowa real estate commission including, as named insureds, all licensees who have paid the necessary premium:

- a. All activities contemplated under Iowa Code chapter 543B are included as covered activities;
- b. A per claim limit is not less than \$100,000;
- c. An annual aggregate limit is not less than \$100,000;
- d. Limits are to apply per licensee, per claim;
- e. Defense costs are to be payable in addition to damages;
- f. The contract of insurance pays, on behalf of the insured person(s), liabilities owed.

2019.2(5) Contract period. The contract between the insurance carrier or program manager and the commission may be written for a one- to three-year period with the option to renew or renegotiate each year thereafter. The commission reserves the right to terminate the contract after written notice to the carrier at least 120 days prior to the end of any policy term and place the contract out for bid.

- a. Policy periods are not less than 12-month policy terms.
- b. The policy provides full and complete prior acts coverage.

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

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

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

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

2019.2(6) Any licensee insured in the state selected program whose license becomes inactive will not be charged an additional premium if the license is reinstated during the policy period.

2019.2(7) Any licenses issued other than at renewal and insured by the state selected program are subject to a pro-rata premium.

[ARC 7781C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2019.3(543B) Other coverage. Licensees are not mandated to purchase insurance coverage through the group policy selected by the commission and may obtain errors and omissions coverage independently if the coverage contained in the policy complies with the following:

2019.3(1) For active individual licensees, all provisions of Iowa Code section 543B.47 apply.

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

2019.3(2) For all active partnerships and corporations, otherwise known as firms, all provisions of Iowa Code section 543B.47 apply.

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

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

2019.3(3) For sole-proprietor single license brokers, all provisions of Iowa Code section 543B.47 apply.

a. If the broker's other coverage is an individual policy, it is each licensee's responsibility to provide proof of the independently carried insurance coverage to the Iowa real estate commission when needed, as provided in subrule 2019.3(1).

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

2019.3(4) For independently carried individual type coverage, the following apply:

- a. All activities contemplated under Iowa Code chapter 543B are included as covered activities.
- b. A per claim limit is not less than \$100,000.
- c. The maximum deductible for an individual policy for damages and defense, each licensee, and each claim is not more than the deductible of the commission group policy for the current policy term.

2019.3(5) For firms and sole-proprietor brokerages with independently carried firm umbrella type coverage, the following apply:

- a. All activities contemplated under Iowa Code chapter 543B are included as covered activities.
- b. A per claim limit is not less than \$100,000.
- c. An aggregate limit is:
 - (1) Not less than \$250,000 for a broker or firm with two through ten licensees;
 - (2) Not less than \$500,000 for a broker or firm with 11 through 40 licensees;
 - (3) Not less than \$1,000,000 for a broker or firm with 41 or more licensees.
- d. There is no maximum deductible limit for firm umbrella type coverage policy.
- e. If a firm size change or a sole-proprietor brokerage size change results in a higher aggregate minimum criteria, that firm or broker corrects the deficiency within one year, or the next renewal term of the insurance policy, whichever comes first.

2019.3(6) To comply with the provisions of the Iowa errors and omissions law, if other independently carried insurance is provided, as proof of errors and omissions coverage for individual or firm umbrella type coverage, the other insurance carrier agrees to either a noncancelable policy, or provides a letter of commitment to notify the Iowa real estate commission 30 days prior to the intention to cancel the policy.

2019.3(7) Whenever commission criteria, coverage, or limits change, the commission provides a reasonable transition period to allow the licensee or firm with other coverage the opportunity to change carriers or coverage to comply with all criteria and limits, providing the present policy was in effect and in compliance with all prior criteria. The licensee or firm corrects the deficiency within one year, or not later than the next renewal term of the insurance policy, whichever comes first.

2019.3(8) It is the responsibility of each individual licensee to notify the commission when changing insurance status, coverage, or provider when necessary or when requested.

2019.3(9) It is the responsibility of the designated broker of the firm to notify the commission when changing insurance status, coverage, or provider when necessary or when requested.

2019.3(10) Self-insurance does not comply with the provisions of the Iowa errors and omissions insurance law.

[ARC 7781C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2019.4(543B) Administrative criteria—general.

2019.4(1) It is the responsibility of the insurance carrier or program manager to obtain approval from the Iowa division of insurance for the group policy before inception of the program or policy period.

2019.4(2) It is the responsibility of the insurance carrier or program manager to handle administrative duties relative to operation of the program selected by the commission, including billing and premium collection, toll-free access for questions, and claim processing and general informational mailings.

2019.4(3) It is the responsibility of the insurance carrier or program manager to send a billing notice to each licensee.

2019.4(4) It is the responsibility of the insurance carrier or program manager to collect all premiums due and verify proper payment.

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

2019.4(5) It is the responsibility of the insurance carrier or program manager to issue individual certificates to each licensee and a master policy to the commission.

2019.4(6) It is the responsibility of the insurance carrier or program manager to market its program and to develop and distribute informational brochures about the coverages provided, services available and criteria of Iowa Code section 543B.47.

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

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

2019.4(7) It is the responsibility of the insurance carrier or program manager to provide educational seminars in the state of Iowa at the request of the commission and subject to terms and conditions agreeable to each party involved.

[ARC 7781C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2019.5(543B) Commission responsibilities. The commission provides the insurance carrier or program manager an electronic schedule of all active licensees approximately three months in advance of inception (or renewal), or as otherwise agreed upon, which the insurance carrier or program manager may use to issue billing notices.

2019.5(1) The insurance carrier or program manager provides the commission with a schedule of insured licensees. The commission will be responsible for comparing this schedule against its own records to determine which licensees elected not to participate in the state program and those that have failed to furnish the commission with acceptable proof of insurance necessary for continued licensure.

2019.5(2) It is the responsibility of the commission to review proof of other insurance received from licensees not participating in the state program and to confirm that the other insurance meets the minimum criteria of these rules.

2019.5(3) The commission may mandate that an approved standard form be used to submit proof of other insurance coverage for review.

[ARC 7781C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2019.6(543B) Compliance.

2019.6(1) The commission needs receipt of proof of errors and omissions insurance from new licensees before the license is issued.

2019.6(2) The commission needs receipt of proof of errors and omissions insurance from the applicant before reinstating an expired license.

2019.6(3) The commission needs receipt of proof of errors and omissions insurance before reactivating an inactive status license to active status.

2019.6(4) Applicants for license renewal need to attest and certify that they have current errors and omissions insurance in effect that meets Iowa insurance criteria.

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

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

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

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

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

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

2019.6(5) A licensee is needed to carry insurance on an uninterrupted basis and cannot avoid discipline simply by acquiring insurance after receipt of an audit notice.

2019.6(6) Failure to comply with Iowa Code section 543B.47(6) within 20 calendar days of the commission's request is prima facie evidence of a violation of Iowa Code sections 543B.15(5) and 543B.47(1) and is grounds for the denial of an application for licensure, the denial of an application to renew a license, or the suspension or revocation of a license.

2019.6(7) Submitting false documentation of insurance coverage, or falsely claiming to have or attesting to having insurance coverage, is prima facie evidence of violation of Iowa Code sections 543B.29(1) and 543B.34(1).

2019.6(8) Failure to provide required proof of insurability within 30 days of written notice by the commission results in the placement of the license on inactive status. A license that has been placed on inactive status pursuant to this provision is not reactivated until satisfactory evidence has been provided verifying that coverage is current and in full force and effect.

[ARC 7781C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2019.7(543B) Records and retention. It is the responsibility of the licensee to maintain records which support the validity of the insurance. Documentation is retained by the licensee for a period of three years after the license renewal date or the anniversary of the license renewal date.

[ARC 7781C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

[Filed 4/26/91, Notice 3/20/91—published 5/15/92, effective 6/19/91]

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[Filed ARC 7781C (Notice ARC 7460C, IAB 1/10/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2020
TIME-SHARE FILING

[Prior to 9/4/02, see 193E—2.8(557A)]

[Prior to 6/10/26, see Real Estate Commission[193E] Ch 20]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2020.1(557A) Time-share interval filing fees. Each initial filing made pursuant to Iowa Code sections 557A.11 and 557A.12 are accompanied by a basic filing fee of \$100 plus \$25 for every 100 time-share intervals or fraction thereof included in the offering.

2020.1(1) A registration fee is paid with the filing of an application for registration consolidating additional time-share intervals with a prior registration and a fee of \$50 plus an additional fee of \$25 for every 100 time-share intervals or fraction thereof included in the offering.

2020.1(2) A fee is not charged for amendments to the property report as a result of amendments to the initial filing, unless the commission determines the amendments are made for the purpose of avoiding the payment of a fee, in which event the amendment may be treated as an application for registration consolidating additional time-share intervals with a prior registration.

This rule is intended to implement Iowa Code chapter 557A.

[ARC 7782C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

[Filed 8/9/02, Notice 6/26/02—published 9/4/02, effective 10/9/02]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2021
ENFORCEMENT PROCEEDINGS AGAINST UNLICENSED PERSONS
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 21]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2021.1(17A,543B) Civil penalties against unlicensed persons.

2021.1(1) *Commission authority.* The commission is authorized to issue a cease and desist order and to impose a civil penalty as authorized by Iowa Code section 543B.34(3) against any person who is not licensed by the commission but who acts in the capacity of a real estate broker or salesperson.

2021.1(2) *Unlicensed person.* An “unlicensed person” includes any individual or business entity that has never been licensed by the commission, has voluntarily surrendered a license issued by the commission, or has allowed a license issued by the commission to lapse and the time in which the license could have been reinstated pursuant to rule 481—2003.6(272C,543B) or 481—2004.6(272C,543B) has passed.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.2(17A,543B) Unlawful practices. Practices by unlicensed persons that are subject to civil penalties include but are not limited to:

1. Acts or practices by unlicensed persons that need licensure pursuant to Iowa Code sections 543B.1, 543B.3, 543B.6, and 543B.56A and that do not fall into the exceptions listed in Iowa Code section 543B.7.
2. Violating Iowa Code section 543B.1.
3. Violating one or more of the provisions of Iowa Code section 543B.34 as they relate to acts or practices by unlicensed persons.
4. Use or attempted use of a licensee’s license or an expired, suspended, revoked, or nonexistent license.
5. Falsely impersonating a licensed real estate professional.
6. Providing false or forged evidence of any kind to the commission in obtaining or attempting to obtain a license.
7. Knowingly aiding or abetting an unlicensed person in any activity identified in this rule.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; ARC 9251C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2021.3(17A,543B) Investigations. The commission is authorized by Iowa Code sections 17A.13(1) and 543B.34(3) to conduct such investigations as are needed to determine whether grounds exist to issue a cease and desist order and to impose civil penalties against an unlicensed person. Such investigations conform to the procedures outlined in 481—Chapter 503 and 481—Chapter 2018. Complaint and investigatory files concerning unlicensed persons are not confidential except as may be provided in Iowa Code chapter 22.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.4(17A,543B) Subpoenas. Pursuant to Iowa Code sections 17A.13(1) and 543B.34, the commission is authorized in connection with an investigation of an unlicensed person to issue subpoenas to compel persons to produce books, papers, records and any other real evidence, whether or not privileged or confidential under law, which the commission deems necessary as evidence in connection with the civil penalty proceeding or relevant to the decision of whether to initiate a civil penalty proceeding. Commission procedures concerning investigatory subpoenas are set forth in rule 481—503.5(17A,272C).

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.5(17A,543B) Notice of intent to impose civil penalty. Prior to issuing a cease and desist order and imposing a civil penalty against an unlicensed person, the commission provides the

unlicensed person written notice and the opportunity to request a contested case hearing. Notice of the commission's intent to issue a cease and desist order and to impose a civil penalty are served by certified mail, return receipt requested, or personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the unlicensed person may accept service personally or through authorized counsel. The notice includes the following:

1. A statement of the legal authority and jurisdiction under which the proposed cease and desist order would be issued and the civil penalty would be imposed.
2. Reference to the particular sections of the statutes and rules involved.
3. A short, plain statement of the alleged unlawful practices.
4. The dollar amount of the proposed civil penalty and the nature of the intended order to obligate compliance with Iowa Code chapter 543B.
5. Notice of the unlicensed person's right to a hearing and the time frame in which hearing is requested.
6. The address to which written request for hearing is made.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.6(17A,543B) Requests for hearings.

2021.6(1) Unlicensed persons request a hearing within 30 days of the date the notice is received if served through certified mail, or within 30 days of the date of service if service is accepted or made in accordance with Iowa Rule of Civil Procedure 1.305. A request for hearing is in writing and is deemed made on the date of the nonmetered United States Postal Service postmark or the date of personal service.

2021.6(2) If a request for hearing is not timely made, the commission chair or the chair's designee may issue an order imposing a civil penalty and compliance with Iowa Code chapter 543B, as described in the notice. The order may be mailed by regular first-class mail or served in the same manner as the notice of intent to impose civil penalty.

2021.6(3) If a request for hearing is timely made, the commission issues a notice of hearing and conducts a contested case hearing in the same manner as applicable to disciplinary cases against licensees. Rules governing such hearings may be found in 481—Chapter 506 and 481—Chapter 2018.

2021.6(4) An unlicensed person who fails to timely request a contested case hearing has failed to exhaust "adequate administrative remedies" as that term is used in Iowa Code section 17A.19(1).

2021.6(5) An unlicensed person who is aggrieved or adversely affected by the commission's final decision following a contested case hearing may seek judicial review as provided in Iowa Code section 17A.19.

2021.6(6) An unlicensed person may waive the right to hearing and all attendant rights and enter into a consent order imposing a civil penalty and compliance with Iowa Code chapter 543B at any stage of the proceeding upon mutual consent of the commission.

2021.6(7) The notice of intent to issue an order and the order are public records available for inspection and copying in accordance with Iowa Code chapter 22. Copies may be published as provided in 481—subrule 506.31. Hearings are open to the public.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.7(17A,543B) Alternative procedure. The commission may, as an alternative to the notice and request for hearing procedures described in rules 481—2021.5(17A,543B) and 481—2021.6(17A,543B), issue a statement of charges and notice of hearing in a format similar to that used for licensee discipline.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.8(17A,543B) Factors to consider. The commission may consider the following when determining the amount of civil penalty to impose, if any:

1. Whether the amount imposed will be a substantial economic deterrent to the violation.
2. The circumstances leading to the violation.

3. The severity of the violation and the risk of harm to the public.
4. The economic benefits gained by the violator as a result of noncompliance.
5. The interest of the public.
6. The time lapsed since the unlawful practice occurred.
7. Evidence of reform or remedial actions.
8. Whether the violation is a repeat offense following a prior warning letter or other notice of the nature of the infraction.
9. Whether the violation involved an element of deception.
10. Whether the unlawful practice violated a prior order of the commission, court order, cease and desist agreement, consent order, or similar document.
11. The clarity of the issue involved.
12. Whether the violation was willful and intentional.
13. Whether the unlicensed person acted in bad faith.
14. The extent to which the unlicensed person cooperated with the commission.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2021.9(17A,543B) Enforcement options. In addition, or as an alternative, to the administrative process described in these rules, the commission may seek an injunction in district court, enter into a consent agreement with the unlicensed person, or issue an informal cautionary letter.

[ARC 7783C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

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

[Filed 6/6/05, Notice 3/16/05—published 7/6/05, effective 8/10/05]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2022
WHOLESALE OF RESIDENTIAL PROPERTY
[Prior to 6/10/26, see Real Estate Commission[193E] Ch 22]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/18/30

481—2022.1(543B) Real estate wholesaling. A licensed real estate broker may engage in residential real estate wholesaling or represent a nonlicensed wholesaler in a residential real estate transaction provided proper disclosure is made under the guidelines in Iowa Code section 543B.6A.

[ARC 9252C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2022.2(543B) Disclosure of wholesaling. A real estate wholesaler shall provide disclosure to all parties to the residential real estate wholesaling transaction prior to executing a contract to purchase or conveying an equitable interest to another party, including but not limited to the following:

2022.2(1) The legal identities of all parties to the transaction, including the current titleholder for the residential property, the wholesaler, the purchaser of the equitable interest, and any real estate licensee who represents a party in the transaction.

2022.2(2) An explanation of the wholesaling process, including but not limited to the following:

- a.* A wholesaler holds an equitable interest in the property, not legal title.
- b.* A wholesaler is selling its equitable interest in the property to another party.
- c.* A wholesaler may earn a profit from the sale of its equitable interest in the property.

2022.2(3) Wholesaling disclosure: “This transaction constitutes real estate wholesaling, meaning the wholesaler holds only an equitable interest in the property and may not be able to convey title.”

[ARC 9252C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

481—2022.3(543B) Penalties. Residential real estate wholesalers who do not comply with the required disclosures or licensing requirements shall be subject to a civil fine of up to \$10,000 or 10 percent of the sale price for each transaction in violation of Iowa Code section 543B.6A, and the seller or buyer may cancel the contract at any time prior to closing without penalty and retain any earnest money paid by the wholesaler. Civil penalties shall be enforced at the discretion of the real estate commission.

[ARC 9252C, IAB 5/14/25, effective 6/18/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 543B.6A.

[Filed ARC 9252C (Notice ARC 8861C, IAB 2/19/25), IAB 5/14/25, effective 6/18/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTERS 2023 to 2030
Reserved

CHAPTER 2031
ORGANIZATION AND ADMINISTRATION

[Prior to 2/20/02, see 193F—Chapters 2, 9 and 11]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 1]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2031.1(543D) Description.

2031.1(1) The purpose of the real estate appraiser examining board is to administer and enforce the provisions of Iowa Code chapter 543D with regard to the appraisal of real property in the state of Iowa, examination of candidates, issuance of licenses, investigation of alleged violations by licensees, and discipline of those regulated by the board. Through its actions, the board seeks to promote and maintain a high level of public trust in professional appraisal practice.

2031.1(2) The board maintains an office at 6200 Park Avenue, Suite 100, Des Moines, Iowa 50321.

2031.1(3) All board action under Iowa Code chapter 543D will be taken under the supervision of the director, as provided in Iowa Code section 543D.23 and these implementing rules.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 1/22/25; Editorial change: IAC Supplement 6/10/26]

481—2031.2(543D) Administrative authority.

2031.2(1) The director is vested with authority to review, approve, modify, or reject all board action pursuant to Iowa Code chapter 543D. The director may exercise all authority conferred upon the board and has to have access to all records and information to which the board has access. In supervising the board, the director will independently evaluate the substantive merits of recommended or proposed board actions which may be anticompetitive.

2031.2(2) In performing its duties and in exercising its authority under Iowa Code chapter 543D, the board may take action without preclearance by the director if the action is ministerial or nondiscretionary. As used in this chapter, the words “ministerial or nondiscretionary” include any action expressly mandated by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee. The board may, for example, grant or deny an application for initial or reciprocal certification as a real estate appraiser, an application for registration as an associate real estate appraiser, or an application for a temporary practice permit by an out-of-state appraiser, on any ground expressly mandated by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee.

2031.2(3) Prior to taking discretionary action under Iowa Code chapter 543D, the board will secure approval of the director if the proposed action is or may be anticompetitive. As used in this chapter, the word “discretionary” includes any action that is authorized but not expressly imposed by state or federal law, rule, or regulation; by the AQB; or by the appraisal subcommittee. Examples of discretionary action include orders in response to petitions for rulemaking, declaratory orders, or waivers from rules, rulemaking, disciplinary proceedings against licensees, administrative proceedings against unlicensed persons, or any action commenced in the district court.

2031.2(4) Determining whether any particular action is or may be anticompetitive is necessarily a fact-based inquiry dependent on a number of factors, including potential impact on the market or restraint of trade. With respect to disciplinary actions, for instance, a proceeding against a single licensee for violating appraisal standards would not have an impact on the broader market and would accordingly not be an anticompetitive action. Commencement of disciplinary proceedings which affect all or a substantial subset of appraisers may have a significant market impact. When in doubt as to whether a proposed discretionary action is or may be anticompetitive, the board may submit the proposed action to the director for preclearance.

2031.2(5) A person aggrieved by any final action of the board taken under Iowa Code chapter 543D may appeal that action to the director within 20 days of the date the board issues the action.

a. The appeal process applies whether the board action at issue was ministerial or nondiscretionary, or discretionary, and whether the proposed action was or was not submitted through a preclearance process before the director.

b. No person aggrieved by a final action of the board may seek judicial review of that action without first appealing the action to the director.

c. Records, filings, and requests for public information. Final board action, regardless of whether such board action is ministerial, nondiscretionary, or discretionary, will be immediately effective when issued by the board but is subject to review or appeal to the director. If a timely review is initiated or a timely appeal is taken, the effectiveness of such final board action will be delayed during the pendency of such review or appeal.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.3(543D) Annual meeting. The annual meeting of the board will be the first meeting scheduled after April 30. At this time, the chairperson and vice chairperson are elected to serve until their successors are elected.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.4(543D) Other meetings. In addition to the annual meeting, and in addition to other meetings, the time and place of which may be fixed by resolution of the board, any meeting may be called by the chairperson of the board or by joint call of a majority of its members.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.5(543D) Executive officer's duties.

2031.5(1) The executive officer is to cause complete records to be kept of applications for examination and registration, certificates and permits granted, and all necessary information in regard thereto.

2031.5(2) The executive officer is to determine when the legal obligations for certification and registration have been satisfied with regard to issuance of certificates or registrations, and the executive officer will submit to the board any questionable application.

2031.5(3) The executive officer will keep accurate minutes of the meetings of the board. The executive officer will keep a list of the names of persons issued certificates as certified general real property appraisers, certified residential real property appraisers and associate real property appraisers.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.6(543D) Records, filings, and requests for public information. Unless otherwise specified by the rules of the department of inspections, appeals, and licensing, the board is the principal custodian of its own agency orders, statements of law or policy issued by the board, legal documents, and other public documents on file with the board.

2031.6(1) Any person may examine public records promulgated or maintained by the board at its office during regular business hours.

2031.6(2) Deadlines. Unless the context dictates otherwise, such as is the case for timely renewal of a registration or certificate, any deadline for filing a document will be extended to the next working day when the deadline falls on a Saturday, Sunday, or official state holiday.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.7(543D) Adoption, amendment or repeal of administrative rules.

2031.7(1) The board is authorized to adopt, amend or repeal its administrative rules in accordance with the provisions of Iowa Code section 17A.4. Prior to the adoption, amendment or repeal of any rule of the board, any interested person, as described in Iowa Code section 17A.4(1) "b," may submit any data, views, or arguments in writing concerning such rule or may request to make an oral presentation concerning such rule. Such written comments or requests to make oral presentations are to be filed with the board at its official address and should clearly state:

a. The name, address, and telephone number of the person or agency authoring the comment or request;

b. The number and title of the proposed rule, which is the subject of the comment or request as given in the Notice of Intended Action;

c. The general content of the oral presentation. A separate comment or request to make an oral presentation will be made for each proposed rule to which remarks are to be asserted.

2031.7(2) The board will acknowledge receipt and acceptance for consideration of written comments and requests to make oral presentations.

2031.7(3) Written comments received after the deadline set forth in the Notice of Intended Action may be accepted by the board although their consideration is not assured. Requests to make an oral presentation received after the deadline will not be accepted and will be returned to the requester.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.8(543D) Types of appraiser classifications. There are four types of appraiser classifications:

1. Associate residential real property appraiser. This classification consists of those persons who meet the obligations of 481—Chapter 2034.

2. Associate general property appraiser. This classification consists of those persons who meet the obligations of 481—Chapter 2034.

3. Certified residential real property appraiser. This classification consists of those persons who meet the obligations of 481—Chapter 2035.

4. Certified general real property appraiser. This classification consists of those persons who meet the obligations of 481—Chapter 2035.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.9(543D) Qualified state appraiser certifying agency.

2031.9(1) The real estate appraiser examining board is a state appraiser certifying agency in compliance with Title XI of the Financial Institutions Reform, Recovery, and Enforcement Act of 1989 (FIRREA). As a result, persons who are issued certificates by the board to practice as certified real estate appraisers are authorized under federal law to perform appraisal services for federally related transactions and are identified as such in the National Registry maintained by the Appraisal Subcommittee (ASC).

2031.9(2) The board will adhere to the criteria established by the Appraiser Qualifications Board (AQB) of the Appraisal Foundation when registering associate appraisers or certifying certified appraisers under Iowa Code chapter 543D. To the extent that the rules conflict with the minimum obligations outlined in the current version of the AQB criteria, the minimum standards established in the criteria will apply and these rules will give way to the minimum obligations to comply with federal rule, law, or policy.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2031.10(543D) AQB criteria.

2031.10(1) No person may be certified as a certified appraiser unless the person is eligible under the January 1, 2026, AQB criteria.

2031.10(2) The January 1, 2026, AQB criteria outline the conditions under which applicants for certification are eligible to take the mandated examinations.

[ARC 7837C, IAB 4/17/24, effective 5/22/24; ARC 0078D, IAB 2/18/26, effective 3/25/26; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 543D.4, 543D.5, 543D.7, 543D.17, 543D.20 and 543D.22 and chapter 272C.

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CHAPTER 2032 DEFINITIONS

[Prior to 2/20/02, see 193F—Chapter 1]

[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 2]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2032.1(543D) Applicability. The following definitions apply to the rules of the real estate appraiser examining board:

“*Appraisal Foundation*” means the same as defined in Iowa Code section 543D.2(3).

“*Appraisal subcommittee*” means the appraisal subcommittee of the Federal Financial Institutions Examination Council.

“*AQB*” means the Appraiser Qualifications Board of the Appraisal Foundation.

“*AQB Criteria*” or “*the Criteria*” means the Real Property Appraiser Qualification Criteria and Interpretations of the Criteria, effective as of January 1, 2026.

“*ASB*” means the Appraisal Standards Board of the Appraisal Foundation.

“*Associate real property appraiser*” means the same as defined in Iowa Code section 543D.2(6).

“*Certified appraiser*” means an individual who has been certified in one of the following two classifications:

1. The certified residential real property appraiser classification is qualified to appraise one to four residential units without regard to value or complexity.
2. The certified general real property appraiser classification is qualified to appraise all types of real property.

“*Director*” means the same as defined in Iowa Code section 543D.2(9)“*a.*”

“*FFIEC*” means the Federal Financial Institutions Examination Council.

“*FIRREA*” means the Financial Institutions Reform Recovery and Enforcement Act of 1989.

“*USPAP*” means the Uniform Standards of Professional Appraisal Practice published by the Appraisal Foundation, effective as of January 1, 2024.

This rule is intended to implement Iowa Code section 543D.2.

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CHAPTER 2033
GENERAL PROVISIONS FOR EXAMINATIONS
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 3]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2033.1(543D) Examinations. Applicants for a license from the board need to take the examination from the board-approved testing service.

[ARC 7839C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2033.2(543D) Conduct of applicant.

2033.2(1) Any individual who subverts or attempts to subvert the examination process may, at the discretion of the board, have the individual's examination scores declared invalid for the purpose of certification in Iowa, be barred from the appraisal certification examinations in Iowa, or be subject to the imposition of other sanctions that the board deems appropriate.

2033.2(2) Conduct that subverts or attempts to subvert the examination process includes, but is not limited to:

a. Conduct that violates the security of the examination materials, such as removing from the examination room any of the examination materials; reproducing or reconstructing any portion of the examination; aiding by any means in the reproduction or reconstruction of any portion of the examination; selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered examination.

b. Conduct that violates the standard of test administration, such as communicating with any other examination candidate during the administration of the examination; copying answers from another candidate or permitting one's answers to be copied by another candidate during the examination; or referencing any books, notes, written or printed materials or data of any kind, other than the examination materials distributed.

c. Conduct that violates the examination process, such as falsifying or misrepresenting educational credentials or other information needed for admission to the examination; impersonating an examination candidate or having an impersonator take the examination on one's behalf.

2033.2(3) Any examination candidate who challenges a decision of the board under this rule may request a contested case hearing. The request for hearing will be in writing, will briefly describe the basis for the challenge, and will be filed in the board's office within 30 days of the date of the board decision that is being challenged.

[ARC 7839C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2033.3(543D) Application for certification or registration. Applicants for certification or registration have to successfully complete the appropriate examination.

2033.3(1) All initial applications for certification or associate registration will be made through the board's online system. The board may deny an application as described in Iowa Code sections 543D.12 and 543D.17. The board may also deny an application based on disciplinary action pending or taken against an applicant consistent with Iowa Code section 272C.12.

2033.3(2) Reserved.

[ARC 7839C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 543D.8.

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CHAPTER 2034
ASSOCIATE REAL ESTATE APPRAISER
[Prior to 2/20/02, see rule 193F—3.6(543D)]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 4]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2034.1(543D) Qualifications to register as an associate appraiser.

2034.1(1) Education. A person applying for registration as an associate appraiser will, at a minimum, satisfactorily complete all AQB-approved, qualifying education courses needed under the AQB criteria specifying educational standards applicable for registration as an associate appraiser.

2034.1(2) Background check. A state and national criminal history check will be performed on any new associate appraiser applicant. The applicant will authorize release of the results of the criminal history check to the board. If the criminal history check was not completed within 180 calendar days prior to the date the license application is received by the board, the board may perform a new state and national criminal history check or may reject and return the application to the applicant.

2034.1(3) Application process. After completing the AQB associate appraiser obligations, a person applying as an associate appraiser can then access the application through the board's online system. A sufficient application within the meaning of Iowa Code section 17A.18(2) will include all information as outlined in the board's online system and be accompanied by the applicable fee.

2034.1(4) Registration denial. The board may deny an application for registration as an associate appraiser on any ground identified in 481—subrule 2033.4(1) or on any ground upon which the board may impose discipline against an associate appraiser, as provided in 481—Chapter 2036.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2034.2(543D) Supervision of associate appraisers.

2034.2(1) Direct supervision. An associate appraiser is subject to the direct supervision obligations set by the AQB criteria.

2034.2(2) Supervisor registration. An associate appraiser, other than a PAREA associate, will identify all supervisors by whom the associate will be supervised through the board's online system and will promptly notify the board in the event of any change in supervisors. An associate appraiser, other than a PAREA associate, who does not have at least one approved active supervisor meeting the supervision obligations will be placed in inactive status until such time as the associate finds a supervisor. Associate appraisers wishing to maintain an inactive license have to continue to renew on a biennial basis in accordance with rule 481—2034.3(543D).

2034.2(3) Scope of practice. The scope of practice for an associate appraiser is set by the AQB criteria.

2034.2(4) Logs. An associate appraiser will maintain an appraisal experience log consistent with the AQB criteria.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2034.3(543D) Renewal of associate appraiser registration. An associate appraiser registration has to be renewed on a biennial basis as more fully described in 481—Chapter 2038. An associate appraiser is subject to the same continuing education obligations applicable to a certified appraiser as a precondition for renewal. Continuing education obligations are outlined in 481—Chapter 2040.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2034.4(543D) Progress toward certification as a certified residential appraiser or certified general appraiser.

2034.4(1) Associate classification. The associate appraiser classification is intended for those persons training to become certified appraisers and is not intended as a long-term method of performing appraisal services under the supervision of a certified appraiser in the absence of progress

toward certification. As a result, the board may impose deadlines for achieving certification, or for satisfying certain prerequisites toward certification.

2034.4(2) *Progress reports.* In order to assess an associate appraiser's progress toward certification, the board may request periodic progress reports from the associate appraiser and from the associate appraiser's supervisory appraiser or appraisers.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2034.5(543D) Applying for certification as a certified residential appraiser or certified general appraiser. An associate appraiser may apply for certification as a certified residential real estate appraiser or as a certified general real estate appraiser as set by the AQB criteria and consistent with Iowa Code chapter 543D and the rules of the board.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2034.6(272C,543D) Reinstating or reactivating an associate registration.

2034.6(1) In order to reinstate or reactivate an associate registration that has lapsed or been placed in inactive or retired status, the applicant has to complete all continuing education obligations for reinstatement as required by board rule and the AQB criteria. Any qualifying education course taken under this rule as continuing education will also apply as qualifying education toward certification. If the applicant has completed all qualifying education prior to applying to reinstate a lapsed, retired, or inactive associate registration, the applicant may use any approved continuing education course as required by board rule and the AQB criteria.

2034.6(2) If an appraiser's registration is placed in inactive status as a result of the appraiser's failure to maintain at least one approved active supervisor meeting the obligations of this chapter pursuant to subrule 2034.2(2), the applicant will complete the continuing education in accordance with subrule 2034.6(1) in order to reinstate the associate registration but is not obligated to pay any reinstatement fee otherwise due so long as the associate has not renewed the registration to inactive status or allowed the registration to lapse prior to reinstating or reactivating the registration.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2034.7(543D) Supervisory appraiser requirements. Iowa follows the AQB criteria and USPAP concerning supervisory appraiser requirements.

[ARC 7840C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 543D and 272C.

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CHAPTER 2035
CERTIFIED REAL ESTATE APPRAISER

[Prior to 4/17/24, see 193F—Chapter 6]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 5]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2035.1(543D) General.

2035.1(1) Iowa Code chapter 543D regulates appraisal services performed in this state when appraiser certification is needed under federal law. Iowa recognizes two types of certification: certified residential real estate appraiser and certified general real estate appraiser. Iowa does not provide licenses for the “licensed real estate appraiser” category recognized under federal law. More information can be found in 12 CFR Section 34.43. Therefore, appraisal services involving federally related transactions in the state have to be performed by an Iowa certified real estate appraiser with the appropriate certification for the property at issue, or by a person holding an appropriate license or certification from a foreign jurisdiction who also has been issued a temporary practice permit under Iowa Code section 543D.11(2).

2035.1(2) The chart below outlines the differences between two certifications issued by the board.

	Certified Residential Real Estate Appraiser	Certified General Real Estate Appraiser
Property type that can be appraised	Residential units ranging from one to four tenants	All real estate, including commercial and agricultural
Qualifying education core curriculum	200 hours	300 hours
Qualifying education	Bachelor’s degree or higher from an accredited college, junior college, community college, or university; or, an associate’s degree in specific fields, 30 semester hours of college-level course working in specific areas, 30 semester hours of CLEP examinations, or any combination CLEP/college-level covering appropriate hours and topics	Bachelor’s degree or higher from an accredited college, junior college, community college, or university
Experience	1,500 hours accumulated in no less than 12 months	3,000 hours with a minimum of 1,500 hours general accumulated in no less than 18 months
Examination	Certified residential real property appraiser examination or the certified general real property appraiser examination	Certified general real property appraiser examination

2035.1(3) All appraisers performing services regulated by the board are obligated to comply with USPAP.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.2(543D) Education. Applicants for certification by the board have to meet the educational obligations of the AQB criteria.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.3(543D) Examination. The prerequisites for taking the AQB-approved examination are collegiate education, experience, work product review, and completion of all creditable course hours as specified in this chapter. The core criteria hours, collegiate education, and all experience have to be completed as specified in this chapter. Equivalency will be determined in accordance with the AQB. USPAP qualifying education will be awarded only when the class is instructed by at least one AQB-certified USPAP instructor who holds a state-issued certified appraiser credential in active status and good standing.

2035.3(1) In order to qualify to sit for the appropriate certified real estate appraiser examination, the applicant has to complete the board's application form and provide copies of documentation of completion of all courses claimed that qualify the applicant to sit for the examination.

a. A sufficient application within the meaning of Iowa Code section 17A.18(2) has to:

- (1) Be through the board's online system;
 - (2) Be signed by the applicant, be certified as accurate, or display an electronic signature by the applicant if submitted electronically;
 - (3) Be fully completed;
 - (4) Reflect, on its face, full compliance with all applicable continuing education obligations; and
 - (5) Be accompanied by the fee specified in 481—Chapter 2041.
- b.* The core criteria, collegiate education, experience, and work product review have to be completed and documentation submitted to the board at the time of application to sit for the examination.

2035.3(2) The board may verify educational credits claimed. Undocumented credits will be sufficient cause to invalidate the examination results.

2035.3(3) Responsibility for documenting the educational credits claimed rests with the applicant.

2035.3(4) An applicant has to supply a true and accurate copy of the original examination scores when applying for certification.

2035.3(5) If an applicant who has passed an examination does not obtain the related appraiser credential within 24 months after passing the examination, that examination result loses its validity to support issuance of an appraiser credential. To regain eligibility for the credential, the applicant has to retake and pass the examination. This obligation applies to individuals obtaining an initial certified credential or upgrading from an associate credential.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.4(543D) Supervised experience needed for initial certification. Except as otherwise permitted herein, all experience needed to obtain certification has to be obtained consistent with Iowa Code section 543D.9.

2035.4(1) *Acceptable experience.* The board will accept as qualifying experience the documented experience attained while the applicant for initial certification was in an educational program recognized by the Appraiser Qualifications Board and Appraisal Subcommittee as providing qualifying experience for certification, whether or not the applicant was registered as an associate real estate appraiser at the time the educational program was completed. Such programs approved by federal authorities (e.g., practical applications of real estate appraisal (PAREA)) will incorporate direct supervision by a certified real estate appraiser and such additional program features as to satisfy the purpose of requiring that qualifying experience be attained by the applicant as a real estate appraiser.

2035.4(2) *Exceptions.* Applicants for certified real estate appraiser certification in Iowa may utilize experience obtained in the absence of registration as an associate real estate appraiser under the following circumstances:

a. Subject to any obligations or limitations established by applicable federal authorities, including the AQB and appraisal subcommittee (ASC), or applicable federal law, rule, or policy, hours qualifying for experience in any jurisdiction will be considered qualifying hours for experience in Iowa without board approval or authorization, as long as the applicant is able to establish by clear and convincing evidence all of the following:

- (1) The qualifying hours obtained were completed in another jurisdiction under the direct supervision of an appropriate active certified real estate appraiser in that jurisdiction in accordance with the AQB and the jurisdiction's laws, rules, or policies.

- (2) The nature of the experience attained in another jurisdiction is qualitatively and substantially equivalent to the experience an associate real estate appraiser would receive under the direct supervision of a certified real estate appraiser in this state.

b. Reserved.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.5(543D) Demonstration of experience. The board applies the dictates of Iowa Code section 543D.9 and the AQB criteria in determining whether the experience necessary for certification has been met.

2035.5(1) An applicant is obligated to appear before the board to supplement or verify evidence of experience.

2035.5(2) The board may inspect documentation relating to an applicant's claimed experience.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.6(543D) Work product review.

2035.6(1) An applicant will submit a complete appraisal log at the time of application for examination and experience consistent with the AQB criteria. Three appraisal reports will be selected by the board from the log. The applicant will submit electronically one copy of each report and work file for each of the selected appraisals along with the appropriate fee. The work product submission will not be redacted by the applicant. The board reserves the right to request additional appraisals if those submitted by the applicant raise issues concerning the applicant's competency or compliance with applicable appraisal standards or the degree to which the submitted appraisals are representative of the applicant's work product.

2035.6(2) The board will treat all appraisals received as confidential pursuant to USPAP. While applicants are encouraged to submit appraisals actually performed for clients, applicants may submit demonstration appraisals if based on factual information and clearly marked as demonstration appraisals.

2035.6(3) An applicant seeking original certification as a certified general real estate appraiser will submit one residential appraisal and two nonresidential appraisals for review. An applicant seeking an upgrade certification to a certified general real estate appraiser will submit two nonresidential appraisals for review.

2035.6(4) The board will submit the appraisals to a peer review consultant for an opinion on the appraiser's compliance with applicable appraisal standards.

2035.6(5) The work product review process is not intended as an endorsement of an applicant's work product. No applicant or appraiser will represent the results of work product review in communications with a client or in marketing to potential clients in a manner that falsely portrays the board's work product review as an endorsement of the appraiser or the appraiser's work product. Failure to comply may be grounds for discipline.

2035.6(6) The board views work product review, in part, as an educational process. While the board may deny an application based on an applicant's failure to adhere to appraisal standards or otherwise demonstrate a level of competency upon which the public interest can be protected, the board will attempt to work with applicants deemed in need of assistance to arrive at a mutually agreeable remedial plan. A remedial plan may include additional education, desk review, a mentoring program, or additional precertification experience.

2035.6(7) An applicant who is denied certification based on the work product review described in this rule, or on any other ground, will be entitled to a contested case hearing. Notice of denial will specify the grounds for denial, which may include any of the work performance-related grounds for discipline against a certified appraiser.

2035.6(8) If probable cause exists, the board may open a disciplinary investigation based on the work product review of an applicant. A potential disciplinary action could arise, for example, if the applicant is a certified residential real estate appraiser seeking an upgrade to a certified general real estate appraiser, or where the applicant is uncertified and is working under the supervision of a certified real estate appraiser who cosigned the appraisal report.

2035.6(9) After accumulating a minimum of 500 hours of appraisal experience, an applicant may voluntarily submit work product to the board to be reviewed by a peer reviewer for educational

purposes only. A maximum of three reports may be submitted for review during the experience portion of the certification process. Work product submitted for educational purposes only will not result in disciplinary action on either the associate appraiser or the associate appraiser's supervisor so long as the appraisal review did not reveal negligent or egregious errors or omissions. The fee for voluntary submissions of work product for review is provided in 481—Chapter 2041.

2035.6(10) The board will retain the appraisals for as long as needed as documentation of the board's actions for the Appraisal Subcommittee or as needed in a pending proceeding involving the work product of the applicant or the applicant's supervisor. When no longer needed for such purposes, the work product may be retained or destroyed at the board's discretion.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.7(543D) PAREA. PAREA utilizes simulated experience training and serves as an alternative to the traditional supervisor/trainee experience model. PAREA programs have to be AQB-approved and meet all the applicable AQB criteria. An applicant who meets the prerequisites of a PAREA program prior to commencement of training and who receives a valid certificate of completion from an AQB-approved PAREA program, has met the allotted experience obligations as outlined in the AQB criteria for that specific PAREA program. PAREA program experience allotment will be awarded per the AQB criteria at the time of program completion.

Applicants claiming PAREA experience credit are not allowed partial credit for PAREA training (rules 481—2035.1(543D) through 481—2035.7(543D)).

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2035.8(543D) Upgrade from a certified residential real estate appraiser to a certified general real estate appraiser. To upgrade from a certified residential real estate appraiser to a certified general real estate appraiser, an applicant has to satisfy all obligations of this rule, which include work product review and a state and national criminal history check as provided in Iowa Code section 543D.22.

2035.8(1) Education.

a. Collegiate education. Certified residential real estate appraisers have to satisfy the college-level education obligations of the AQB.

b. Core criteria. In addition to the formal education and core criteria educational obligations originally needed to obtain a certified residential credential, an applicant has to meet the current AQB obligations before taking the AQB-approved examination.

2035.8(2) Examination. An applicant has to satisfy the examination obligations.

2035.8(3) Supervision and experience.

a. Experience. An applicant has to satisfy all of the experience obligations while in active status and in accordance with AQB criteria.

b. Supervision. Subject to applicable exceptions, all nonresidential experience obtained and applied toward obtaining a certified general credential as part of the upgrade process will be performed under the tutelage of a certified general real property appraiser, subject to AQB-required coursework.

[ARC 7842C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 543D.5, 543D.8, 543D.9, and 543D.22.

[Filed ARC 7842C (Notice ARC 7262C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2036
DISCIPLINARY ACTIONS AGAINST CERTIFIED AND
ASSOCIATE APPRAISERS

[Prior to 4/17/24, see 193F—Chapter 7]

[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 6]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2036.1(17A,272C,543D) Disciplinary authority. The board is empowered to regulate the real estate appraiser profession for the protection and well-being of the public trust. To perform these functions, the board is broadly vested with authority to review and investigate alleged acts or omissions of applicants and licensees and to address disciplinary concerns under Iowa law.

[ARC 7843C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2036.2(543D) Standards of practice. All registered associate appraisers and certified real estate appraisers will comply with the USPAP edition applicable to each appraisal assignment.

[ARC 7843C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2036.3(17A,272C,543D) Grounds for discipline. The board may initiate disciplinary action against a registered associate appraiser or a certified real estate appraiser based on any one or more of the following grounds:

2036.3(1) Code violations. Any violation of an Iowa Code provision that authorizes imposition of licensee sanctions:

- a. False representation of a material fact, whether by word or by conduct, by false or misleading allegation, or by concealment of that which should have been disclosed;
- b. Attempting to file or filing with the board any false or forged diploma, course certificate, identification, credential, license, registration, certification, examination report, affidavit, or other record;
- c. Failing or refusing to provide complete information in response to a question on an application for initial or renewal registration or certification; or
- d. Otherwise participating in any form of fraud or misrepresentation by act or omission.

2036.3(2) Professional incompetence. Professional incompetence includes, but is not limited to:

- a. A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.
- b. A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other practitioners in the state of Iowa acting in the same or similar circumstances.
- c. A failure to exercise the degree of care that is ordinarily exercised by the average practitioner acting in the same or similar circumstances.
- d. Failure to conform to the minimal standards of acceptable and prevailing practice of registered associate appraisers or certified real property appraisers in this state.
- e. A willful, repeated, or material deviation from USPAP standards, or other act or omission that demonstrates an inability to safely practice in a manner protective of the public's interest, including any violation of USPAP's competency rule.

2036.3(3) Deceptive practices. Deceptive practices are grounds for discipline, whether or not actual injury is established, and include but are not limited to:

- a. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of real property appraising.
- b. Use of untruthful or improbable statements in advertisements. Use of untruthful or improbable statements in advertisements includes, but is not limited to, an action by a registrant or certificate holder in making information or intention known to the public that is false, deceptive, misleading or promoted through fraud or misrepresentation.

c. Falsification of business records or appraisal logs through false or deceptive representations or omissions.

d. Submission of false or misleading reports or information to the board including information supplied in an audit of continuing education, reports submitted as a condition of probation, or any reports identified in this rule.

e. Making any false or misleading statement in support of an application for registration or certification submitted by another.

f. Knowingly presenting as one's own a certificate or registration, certificate or registration number, or signature of another or of a fictitious registrant or certificate holder, or otherwise falsely impersonating a certified appraiser or registered associate appraiser.

g. Representing oneself as a registered associate appraiser or certified appraiser when one's registration or certificate has been suspended, revoked, surrendered, or placed on inactive or retired status, or has lapsed.

h. Permitting another person to use the registrant's or certificate holder's registration or certificate for any purposes.

i. Fraud in representations as to skill or ability.

j. Misrepresenting a specialized service as an appraisal assignment in violation of Iowa Code section 543D.18(3) or (5).

2036.3(4) *Unethical, harmful or detrimental conduct.* Registrants and certificate holders engaging in unethical conduct or practices harmful or detrimental to the public may be disciplined whether or not injury is established. Behaviors and conduct that are unethical, harmful or detrimental to the public may include, but are not limited to, the following actions:

a. Verbal or physical abuse, improper sexual contact, or making suggestive, lewd, lascivious, offensive or improper remarks or advances, if such behavior occurs within the practice of real property appraising or if such behavior otherwise provides a reasonable basis for the board to conclude that such behavior within the practice of real estate appraising would place the public at risk.

b. Engaging in a professional conflict of interest, or otherwise violating the public trust, as provided in USPAP's ethics rule.

c. Aiding or abetting any unlawful activity for which a civil penalty can be imposed under rule 481—2042.2(543D).

2036.3(5) *Lack of proper qualifications.*

a. Continuing to practice as a registered associate appraiser or certified real property appraiser without satisfying the continuing education for registration or certificate renewal.

b. Acting as a supervisor without proper qualification, as provided in rule 481—2034.7(543D).

c. Habitual intoxication or addiction to the use of drugs, or impairment that adversely affects the registrant's or certificate holder's ability to practice in a safe and competent manner.

d. Any act, conduct, or condition, including lack of education or experience and careless or intentional acts or omissions, that demonstrates a lack of qualifications that are necessary to ensure a high standard of professional care as provided in Iowa Code section 272C.3(2) "b," or that impairs a practitioner's ability to safely and skillfully practice the profession.

e. Failure to meet the minimum qualifications for registration as an associate appraiser or certification as a certified real property appraiser.

f. Practicing outside the scope of a certification, or outside the scope of a supervisor's certification.

2036.3(6) *Negligence by the registrant or certificate holder in the practice of the profession.* Negligence by the registrant or certificate holder in the practice of the profession includes but is not limited to:

a. A failure to exercise due care including negligent delegation of duties to or supervision of associate appraisers, or other employees, agents, or persons, in developing an appraisal, preparing an appraisal report, or communicating an appraisal, whether or not injury results.

b. Neglect of contractual or other duties to a client.

2036.3(7) *Professional misconduct.*

- a. Violation of a regulation or law of this state, another state, or the United States, which relates to the practice of real estate appraising.
- b. Engaging in any conduct that subverts or attempts to subvert a board investigation.
- c. Revocation, suspension, or other disciplinary action taken by a licensing authority of this state or another state, territory, or country. A stay by an appellate court will not negate this obligation; however, if such disciplinary action is overturned or reversed by a court of last resort, discipline by the board based solely on such action will be vacated.
- d. A violation of Iowa Code section 543D.18.
- e. A violation of Iowa Code section 543D.20 (limitations on persons assisting in the development or reporting of a certified appraisal).
- f. Failure to retain records as provided in Iowa Code section 543D.19.
- g. Violation of the terms of an initial agreement with the impaired practitioner review committee or violation of the terms of an impaired practitioner recovery contract with the impaired practitioner review committee.

2036.3(8) *Willful or repeated violations.* The willful or repeated violation or disregard of any provision of Iowa Code chapter 272C or 543D, or any administrative rule adopted by the board in the administration or enforcement of such chapters.

2036.3(9) *Failure to report.*

- a. Failure by a registrant or certificate holder or an applicant for a registration or certificate to report in writing to the board any revocation, suspension, or other disciplinary action taken by a licensing authority, in Iowa or any other jurisdiction, within 30 calendar days of the final action.
- b. Failure of a registrant or certificate holder or an applicant for a registration or certificate to report, within 30 calendar days of the action, any voluntary surrender of a professional license to resolve a pending disciplinary investigation or action, in Iowa or any other jurisdiction.
- c. Failure to notify the board of a criminal conviction within 30 calendar days of the action, regardless of the jurisdiction where it occurred.
- d. Failure to notify the board within 30 calendar days after occurrence of any adverse judgment in a professional or occupational malpractice action, or settlement of any claim involving malpractice, regardless of the jurisdiction where it occurred.
- e. Failure to report another registrant or certificate holder to the board for any violation listed in these rules, pursuant to Iowa Code section 272C.9(2), promptly after the registrant or certificate holder becomes aware that a reportable violation has occurred.
- f. Failure to report to the board the appraiser's principal place of business and any change in the appraiser's principal place of business within 30 calendar days of such change.
- g. Failure of an associate appraiser or supervisor to timely respond to board requests for information, as provided in 481—Chapter 2034.

2036.3(10) *Failure to comply with board order.* Failure to comply with the terms of a board order or the terms of a settlement agreement or consent order, or other decision of the board imposing discipline.

2036.3(11) *Conviction of a crime.*

- a. Conviction, in this state or any other jurisdiction, of any felony offense that directly relates to the profession, or of any crime that is substantially related to the qualifications, functions, duties or practice of a person developing or communicating real estate appraisals to others. Any crime involving deception, dishonesty or disregard for the safety of others will be deemed directly related to the practice of real property appraising. A certified copy of the final order or judgment of conviction or plea of guilty in this state or in another jurisdiction will be conclusive evidence of the conviction. "Conviction" includes any plea of guilty or nolo contendere, including Alford pleas, or finding of guilt whether or not judgment or sentence is deferred, withheld, or not entered, and whether or not the conviction is on appeal. If such conviction is overturned or reversed by a court of last resort, discipline by the board based solely on the conviction will be vacated. A conviction qualifies as a felony offense

if the offense is designated as a felony in the jurisdiction in which the conviction occurred, or if the offense is committed in this state, the offense would be a felony, without regard to its designation elsewhere. An offense directly relates to the profession if either:

(1) The actions taken in furtherance of an offense are actions customarily performed within the scope of practice of the profession, or

(2) The circumstances under which an offense was committed are circumstances customary to the profession.

b. Notwithstanding the foregoing, a conviction may be grounds for revocation or suspension only if an unreasonable risk to public safety exists because the offense directly relates to the duties and responsibilities of the profession.

[ARC 7843C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A, 272C and 543D and 2007 Iowa Acts, Senate File 137.

[Filed ARC 7843C (Notice ARC 7263C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2037
INVESTIGATIONS AND DISCIPLINARY PROCEDURES

[Prior to 4/17/24, see 193F—Chapter 8]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 7]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2037.1(272C,543D) Disciplinary action. The real estate appraiser examining board has authority under applicable law to impose discipline for violations of law.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.2(17A,272C,543D) Initiation of disciplinary investigations. The board may initiate a licensee disciplinary investigation upon the board's receipt of information suggesting that a licensee may have violated the licensee's legal obligations under the Iowa Code or board rule.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.3(17A,272C,543D) Conflict of interest. If the subject of a complaint is a member of the board, or if a member of the board has a conflict of interest in any disciplinary matter before the board, that member will abstain from participation in any consideration of the complaint and from participation in any disciplinary hearing that may result from the complaint.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.4(272C,543D) Complaints. Written complaints need to be submitted to the board through the board's online system. The board may also initiate its own complaints.

2037.4(1) Role of complainant. The role of the complainant in the disciplinary process is limited to providing the board with factual information relative to the complaint. A complainant is not party to any disciplinary proceeding which may be initiated by the board based in whole or in part on information provided by the complainant.

2037.4(2) Role of the board. The board does not act as an arbiter of disputes between private parties, nor does the board initiate disciplinary proceedings to advance the private interest of any person or party. The role of the board in the disciplinary process is to protect the public by investigating complaints and initiating disciplinary proceedings in appropriate cases. The board possesses sole decision-making authority throughout the disciplinary process, including the authority to determine whether a case will be investigated, the manner of the investigation, whether a disciplinary proceeding will be initiated, and the appropriate licensee discipline to be imposed, if any.

2037.4(3) Initial complaint screening. Tips that are not complaints will be evaluated by the disciplinary committee but may not be assigned a case number or further investigated. Complaints that have been submitted and assigned a case number will be referred to the discipline committee. Final decisions on complaints will be made by the board.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.5(272C,543D) Case numbers. Whether based on written complaint received by the board or complaint initiated by the board, all complaint files will be tracked by a case numbering system. Once a case file number is assigned to a complaint, all persons communicating with the board regarding that complaint are encouraged to include the case file number to facilitate accurate records and prompt response.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.6(17A,272C,543D) Investigation procedures.

2037.6(1) Disciplinary committee. The board chairperson will annually appoint two to three members of the board to serve on the board's disciplinary committee. The disciplinary committee is a purely advisory body that reviews complaint files referred by the board's executive officer, generally

supervises the investigation of complaints, and makes recommendations to the full board on the disposition of complaints. Members of the committee will not personally investigate complaints, but they may review the investigative work product of others in formulating recommendations to the board.

2037.6(2) *Screening of complaints.* All complaints presented to the board will be screened, evaluated and, where appropriate, investigated.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.7(17A,272C,543D) Informal discussion. If the disciplinary committee considers it advisable, or if requested by the affected licensee, the committee may grant the licensee any opportunity to appear before the committee for a voluntary informal discussion of the facts and circumstances of an alleged violation, subject to the provisions of this rule.

2037.7(1) Because disciplinary investigations are confidential, only the licensee's legal representative may attend the information discussion with the board.

2037.7(2) 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, licensees who desire to attend an informal discussion waive their 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. Licensees would not be waiving their 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.

2037.7(3) 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.

2037.7(4) The disciplinary committee, subject to board approval, may propose a consent order at the time of the informal discussion.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.8(272C,543D) Peer review committee (PRC). A peer review committee may be appointed by the board to investigate a complaint.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.9(17A,272C,543D) Closing complaint files.

2037.9(1) *Grounds for closing.* The board may close a complaint file, with or without prior investigation.

2037.9(2) *Cautionary letters.* The board may issue a confidential letter of caution to a licensee when a complaint file is closed that informally cautions or educates the licensee about matters that could form the basis for disciplinary action in the future if corrective action is not taken by the licensee. Informal cautionary letters do not constitute disciplinary action, but the board may take such letters into consideration in the future if a licensee continues a practice about which the licensee has been cautioned.

2037.9(3) *Reopening closed complaint files.* The board may reopen a closed complaint file if additional information arises after closure that provides a basis to reassess the merits of the initial complaint. Complaint files may also be reopened when a complaint has been previously closed due to the lapse of the licensee's license.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.10(17A,272C,543D) Initiation of disciplinary proceedings. Disciplinary proceedings may only be initiated by the affirmative vote of a majority of a quorum of the board at a public meeting. Board members who are disqualified will not be included in determining whether a quorum exists. If, for example, two members of the board are disqualified, three members of the board constitute a quorum of the remaining five board members for purposes of voting on the case in which the two members are disqualified. When three or more members of the board are disqualified or otherwise unavailable for any reason, the executive officer may request the special appointment of one or more substitute board members pursuant to Iowa Code section 17A.11(5).

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.11(543D) Decisions. The board will make findings of fact and conclusions of law, and set forth the board's decision, order, or both in the case. The board's decision may include, without limitation, any of the following outcomes, either individually or in combination:

1. Dismissing the charges;
2. Suspending or revoking the appraiser's certification or associate's registration as authorized by law;
3. Imposing civil penalties, the amount to be set at the discretion of the board but not exceeding \$1,000 per violation. Civil penalties may be imposed for any of the disciplinary violations specified in Iowa Code section 543D.17 and chapter 272C or for any repeat offenses;
4. Imposing a period of probation, either with or without conditions;
5. Obligating the licensee to undergo reexamination;
6. Obligating the licensee to take additional professional education, reeducation, or continuing education;
7. Issuing a citation and a warning;
8. Imposing desk review of the appraiser's work product;
9. Issuing a consent order either with or without conditions;
10. Imposing consultation with one or more peer reviewers;
11. Revoking an appraiser's eligibility to supervise;
12. Compelling submission of monthly logs;
13. Placing limitations on a licensee's practice, such as removing a licensee's authority to act as an instructor; and
14. Imposing any other form of discipline authorized by a provision of law that the board, in its discretion, believes is warranted under the circumstances of the case.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.12(272C,543D) Mitigating and aggravating factors. Factors the board may consider when determining whether to impose discipline and what type of discipline to impose include but are not limited to:

2037.12(1) History and background of respondent.

- a. Whether the respondent was a registered associate appraiser or a certified appraiser at the time of the violation.
- b. Prior disciplinary history or cautionary letters.
- c. Length of certification or registration at the time of the violation.
- d. Disciplinary history of current or prior supervisor.
- e. Degree of cooperation with investigation.
- f. Extent of self-initiated reform or remedial action after the date of the violation.
- g. Whether the volume or geographic range of the respondent's practice is, or was at the time of the violation, reasonable under the circumstances.
- h. Whether the respondent practiced with a lapsed, inactive, retired, suspended, revoked, or surrendered certificate or registration.

2037.12(2) Nature of violations, not limited to:

- a. Length of time since the date of the violation.

- b.* Whether the violation is isolated or recurring.
- c.* Whether there are multiple violations or appraisals involved.
- d.* Whether the violation is in the nature of an error or situational carelessness or neglect, or reflects a more fundamental lack of familiarity with applicable appraisal methodology or standards.
- e.* Indicia of bad faith, false statements, deceptive practices, or willful and intentional acts, whether within the circumstances of the violation or in the course of the board's investigation or disciplinary proceeding.
- f.* Evidence of improper advocacy or other violation of the USPAP ethics rule or of Iowa Code section 543D.18 or 543D.18A(1).
- g.* The clarity of the issue or standard involved.
- h.* Whether the respondent practiced outside the scope of practice authorized by respondent's certification or registration.
- i.* Whether the violation relates to the respondent's supervisory role, the respondent's individual appraisal practice, or both.

2037.12(3) Interest of the public, not limited to:

- a.* Degree of financial or other harm to a client, consumer, lending institution, or others.
- b.* Risk of harm, whether or not the violation caused actual harm.
- c.* Economic or other benefit gained by respondent or by others as a result of the violation.
- d.* Deterrent impact of discipline.
- e.* Whether the respondent issued a corrected appraisal report when warranted.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.13(272C,543D) Voluntary surrender. The board may accept the voluntary surrender of a license to resolve a pending disciplinary contested case or pending disciplinary investigation. The board will not accept a voluntary surrender of a license to resolve a pending disciplinary investigation unless a statement of charges is filed along with the order accepting the voluntary surrender. Such voluntary surrender is considered disciplinary action and will be published in the same manner as is applicable to any other form of disciplinary order.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2037.14(272C,543D) Reinstatement. The following provisions apply to license reinstatement proceedings:

2037.14(1) The board may grant an applicant's request to appear informally before the board prior to the issuance of a notice of hearing on an application to reinstate if the applicant requests an informal appearance in the application and agrees not to seek to disqualify, on the ground of personal investigation, board members or staff before whom the applicant appears.

2037.14(2) An order granting an application for reinstatement may impose such terms and conditions as the board deems desirable, which may include one or more of the types of disciplinary sanctions described in rule 481—2037.14(272C,543D).

2037.14(3) The board will not grant an application for reinstatement when the initial order that revoked, suspended or placed limitations on the license, denied license renewal, or accepted a voluntary surrender was based on a criminal conviction and the applicant cannot demonstrate to the board's satisfaction that:

- a.* All terms of the sentencing or other criminal order have been fully satisfied;
- b.* The applicant has been released from confinement and any applicable probation or parole; and
- c.* Restitution has been made or is reasonably in the process of being made to any victims of the crime.

2037.14(4) A state and national criminal history check may be performed on any applicant applying to reinstate registration or credential consistent with Iowa Code section 543D.22.

[ARC 7844C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 543D.5, 543D.17, and 543D.18 and chapters 17A and 272C.

[Filed ARC 7844C (Notice ARC 7264C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2038
RENEWAL, EXPIRATION AND REINSTATEMENT OF
CERTIFICATES AND REGISTRATIONS, RETIRED STATUS, AND INACTIVE STATUS

[Prior to 4/17/24, see 193F—Chapter 9]

[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 8]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2038.1(272C,543D) Biennial renewal.

2038.1(1) Licenses have to be renewed on a biennial basis or they lapse.

2038.1(2) Persons licensed before June 30, 2024, will maintain their biennial renewal timelines. For licensees initially licensed after June 30, 2024, all licenses will expire biennially on June 30.

Example: Certified general licensee obtains licensure on May 25, 2025. License will expire on June 30, 2026, with the first year being a partial year.

2038.1(3) An application to renew a certificate or registration has to be submitted through the board's online system.

2038.1(4) All continuing education claimed on a biennial renewal needs to have been acquired during the renewal period. In addition, all continuing education claimed on a biennial renewal has to have been taken and completed prior to submission of the renewal application.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2038.2(272C,543D) Notices.

2038.2(1) The board may send renewal notices to licensed appraisers. However, it is the licensee's responsibility to renew timely.

2038.2(2) Certified and associate appraisers have to ensure that their contact information on file with the board office is current and that the board is notified within 30 days of any changes.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2038.3(272C,543D) Renewal procedures.

2038.3(1) *Date of filing.* Certified and associate appraisers have to file a complete renewal application with the board by the June 30 deadline in the biennial renewal year. An application will be deemed filed on the date of board receipt, the date of electronic submission or, if payment is mailed, the date postmarked but not the date metered.

2038.3(2) *Continuing education.* An applicant for renewal has to report the applicant's compliance with the continuing education obligations provided in 481—Chapter 2040.

2038.3(3) *Background disclosures.* An applicant for renewal has to disclose such background and character information as the board requests, which may include disciplinary action taken by any jurisdiction regarding a professional license of any type, the denial of an application for a professional license of any type by any jurisdiction, and the conviction of any crime.

2038.3(4) *Insufficient applications.* The board will reject applications that are insufficient.

2038.3(5) *Resubmission of rejected applications.* The board will promptly notify an applicant of the basis for rejecting an insufficient renewal application. Applicants may correct deficiencies and resubmit an application. Resubmitted applications are deemed received on the date of electronic submission.

2038.3(6) *Administrative processing not determinative.* The administrative processing of an application to renew a certificate or registration will not prevent the board from subsequently challenging the application based on new information, such as after-acquired information of continuing education violations.

2038.3(7) *Denial of timely and sufficient application to renew.* If grounds exist to deny an application to renew, the board will send notification to the applicant stating the grounds for denial.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2038.4(272C,543D) Failure to renew.

2038.4(1) The certificate or registration of a certified or associate appraiser lapses unless the appraiser submits a timely and sufficient renewal application by the expiration date.

2038.4(2) Certified and associate appraisers are not authorized to practice or to hold themselves out to the public as certified or registered appraisers during the period of time that the certificate or registration is lapsed. Any violation of this subrule will be grounds for discipline.

2038.4(3) Reinstatement. The board may reinstate a lapsed certificate or registration upon the applicant's submission of an application to reinstate and completion of all of the following:

- a. Paying a penalty as provided by board rule; and
- b. Paying the current renewal fee as provided by board rule; and
- c. Paying the Appraisal Subcommittee National Registry fee as provided by board rule; and
- d. Completing a state and national criminal history check as required by law; and
- e. Providing evidence of completed continuing education outlined in rule 481—2040.2(272C,543D), as modified for associate appraisers in subrule 2038.4(6), if the licensee wishes to reinstate to active status; and
- f. Providing a written statement outlining the professional activities of the applicant in the state of Iowa during the period in which the applicant's license had lapsed. The statement will describe all appraisal services performed, with or without the use of the titles described in Iowa Code section 543D.15, for all appraisal assignments that federal or state law, rule, or policy mandate to be performed by a certified real estate appraiser.

2038.4(4) Reinstating associate appraisers are to follow special continuing education obligations. The board seeks to ensure that associate appraisers make progress toward full completion of all qualifying education needed for eventual certification, as provided in the rules. As a result, an associate appraiser applying to reinstate a registration that has been lapsed for 12 months or longer will complete the most recent seven-hour USPAP course, and only qualifying education toward the continuing education needed for reinstatement, until all qualifying education has been completed. If the applicant has already completed all qualifying education or has to have continuing education hours beyond those needed to fully complete all qualifying education, the applicant may use any approved continuing education course in addition to the mandatory seven-hour USPAP course.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2038.5(272C,543D) Inactive status.

2038.5(1) *General purpose.* A licensee who is not engaged in Iowa in any practice licensed by the board may allow a license to lapse or register as inactive. The board will continue to maintain a database of persons registered as inactive as well as those whose license has lapsed. A person registered in inactive status is not allowed to perform services in this state regulated by the board. Continuing education is not required for licensees in inactive status.

2038.5(2) *Eligibility.* A person holding an active license may apply on forms through the board's online system to register as inactive if the person is not engaged in appraisal practice in the state of Iowa for which a certificate or associate registration is needed. Inactive status is not available to an individual who has had a board-issued license revoked or suspended. A person seeking inactive status may be actively engaged in the practice of real estate appraising in another jurisdiction.

2038.5(3) *Affirmation.* The application form will contain a statement in which the applicant affirms that the applicant will not engage in any conduct that would require an Iowa license without first complying with all rules governing reactivation to active status. A person in inactive status may reactivate to active status at any time pursuant to subrule 2038.5(6).

2038.5(4) *Renewal.* A person registered as inactive will need to renew biennially. Licensees in inactive status may continue to renew in inactive status. Active licensees may register in inactive status if, for instance, they have not completed all continuing education obligations needed for active status renewal. Any licensee in inactive status must satisfy all outstanding continuing education

obligations before reinstating to active status. Continuing education obligations do not accrue during the period of inactive registration.

2038.5(5) *Grounds for discipline.* Licensees are not authorized to practice or to hold themselves out to the public as board-licensed appraisers during the period of time that the licensee is in retired or inactive status. Any violation of this subrule will be grounds for discipline.

2038.5(6) *Reactivation.* A person registered as inactive will apply to reactivate to active status prior to engaging in any practice in Iowa that necessitates active licensure by the board. An application to reactivate to active status will be through the board's online system. Prior to reactivation to active status, the applicant has to complete all education that would have been needed had the applicant been on active status, including the required courses set by the AQB criteria. All such continuing education has to be verified whether or not the applicant has been in active practice in another jurisdiction. Such an applicant will be given credit for the most recent renewal fees previously paid if the applicant applies to reactivate in the same biennium at other than the applicant's regular renewal date. An associate licensee changing from active to inactive status during a biennial renewal period will not, however, be entitled to a refund of any of the fees previously paid to attain active status.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2038.6(272C,543D) Retired status. A certified licensee may place the licensee's license in retired status. For purposes of this rule, the term "retired" means the person has retired from working as a certified appraiser and has requested to be placed in retired status through the board's online system. A licensee in retired status may request that the license be placed back into active status so long as the licensee is still within the biennial period of the last active status. The board will not provide a refund of biennial registration and certification fees when 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 in retired status are exempt from the renewal obligation. While in retired status, appraisers cannot hold themselves out to the public as being certified appraisers during the period of time that the license is in retired status.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2038.7(272C,543D) Property of the board. Every license issued by the board will, while it remains in the possession of the holder, be preserved by the holder but will, nevertheless, always remain the property of the board.

[ARC 7845C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 543D.5.

[Filed ARC 7845C (Notice ARC 7265C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2039 RECIPROCITY

[Prior to 4/17/24, see 193F—Chapter 10]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 9]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2039.1(543D) Nonresident certification by reciprocity.

2039.1(1) A nonresident of Iowa seeking certification in this state can apply for reciprocity through the board's online system and pay the board-established fee.

2039.1(2) The board may issue a reciprocal certificate to a nonresident individual who is certified and demonstrates good standing in another state. An appraiser who is listed in good standing on the National Registry of the Appraisal Subcommittee satisfies the good standing obligation without additional documentation. An appraiser who is not listed in good standing on the National Registry of the Appraisal Subcommittee will need to supply an official letter of good standing issued by the licensing board of the appraiser's resident state and bearing its seal.

2039.1(3) A reciprocal certified appraiser will comply with all provisions of Iowa law and rules.

2039.1(4) Reciprocal certified appraisers are obligated to pay the federal registry fee as set forth in the board's rules.

[ARC 7846C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2039.2(543D) Temporary practice permit.

2039.2(1) The board will recognize, on a temporary basis, the license of a certified appraiser issued by another state for a period of six months, unless the applicant requests, and is approved for, a one-time extension. An extension request has to be received prior to the expiration date of the issuance of the temporary practice permit. An extension may be granted for up to six months past the original expiration date so long as the applicant is still eligible for a temporary practice permit.

2039.2(2) The appraiser has to apply through the board's online system. The appraiser seeking a temporary practice permit must meet the other qualifying factors associated with reciprocity, including good standing and payment of the appropriate fee. The temporary practice permit will authorize the licensee to perform appraisal on the properties listed on the permit.

2039.2(3) An appraiser holding an inactive, retired, or lapsed certificate as a real estate appraiser in Iowa may apply for a temporary practice permit if the appraiser holds an active, unexpired certificate as a real estate appraiser in good standing in another jurisdiction and is otherwise eligible for a temporary practice permit.

2039.2(4) An appraiser who was previously a registered associate or certified appraiser in Iowa whose Iowa license has been revoked or surrendered in connection with a disciplinary investigation or proceeding is ineligible to apply for a temporary practice permit in Iowa.

2039.2(5) The board may deny an application for a temporary practice permit based on prior discipline in this jurisdiction or other jurisdictions.

2039.2(6) An appraiser holding an inactive, retired, or lapsed Iowa certificate who applies to reinstate to active status in Iowa will not be given credit for any fees paid during the biennial period for one or more temporary practice permits.

2039.2(7) An appraiser holding a license to practice as a real estate appraiser in another jurisdiction may practice in Iowa without applying for a temporary practice permit or paying any fees as long as the appraiser does not perform appraisal services in Iowa that require licensure in this state.

2039.2(8) The board will receive and approve an application for a temporary practice permit before the applicant is eligible to practice in Iowa under a temporary practice permit. Applicants will apply using the board's online system. The board will grant or deny all applications for temporary practice permits within the requirements set by the ASC. Applicants disclosing discipline or criminal convictions will need to attach supporting documentation so that the board can assess whether grounds

exist to deny the application. Falsification of information or failure to disclose material information will be grounds to deny the application, deny subsequent applications, or to reinstate a lapsed or inactive Iowa license.

[ARC 7846C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 543D.10 and 543D.11.

[Filed ARC 7846C (Notice ARC 7266C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2040
CONTINUING EDUCATION

[Prior to 4/17/24, see 193F—Chapter 11]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 10]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2040.1(272C,543D) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Approved program*” means a continuing education program, course, or activity that satisfies the standards set forth in these rules and has received advance board approval pursuant to these rules.

“*Approved provider*” means a person or an organization that has been approved by the board to conduct continuing education programs pursuant to these rules.

“*Asynchronous*” means that the instructor and student interact in an educational offering in which the student progresses at the student’s own pace through structured course content and scheduled quizzes and examinations.

“*Board*” means the same as defined in Iowa Code section 543D.2(7).

“*Continuing education*” means education that is obtained by a person certified to practice real estate appraising in order to maintain, improve, or expand skills and knowledge obtained prior to initial certification or registration, or to develop new and relevant skills and knowledge, all as a condition of renewal.

“*Credit hour*” means the value assigned by the board, or the AQB, to a continuing or qualifying education program.

“*Distance education*” means any education process based on the geographical separation of student and instructor. “Distance education” includes asynchronous, synchronous, and hybrid educational offerings.

“*Guest speaker*” means an individual who teaches an appraisal education program on a one-time-only or very limited basis and who possesses a unique depth of knowledge and experience in the subject matter.

“*Hybrid*,” also known as a blended course, means a learning environment that allows for both in-person and online (synchronous or asynchronous) interaction.

“*Live instruction*” means an educational program delivered in a classroom setting where both the student and the instructor are present in the same room.

“*Qualifying education*” means education that is obtained by a person seeking certification as a real property appraiser prior to initial certification or registration.

“*Synchronous*” means that in an educational offering the instructor and student interact online simultaneously, as in a phone call, video chat or live webinar, or web-based meeting.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.2(272C,543D) Continuing education obligations.

2040.2(1) Board-licensed appraisers have to demonstrate compliance with the continuing education set by the AQB criteria.

2040.2(2) All continuing education credit hours may be acquired in approved education programs.

2040.2(3) Instructors claiming continuing education credit may be requested to provide supporting documentation to ascertain course content and related details.

2040.2(4) An applicant seeking to renew an initial license issued less than 185 days prior to renewal is not obligated to report any continuing education. An applicant seeking to renew an initial certificate or registration issued for 185 days to 365 days prior to renewal has to demonstrate completion of at least 14 credit hours, including the National USPAP continuing education course or its AQB equivalent. An applicant seeking to renew an initial certificate or registration issued 365 days

prior to renewal or more has to demonstrate completion of at least 28 credit hours, including seven credit hours of the most recent National USPAP continuing education.

2040.2(5) Prior to reinstatement or reactivation of a certified general or residential registration, a licensee in inactive, retired, or lapsed status has to complete all continuing education hours that would have been needed if the licensee was in active status. The hours will also include the most recent edition of a National USPAP Update course.

2040.2(6) During each two-year renewal period, a continuing education program may be taken for credit only once.

2040.2(7) At least 50 minutes of every class hour have to be attended by the student to count as an hour of continuing education.

2040.2(8) An applicant may claim continuing education credits that have been approved by another jurisdiction that has a continuing education obligation for license renewal in that jurisdiction if the applicable program was approved by the other jurisdiction's appraisal regulatory body or the AQB for continuing education purposes at the time the applicant completed the course. The burden of proof in this regard is on the applicant. All other programs have to be approved upon application to the board pursuant to this chapter.

2040.2(9) A person certified or registered to practice real estate appraising in Iowa will be deemed to have complied with Iowa's continuing education obligation for periods in which the person is a resident of another state or district having continuing education obligations for real estate appraising and meets all obligations of that state or district.

2040.2(10) A person certified or registered to practice real estate appraising in Iowa who completes an education course approved by both the board and another appraiser regulatory body, for which the approved hours vary, will only be allowed to claim the hours approved by the board to meet the obligations of renewal of the person's associate registration or certified credential in Iowa. A person certified or registered to practice real estate appraising in Iowa who completes an educational course not approved in Iowa, but approved by either the AQB or by another appraiser regulatory body, may claim the hours awarded by either the AQB or the appraiser regulatory body of the other jurisdiction.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.3(272C,543D) Minimum program qualifications.

2040.3(1) The board will only approve continuing education programs that provide a formal program of learning that contributes to the growth in the professional knowledge and professional competence of real estate appraisers.

2040.3(2) Continuing education programs as listed in the AQB criteria are accepted by the board, as well as the following appraisal topics, which the board has determined are integrally related to appraisal topics in the state:

- a.* Agriculture production and economics;
- b.* Agronomy/soil; and
- c.* Real estate appraisal technology (e.g., drones).

2040.3(3) The following programs will not be acceptable:

- a.* Sales promotion meetings held in conjunction with the appraiser's general business;
- b.* Time devoted to breakfast, lunch, or dinner;
- c.* A program certified by the use of a challenge examination. The number of hours will be completed to receive credit hours; and
- d.* Programs that do not provide at least two credit hours.

2040.3(4) Continuing education credit will be granted only for whole hours, with a minimum of 50 minutes constituting one hour.

2040.3(5) Continuing education credit may be approved for university or college courses, when an official transcript is provided, in qualifying topics according to the following formula: Each

semester hour of credit will equal 15 credit hours and each quarter hour of credit will equal 10 credit hours.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.4(272C,543D) Standards for provider and program approval. Providers and programs will satisfy the following minimum standards in order to be preapproved in accordance with the procedures established in this chapter and in order to maintain approved status:

2040.4(1) The program will be taught or developed by individuals who have the education, training and experience to be considered experts in the subject matter of the program and competent in the use of teaching methods appropriate to the program.

2040.4(2) Programs will be taught by instructors who have successfully completed an instructor development workshop within 24 months preceding board approval of the program. Certified USPAP instructors and instructors approved via a course delivery mechanism approval per the AQB criteria will be considered to have met this obligation.

2040.4(3) In determining whether an instructor is qualified to teach a particular program, the board will consider whether the instructor has an ability to teach and an in-depth knowledge of the subject matter.

2040.4(4) An instructor may demonstrate the ability to teach by meeting one or more of the following criteria:

- a. Hold a bachelor's degree or higher in education from an accredited college;
- b. Hold a current teaching credential or certificate in any real estate or real estate-related fields;
- c. Hold a certificate of completion in the area of instruction from an instructor institute, workshop or school that is sponsored by a member of the Appraisal Foundation;
- d. Hold a full-time current appointment to the faculty of an accredited college; and
- e. Other, as the board may determine.

2040.4(5) An instructor may demonstrate in-depth knowledge of the program's subject matter by meeting one or more of the following criteria:

- a. Hold a bachelor's degree or higher from an accredited college with a major in a field of study directly related to the subject matter of the course the instructor proposes to teach, such as business, economics, accounting, real estate or finance;
- b. Hold a bachelor's degree or higher from an accredited college and have five years of appraisal experience related to the subject matter of the course the instructor proposes to teach;
- c. Hold a generally recognized professional real property appraisal designation or be a sponsor member of the Appraisal Foundation; and
- d. Other, as the board may determine.

2040.4(6) Only AQB-certified USPAP instructors, listed on the website of the Appraisal Foundation may teach the National USPAP courses, or the AQB-approved equivalent.

2040.4(7) Course content and materials will be accurate, consistent with currently accepted standards relating to the program's subject matter and updated no later than 30 days after the effective date of a change in standards, laws, or rules.

2040.4(8) Programs will have an appropriate means of written evaluation by participants. Evaluations will include the relevance of the materials, effectiveness of presentation, content, facilities, and such additional features as are appropriate to the nature of the program.

2040.4(9) No part of any course will be used to solicit memberships in organizations, recruit appraisers for affiliation with any organization or advertise the merits of any organization or sell any product, or service.

2040.4(10) Providers will clearly inform prospective participants of the number of credit hours preapproved by the board for each program and all applicable policies concerning registration, payment, refunds, attendance obligations, and examination grading.

2040.4(11) Procedures will be in place to monitor whether the person receiving credit hours is the person who attended or completed the program.

2040.4(12) Providers will be accessible to students during normal business hours to answer questions and provide assistance as necessary.

2040.4(13) Providers will comply with or demonstrate exemption from the provisions of Iowa Code sections 714.14 to 714.25.

2040.4(14) Providers will designate a coordinator in charge of each program who will act as the board's contact on all compliance issues.

2040.4(15) Programs will not offer more than eight credit hours in a single day.

2040.4(16) Providers will not provide any information to the board, the public, or prospective students that is misleading in nature. For example, providers will not refer to themselves as a "college" or "university" unless qualified as such under Iowa law.

2040.4(17) Providers will establish and maintain for a period of five years complete and detailed records on the programs successfully attended by each Iowa participant.

2040.4(18) Providers will issue an individual certificate of attendance to each participant upon successful completion of the program.

2040.4(19) Program providers and instructors are solely responsible for the accuracy of all program materials, instruction, and examinations. Board approval of a provider or program is not an assurance or warranty of accuracy and will not be explicitly or implicitly marketed or advertised as such.

2040.4(20) Providers will apply for approval using the board's online system.

2040.4(21) Providers will notify the board within 30 days of a change in the provider's primary contact, name, business address, or any other change that may affect the provider's tax identification number or bond obligations with the Iowa college aid commission.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.5(272C,543D) Acceptable distance education courses. Distance education involves geographical separation of student and instructor. A distance education course is acceptable to meet class hour obligations if it complies with the generic education criteria in the current AQB criteria.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.6(272C,543D) Applications for approval of programs. Applications for approval of programs will be submitted through the board's online system. All non-AQB courses are approved for 24 months, including the month of approval. Programs approved for distance education or by the AQB may be approved by the board. Board approval of a program will only be valid for the shortest period of time such a program is approved by either organization.

2040.6(1) Approval will be obtained for each program separately. With the exception of hybrid courses, courses that are offered via more than one delivery method will require separate program approvals.

2040.6(2) A nonrefundable fee of \$50 will be submitted for each program except for programs that are submitted for approval by the primary provider and that have been approved by the AQB through the AQB Course Approval Program (CAP).

2040.6(3) All online applications and attachments will be submitted for approval at least 30 days prior to the first offering of each program or, if renewing, within 30 days of the course expiration date. The board will approve or deny each program, in whole or part, within 15 days of the date the board receives a fully completed application. Upon approval of an application for course offering, the board will specify the number of credit hours allowed. Payments for course program applications will be made within 30 calendar days of board approval or the application approval may be reversed.

2040.6(4) Applications for non-AQB CAP courses will request information including, but not limited to, the following:

- a. Program description;
- b. Program purpose;
- c. Learning objectives that specify the level of knowledge or competency the student should demonstrate upon completing the program;

- d. Description of the instructional methods utilized to accomplish the learning objective;
- e. Identifying information for all guest speakers or instructors and such documentation as is necessary to verify compliance with the instructor qualifications described in this chapter;
- f. Copies of all instructor and student program materials or, in the case of a one-time course offering, a statement that attests all instructor and student materials will be submitted to the board within ten calendar days of the course offering;
- g. Copies of all examinations and a description of all grading procedures;
- h. A description of the diagnostic assessment method(s) used when examinations are not given;
- i. Such information as needed to verify compliance with board rules;
- j. The name, address, telephone number, and email address for the program's coordinator; and
- k. Such other information as the board deems reasonably needed for informed decision making.

2040.6(5) Application forms for courses that are AQB CAP-approved will include information as deemed necessary for accurate documentation but may be more limited than information set forth in this chapter.

2040.6(6) The board will assign each provider and program a number. This number will be placed on all correspondence with the board, all subsequent applications by the same provider, and all certificates of attendance issued to participants.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.7(272C,543D) Waiver of application fees. Application fees may be waived for approved programs sponsored by a governmental entity when the program is offered at no cost or at a nominal cost to participants. A request for waiver of application fees should be made by the provider or certificate holder at the time the application is filed with the board.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.8(272C,543D) Authority to approve education. The executive officer has the authority to approve or deny education applications subject to the applicant's right to a hearing as provided for in this chapter.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.9(272C,543D) Appraiser request for preapproval of continuing education programs.

An appraiser seeking credit for attendance and participation in a program that is to be conducted by a provider not accredited or otherwise approved by the board will apply for approval to the board at least 15 days in advance of the commencement of the activity. The board will approve or deny the application in writing. The online application for prior approval of a continuing education activity will include the following fee and information:

1. Application fee of \$25;
2. School, firm, organization or person conducting the program;
3. Location of the program;
4. Title and hour-by-hour outline of the program, course or activity;
5. Credit hours requested for approval;
6. Date of program; and
7. Principal instructor(s).

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.10(272C,543D) Appraiser request for postapproval of continuing education program.

An appraiser seeking credit for attendance and participation in a program that was not conducted by an approved provider or approved by the licensing authority in another state or otherwise approved by the board may submit a request for credit for the program. Within 15 days after receipt of the request, the board will advise the requester in writing whether the program is approved and the number of hours allowed. Appraisers not complying with the obligation of this rule may be denied credit for the

program. Application for postapproval of a continuing education program will include the following fee and information:

1. Application fee of \$25;
2. School, firm, organization or person conducting the program;
3. Location of the program;
4. Title of program and description of program;
5. Credit hours requested for approval;
6. Date(s) of program;
7. Student and instructor materials;
8. Principal instructor(s); and
9. Verification of attendance.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.11(272C,543D) Review of provider or program. The board on its own motion or upon receipt of a complaint or negative evaluation may monitor or review any approved program or provider and may withdraw approval of the provider or program and disallow all or any part of the approved hours granted to the provider based on evidence that the obligations of this chapter have not been met. The provider, as a condition of approval, agrees to allow the board or its authorized representatives to monitor ongoing compliance with board rules through means including, but not limited to, unannounced attendance at programs.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2040.12(272C,543D) Hearings. Any person aggrieved by board action related to this chapter may request a contested case hearing before the board.

[ARC 7847C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 543D.5, 543D.9 and 543D.16 and chapter 272C.

[Filed ARC 7847C (Notice ARC 7267C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2041

FEES

[Prior to 4/17/24, see 193F—Chapter 12]

[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 11]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2041.1(543D) Fees.

Initial examination application fee	\$150
Biennial registration fee for active status (initial, reciprocal, renewal):	
Associate/Certified real property appraiser > one year	\$200
Associate/Certified real property appraiser < one year	\$100
Biennial registration fee for inactive status (initial, reciprocal, renewal):	
Certified real property appraiser	\$100
Associate real property appraiser	\$50
Temporary practice permit fee (each request)	\$100
Reinstatement of a lapsed or retired license (lapsed or retired to active status)	\$150 (plus the registration fee)
Reactivation of an inactive or retired license (inactive or retired to active status)	\$50 (plus the registration fee)
Formal wall certificate	\$25
Work product review fees:	
Original submission, certified residential	\$300
Original submission, certified general	\$650
Additional residential reports as requested by the board	\$150 per report
Additional nonresidential reports as requested by the board	\$250 per report
Voluntary submission of residential reports for review	\$150 per report
Voluntary submission of nonresidential reports for review	\$250 per report
Course application fee (non-AQB-approved courses and secondary providers)	\$50
Pre-/post-course application fee	\$25
Background check	\$51
Add supervisory appraiser	\$25
Add course instructor	\$10
Waiver to administrative rules	\$25
Late renewal of associate or certified	\$50
ASC National Registry fee > one year, separate from registration fee (collected by the board for FFIEC)	\$80
ASC National Registry fee < one year, separate from registration fee (collected by the board for FFIEC)	\$40
Examination fee (and reexamination fee) (to be paid to the examination provider)	Current provider rate

[ARC 7848C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2041.2(543D) Prorating of registration fees. An applicant applying for initial or reciprocal registration or certification within 12 months from the applicant's renewal date, pursuant to rule 481—2038.1(543D), will pay half the fee. An applicant applying for initial or reciprocal registration or certification more than 12 months from the applicant's renewal date will pay the full registration fee. An applicant applying to reinstate or reactivate a lapsed registration or certification within 12 months from the applicant's renewal date, pursuant to rule 481—2038.1(543D), will pay half the renewal fee plus the applicable reactivation or reinstatement fee. An applicant applying to reinstate or reactivate a lapsed registration or certification more than 12 months from the applicant's renewal date will pay the full renewal fee plus the applicable reactivation or reinstatement fee.

[ARC 7848C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 543D.6.

[Filed ARC 7848C (Notice ARC 7268C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2042
ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

[Prior to 4/17/24, see 193F—Chapter 16]
[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 12]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2042.1(543D) Civil penalties against nonlicensees. The board may impose civil penalties by order against a person who is not licensed by the board based on the unlawful practices specified in Iowa Code section 543D.21.

[ARC 7855C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2042.2(543D) Grounds for imposing civil penalties. Grounds for issuing an order requiring compliance with Iowa Code chapter 543D or imposing civil penalties up to \$1,000 for each violation include:

2042.2(1) Violating Iowa Code section 543D.15(1) “a.”

2042.2(2) Failing to obtain a temporary practice permit under Iowa Code section 543D.11(2).

2042.2(3) Falsely impersonating a licensee by using the certification or registration title, number or signature of a licensee, or by using the nonexistent certification or registration title, number or signature of a fictitious holder of a board-issued license.

2042.2(4) Violating Iowa Code section 543D.21(4) “e.”

2042.2(5) Violating Iowa Code section 543D.20(1) “a,” “b,” “c,” or “d.”

2042.2(6) Violating Iowa Code section 543D.18A.

[ARC 7855C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2042.3(543D) Notice of intent to impose civil penalties.

2042.3(1) The notice of the board’s intent to issue an order to compel compliance with Iowa Code section 543D.21 and to impose a civil penalty will be served upon the nonlicensee by certified mail, return receipt requested, or by personal service in accordance with Iowa Rule of Civil Procedure 1.305. Alternatively, the nonlicensee may accept service personally or through authorized counsel.

2042.3(2) The notice will include the following:

a. A statement of the legal authority and jurisdiction under which the proposed civil penalty would be imposed.

b. Reference to the particular sections of the statutes and rules involved.

c. A short, plain statement of the alleged unlawful practices.

d. The dollar amount of the proposed civil penalty and the nature of the intended order to compel compliance with Iowa Code section 543D.21.

e. Notice of the nonlicensee’s right to a hearing and the time frame in which hearing has to be requested.

f. The address to which a written request for hearing has to be made.

[ARC 7855C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2042.4(543D) Request for hearing.

2042.4(1) Nonlicensees have to request a hearing within 30 days of the date the notice is received or service is accepted. A request for hearing has to be in writing and is deemed made on the date of the non-metered United States Postal Service postmark or the date of personal delivery to the board office.

2042.4(2) If a request for hearing is not timely made, as described in the notice, the board chairperson or the chairperson’s designee may issue an order imposing a civil penalty and requiring compliance with Iowa Code chapter 543D. The order may be mailed by regular first-class mail or served in the same manner as the notice of intent to impose a civil penalty.

2042.4(3) If a request for hearing is timely made, the board will issue a notice of hearing and conduct a hearing in the same manner as applicable to disciplinary cases against licensees. Hearings involving nonlicensees are open to the public.

2042.4(4) A nonlicensee may waive the right to hearing and all attendant rights and enter into a consent order imposing a civil penalty and requiring compliance with Iowa Code chapter 543D at any stage of the proceeding upon mutual consent of the board.

2042.4(5) The notice of intent to issue an order and the order are public records available for inspection and copying in accordance with Iowa Code chapter 22.

[ARC 7855C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 17A and 543D.

[Filed ARC 7855C (Notice ARC 7272C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 2043
LICENSURE OF PERSONS LICENSED IN OTHER JURISDICTIONS

[Prior to 4/17/24, see 193F—Chapter 26]

[Prior to 6/10/26, see Real Estate Appraiser Examining Board[193F] Ch 13]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/22/29

481—2043.1(272C) Definitions.

“Issuing jurisdiction” means the duly constituted authority in another state that has issued a professional license, certificate, or registration to a person.

“License” or *“licensure”* means any license that may be granted by the board.

[ARC 7865C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

481—2043.2(272C) Licensure of persons licensed in other jurisdictions.

2043.2(1) An individual who establishes residency in this state or who is married to an active duty member of the military forces of the United States and who is accompanying the member on an official permanent change of station to a military installation located in this state may apply for licensure under this rule on forms provided by the board. A certification or registration will be issued if all of the following conditions are met:

a. The person is currently licensed, certified, or registered by at least one other issuing jurisdiction in the profession or occupation applied for with a substantially similar scope of practice and is in good standing in all issuing jurisdictions in which the person holds a license, certificate, or registration. A license, certificate, or registration issued by another jurisdiction that is classified as a licensed residential real property credential or with a scope of practice of a licensed residential real property appraiser, as defined by the AQB criteria, other applicable federal law, rule, or policy, will not be considered a profession or occupation with a substantially similar scope of practice as it relates to a certification or registration as an associate real property appraiser, certified residential real property appraiser, or a certified general real property appraiser.

b. The person has been licensed, certified, or registered by the other issuing jurisdiction forming the basis of the application.

c. When the person was licensed by the other issuing jurisdiction forming the basis of the application, the issuing jurisdiction imposed minimum educational and experience obligations, and the issuing jurisdiction verifies that the person met those obligations in order to be licensed in that issuing jurisdiction. Generally, given federal mandates, the minimum educational and experience obligations to become certified as a real estate appraiser are substantially the same nationwide within the applicable classification and scope of practice.

d. The person previously passed an AQB-approved examination by the other issuing jurisdiction for licensure, certification, or registration.

e. The person has not had a license, certificate, or registration revoked and has not voluntarily surrendered a license, certificate, or registration in any other issuing jurisdiction or country while under investigation for unprofessional conduct.

f. The person has not had discipline imposed by any other regulating entity in this state or another issuing jurisdiction or country. If another jurisdiction has taken disciplinary action against the person, the appropriate licensing board shall determine if the cause for the action was corrected and the matter resolved. If the licensing board determines that the matter has not been resolved by the jurisdiction imposing discipline, the licensing board will not issue or deny a license, certificate, or registration to the person until the matter is resolved.

g. The person does not have a complaint, allegation, or investigation pending before any regulating entity in another issuing jurisdiction or country that relates to unprofessional conduct. If the person has any complaints, allegations, or investigations pending, the appropriate licensing board shall not issue or deny a license, certificate, or registration to the person until the complaint, allegation, or investigation is resolved.

h. The person pays all applicable fees. The fees for applying for licensure under this rule will be the same as the fees for reciprocal licensure.

i. The person does not have a criminal history that would prevent the person from holding the license applied for in this state.

2043.2(2) An individual applying for licensure under this rule will provide, as applicable, proof of current residency in the state of Iowa or proof of the military member's official permanent change of station to the state of Iowa.

a. Proof of residency may include, by way of example:

- (1) Residential mortgage, lease, or rental agreement;
- (2) Utility bill;
- (3) Bank statement;
- (4) Paycheck or pay stub;
- (5) Property tax statement;
- (6) A federal or state government document; or
- (7) Any other document that reliably confirms Iowa residency.

b. Proof of permanent change of station to the state of Iowa includes documentation issued by the appropriate branch of the military requiring a permanent change of station or otherwise indicating or demonstrating a permanent change of station has occurred.

2043.2(3) In order to be considered a sufficient application, an application for licensure under this rule must include all appropriate information as required by this rule and, if applicable, the submission of fingerprints and an appropriate authorization of release as may be necessary to facilitate the board's completion of a criminal history check and any corresponding fee.

2043.2(4) A person issued a license under this rule is subject to the jurisdiction of the board.

2043.2(5) An applicant who is aggrieved by the board's decision to deny an application for a license under this rule may request a contested case hearing. A request for such a contested case hearing will be granted only if the board receives the request within 30 days of issuance of the board's decision.

[ARC 7865C, IAB 4/17/24, effective 5/22/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 543D and 272C and 2019 Iowa Acts, House File 288.

[Filed ARC 7865C (Notice ARC 7275C, IAB 1/24/24), IAB 4/17/24, effective 5/22/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTERS 2044 to 2049
Reserved

CERTIFICATE OF NEED PROGRAM

CHAPTER 2202

CERTIFICATE OF NEED PROGRAM

[Prior to 7/29/87, Health Department[470] Ch 202]

[Prior to 9/4/24, see Public Health Department[641] Ch 202]

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/5/29

481—2202.1(10A) Definitions. For purposes of this chapter, the following definitions apply:

“Acute care category of bed usage,” as the term applies in Iowa Code section 10A.713(2) *“k,”* is the same as the acute care categories listed in the state survey section of the American Hospital Association Annual Survey of Hospitals.

“Any expenditure in excess of five hundred thousand dollars,” as defined in Iowa Code section 10A.711(18) *“e,”* means new capital expenditures necessary to operate the service for a year.

“Any mobile health service with a value in excess of one million five hundred thousand dollars,” as defined in Iowa Code section 10A.711(18) *“l,”* means the value of all equipment used to provide the service, including the trailer. The party providing the equipment is the applicant regardless of the location of that party.

“Appropriate geographic service area,” as the term applies to defining affected persons in Iowa Code section 10A.711(1) *“c,”* is defined as follows:

1. For applications regarding hospitals, hospitals located in the same county and in Iowa counties contiguous to the county wherein the applicant hospital’s proposed project will be located.

2. For applications regarding health care facilities, other health care facilities located in the same county and in Iowa counties contiguous to the county wherein the applicant’s proposed health care facility will be located.

3. For applications sponsored by other than the hospitals or health care facilities specified in paragraphs “1” and “2,” those providers within the same county who offer similar service or might logically be viewed as potential providers of such service.

“Bed capacity” is defined as follows:

1. For hospitals, bed capacity is defined as the total facility licensed beds as reported on the state survey section of the American Hospital Association Annual Survey of Hospitals.

2. For health care facilities, bed capacity is defined as a facility’s licensed bed capacity according to the department of inspections, appeals, and licensing.

“Cardiac catheterization service,” as the term applies to a new or changed institutional health service in Iowa Code section 10A.711(18) *“m”*(1), means the initiation or expansion of this service.

“Consumers served by a new institutional health service” means those consumers residing in the service area as determined by the department.

“Long-term (acute) care hospital,” for purposes of these rules, means a hospital that has been approved to participate in the Title XVIII (Medicare) program as a long-term care hospital-prospective payment system (LTCH-PPS) hospital in accordance with 42 CFR Part 412 as amended to March 29, 1985.

“Open heart surgical service,” as the term applies to new or changed institutional health service in Iowa Code section 10A.711(18) *“m”*(2), means the initiation or expansion of this service.

“Organ transplantation service,” as the term applies to a new or changed institutional health service in Iowa Code section 10A.711(18) *“m”*(3), means the initiation or expansion of this service. Each type of organ transplant shall be considered separately.

“Permanent change in bed capacity of an institutional health facility” includes but is not limited to the following:

1. A conversion of a long-term acute care hospital, a rehabilitation hospital or a psychiatric hospital as defined by federal regulations to a general acute care hospital or to a different type of specialty hospital.

2. A hospital that has deleted beds pursuant to Iowa Code section 10A.713(2) “g” for the purpose of receiving designation as a critical access hospital reestablishes the deleted beds at a later time, provided that the number of beds reestablished does not exceed the number of beds maintained prior to the deletion as reported on the bed reduction form.

“Physical facility,” as the term applies in Iowa Code section 10A.711(18) “f,” means a separately licensed facility.

“Private offices and private clinics of an individual physician, dentist, or other practitioner or group of health care providers.” The meaning of this term as used in Iowa Code section 10A.713(2) “a” is determined by looking at factors that include but are not limited to:

1. The type of health care service delivered.
2. The control and supervision of medical judgment in the care of and treatment of patients.
3. The control and supervision of professional assistants, including nurses, physician associates, and technicians.
4. The ownership and maintenance of medical records of patients.

This term excludes an ambulatory surgical center as defined in Iowa Code section 135R.1.

“Radiation therapy service applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment,” as the term applies to new or changed institutional health service in Iowa Code section 10A.711(18) “m”(4), means the initiation or expansion of this service.

“Rehabilitation hospital,” for the purposes of these rules, means a hospital that has been approved to participate in the Title XVIII (Medicare) program as an inpatient rehabilitation facility-prospective payment system (IRF-PPS) hospital in accordance with 42 CFR Part 412.23(b), 412.25 or 412.29 as amended to March 29, 1985.

“Relocation of an institutional health facility,” as the term applies to new or changed institutional health service in Iowa Code section 10A.711(18) “b,” means the replacement of a facility located in one county with a facility located in another county.

“Value in excess of one million five hundred thousand dollars,” as used in Iowa Code section 10A.711(18) “g,” “h,” “i” and “j,” means the value of the equipment including any applicable sales tax, delivery charge and installation charge. With respect to the initiation of radiation therapy services applying ionizing radiation for the treatment of malignant disease using the megavoltage external beam equipment, the term includes the cost of constructing a vault.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24; Editorial change: IAC Supplement 6/10/26]

481—2202.2(10A) Letter of intent.

2202.2(1) Before applying for a certificate of need, the sponsor of a proposed new institutional health service or changed institutional health service will electronically submit a letter of intent meeting the criteria noted in Iowa Code section 10A.715(1) and containing the project’s estimated cost (site costs, land improvements, facility costs, movable equipment and financing costs, and any applicable sales tax for movable equipment, any applicable delivery charge for movable equipment, and any applicable installation charge for movable equipment).

2202.2(2) The department will make available on the certificate of need web page all criteria and standards that are pertinent to an application.

2202.2(3) A letter of intent received by the department is valid for a period of one year from the date of receipt by the department. The sponsor may renew the validity of a letter of intent by providing written notification to the department prior to the one-year expiration date.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.3(10A) Determination of reviewability. A sponsor of a proposed project may submit a written request for a determination of reviewability as to whether the project requires a certificate of need.

2202.3(1) The request should include sufficient details of the proposed project and cite the sections of the Iowa Code that the sponsor relies upon to assert the project is not reviewable.

2202.3(2) Upon receipt of a written request from the sponsor of a project, the department will determine if a proposed project requires a certificate of need under Iowa Code sections 10A.711 through 10A.729. The department may request additional information about the project to make the determination.

a. If it is determined that a certificate of need is required, the sponsor will be notified by the department and the request for nonreviewability will be considered the letter of intent for purposes of 2202.2(2).

b. If it is determined that a certificate of need is not required, the sponsor will be notified by the department and the determination of nonreviewability will be placed on the next agenda of the state health facilities council for consideration.

c. The notification to the sponsor of the results of the department's review of the request will include specific Iowa Code citations relied upon to support the determination.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.4(10A) Submission of application.

2202.4(1) *Application form.*

a. A sponsor of a proposed project for a new or changed institutional health service will submit to the department an application for certificate of need by using the appropriate application form found on the certificate of need web page. All information requested in the application form will be required in the absence of a waiver by the department.

b. An original application and all attachments shall be submitted via electronic mail.

c. The department will establish and maintain electronic files on each application.

2202.4(2) *Application fee.* The application fee specified in Iowa Code section 10A.713(1) is based on the total cost of the project, including site costs, land improvements, facility costs, movable equipment, and financing costs.

a. The fee for leased or donated new institutional health services is calculated in the same manner as if the new institutional health services were purchased.

(1) The leased equipment fee is based on total value of the lease, plus sales tax, delivery and installation.

(2) The lease of space includes the cost of a one-year-lease payment for the space, in addition to other costs associated with the project.

(3) Financing costs are not applicable on leases or cash purchases.

b. The application fee will be refunded by the department for any application that is voluntarily withdrawn from the review process in the amounts specified in Iowa Code section 10A.713(1).

c. For purposes of this subrule and Iowa Code section 10A.713(1), the term "submission" means the day the application is received by the department.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.5(10A) Organizational procedures.

2202.5(1) The presence of three members of the council shall constitute a quorum.

2202.5(2) The chair and all other council members present will cast votes or abstain, as the case may be, on all council action. No proxy votes shall be allowed.

2202.5(3) A vote of a majority of those present will be necessary to take action on any motion before the council. A tie vote means no action on the motion.

2202.5(4) The council will, at the first meeting after July 1 of each odd-numbered year, elect a vice-chair to perform the duties of the chair in the chair's absence, when the chair has a conflict of interest or when the chair so directs.

2202.5(5) A council member will refrain from participating in an application review process if the member:

a. Has a personal bias or prejudice concerning the applicant;

b. Has acted as counsel to the applicant or a competitor of the applicant in the same or adjoining county within the past two years;

- c. Has a financial interest in the outcome of the application process or any other significant personal interest that could be substantially affected by the outcome of the case;
- d. Has a spouse or relative within the third degree of relationship that (1) is affiliated with or represents the applicant or a competitor of the applicant in the same or adjoining county; (2) has a known financial or significant personal interest that could be substantially affected by the outcome of the application process; or (3) is likely to testify on behalf of the applicant or an affected person at public hearing; or
- e. Has any other legally sufficient cause to refrain from participating in the application review process.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.6(10A) Public hearing on application. Public hearings conducted pursuant to Iowa Code section 10A.716(3)“b” are not contested cases. Judicial review pursuant to Iowa Code section 17A.19 of final agency decisions under Iowa Code section 10A.719 will be treated as other agency action.

2202.6(1) The council will use the following meeting format:

- a. Announcement of application under review.
- b. Presentation of department report.
- c. Applicant presentation.
- d. Affected persons’ presentation.
- e. Applicant’s rebuttal.
- f. Council discussion, motion and final decision.

2202.6(2) The notice of an accepted application issued pursuant to Iowa Code section 10A.716(2) will inform the applicant and affected persons of the deadlines for the electronic submission to the department of written statements or other materials. These deadlines will also be posted on the certificate of need web page.

Written submissions received by the department after the deadlines established in this notice will not be considered by the department or the council unless submitted at the public hearing solely to support oral testimony or upon a showing of good cause.

2202.6(3) The applicant, affected persons, or their designated representatives will be given the opportunity to make oral presentations to the council. Other interested persons may be given the opportunity to make oral presentations to the council.

2202.6(4) Oral testimony that simply duplicates material received in writing will not be heard. The applicant and affected persons will present only one witness for each issue raised unless permission is requested and granted by the chair.

2202.6(5) All questions to an applicant or affected person presenting oral testimony will be directed from the council or council staff unless permission is requested and granted by the chair. Persons making oral presentations to the council are not expected to be placed under oath.

2202.6(6) The council may designate technical consultants or experts to assist in its activities as defined by the council.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.7(10A) Summary review. Pursuant to Iowa Code section 10A.717, an applicant requesting a summary review will abide by the following procedures:

2202.7(1) Electronically submit a written request for summary review and a copy of the application and all attachments. The applicant is not required to submit a letter of intent pursuant to Iowa Code section 10A.715 prior to submitting a written request for a summary review.

2202.7(2) The eligibility of an application for summary review pursuant to Iowa Code section 10A.717 does not mandate or require such review. The department will make the decision as to whether an application will be reviewed in the summary review process.

2202.7(3) Upon receipt of a written request for summary review, an application, and the fee required by Iowa Code section 10A.713(1), the department will notify the applicant in writing within 15 calendar days if the application is complete and if a summary review will be granted.

2202.7(4) If an application is deemed incomplete, the department will state specifically in writing what information is needed to make the application complete.

2202.7(5) If the department notifies the applicant that a summary review will not be performed, this decision is binding on the applicant and the application will be entered into the formal review process on the date of written notice that such application will not be reviewed summarily.

2202.7(6) A summary review of an application for a certificate of need will be completed within 60 calendar days of the acceptance of an application by the department.

2202.7(7) At any time during the summary review process, an application may be withdrawn without prejudice from the process. The applicant may then submit the application for a formal 90-day review.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.8(10A) Extension of review time.

2202.8(1) A formal review of an application for a certificate of need pursuant to Iowa Code section 10A.716 may be extended by the department on the basis of any of the following criteria:

- a.* In order to review competing applications simultaneously;
- b.* In the case of technologically innovative equipment, to obtain additional information necessary to evaluate the proposal. The department will specify in writing such additional information as necessary;
- c.* At the request of the applicant;
- d.* At the request of at least two members of the state health facilities council in order to allow additional time for deliberation on all evidence present. The council will specify the time of the delay and the date on which the final decision will be rendered.

2202.8(2) An extension by the department made pursuant to 2202.8(1) will in no case be more than 60 calendar days beyond the time a decision is required under Iowa Code section 10A.719 unless the applicant and department agree.

2202.8(3) Where none of the provisions of 2202.8(1) are applicable and where an application will be automatically denied because of the expiration of time required by Iowa Code section 10A.719 for the issuance of a written decision by the council, the department will notify the applicant of the likelihood of an automatic denial and will ask the applicant to request in writing an extension of the review time. Where an extension is so requested, the application will be heard at the next regularly scheduled meeting of the council or at any time agreeable to the applicant and the department.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.9(10A) Rehearing of certificate of need decision.

2202.9(1) The applicant or any affected person who has participated or sought unsuccessfully to participate in the formal review procedure prescribed in Iowa Code section 10A.716 may, for good cause shown, file an application for rehearing in writing with the department stating the specific grounds therefor and the relief sought, within 20 calendar days after the date of the issuance of the final decision on an application for certificate of need.

2202.9(2) Grounds for rehearing include but are not limited to:

- a.* New significant, relevant information that was unavailable at the date of the hearing;
- b.* Significant changes in factors or circumstances relied upon by the council in reaching its decision;
- c.* Demonstration that the council has materially failed to follow its adopted procedures in reaching its decision; or
- d.* Such other bases as the council determines constitute good cause.

2202.9(3) An application for rehearing is deemed to have been denied unless the council grants the application in writing within 20 calendar days after its filing.

2202.9(4) If the application for rehearing is granted, the council may issue an order modifying the initial final order, or may set the matter for consideration at a subsequent meeting date. If public hearing is granted on the application for rehearing, notice will be provided ten calendar days prior to

hearing to the person applying for rehearing, the applicant and other affected persons upon request pursuant to 481—2202.10(10A).

2202.9(5) The council will issue the final decision on rehearing, stating the basis for its decision, within 30 calendar days after the application for rehearing was granted or 30 calendar days after public hearing on rehearing, whichever is later.

2202.9(6) If a rehearing is not requested or an affected party remains dissatisfied after the request for rehearing, an appeal may be taken in the manner provided by Iowa Code chapter 17A. A request for rehearing is not required prior to appeal under Iowa Code section 17A.19.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.10(10A) Status reports to affected persons. Affected persons are entitled to status reports from the department while a formal application review is in progress pursuant to Iowa Code section 10A.718. The department will maintain a log of all requests for written status reports by affected persons. Affected persons who request written status reports will submit an electronic request, identifying the specific information requested, which may include notification of the council's final decision, any application for rehearing, or the filing of a petition for judicial review. The formal process does not preclude informal contacts with department staff for verbal status reports. Printed copies of the council's final decision, an application for rehearing, a petition for judicial review, or any other public record will be provided upon request.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.11(10A) Finality. The certificate of need application process is continuous beginning with submission of a letter of intent or request for waiver of a letter of intent through issuance of a final decision by the council subject to judicial review under Iowa Code chapter 17A.

2202.11(1) The following stages of the process are intermediate and subject to judicial review only to the extent they meet criteria for intermediate review under Iowa Code section 17A.19:

- a.* A decision by the department pursuant to 481—2202.3(10A) that a proposed project does not require a certificate of need;
- b.* A decision by the department to waive submission of the letter of intent and substitute summary review; and
- c.* The rejection of an application by the department that fails to provide all information required under Iowa Code section 10A.713(1).

2202.11(2) The following stages of the process are final decisions subject to judicial review as final agency action under Iowa Code section 17A.19:

- a.* A decision by the department to disallow summary review;
- b.* A decision by the council that a proposed project does not require a certificate of need;
- c.* A decision by the council to approve or deny an application;
- d.* The council's final ruling on an application for rehearing; and
- e.* A decision by the council to revoke a certificate of need pursuant to 481—2202.13(10A).

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.12(10A) Project progress reports.

2202.12(1) The sponsor of an approved application will submit a progress report using the form available on the certificate of need web page six months after approval at hearing.

2202.12(2) Progress reports shall fully identify the project and indicate the current status of the project in descriptive terms. The reports should also reflect an amended project schedule if necessary.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.13(10A) Request for extension of certificate.

2202.13(1) A request by the applicant for an extension of a certificate of need should be filed with the department using the form available on the certificate of need web page no later than 30 days prior to the expiration of the certificate of need.

2202.13(2) A request for extension should fully identify the project and indicate the current status of the project in descriptive terms.

2202.13(3) Any affected person has the right to submit to the department in writing, or orally at the council meeting at which the extension request is considered, information that may be relevant to the question of granting an extension.

2202.13(4) When an extension has been requested, the council will approve or deny the request at a meeting of the council preceding the expiration of the certification. The certificate of need may be revoked by the council at the end of the certification period for insufficient progress in developing the project.

2202.13(5) If the extension is denied, the applicant has the right to appeal under the provisions of Iowa Code section 10A.720.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.14(10A) Application changes after approval.

2202.14(1) Once a project has been approved by the council, no changes that vary from or alter the number of approved beds, the approved services or the approved cost by an amount indicated in 2202.14(2) may be made unless requested by the applicant and approved by the council. Requests should be made in writing and filed with the department electronically.

2202.14(2) An increase in the actual cost of the project over and above that originally approved will automatically generate review by the council if the increase exceeds the originally approved amount by:

- a. Fifteen percent for projects up to \$999,999.99;
- b. Twelve percent for projects from \$1,000,000.00 to \$4,999,999.99;
- c. Eight percent for projects \$5,000,000.00 and over.

An increase in the approved cost that falls below the above percentages will be reported to the department.

2202.14(3) Failure to notify and receive permission of the council to change the project as originally approved may result in the imposition of sanctions provided in Iowa Code section 10A.723. The council may make a recommendation to the department regarding the imposition of a sanction and the amount of the fine to be imposed.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.15(10A) Sanctions. Hearings to determine class I or class II violations pursuant to Iowa Code section 10A.723 will be conducted in accordance with the department's procedural rules for contested cases found at 481—Chapter 9.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

481—2202.16(10A) Reporting requirements. For the purposes of the annual reports and data compilation required in Iowa Code sections 10A.725 and 10A.727, the department will utilize the AHA Annual Survey of Hospitals with the state survey addendum for hospitals and the cost reports for health care facilities submitted to the Medicaid enterprise of the department of health and human services.

[ARC 7932C, IAB 5/1/24, effective 6/5/24; Editorial change: IAC Supplement 9/4/24]

These rules are intended to implement Iowa Code sections 10A.711 through 10A.729.

[Filed emergency 7/26/78—published 8/23/78, effective 7/26/78]

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[Filed emergency 7/10/87—published 7/29/87, effective 7/10/87][◇]
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[Filed 9/14/92, Notice 8/5/92—published 9/30/92, effective 11/4/92]
[Filed emergency 7/11/97 after Notice 6/4/97—published 7/30/97, effective 7/11/97]
[Filed 11/16/04, Notice 8/4/04—published 12/8/04, effective 1/12/05]
[Filed 1/13/05, Notice 12/8/04—published 2/2/05, effective 3/9/05]
[Filed 3/11/05, Notice 2/2/05—published 3/30/05, effective 5/4/05]
[Filed ARC 1748C (Notice ARC 1655C, IAB 10/1/14), IAB 12/10/14, effective 1/14/15]
[Filed ARC 7932C (Notice ARC 7379C, IAB 1/10/24), IAB 5/1/24, effective 6/5/24]
[Editorial change: IAC Supplement 9/4/24]
[Editorial change: IAC Supplement 4/2/25]
[Editorial change: IAC Supplement 6/10/26]

◇ Two or more ARCs

CHILD ADVOCACY BOARD[489]

[Prior to 3/23/88, see Foster Care Review Board, State[445];
transferred to Inspections and Appeals Department “umbrella” pursuant to 1986 Iowa Acts, chapter 1245, section 549]
[Former Foster Care Review Board[489] renamed Child Advocacy Board[489] by 2002 Iowa Acts, chapter 1162]

CHAPTER 1

FUNCTIONS AND PROVISIONS OF THE CHILD ADVOCACY BOARD

1.1(237)	Definitions
1.2(237)	Membership and term
1.3(237)	Leadership
1.4(237)	Foster care registry
1.5(237)	Foster care review
1.6(237)	Children eligible for review
1.7(237)	Court appointed special advocate program
1.8(237)	Program requirements
1.9(237)	Adherence to national guidelines
1.10(237)	Training
1.11(237)	Children eligible for assignment of a court appointed special advocate

CHAPTER 1
FUNCTIONS AND PROVISIONS OF THE CHILD ADVOCACY BOARD
[Prior to 3/23/88, see Foster Care Review Board[445] Ch 1]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/31

489—1.1(237) Definitions. The following definitions apply to the rules of the child advocacy board:

“Approved” means that the applicant has met the requirements to become a court appointed special advocate.

“CASA volunteer” or *“CASA”* or *“advocate”* means a person who is duly trained and approved by the department of health and human services for participation in the court appointed special advocate program and appointed by the court to represent the interest of a child in any judicial proceeding to which the child is a party or is called as a witness or relating to any dispositional order involving the child resulting from the proceeding. Unless otherwise directed by a court, the duties of a court appointed special advocate with respect to a child are pursuant to Iowa Code section 237.24.

“Case permanency plan” means the same as defined in Iowa Code section 232.2(6).

“Coach” or *“CASA coach”* means a duly approved court appointed special advocate volunteer who has received additional training to assist the coordinator by overseeing facets of the court appointed special advocate’s case work.

“Court appointed special advocate” means the same as defined in Iowa Code section 232.2(12).

“Family” means the same as defined in Iowa Code section 237.15(4).

“Fictive kin” means the same as defined in Iowa Code section 232.2(24).

“Person or court responsible for the child” means the department, including but not limited to the department, agency, or individual who is the guardian of a child by court order issued by the juvenile or district court and has the responsibility of the care of the child, or the court having jurisdiction over the child.

“State board” means the child advocacy board created pursuant to Iowa Code section 237.16.

This rule is intended to implement Iowa Code sections 17A.3, 237.15, and 237.16.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.2(237) Membership and term.

1.2(1) The state board is created within the department. Membership and terms of appointment are detailed in Iowa Code section 237.16(1).

1.2(2) The state board shall meet as necessary, as set forth in Iowa Code section 237.16(2).

a. A quorum shall consist of a majority of the members. When a quorum is present, a position is carried by an affirmative vote of a majority of the members present.

b. Minutes of state board meetings are available on the department’s website.

c. Notice of each meeting shall be given pursuant to Iowa Code chapter 21.

d. When the chairperson of the state board determines that a special or electronic meeting is required, the meeting shall be held in accordance with Iowa Code section 21.4 or 21.8.

e. Persons wishing to appear before the state board shall submit the request to the state board office not less than ten days prior to the meeting. Presentations may be made at the discretion of the chairperson and only upon matters appearing on the agenda. Persons wishing to submit written material should do so at least ten days in advance of the scheduled meeting to ensure that state board members have adequate time to receive and evaluate the material.

This rule is intended to implement Iowa Code sections 17A.3, 237.16, and 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.3(237) Leadership.

1.3(1) The director ensures adequate leadership, oversight of programs, and ongoing administration of the state board’s activities and of the court appointed special advocate program.

The director employs, discharges, trains, and supervises foster care review and court appointed special advocate program employees.

1.3(2) The department will:

- a.* Administer funds necessary for operations of foster care reviews and the court appointed special advocate program.
- b.* Develop and implement policies and procedures needed to implement requirements of federal law and regulations and state law and administrative rules.
- c.* Develop and recommend administrative rules for promulgation by the state board as needed to govern the operation of the state board, foster care reviews, and the court appointed special advocate program.
- d.* Ensure training is provided for state board members, court appointed special advocates and coaches, and any other volunteers supporting the state board's programs.
- e.* Ensure that relationships are developed and maintained with judges, juvenile court referees, local departments, juvenile court services, and advocacy groups.
- f.* Coordinate efforts to ensure community awareness of the state board and the court appointed special advocate program.
- g.* Work closely with allied agencies and associations to ensure that efforts relating to the state board and the court appointed special advocate program are coordinated and consistent.

This rule is intended to implement Iowa Code sections 17A.3 and 237.18(5).

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.4(237) Foster care registry.

1.4(1) *Placement.* The state board shall establish a registry of the placements of all children receiving foster care as set forth in Iowa Code section 237.17.

This subrule is intended to implement Iowa Code sections 17A.3 and 237.17.

1.4(2) *Confidentiality of records.* The state board, court appointed special advocates and coaches, and child advocacy employees shall adhere to the confidentiality requirements established in Iowa Code section 237.21.

This subrule is intended to implement Iowa Code sections 17A.3 and 237.21.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.5(237) Foster care review. The state board is required by Iowa Code section 237.18 to establish procedures and protocols for completing reviews of the cases of children in foster care, including a recordkeeping system and training requirements for individuals completing reviews.

1.5(1) *Establishing procedures and protocols.*

- a.* The state board is responsible for approval of policy and procedures consistent with the Iowa Code.
- b.* The department establishes and submits to the state board for approval policy and procedures that provide detailed guidance to individuals reviewing the cases of children in foster care on application of these rules and the statutes that govern foster care reviews.
- c.* Individuals reviewing the cases of children in foster care under the oversight of the state board are required to comply with the protocols and procedures approved by the state board.
- d.* Implementation of policy and procedures is the responsibility of the department.

This subrule is intended to implement Iowa Code sections 17A.3 and 237.19.

1.5(2) *Findings and recommendations.* The department will submit the findings and recommendations of foster care reviews to the state board. The report to the state board will include information regarding the permanency plan and the progress in attaining the permanency goals.

This subrule is intended to implement Iowa Code section 237.19.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.6(237) Children eligible for review. To be eligible for review, the child shall have received services from the department during the period under review.

This rule is intended to implement Iowa Code sections 17A.3 and 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.7(237) Court appointed special advocate program. The state board is required by Iowa Code section 237.18 to establish procedures and protocols for administering the court appointed special advocate program.

This rule is intended to implement Iowa Code section 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.8(237) Program requirements.

1.8(1) *Establishing additional procedures and protocols.*

a. The state board is responsible for approval of procedures and protocols consistent with the Iowa Code.

b. The department establishes and submits to the state board for approval a program policy and procedures manual that provides detailed guidance to department staff and volunteers on application of these rules and the statutes that govern the operation of the court appointed special advocate program.

c. Department staff and volunteers are required to comply with the protocols and procedures approved by the state board and the provisions of the policy and procedures manual established by the department and approved by the state board.

d. Implementation of program policy is the responsibility of the department.

e. The department is responsible for recruiting, screening, selecting, training, and supervising court appointed special advocates.

f. The CASA selection is made in a manner that provides the best match available between the knowledge, skills, abilities, and availability of the advocate and the needs of the child. The assignments shall be made in a manner that avoids conflicts of interest, risk to the child's or advocate's safety, or jeopardy to the program's integrity.

g. Upon selection of the CASA who will serve on an individual case, the court and all interested parties are notified of the selection.

h. The selected CASA continues to serve on the case until the assignment is terminated by the court.

1.8(2) Reserved.

This rule is intended to implement Iowa Code section 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.9(237) Adherence to national guidelines. The National Court Appointed Special Advocate/Guardian ad Litem Association for Children has established a national quality assurance system for CASA programs. The primary goal of the system is to strengthen CASA organizations and support their efforts to provide high-quality child advocacy and achieve the maximum level of excellence. CASA of Iowa shall continue to maintain compliance with the standards and, within the limits of available funding, shall deploy resources to maintain compliance in the future.

1.9(1) *CASA advocate qualifications.* Potential coaches and advocates shall meet the qualifications defined by the National CASA Association for Children Standards as amended to August 1, 2026.

1.9(2) *Application requirements for CASA volunteers.* All CASA volunteer applicants shall complete the requirements defined in the National CASA Association for Children Standards as amended to August 1, 2026.

This rule is intended to implement Iowa Code sections 17A.3 and 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.10(237) Training. All court appointed special advocates, volunteers, and staff shall complete pre-service and continuing education requirements as defined in the National CASA Association for Children Standards as amended to August 1, 2026.

This rule is intended to implement Iowa Code sections 17A.3 and 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

489—1.11(237) Children eligible for assignment of a court appointed special advocate. CASA of Iowa serves any child for whom the court appoints a court appointed special advocate as long as the resources to do so are available.

This rule is intended to implement Iowa Code sections 17A.3 and 237.18.

[ARC 0344D, IAB 6/10/26, effective 8/1/26]

[Filed emergency 5/30/85—published 6/19/85, effective 5/30/85]

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[Filed ARC 3054C (Notice ARC 2974C, IAB 3/15/17), IAB 5/10/17, effective 6/14/17]

[Filed ARC 6676C (Notice ARC 6544C, IAB 9/21/22), IAB 11/16/22, effective 12/21/22]

[Filed ARC 7698C (Notice ARC 7065C, IAB 8/23/23), IAB 3/6/24, effective 7/1/24]¹

[Filed ARC 0344D (Notice ARC 0195D, IAB 4/15/26), IAB 6/10/26, effective 8/1/26]

¹ The effective date of **ARC 7698C** was corrected to July 1, 2024, in the April 3, 2024, Iowa Administrative Bulletin.

CHAPTER 2
RULES AND OPERATION FOR THE STATE BOARD
[Prior to 3/23/88, see Foster Care Review Board[445] Ch 2]
Rescinded **ARC 0345D**, IAB 6/10/26, effective 8/1/26

CHAPTER 3
LOCAL FOSTER CARE REVIEW BOARDS
[Prior to 3/23/88, see Foster Care Review Board[445] Ch 3]
Rescinded **ARC 0346D**, IAB 6/10/26, effective 8/1/26

CHAPTER 4
COURT APPOINTED SPECIAL ADVOCATE PROGRAM
Rescinded **ARC 0343D**, IAB 6/10/26, effective 8/1/26

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
Rescinded **ARC 7698C**, IAB 3/6/24, effective 7/1/24¹

¹ The effective date of **ARC 7698C** was corrected to July 1, 2024, in the April 3, 2024, Iowa Administrative Bulletin.

STATE PUBLIC DEFENDER[493]

Created within the Department of Inspections and Appeals[481] by Iowa Code section 13B.2

CHAPTER 1 ADMINISTRATION

1.1(13B)	Scope
1.2(13B)	Function
1.3(13B)	Overall organization and method of operations
1.4(13B)	Information

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2.1(17A)	Petition for rulemaking
2.3(17A)	Inquiries

CHAPTER 3 DECLARATORY ORDERS

3.1(17A)	Petition for declaratory order
3.2(17A)	Notice of petition
3.3(17A)	Intervention
3.4(17A)	Briefs
3.5(17A)	Inquiries
3.6(17A)	Service and filing of petitions and other papers
3.7(17A)	Consideration
3.8(17A)	Action on petition
3.9(17A)	Refusal to issue order
3.12(17A)	Effect of a declaratory order

CHAPTER 4 Reserved

CHAPTER 5 AGENCY PROCEDURE FOR RULEMAKING

5.3(17A)	Public rulemaking docket
5.4(17A)	Notice of proposed rulemaking
5.5(17A)	Public participation
5.6(17A)	Regulatory analysis
5.10(17A)	Exemptions from public rulemaking procedures
5.11(17A)	Concise statement of reasons
5.13(17A)	Agency rulemaking record

CHAPTER 6 UNIFORM WAIVER RULES

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6.2(13B,17A)	Interpretive rules
6.3(13B,17A)	Compliance with statute
6.4(13B,17A)	Criteria for waiver
6.5(13B,17A)	Filing of petition
6.6(13B,17A)	Content of petition
6.7(13B,17A)	Additional information
6.8(13B,17A)	Notice
6.9(13B,17A)	Hearing procedures
6.10(13B,17A)	Ruling
6.11(13B,17A)	Public availability
6.12(13B,17A)	Voiding or cancellation
6.13(13B,17A)	Violations
6.14(13B,17A)	Defense
6.15(13B,17A)	Appeals
6.16(13B,17A)	Sample petition for waiver

CHAPTER 7 DEFINITIONS

7.1(13B,815) Definitions

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CHAPTER 10 ELIGIBILITY GUIDELINES FOR COURT-APPOINTED COUNSEL

10.1(815) Eligibility
10.2(815) Income guidelines
10.3(815) Designation of eligibility reviewer
10.4(815) Application
10.5(815) Evaluation of affidavit of financial status
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11.1(13B) Scope
11.2(13B) Contracts
11.3(13B) Attorney minimum qualifications
11.4(13B) Contract approval or denial
11.5(13B) Contract renewal
11.6(13B) Termination
11.7(13B) Grounds to deny or terminate a contract
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12.1(13B,815) Scope
12.2(13B,815) Submission and payment of attorney claims
12.3(13B,815) Interim claims
12.4(13B,815) Rate of compensation
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12.6(13B,815) Attorney fee limitations
12.7(13B,815) Reimbursement for specific expenses
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CHAPTER 13 CLAIMS FOR OTHER PROFESSIONAL SERVICES

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13.2(815) Claims for other professional services
13.3(13B,815) Court review
13.4(13B,815) Processing and payment
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CHAPTER 14 CLAIMS FOR ATTORNEY FEES IN 600A TERMINATIONS

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14.3(13B,600A,815) Hourly rate and fee limitations
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CHAPTERS 15 to 2504

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CHAPTER 2505

FAIR INFORMATION PRACTICES

2505.9(17A,22)

Confidential records

2505.10(17A,22)

Personally identifiable information

CHAPTER 4
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
Rescinded **ARC 0325D**, IAB 6/10/26, effective 5/8/26

CHAPTERS 15 to 2504
Reserved

CHAPTER 2505
FAIR INFORMATION PRACTICES

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/8/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0325D, IAB 6/10/26, effective 5/8/26]

493—2505.9(17A,22) Confidential records. The following records are assumed confidential and may be withheld from public inspection:

2505.9(1) Records that constitute attorney work product, that constitute attorney-client communications, or that are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4), 622.10 and 622.11; Iowa Rule of Civil Procedure 1.503; the rules of evidence; the Code of Professional Responsibility; and case law.

2505.9(2) Criminal investigative reports pursuant to Iowa Code section 22.7(5).

2505.9(3) A claim for compensation and reimbursement for legal assistance and supporting documents submitted to the state public defender for payment of costs incurred in the legal representation of an indigent person pursuant to Iowa Code section 13B.4A, except as disclosure is authorized under that section.

[ARC 0325D, IAB 6/10/26, effective 5/8/26]

493—2505.10(17A,22) Personally identifiable information. The state public defender maintains the following systems of records that contain personally identifiable information and may be withheld from public inspection.

2505.10(1) *Juvenile records.* Pursuant to Iowa Code section 915.36, the names of child victims shall not be disclosed. Confidential juvenile records under Iowa Code section 232.147 shall not be disclosed, except as otherwise permitted by law. Presentence investigation reports in the possession of any public defender are confidential records pursuant to Iowa Code section 901.4.

2505.10(2) *Litigation records or files.* Litigation records or files contain information regarding litigation or anticipated litigation, which include judicial and administrative proceedings. Litigation records include briefs, depositions, docket sheets, documents, correspondence, attorney's notes, memoranda, research materials, witness information, investigation materials, information compiled under the direction of the attorney, and case management records. Litigation files contain materials that are confidential as attorney work product and attorney-client communications. Some materials are confidential under other applicable provisions of law or because of a court order. Persons wishing to obtain copies of pleadings and other documents filed in litigation should obtain them from the clerk of the appropriate court that maintains the official copy.

2505.10(3) *Contracts.* Contractual agreements are maintained by the state public defender. These records contain personally identifiable information when the agreement is with a specific individual. In those instances, the records include the name, address, and social security number of the contracting attorney. Other information in these records may include the proposal of the contracting attorney, budget figures, correspondence, and business information. Personally identifiable information is contained in a data processing system and may be compared with the information in any data processing system.

[ARC 0325D, IAB 6/10/26, effective 5/8/26]

[Filed Emergency ARC 0325D, IAB 6/10/26, effective 5/8/26]

APPEAL BOARD, STATE[543]

Rules transferred from agency number 60 to 543 under the “umbrella” of Management Department pursuant to 1986 Iowa Acts, chapter 1245, section 107

CHAPTER 1 GENERAL PROVISIONS

- 1.1(669) Definitions
- 1.2(17A) Organization
- 1.3(669) Meetings of the board

CHAPTER 2 TORT CLAIMS

- 2.1(669) Form of claims
- 2.2(669) Content
- 2.3(669) Attorney general
- 2.4(669) Notification
- 2.5(669) Release
- 2.6(669) Acceptance
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CHAPTER 3 GENERAL CLAIMS

- 3.1(25) Claims
- 3.2(25) Content
- 3.3(25) Investigation
- 3.4(25) Notification
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CHAPTER 4 BUDGET APPEALS

- 4.1(24) Budget appeals
- 4.2(24) Inquiries
- 4.3(24) Filings
- 4.4(24) Scheduling and notice of hearings
- 4.5(24) Hearings
- 4.6(24) Decision
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CHAPTER 5 UNIFORM RULES

- 5.1(17A,22) Fair information practices
- 5.2(17A,22) Additional fair information practices—uses and disclosures of information
- 5.3(17A) Petition for rulemaking
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- 5.5(17A) Board procedure for rulemaking

CHAPTERS 6 to 2505 Reserved

CHAPTER 2506 CONTESTED CASES

- 2506.1(17A) Scope and applicability

CHAPTER 6
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
Rescinded **ARC 9700C**, IAB 11/12/25, effective 12/17/25

CHAPTER 7
AGENCY PROCEDURE FOR RULE MAKING
Rescinded **ARC 9700C**, IAB 11/12/25, effective 12/17/25

CHAPTERS 8 to 2505
Reserved

CHAPTER 2506
CONTESTED CASES

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0340D, IAB 6/10/26, effective 6/30/26]

543—2506.1(17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the agency, including vendor appeals. However, this chapter does not apply to the extent that a claim being addressed by the agency is governed by Iowa Code chapter 669.

[ARC 0340D, IAB 6/10/26, effective 6/30/26]

[Filed Emergency ARC 0340D, IAB 6/10/26, effective 6/30/26]

PUBLIC HEALTH DEPARTMENT[641]

CHAPTER 1

REPORTABLE DISEASES, POISONINGS AND CONDITIONS, AND QUARANTINE AND ISOLATION

- 1.1(139A) Definitions
- 1.2(139A) Authority
- 1.3(139A,141A) Reportable communicable and infectious diseases, poisonings or conditions, and cancers
- 1.4(135,139A) Reporting requirements

INVESTIGATION

- 1.5(135,139A) Investigation of reportable diseases

ISOLATION AND QUARANTINE

- 1.6(135,193A) Isolation and quarantine
- 1.7(139A,22) Confidentiality

STATE HYGIENIC LABORATORY

- 1.8(135,139A) Specimens for which the fee charged by the state hygienic laboratory will be waived

CHAPTER 2

HEPATITIS PROGRAMS

VIRAL HEPATITIS PROGRAM—VACCINATIONS AND TESTING

- 2.1(135) Definitions
- 2.2(135) Exposure risks for hepatitis C virus
- 2.3(135) Information for public distribution
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CHAPTER 3

EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

- 3.1(135) Definitions
- 3.2(135) Program components
- 3.3(135) Screening the hearing of all newborns
- 3.4(135) Procedures required of birthing hospitals
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- 3.6(135) Procedures to ensure that children born in locations other than a birth center or birthing hospital receive a hearing screening
- 3.7(135) Reporting hearing screening results and information to the department and child's primary care provider
- 3.8(135) Conducting and reporting screening results and diagnostic audiologic assessments to the department and child's primary care provider
- 3.9(135) Congenital cytomegalovirus (cCMV) testing for newborns who do not pass the initial newborn hearing screening
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CHAPTER 4

CONGENITAL AND INHERITED DISORDERS

- 4.1(136A) Definitions
- 4.2(136A) Iowa newborn screening program (INSP)
- 4.3(136A) Iowa maternal prenatal screening program (IMPSP)
- 4.4(136A) Regional genetic consultation service (RGCS)
- 4.5(136A) Neuromuscular and other related genetic disease program (NMP)
- 4.6(136A) Iowa registry for congenital and inherited disorders (IRCID)

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Reserved

CHAPTER 7

IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING
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CHAPTER 1
REPORTABLE DISEASES, POISONINGS AND CONDITIONS,
AND QUARANTINE AND ISOLATION

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/17/29

641—1.1(139A) Definitions. For the purpose of these rules, the following definitions will apply:

“*AIDS*” means the same as defined in Iowa Code chapter 141A.

“*Area quarantine*” means the same as defined in Iowa Code chapter 139A.

“*Business*” means the same as defined in Iowa Code chapter 139A.

“*Care provider*” means the same as defined in Iowa Code chapter 139A.

“*Case*” means an individual who has confirmatory evidence of disease.

“*Clinical laboratory*” means any laboratory performing analyses on specimens taken from the body of a person in order to assess that person’s health status.

“*Communicable disease*” means the same as defined in Iowa Code chapter 139A.

“*Congenital or inherited disorder*” means any congenital disorder as defined in Iowa Code chapter 136A or any inherited disorder as defined in Iowa Code chapter 136A.

“*Disease surveillance*” means the ongoing, systematic collection, analysis, and interpretation of health-related data essential for planning, implementation, and evaluation of public health programs and practices.

“*Exposure*” means contact with an agent in a manner that could cause disease or infection.

“*HBV*” means the same as defined in Iowa Code chapter 139A.

“*Health care facility*” means the same as defined in Iowa Code chapter 139A.

“*Health care provider*” means the same as defined in Iowa Code chapter 139A.

“*HIV*” means the same as defined in Iowa Code chapter 141A.

“*Hospital*” means the same as defined in Iowa Code chapter 135B.

“*IDSS*” means the Iowa disease surveillance system, a secure electronic statewide disease reporting and surveillance system.

“*Infectious disease*” means a disease caused by the entrance into the body of organisms, including but not limited to bacteria, protozoans, fungi, prions, or viruses that grow and multiply.

“*Infectious tuberculosis*” means pulmonary or laryngeal tuberculosis as evidenced by:

1. Isolation of *M. tuberculosis* complex (positive culture) from a clinical specimen or positive nucleic acid amplification test, or

2. Both radiographic evidence of tuberculosis, such as an abnormal chest X ray, CT, PET or MRI scan, and clinical evidence, such as a positive skin test or whole blood assay test for tuberculosis infection, coughing, sputum production, fever, or other symptoms compatible with infectious tuberculosis that lead a health care provider to diagnose infectious tuberculosis according to currently acceptable standards of medical practice and to initiate treatment for tuberculosis.

“*Investigation*” means an inquiry conducted to determine the specific source, mode of transmission, and cause of a disease or suspected disease occurrence and to determine the specific incidence, prevalence, and extent of the disease in the affected or general population. “Investigation” may also include the application of scientific methods and analysis to institute appropriate control measures.

“*Isolation*” means the same as defined in Iowa Code chapter 139A.

“*Local board*” means the same as defined in Iowa Code chapter 139A.

“*Local department*” means the same as defined in Iowa Code chapter 139A.

“*Placard*” means the same as defined in Iowa Code chapter 139A.

“*Poison control or poison information center*” means any organization or program that has as one of its primary objectives the provision of toxicologic and pharmacologic information and referral services to the public and to health care providers (other than pharmacists) in response to inquiries about actual or potential poisonings.

“Public health disaster” means an incident as defined in Iowa Code section 135.140.

“Quarantinable disease” means any communicable disease that presents a risk of serious harm to public health and that may require isolation or quarantine to prevent its spread. “Quarantinable disease” includes but is not limited to cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, novel influenza, and severe acute respiratory syndrome (SARS).

“Quarantine” means the same as defined in Iowa Code chapter 139A.

“Reportable cancers” means those cancers included in the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) Program.

“Reportable disease” means any disease or condition approved by the state epidemiologist or medical director and designated by this chapter.

“Sexually transmitted disease or infection” or *“STI”* means a disease or infection as identified by this chapter that is transmitted through sexual practices. “Sexually transmitted disease or infection” includes but is not limited to acquired immunodeficiency syndrome (AIDS), chlamydia, gonorrhea, hepatitis B, hepatitis C, human immunodeficiency virus (HIV), human papillomavirus, and syphilis.

“Suspected case” means an individual who presents with clinical signs or symptoms indicative of a reportable or quarantinable disease.

“Toxic agent” means any noxious substance in solid, liquid or gaseous form capable of producing illness in humans including but not limited to pesticides as defined in Iowa Code chapter 206, heavy metals, organic and inorganic dusts and organic solvents. Airborne toxic agents may be in the form of dusts, fumes, vapors, mists, gases or smoke.

[ARC 8070C, IAB 6/12/24, effective 7/17/24]

641—1.2(139A) Authority. The director is the principal officer of the state to administer disease, poisoning and condition, and incident reporting and control. The Iowa Cancer Registry, administered by the Department of Epidemiology of the College of Public Health at the University of Iowa, is a public health authority for purposes of collecting cancer data in accordance with this chapter.

[ARC 8070C, IAB 6/12/24, effective 7/17/24]

641—1.3(139A,141A) Reportable communicable and infectious diseases, poisonings or conditions, and cancers. Reportable communicable and infectious diseases, poisonings and conditions under this chapter are those listed in Appendices A and B. The director may also designate any disease, poisoning or condition or syndrome temporarily reportable for the purpose of a special investigation.

1.3(1) Cancer. Pursuant to Public Law 92-218 and Public Law 102-515, each occurrence of a reportable cancer that is diagnosed or treated in an Iowa resident or occurs in a nonresident who is diagnosed or treated in an Iowa facility shall be reported to the Iowa Cancer Registry.

1.3(2) Congenital and inherited disorders. Each occurrence of a congenital and inherited disorder that is diagnosed or treated in an Iowa resident or occurs in a nonresident who is diagnosed or treated in an Iowa facility is a reportable condition pursuant to Iowa Code chapter 136A, and records of these congenital and inherited disorders shall be abstracted and maintained in a central registry. Congenital and inherited disorder surveillance shall be performed to determine the occurrence and trends of congenital and inherited disorders, to conduct thorough and complete epidemiological surveys, to assist in the planning for and provision of services to children with congenital and inherited disorders and their families, and to identify environmental and genetic risk factors for congenital and inherited disorders.

[ARC 8070C, IAB 6/12/24, effective 7/17/24]

641—1.4(135,139A) Reporting requirements.

1.4(1) Who is required to report.

a. Communicable and infectious diseases, and poisonings.

(1) Health care providers, hospitals, and clinical laboratories and other health care facilities are required to report cases of reportable diseases, poisonings and conditions. Health care providers and hospitals are exempted from reporting communicable and infectious disease laboratory results and blood lead testing if the health care provider or hospital ensures that the laboratory performing the analysis provides a report containing the required information to the department.

(2) School nurses are required to report suspected cases of a reportable disease, poisoning or condition occurring among the children supervised.

(3) Poison control and poison information centers are required to report inquiries about cases of a reportable disease, poisoning or condition received by them.

(4) Medical examiners are required to report their investigatory findings of any death that was caused by or otherwise involved a reportable disease, poisoning or condition.

(5) Occupational nurses are required to report cases of reportable diseases, poisonings and conditions.

(6) Hospitals, health care providers and clinical laboratories outside the state of Iowa shall immediately report any confirmed or suspected case of a reportable disease, poisoning or condition in an Iowa resident.

b. Reportable cancers. Health care providers, hospitals, clinical laboratories and health care facilities involved in the diagnosis, care or treatment of individuals are required to report individuals with a reportable cancer.

c. Congenital and inherited disorders. Health care providers, clinics, clinical laboratories and other health care facilities are required to report cases of a congenital or inherited disorder.

1.4(2) *What to report.* Each report will contain all information as listed in Iowa Code chapter 139A, in addition to:

a. For communicable and infectious diseases:

- (1) The name of the reportable disease.
- (2) The treatment provided for the reportable disease.

b. For poisonings:

- (1) The analytical result.
- (2) In the case of blood lead testing, whether the sample is a capillary or venous blood sample.
- (3) For conditions not identified by a laboratory analysis, the date that the condition was diagnosed.

(4) In the case of occupational conditions, the name of the patient's employer.

c. For reportable cancers:

- (1) Follow-up data.
- (2) Demographic, diagnostic, prognostic, treatment, and other medical information.

d. For congenital and inherited conditions:

- (1) Follow-up data.
- (2) Demographic, diagnostic, treatment and other medical information.
- (3) Tissue samples, which may also be submitted.

1.4(3) *How to report.* Information on when and how to report any of the diseases, conditions, or injuries included in this chapter can be found in Appendices A and B.

a. Immediate reporting by telephone of diseases identified as immediately reportable. A health care provider and a public, private, or hospital clinical laboratory will immediately report any confirmed or suspect case of a disease identified in Appendix A as immediately reportable to the department.

b. Other diseases that carry serious consequences or spread rapidly. A health care facility, health care provider and a public, private, or hospital clinical laboratory will immediately report any confirmed or suspected case of a common source epidemic or disease outbreak of unusual numbers.

c. Reporting to other public health authorities. The department may authorize hospitals, health care providers or clinical laboratories outside the state of Iowa to report any confirmed or suspect case

of a reportable disease, poisoning, or condition to another public health authority for the purpose of facilitating a report to the department.

d. Cancers. The department has delegated to the Iowa Cancer Registry the responsibility for collecting cancer data.

(1) Those required to report shall submit required data to the Iowa Cancer Registry monthly, in an electronic format specified by the Iowa Cancer Registry. Those required to report may employ registrars with Iowa Cancer Registry-approved training, or contract with the Iowa Cancer Registry or an outside vendor to submit reportable cancer cases and required data elements to the Iowa Cancer Registry.

(2) As needed for SEER surveillance activities, the Iowa Cancer Registry shall have remote electronic access, where available, or physical access to all cancer-relevant medical records.

e. Congenital and inherited disorders. The department has delegated to the Iowa Registry for Congenital and Inherited Disorders the responsibility to maintain a central registry for congenital and inherited disorders. The Iowa Registry for Congenital and Inherited Disorders shall:

(1) Prior to collecting the data from health care providers, hospitals, clinics, clinical laboratories and other health care facilities, work with the reporting facility to develop a process for abstracting records that is agreeable to the reporting facility.

(2) Develop and distribute reporting forms where applicable.

(3) Develop an abstracting process for data to be supplemented with information obtained from records from hospitals, treatment centers, outpatient centers, clinics, pathology laboratories and physician offices.

[ARC 8070C, IAB 6/12/24, effective 7/17/24]

INVESTIGATION

641—1.5(135,139A) Investigation of reportable diseases.

1.5(1) A health care provider and a public, private, or hospital clinical laboratory will provide the department, local board, or local department with all information necessary to conduct the investigation, including but not limited to medical records; exposure histories; medical histories; contact information; and test results necessary to the investigation, including positive, pending, and negative test results.

1.5(2) Issuance of investigatory subpoenas.

a. The department may, upon the written request of a local board of health, the state public health medical director or the state public health epidemiologist or designee, subpoena records, reports, or any other evidence necessary to conduct a disease investigation. The subpoena will be signed by the department following review and approval of the written request for subpoena.

b. Process to challenge a subpoena. Any person who is aggrieved or adversely affected by compliance with the subpoena and who desires to challenge the subpoena shall follow 441—Chapter 2506.

[ARC 8070C, IAB 6/12/24, effective 7/17/24; Editorial change: IAC Supplement 6/10/26]

ISOLATION AND QUARANTINE

641—1.6(135,193A) Isolation and quarantine. Isolation and quarantine should be consistent with guidelines provided by the Centers for Disease Control and Prevention.

1.6(1) *General provisions.*

a. Voluntary confinement. Prior to instituting mandatory isolation or quarantine pursuant to this rule, the department or a local board of health may request that an individual or group of individuals voluntarily confine themselves to a private home or other facility.

b. Quarantine and isolation. The department and local boards of health are authorized to impose and enforce quarantine and isolation restrictions. Quarantine and isolation shall rarely be imposed by the department or by local boards of health. If a quarantinable disease occurs in Iowa, individuals with

a suspected or active quarantinable disease and contacts to the case may be quarantined or isolated as the particular situation requires. Any quarantine or isolation imposed by the department or a local board of health shall be established and enforced in accordance with this rule.

1.6(2) *Issuance of isolation or quarantine orders.* The department or the local board of health may isolate or quarantine an individual or groups of individuals, and area quarantine in the rarest of instances, through a written order issued pursuant to this rule. The isolation or quarantine of an individual or group, whether during a declared state of emergency or not, shall be conducted as follows:

a. A written administrative order to isolate or quarantine an individual or group of individuals shall be issued when voluntary measures are deemed impracticable or ineffective. Orders shall become effective immediately upon issuance.

b. Orders for isolation and quarantine may include, without limitation, confinement in a residence or other private or public premises including medical and nonmedical facilities; conditions on travel or behavior; and exclusion of individuals or groups from certain places, including but not limited to school, workplace, public conveyances, and other places where members of the public may congregate; or a requirement that a person self-monitor specified health conditions (e.g., body temperature) and report the findings.

c. Administrative orders to isolate or quarantine an individual or a group of individuals may be issued orally if delay in imposing the isolation or quarantine would pose a serious imminent danger to the public health. If an oral order is issued, a written order shall be issued as soon as is reasonably possible, but in no event later than 24 hours following the issuance of the oral order.

d. A copy of the written order shall be provided to the individual to be isolated or quarantined or, if that is not possible, by any means reasonably calculated to provide actual notice. If the order applies to a group of individuals and it is impractical to provide individual copies, the order shall be posted in a conspicuous place in the isolation or quarantine premises.

e. The order of isolation or quarantine shall include the following:

(1) Full name and address of person or description of the group subject to the order.
(2) The clinical grounds for believing that the individual or group is infected with, or may have been exposed to, a communicable disease.

(3) The location where the individual or group will be confined during the period of isolation or quarantine.

(4) The exact date and time when the period of isolation or quarantine will expire. If it is not possible to fix an exact date, the order should specify the conditions or circumstances under which the individual or group would no longer pose a threat to the public health and confinement would end (e.g., the disappearance or absence of specified clinical symptoms).

(5) The conditions under which the individual or group will be isolated or quarantined.

(6) Notice of right to challenge the isolation or quarantine.

f. When individuals or groups are isolated or quarantined, whether through an administrative order or through voluntary compliance, the department or county board of health shall determine what method and place of isolation or quarantine is appropriate based upon the suitability of an individual's home or other designated facility and the services available.

g. To the greatest extent that it is possible to do so without jeopardizing the integrity of the isolation or quarantine, the authority issuing the isolation or quarantine order shall preserve and facilitate the ability of isolated and quarantined individuals to communicate with the outside world and, in particular, to exchange confidential communications with legal and medical advisors of their choice.

h. A person diagnosed with or clinically suspected of having infectious tuberculosis shall complete voluntary treatment until, in the opinion of the health care provider or the state public health medical director and epidemiologist, the person's tuberculosis is cured or such person is no longer a threat to public health. If such person refuses to complete the course of voluntary treatment, the department or local board of health may issue an order compelling mandatory treatment. Such

order shall include the identity of the person subject to the mandatory treatment order, a description of the treatment ordered, the medical basis upon which the treatment is ordered, and a description of the potential medical and legal consequences of violating such order. A person who violates a mandatory treatment order may be subject to the penalties provided in Iowa Code section 135.38 or 137.117 and may be placed under mandatory quarantine or isolation in accordance with the provisions of this chapter.

1.6(3) *Appeal from department order imposing isolation or quarantine.*

a. Individuals have the right to appeal an order imposing isolation or quarantine. Appeal procedures for department orders are as laid forth in 441—Chapter 2506.

b. A request for a hearing shall not stay an isolation or quarantine order unless by order of the issuing department or board, or by a district court.

1.6(4) *Appeal from a local board of health order imposing isolation or quarantine.*

a. Appeal. The subject of a board order imposing isolation or quarantine may appeal a written order by submitting a written appeal within ten days of receipt of the written order. The appeal shall be addressed to the issuing board. Unless stayed by order of the board or a district court, the written order for quarantine or isolation shall remain in force and effect until the appeal is finally determined and disposed of upon its merits.

b. Proceeding. The appeal proceeding shall be conducted in accordance with this rule and specific local board of health rules governing appeal proceedings. The proceeding shall be held as soon as is practicable and in no case later than ten days from the date of receipt of the appeal. The hearing may be held by telephonic or other electronic means if necessary to prevent additional exposure to the communicable or possibly communicable disease. In extraordinary circumstances and for good cause shown, the board may continue the proceeding date for up to ten days, giving due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence. At the appeal proceeding, the subject of the appeal shall have the right to introduce evidence on all issues relevant to the order. The board, by majority vote, may modify, withdraw, or order compliance with the order under appeal.

c. Judicial review. The aggrieved party to the final decision of the board may petition for judicial review of that action by filing an action in the appropriate district court. Petitions for judicial review shall be filed within 30 days after the decision becomes final.

d. Immediate judicial review of board order. The board acknowledges that in certain circumstances the subject or subjects of a board order may desire immediate judicial review of a board order in lieu of proceeding with the board's appeal process. The board may consent to immediate jurisdiction of the district court when requested by the subject or subjects of a board order and justice so requires. Unless stayed by order of the board or a district court, the written order for quarantine or isolation shall remain in force and effect until the judicial review is finally determined and disposed of upon its merits.

1.6(5) *Implementation and enforcement of isolation and quarantine.*

a. Jurisdictional issues. The department has primary jurisdiction to isolate or quarantine individuals or groups of individuals if the communicable disease outbreak has affected more than one county or has multicounty, statewide, or interstate public health implications. When imposing isolation or quarantine, the department will coordinate with the local health department as appropriate. If isolation or quarantine is imposed by the department, a local board of health or local health department may not alter, amend, modify, or rescind the isolation or quarantine order.

b. Assistance of local boards of health and local health departments. If isolation or quarantine is imposed by the department, the local boards of health and the local health departments in the affected areas will assist in the implementation of the isolation or quarantine order.

c. Assistance of law enforcement. Pursuant to Iowa Code chapter 135, all peace officers of the state will enforce and execute a lawful department order for isolation or quarantine within their respective jurisdictions. The department will take all reasonable measures to minimize the risk of exposure to peace officers and others assisting with enforcement of an isolation or quarantine order.

d. Penalty. Violation of a lawful isolation or quarantine order will be subject to penalties pursuant to Iowa Code chapter 135.

e. Enforcement action. The department may file a civil action in the Polk County district court or in the district court for the county in which the individual resides or is located to enforce a department order for isolation or quarantine. Such action will be filed in accordance with the Iowa Rules of Civil Procedure.

1.6(6) Control of isolation and quarantine premises.

a. The department or local board of health may authorize physicians, health care workers, or others access to individuals in isolation or quarantine as necessary to meet the needs of isolated or quarantined individuals.

b. No person shall enter isolation or quarantine premises unless authorized to do so by the department or local board of health.

c. Any person entering isolation or quarantine premises may be required to wear personal protective equipment or receive vaccination or any other preventative care as appropriate.

d. Any person entering isolation or quarantine premises, with or without authorization, may be subject to an order of quarantine as deemed medically necessary.

[ARC 8070C, IAB 6/12/24, effective 7/17/24; Editorial change: IAC Supplement 6/10/26]

641—1.7(139A,22) Confidentiality. Reportable disease records and information, with the exception of AIDS and HIV records, that identify a person or a business named in a report may be disclosed under the following limited circumstances:

1.7(1) By and between department employees and agents who have a need for the record in the performance of their duties.

1.7(2) By and between department employees and agents and local boards of health and local health departments as necessary to conduct disease surveillance and investigation, to the extent necessary to protect the health or life of the named party, or to enforce a department order or an order of a local board of health.

1.7(3) By and between department employees and agents and health care providers, laboratories, and hospitals as necessary to conduct disease surveillance or an investigation, to the extent necessary to protect the health or life of the named party, or to enforce a department order or an order of a local board of health.

1.7(4) By and between department employees and agents and employees and agents of federal, state, and local agencies as necessary to conduct disease surveillance or an investigation or to enforce a department order or an order of a local board of health.

1.7(5) By and between department employees and agents and employees and agents of tribes and tribal public health authorities as necessary to conduct disease surveillance or an investigation or to enforce a department order or an order of a local board of health.

1.7(6) Reportable disease information may be included in an isolation or quarantine order or placard as necessary to prevent the spread of a quarantinable disease.

[ARC 8070C, IAB 6/12/24, effective 7/17/24]

STATE HYGIENIC LABORATORY

641—1.8(135,139A) Specimens for which the fee charged by the state hygienic laboratory will be waived. Pursuant to Iowa Code section 263.8, the state hygienic laboratory will waive testing fees for conditions deemed to be of public health significance by the department with approval from the state medical director or the state epidemiologist. A list of conditions and the criteria for which the fee is waived can be found on the HHS website.

[ARC 8070C, IAB 6/12/24, effective 7/17/24]

APPENDIX A

**Iowa Department of Health and Human Services
Table of Reportable Communicable and Infectious Diseases**

Report cases of the diseases listed in the following table to the department within the time frame specified in the When to Report column and by the reporting method in the How to Report column.

To report diseases immediately, use the 24/7 disease reporting telephone hotline: 1-800-362-2736.

IMMEDIATELY report diseases, syndromes, poisonings and conditions of any kind suspected or caused by a biological, chemical, or radiological agent or toxin when there is reasonable suspicion that the disease, syndrome, poisoning or condition may be the result of a deliberate act such as terrorism.

IMMEDIATELY report to the department outbreaks of any kind, diseases that occur in unusual numbers or circumstances, unusual syndromes, or uncommon diseases. Outbreaks may be infectious, environmental or occupational in origin and include food-borne outbreaks or illness secondary to chemical exposure (e.g., pesticides, anhydrous ammonia).

Report diseases by:

Entering into the Iowa Disease Surveillance System (IDSS): For IDSS-related questions, call the Center for Acute Disease Epidemiology (CADE) at 1-800-362-2736.

Fax: (515)281-5698

Mail:

Iowa Department of Health and Human Services
Center for Acute Disease Epidemiology
Lucas State Office Building
321 E. 12th Street
Des Moines, Iowa 50319

Isolates or specimens shall be sent to:

State Hygienic Laboratory at the University of Iowa (SHL)
U of I Research Park
2490 Crosspark Road
Coralville, Iowa 52241-4721

For specimen submission questions, call (319)335-4500 or go to www.shl.uiowa.edu.

Diseases	When to Report	How to Report
Acquired immune deficiency syndrome (AIDS) and AIDS-defining conditions	7 days	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Report by one of the following methods: Phone (515)322-8819 or mail ● Health care providers: use the Pediatric or Adult Confidential Case Report Form ● Laboratories: send copy of lab report or the Iowa Confidential Report of Sexually Transmitted Disease & HIV Infection. Mark envelope "Attention 03" For HIV/AIDS-related questions, call (515)322-8819

Diseases	When to Report	How to Report
Acute Flaccid Myelitis (AFM)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Anthrax	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Botulism (including infant botulism)	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Brucellosis (Brucella)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Campylobacteriosis (Campylobacter)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Candida auris	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Carbapenemase-Producing Organisms (CPO)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Chlamydia	3 days	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Report by one of the following methods: Phone (515)281-3031, IDSS, fax (515)725-1278 or mail ● Use the Iowa Confidential Report of Sexually Transmitted Disease ● Mark envelope “Attention 00”
Cholera	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax Laboratories: send isolate or specimen to the SHL
Cronobacter invasive infection (in infants)	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax
Cryptosporidiosis	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Cyclospora	3 days	Report for Iowa residents. Phone, IDSS, fax or mail Laboratories: send isolate or specimen to the SHL
Cytomegalovirus (CMV)	3 days	Report for Iowa residents. IDSS or fax: 1-515-242-6013
Diphtheria	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Escherichia coli shiga toxin-producing and related diseases (includes HUS and TTP)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail Laboratories: send isolate or specimen to the SHL
Giardiasis (Giardia)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Gonorrhea	3 days	Report for Iowa residents and for residents of

Diseases	When to Report	How to Report
		other states diagnosed or treated in Iowa. Report by one of the following methods: Phone (515)281-3031, IDSS, fax (515)725-1278 or mail ● Use the Iowa Confidential Report of Sexually Transmitted Disease ● Mark envelope “Attention 00”
Haemophilus influenzae type B invasive disease	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736 Laboratories send isolate or specimen to the SHL
Hansen’s disease (leprosy)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Hantavirus syndromes	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Hepatitis A	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax
Hepatitis B, C, D, E	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Human immunodeficiency virus (HIV) cases Death of a person with HIV Perinatally exposed newborn and child (newborn and child who was born to an HIV-infected mother)	7 days	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Report by one of the following methods: Phone (515)322-8819 or mail ● Health care providers: use the Pediatric or Adult Confidential Case Report Form ● Laboratories: send copy of lab report or the Iowa Confidential Report of Sexually Transmitted Disease & HIV Infection. Mark envelope “Attention 03” For HIV/AIDS-related questions, call (515)322-8819
Legionellosis (Legionella)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Listeria monocytogenes invasive disease	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax Laboratories: send isolate or specimen to the SHL
Malaria	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Measles (rubeola)	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Meningococcal invasive disease	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736 Laboratories: send isolate or specimen to the SHL

Diseases	When to Report	How to Report
Mosquito-borne diseases (e.g., chikungunya, dengue, eastern equine encephalitis, Jamestown Canyon, La Crosse, St. Louis, Venezuelan equine encephalitis, West Nile, western equine encephalitis and Zika)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Mpox	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax
Mumps	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with COVID-19	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Pertussis	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Plague	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Poliomyelitis	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Psittacosis	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Q fever	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Rabies, animal	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Rabies, human	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Rubella (including congenital)	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax
Salmonellosis (Salmonella)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail Laboratories: send isolate or specimen to the SHL
Severe acute respiratory syndrome (SARS)	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Shigellosis (Shigella)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail Laboratories: send isolate or specimen to the SHL
Smallpox	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Syphilis	3 days	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa.

Diseases	When to Report	How to Report
		Report by one of the following methods: Phone (515)281-3031, IDSS, fax (515)725-1278 or mail ● Use the Iowa Confidential Report of Sexually Transmitted Disease ● Mark envelope "Attention 00"
Tetanus	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Tickborne diseases (e.g., alpha-gal syndrome, anaplasmosis, babesiosis, Bourbon virus disease, ehrlichiosis, Heartland virus disease, Lyme disease, Powassan virus disease, spotted fever group rickettsioses and tickborne relapsing fever)	3 days	Report for Iowa residents. Phone, IDSS, fax or mail
Tuberculosis, pulmonary and laryngeal (infectious)	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone (515)281-7504, IDSS or fax (515)281-4570
Tuberculosis, extrapulmonary	3 days	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone (515)281-7504, IDSS or fax (515)281-4570
Tularemia	3 days	Report for Iowa residents. Phone, IDSS or fax
Typhoid fever	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax
Vancomycin intermediate Staphylococcus aureus (VISA) and vancomycin-resistant Staphylococcus aureus (VRSA)	1 day	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. Phone, IDSS or fax Laboratories: send isolate or specimen to the SHL
Viral hemorrhagic fever (VHF) (e.g., Lassa, Marburg, Ebola, and Crimean-Congo)	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736
Yellow fever	Immediately	Report for Iowa residents and for residents of other states diagnosed or treated in Iowa. 24/7 disease reporting telephone hotline: 1-800-362-2736

APPENDIX B

**Iowa Department of Health and Human Services
Table of Reportable Poisonings and Conditions**

Report cases of the poisonings and conditions listed in the following table to the department within the time frame specified in the When to Report column and by the reporting method in the How to Report column.

To report diseases immediately, use the 24/7 disease reporting telephone hotline: 1-800-362-2736.

IMMEDIATELY report diseases, syndromes, poisonings and conditions of any kind suspected or caused by a biological, chemical, or radiological agent or toxin when there is reasonable suspicion that the disease, syndrome, poisoning or condition may be the result of a deliberate act such as terrorism.

IMMEDIATELY report to the department outbreaks of any kind, diseases that occur in unusual numbers or circumstances, unusual syndromes, or uncommon diseases. Outbreaks may be infectious, environmental or occupational in origin and include food-borne outbreaks or illness secondary to chemical exposure (e.g., pesticides, anhydrous ammonia).

Mailing address:

Bureau of Environmental Health Services
Iowa Department of Health and Human Services
321 East 12th Street
Des Moines, Iowa 50319-0075

Telephone: 1-800-972-2026

Fax: (515)281-4529

Poisoning or Condition	Cases to Report	When to Report	How to Report
Arsenic poisoning	Blood arsenic values equal to or greater than 70 µg/L Urine arsenic values equal to or greater than 100 µg/g of creatinine	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Blood lead testing	All analytical results greater than or equal to 20 micrograms per deciliter (µg/dL) in a child under the age of 6 years or a pregnant woman	Daily	By telephone: 1-800-972-2026
	All other analytical values for all blood lead analyses	Weekly	Electronic format specified by the department
Cadmium poisoning	Blood cadmium values equal to or greater than 5 µg/L Urine cadmium values equal to or greater than 3 µg/g of creatinine	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Carbon monoxide (CO) poisoning	Blood carbon monoxide level equal to or greater than 10% carboxyhemoglobin or its equivalent with a breath analyzer test, or a clinical diagnosis of CO	Daily	By telephone: 1-800-972-2026

Poisoning or Condition	Cases to Report	When to Report	How to Report
	poisoning regardless of any test results		
Hypersensitivity pneumonitis	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Mercury poisoning	Blood mercury values equal to or greater than 2.8 µg/dL Urine mercury values equal to or greater than 20 µg/L	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Methemoglobinemia	Blood analyses showing greater than 5% of total hemoglobin present as methemoglobin	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Microcystin toxin poisoning	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Noncommunicable respiratory illness	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Occupationally related asthma, bronchitis or respiratory hypersensitivity reaction	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Pesticide poisoning (including pesticide-related contact dermatitis)	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Severe skin disorder	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.
Toxic hepatitis	All cases	Weekly	Format specified by department. Electronic reporting if available. Alternatives include by mail, telephone, and facsimile.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 3
EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 12/1/30

641—3.1(135) Definitions. For the purposes of this chapter, the following definitions will apply:

“Audiologist” means a person licensed pursuant to Iowa Code chapter 147 or certified by the Iowa board of educational examiners pursuant to 282—Chapter 14 or a person appropriately licensed in the state where the person practices.

“Audiology assistant” means a person who works under the supervision of an Iowa-licensed speech pathologist or audiologist, does not meet the requirements to be licensed as a speech pathologist or audiologist, and meets the minimum requirements set forth in 481—Chapter 781.

“Audiometrist” means a technician who has received special training in the use of pure-tone audiometry equipment. An audiometrist conducts the hearing tests selected and interpreted by an audiologist, who supervises the process.

“Birth center” means the same as defined in Iowa Code section 10A.711.

“Birthing hospital” means the same as defined in Iowa Code section 135.131.

“Congenital cytomegalovirus” or *“cCMV”* means an infection where cytomegalovirus is transmitted to the fetus in the prenatal period.

“Cytomegalovirus” or *“CMV”* means a kind of herpes virus that usually produces very mild symptoms in an infected person but may cause severe neurological damage in a person with a weakened immune system and in a newborn.

“Diagnostic audiologic assessment” means physiological or behavioral procedures completed by an audiologist to evaluate and diagnose hearing loss.

“Discharge” means a release from a birthing hospital to the parent or legal guardian of the child.

“Early ACCESS” means Iowa’s Individuals with Disabilities Education Act (IDEA), Part C, program for infants and toddlers. It is a statewide, comprehensive, interagency system of integrated early intervention services that supports eligible children and their families as defined in 281—Chapter 120.

“Guardian” means a person who is not the parent of a minor child, but who has legal authority to make decisions regarding life or program issues for the child. A guardian may be a court or a juvenile court. “Guardian” does not mean conservator as defined in Iowa Code section 633.3, although a person who is appointed to be a guardian may also be appointed to be a conservator.

“Health care professional” means a licensed physician, nurse practitioner, physician associate, certified midwife, registered nurse, licensed practical nurse, patient care technician, certified nursing assistant, licensed audiologist, audiology assistant, audiometrist, hearing aid specialist, speech-language pathologist or other licensed or certified professional for whom hearing screening is within the professional’s scope of practice.

“Hearing loss” means a permanent unilateral or bilateral hearing loss of greater than 30 dB hearing loss (HL) in the frequency region important for speech recognition (500-4000 Hz).

“Hearing screening” means a physiological measurement of hearing of a newborn or infant with a “pass” or “refer” result. Screening is used to determine the newborn’s or infant’s need for further testing and must be performed bilaterally, when applicable.

“Initial screening” or *“newborn hearing screening”* means a screening performed in a birthing hospital, birth center or facility other than a birthing hospital within the first month of life. This is a physiological test to separate those newborns with normal hearing from those newborns who may have hearing thresholds of greater than 30 dB HL in either ear in the frequency region important for speech recognition (500-4000 Hz).

“Normal hearing” means hearing thresholds in both ears of 30 dB HL or less in the frequency region important for speech recognition (500-4000 Hz).

“Parent” means:

1. A biological or adoptive parent of a child;
2. A guardian, but not the state if the child is a ward of the state;
3. A person acting in the place of a parent, such as a grandparent or stepparent with whom a child lives, or a person who is legally responsible for the child's welfare;
4. A surrogate parent who has been assigned in accordance with 281—120.422(34CFR303); or
5. A foster parent, if:
 - A biological parent's authority to make the decisions required of parents under state law has been terminated; and
 - The foster parent has an ongoing, long-term parental relationship with the child, is willing to make the decisions required of a parent, and has no interest that would conflict with the interests of the child.

"Physician" means an individual licensed under Iowa Code chapter 148.

"Primary care provider" means a licensed physician, nurse practitioner, physician associate or certified midwife who undertakes primary pediatric care responsibility for an infant or child to provide ongoing medical care and referrals to promote overall health and well-being.

"Protocol" means a document that guides decision making and provides the criteria to be used regarding screening, diagnosis, management, and treatment of children related to hearing health care. Early hearing detection and intervention protocols not otherwise specified in this chapter are available on the department's website.

"Provider" means a licensed audiologist, otolaryngologist or hearing aid specialist who agrees to provide hearing aids or audiologic services to eligible patients.

"Rescreen" means a newborn hearing screening performed after two weeks of age on an infant who did not pass the initial screening.

[ARC 9616C, IAB 10/15/25, effective 12/1/25; Editorial change: IAC Supplement 6/10/26]

641—3.2(135) Program components.

3.2(1) The EHDI coordinator assigned within the department provides administrative oversight, including follow-up activities, for the EHDI program within Iowa.

3.2(2) The EHDI advisory committee represents the interests of the people of Iowa and assists in the development of programming that ensures the availability and access to quality hearing health care for Iowa children.

3.2(3) The EHDI program has an association with the Iowa Title V maternal and child health programs to promote comprehensive services for infants and children with special health care needs.

3.2(4) The EHDI program provides hearing screening surveillance and follow-up for infants and children under the age of three. Follow-up may include:

- a. Contact with the parent or legal guardian of an infant who was not screened or does not pass the initial hearing screening, outpatient hearing screening or diagnostic audiologic assessment.
- b. Contact with the infant's primary care provider to ensure the infant receives appropriate follow-up no later than the recommended timeline as outlined in the Joint Committee on Infant Hearing position statement at www.jcih.org as amended to August 1, 2025.
- c. Contact with the birthing hospital or health care professional for inquiries on missing results, data entry discrepancies and recommendations for additional referrals.
- d. Referrals to family support or early intervention service providers for infants or toddlers diagnosed with a hearing loss.
- e. Technical assistance to birthing facilities, primary care providers and health care professionals regarding best practices related to newborn hearing screening, diagnosis and follow-up best practices.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.3(135) Screening the hearing of all newborns. All newborns and infants born in Iowa, except those born with a condition that is incompatible with life, shall be screened for hearing loss. The person required to perform the screening shall use at least one of the following procedures:

1. Automated or screening auditory brainstem response, or
2. Evoked otoacoustic emissions.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.4(135) Procedures required of birthing hospitals. Each birthing hospital in Iowa shall follow these procedures:

3.4(1) Each birthing hospital shall designate an employee of the hospital to be responsible for the newborn hearing screening program in that institution. If a birthing hospital contracts with a third party for newborn screening services, the hospital retains ultimate responsibility for screening and reporting.

3.4(2) Prior to the discharge of the newborn, each birthing hospital shall provide hearing screening to every newborn delivered in the hospital, except in the following circumstances:

- a. The newborn is transferred for acute care prior to completion of the hearing screening.
- b. The newborn is born with a condition that is incompatible with life.

3.4(3) If a newborn is transferred for acute care, the birthing hospital shall notify the receiving facility of the status of the hearing screening. The receiving facility shall then be responsible for completion of the newborn hearing screening prior to discharge of the newborn from the nursery.

3.4(4) Newborn hearing screening shall be performed by a health care professional.

3.4(5) The birthing hospital shall report newborn hearing screening results to the parent or guardian in written form.

3.4(6) The birthing hospital shall report newborn hearing screening results to the department pursuant to 641—3.7(135).

3.4(7) The birthing hospital shall report the results of the hearing screening to the primary care provider of the newborn or infant upon the newborn's or infant's discharge from the birthing hospital. If the newborn or infant was not tested prior to discharge, the birthing hospital shall report the status of the hearing screening to the primary care provider of the newborn or infant.

3.4(8) The birthing hospital shall follow the hearing screening protocols prescribed by the department.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.5(135) Procedures required of birth centers. Each birth center in Iowa shall follow these procedures:

3.5(1) Each birth center shall designate an employee of the birth center to be responsible for the newborn hearing screening program in that institution.

3.5(2) Prior to discharge of the newborn, each birth center shall refer every newborn delivered in the birth center to a health care professional for a newborn hearing screening. Before discharge of the newborn, the birth center shall arrange an appointment for the newborn hearing screening no more than 15 days from the date of discharge and report the appointment time, date and location to the parent.

3.5(3) The health care professional to whom the newborn is referred for screening shall complete the screening within 30 days of the newborn's discharge from the birth center, unless the parent fails to attend the appointment. If the parent fails to attend the appointment, the health care professional shall document such failure in the medical or educational record and shall report such failure to the department.

3.5(4) The health care professional who completes the newborn hearing screening shall report screening results to the parent in written form.

3.5(5) The health care professional who completes the newborn hearing screening shall report screening results to the department pursuant to 641—3.7(135).

3.5(6) The health care professional who completes the newborn hearing screening shall report the results of the hearing screening to the primary care provider of the newborn or infant.

3.5(7) The person who completes the screening shall follow the hearing screening protocols prescribed by the department.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.6(135) Procedures to ensure that children born in locations other than a birth center or birthing hospital receive a hearing screening.

3.6(1) The physician or other health care professional who undertakes primary pediatric care of a newborn delivered in a location other than a birthing hospital or birth center shall ensure a hearing screening is performed pursuant to Iowa Code section 135.131(5). The health care professional shall arrange an appointment for the newborn hearing screening and report to the parent the appointment time, date, and location.

3.6(2) The health care professional who completes the newborn hearing screening shall report screening results to the parent in written form.

3.6(3) The health care professional who completes the newborn hearing screening shall report screening results to the department pursuant to 641—3.7(135). If the parent fails to attend the appointment, the facility shall document such failure in the medical or educational record and shall report such failure to the department.

3.6(4) The health care professional who completes the newborn hearing screening shall report the results of the hearing screening to the primary care provider of the newborn or infant.

3.6(5) The person who completes the newborn hearing screening shall follow the hearing screening protocols prescribed by the department.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.7(135) Reporting hearing screening results and information to the department and child's primary care provider.

3.7(1) Any birthing hospital, birth center, physician, audiologist or other health care professional required to report information pursuant to Iowa Code section 135.131 shall report all of the following information to the department relating to each newborn's hearing screening within six working days of the birth of the newborn and within six working days of any hearing rescreen, utilizing the department's designated reporting system:

- a.* The name, date of birth, and sex of the newborn.
- b.* The name, address, and telephone number, if available, of the mother of the newborn. If the mother is not the person designated as legally responsible for the child's care, the name, address, and telephone number of the parent, as defined in 641—3.1(135), shall be reported.
- c.* The name of the primary care provider for the newborn upon the newborn's discharge from the birthing hospital or birth center.
- d.* The results of the newborn hearing screening, either "pass," "refer," or "not screened," for each ear separately.
- e.* The results of any rescreening, either "pass" or "refer," and the diagnostic audiologic assessment procedures used for each ear separately.
- f.* Known risk indicators for hearing loss of the infant or child.

3.7(2) If the parent fails to attend the appointment, the facility shall document such failure in the medical or educational record and shall report such failure to the department.

3.7(3) The person who completes the newborn hearing screening shall report the results of the hearing screening to the primary care provider of the infant or child.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.8(135) Conducting and reporting screening results and diagnostic audiologic assessments to the department and child's primary care provider. Any health care professional conducting newborn hearing screens, rescreens, or diagnostic audiologic assessments shall report the results within six working days for any child under three years of age to the department utilizing the department's designated reporting system. The health care professional shall conduct the diagnostic hearing assessment in accordance with the Pediatric Audiologic Diagnostic Protocol as amended

to August 1, 2025, posted on the department's website. Results of a hearing screen, rescreen or diagnostic audiologic assessment shall be reported as follows.

3.8(1) Reports shall include:

- a. The name, date of birth, and sex of the child.
- b. The name, address, and telephone number, if available, of the mother of the child. If the mother is not the person designated as legally responsible for the child's care, the name, address, and telephone number of the parent, as defined in 641—3.1(135), shall be reported.
- c. The name of the primary care provider for the child.
- d. Known risk indicators for hearing loss.
- e. The date the child is fit with a hearing aid(s) or a cochlear implant(s), if applicable.
- f. The date of referral to early intervention, if applicable.
- g. The date of referral to family support, if applicable.

3.8(2) Results of the newborn hearing screening shall be reported as either "pass" or "refer" for each ear separately.

3.8(3) Results of the hearing rescreen shall be reported as either "pass" or "refer" for each ear separately.

3.8(4) If an assessment results in a diagnosis of normal hearing for both ears, this shall be reported.

3.8(5) Any diagnosis of hearing loss shall also be reported except for transient conductive hearing loss lasting for less than 90 days in the professional judgment of the practitioner. This exception will apply only if the child passed the initial hearing screening or rescreening or had a diagnostic assessment resulting in normal hearing for both ears.

3.8(6) Diagnostic audiologic assessment results shall include a statement of the severity (mild, moderate, moderately severe, severe, profound, or undetermined) and type (sensorineural, conductive, mixed, or undetermined) of hearing loss.

3.8(7) Any health care professional conducting newborn hearing screens, rescreens, or diagnostic audiologic assessments shall report the results to the primary care provider of the infant or child.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.9(135) Congenital cytomegalovirus (cCMV) testing for newborns who do not pass the initial newborn hearing screening. If the newborn hearing screen indicates potential hearing loss, as evidenced when a newborn does not pass the initial newborn hearing screening, the birthing hospital, birth center, physician, or other health care professional required to ensure that the hearing screening is performed shall follow the procedures related to cCMV testing outlined in Iowa Code section 135.131(9). If a parent objects to the testing, the birthing hospital, birth center, physician, or other health care professional required to ensure that the hearing screening is performed shall follow the procedures in 641—3.11(135).

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.10(135) Information sharing and confidentiality. Reports, records, and other information collected by or provided to the department relating to a child's newborn hearing screening, rescreen, diagnostic audiologic assessment, and early intervention enrollment are confidential records pursuant to Iowa Code section 22.7.

3.10(1) Personnel of the department shall maintain the confidentiality of all information and records used in the review and analysis of newborn hearing screenings, rescreens, diagnostic audiologic assessments, and early intervention enrollment, including information which is confidential under Iowa Code chapter 22 or any other provisions of state law.

3.10(2) No individual or organization providing information to the department in accordance with this rule shall be deemed to be or held liable for divulging confidential information.

3.10(3) The department shall not release confidential information except to the following persons and entities under the following conditions:

- a. The parent or guardian of an infant or child for whom the report is made.
- b. A local birth-to-three coordinator with the Early ACCESS program or an agency under contract with the department to administer the children with special health care needs program.
- c. A health care professional or primary care provider.
- d. A representative of a federal or state agency, to the extent that the information is necessary to perform a legally authorized function of that agency.
- e. A representative of a state agency, or an entity bound by that state, to the extent that the information is necessary to perform newborn hearing screening follow-up. The state agency or the entity bound by that state shall be subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa. The state agency or the entity bound by that state shall not use the information obtained from the department to market services to patients or nonpatients or identify patients for any purposes other than those expressly provided in this rule.

3.10(4) Research purposes. All proposals for research using the department's data to be conducted by persons other than program staff shall first be submitted to and accepted by the researchers' institutional review board. The department will then review and approve programs before research can commence.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.11(135) Procedure to accommodate parental objection. These rules will not apply if the parent objects to the hearing screening, diagnostic audiologic assessment, or cCMV testing.

3.11(1) If a parent objects to the screening, the birthing hospital, birth center, physician, or other health care professional shall obtain a written refusal from the parent or guardian on the department newborn hearing screening or diagnostic audiologic assessment refusal form and shall maintain the original copy of the written refusal in the newborn's, infant's or child's medical record.

3.11(2) The birthing hospital, birth center, physician, or other health care professional shall send a copy of the written newborn hearing screening or diagnostic audiologic assessment refusal form to the department within six days of the birth of the newborn.

3.11(3) If a parent objects to a hearing rescreen or diagnostic audiologic assessment orally to a department EHDI staff member during follow-up, the staff member shall document the refusal in the department's designated reporting system and mail to the parent or guardian the department newborn hearing screening or diagnostic audiologic assessment refusal form in an attempt to obtain a written refusal to be maintained in the newborn's, infant's or child's medical record.

3.11(4) If a parent objects to cCMV testing, the birthing hospital, birth center, physician, or other health care professional required to ensure cCMV testing shall obtain, on the department cCMV testing refusal form, a written refusal from the parent or guardian, shall maintain the original copy of the written refusal in the child's medical record, and shall send a copy of the written refusal to the department within 21 days of the child's birth.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

641—3.12(135) Civil/criminal liability. A person who acts in good faith in complying with these rules shall not be held civilly or criminally liable for reporting the information required.

[ARC 9616C, IAB 10/15/25, effective 12/1/25]

These rules are intended to implement Iowa Code section 135.131.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 4
CONGENITAL AND INHERITED DISORDERS
[Prior to 7/29/87, Health Department[470]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

641—4.1(136A) Definitions. For the purposes of this chapter, the following definitions apply:

“Anonymized specimen” means a specimen that cannot be traced back to or linked with the particular individual from whom the specimen was obtained.

“Attending health care provider” means the same as defined in Iowa Code section 136A.2.

“Birth defect” means any major structural abnormality or metabolic disorder that may adversely affect a child’s health and development. The abnormality or disorder must be diagnosed or its signs and symptoms must be recognized within the first two years of life.

“Birthing facility” means a private or public facility licensed pursuant to Iowa Code chapter 135B that has a licensed obstetric unit or is licensed to provide obstetric services.

“Central laboratory” means the state hygienic laboratory (SHL), which is designated as the screening laboratory to perform testing and reporting for the Iowa newborn screening and Iowa maternal prenatal screening programs.

“Central registry” means the Iowa registry for congenital and inherited disorders (IRCID).

“Congenital condition” means a condition that exists at birth and may be hereditary, result from an action or exposure occurring during pregnancy or at birth, or may be due to a combination of both factors.

“Consulting physician” means a physician designated by the center for congenital and inherited disorders to interpret screen results and provide consultation to a licensed health care provider.

“Council” means the council on health and human services.

“Critical congenital heart disease” or *“CCHD”* means the presence of one or more of the following specific heart lesions: hypoplastic left heart syndrome, pulmonary atresia, tetralogy of Fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus.

“Discharge” means a release of an infant from a hospital or birth center.

“Early ACCESS” means the statewide, comprehensive, interagency system of integrated early intervention services that supports eligible children and their families as defined in 281—Chapter 120.

“Early hearing detection and intervention program” means Iowa’s newborn hearing screening and follow-up program, which ensures that all newborns and toddlers with hearing loss are identified as early as possible and provided with timely and appropriate audiological, educational and medical intervention and family support.

“Follow-up program” means the services provided to follow up on an abnormal screening result.

“Guardian” means a person who is not the parent of a minor child, but who has legal authority to make decisions regarding life or program issues for the child.

“Health care provider” means a licensed physician, nurse practitioner, certified nurse midwife, registered nurse, or physician associate providing medical care to an individual.

“Iowa maternal prenatal screening program” or *“IMPSP”* means a program that provides a screening test designed to identify increased risk of having a baby with a congenital or inherited disorder or developing a problem later in pregnancy.

“Iowa newborn screening panel” or *“newborn screening panel”* means the list of disorders for which the department screens Iowa newborns.

“Iowa newborn screening program” or *“INSP”* means a program that provides screening of live-born Iowa newborns for the disorders listed on the Iowa newborn screening panel.

“Neuromuscular disorder” means Duchenne, Becker, congenital, distal, Emery-Dreifuss, facioscapulohumeral, limb-girdle, myotonic, and oculopharyngeal muscular dystrophy.

“Newborn critical congenital heart disease (CCHD) screening” means the screening of newborns for seven targeted heart conditions (hypoplastic left heart syndrome, pulmonary atresia, tetralogy of Fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus) using pulse oximetry or other means to detect blood oxygen saturation levels.

“Primary health care provider” means a licensed physician, physician associate, nurse practitioner, or certified nurse midwife providing ongoing primary medical care to a patient.

“Receiving facility” means the facility receiving an infant from a birthing facility.

“Residual maternal prenatal serum screening specimen” means the portion of the specimen that may be left over after all necessary activities of the Iowa maternal prenatal screening program are completed.

“Residual newborn screening specimen” means the portion of the dried blood spot specimen that may be left over after all activities necessary for the Iowa newborn screening program are completed.

“Specialty genetics provider” means a medical geneticist, genetic nurse, genetic physician associate, genetic nurse practitioner, or genetic counselor.

“State hygienic laboratory” or *“SHL”* means the designated central testing laboratory.

“Stillbirth” means the same as defined in Iowa Code section 136A.2.

“Transferring facility” means the birthing facility that transfers the infant to another facility.

[ARC 9319C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

641—4.2(136A) Iowa newborn screening program (INSP). This program provides comprehensive newborn screening services for hereditary and congenital disorders for the state.

4.2(1) Newborn screening policy.

a. All newborns and infants born in the state of Iowa shall be screened for all congenital and inherited disorders on the Iowa newborn screening panel as specified by the department.

b. As new disorders are recognized and new technologies and tests become available, the department will develop and follow protocols for the addition of disorders to or the deletion of disorders from the screening panel.

c. The department may monitor individuals identified as having a genetic or metabolic disorder for the purpose of conducting public health surveillance or intervention and for determining whether early detection, treatment, and counseling lead to the amelioration or avoidance of the adverse outcomes of the disorder. Birthing facilities and health care providers shall provide patient data and records to the department upon request to facilitate the monitoring. Any identifying information provided to the department shall remain confidential pursuant to Iowa Code section 22.7(2).

d. For purposes of newborn screening, the department will collect newborn screening specimens and data, test the specimens for disorders on the universal screening panel, conduct follow-up on abnormal screening results, conduct quality improvement and quality assurance activities, and store specimens for a time period determined by its policies.

4.2(2) Newborn blood spot screening procedure for facilities and providers.

a. *Educating parent or guardian.* Before a specimen from an infant is obtained, a parent or guardian will be informed of the type of specimen, how it is obtained, the nature of the disorders for which the infant is being screened, the consequences of treatment and nontreatment, and the retention, use and disposition of residual specimens.

b. *Refusal of screening.* Should a parent or guardian refuse the screening, said refusal shall be documented in the infant’s medical record, and the parent or guardian shall sign the refusal of screening form. The birthing facility or attending health care provider shall submit the signed refusal of screening form to the INSP within six days of the refusal. The birthing facility or attending health care provider may submit refusal forms via the courier service established for the transportation of newborn screening specimen collection forms or via secure fax.

c. *Collection of specimens.* A filter paper blood specimen shall be collected from the infant between 24 to 48 hours after the infant’s birth. A specimen shall not be collected from an infant less than 24 hours after birth except as follows:

(1) A blood specimen must be collected before any initial transfusion, even if the infant is less than 24 hours old.

(2) A blood specimen must be collected before the infant leaves the hospital, whether by discharge or by transfer to another hospital, even if the infant is less than 24 hours old.

d. Submission of specimens. All specimens shall be delivered to the SHL via courier service or, if courier service is not available, overnight postage, overnight express delivery service, or other appropriate means within 24 hours after collection.

4.2(3) Primary health care provider responsibility.

a. The health care provider or a designee shall ensure that infants under the provider's care are screened.

b. Procedures for specimen collection for newborn blood spot screening shall be followed in accordance with subrule 4.2(2).

c. A physician or other health care professional who undertakes primary pediatric care of an infant delivered in Iowa shall arrange for the newborn screening if a newborn screening result is not in the infant's medical record.

d. The primary care provider of an infant delivered in Iowa shall discuss the newborn screening results with the parent or guardian of the newborn, including follow-up on abnormal results.

4.2(4) Birthing facility. The birthing facility shall ensure that all infants receive newborn screening.

a. Designee. Each birthing facility shall designate an employee to be responsible for the newborn screening program in that institution.

b. Procedures for specimen collection for newborn screening shall be followed in accordance with subrule 4.2(2).

c. Transfer. The following apply if an infant is transferred:

(1) If an infant is transferred within the hospital for acute care, the newborn nursery shall notify the acute care unit of the status of the newborn screening. The acute care unit shall then be responsible for the status of the newborn screening prior to discharge of the infant.

(2) If the infant is transferred to another facility within the state, the facility shall notify the receiving facility of the status of the newborn screening. The receiving facility shall then be responsible for completion of the newborn screening prior to discharge of the infant.

d. Discharge. Each birthing facility shall collect a newborn screening specimen on every infant prior to discharge, including under the following circumstances:

(1) The infant is discharged or transferred to another facility before the infant is 24 hours old.

(2) The infant is born with a condition that is incompatible with life.

(3) The infant has received a transfusion.

e. Notification. The birthing facility shall report the newborn screening results to the health care provider who has undertaken ongoing primary pediatric care of the infant.

4.2(5) SHL responsibility. The SHL will:

a. Contract with a courier service to provide transportation and delivery of newborn screening specimens.

b. Contact all birthing facilities to provide education on ordering specimen transport from the courier.

c. Process specimens within 24 hours of receipt.

d. Notify the submitting health care provider, birthing facility, or drawing laboratory of an unacceptable specimen and the need for another specimen.

e. Report a presumptive positive screen result within 24 hours to the consulting physician or the physician's designee.

f. Distribute specimen collection forms, specimen collection procedures, refusal of newborn screening forms, and other materials to drawing laboratories, birthing facilities, and health care providers.

g. Report normal and abnormal screening results to the submitting facility or provider.

h. Submit a written annual report of the previous calendar year to the department by July 1 of each year. This report will include:

- (1) Number of infants screened,
- (2) Number of repeat screens,
- (3) Number of presumptive positive results by condition and disorder,
- (4) Number of rejected specimens,
- (5) Number of waivers,
- (6) Results of quality assurance testing, including any updates to the INSP quality assurance policies, and
- (7) Screening and educational activity details.

i. In collaboration with the program consulting physicians, submit a proposed budget and narrative justification for the upcoming state fiscal year by January 31 of each year.

j. Act as fiscal agent for program expenditures encompassing the analytical, technical, administrative, educational, and follow-up costs for the screening program.

k. Submit a fiscal expenditures report to the department within 90 days after the end of the state fiscal year.

4.2(6) *Follow-up program responsibility.* Follow-up programs will be available for all individuals identified by the newborn screening as having an abnormal screen result.

a. The follow-up activities will include care coordination, consultation, genetic counseling or recommendations for treatment when indicated, case management, education and quality assurance.

b. The follow-up programs shall submit a written annual report of the previous calendar year by July 1 of each year. The report shall include:

- (1) The number of presumptive positive results and confirmed positive results by condition and disorder,
- (2) Number of confirmed cases receiving follow-up,
- (3) A written summary of educational and follow-up activities.

c. In collaboration with the SHL, the follow-up programs shall submit a proposed budget and narrative justification for the upcoming fiscal year to the department by January 31 of each year.

d. The follow-up programs shall submit a fiscal expenditures report to the department within 90 days of the end of the state fiscal year.

4.2(7) *Information sharing and confidentiality.* Reports, records, and other information collected by or provided to the Iowa newborn screening program relating to an infant's newborn screening results and follow-up information are confidential records pursuant to Iowa Code sections 22.7 and 136A.7. INSP data may be retained for 19 years.

a. Personnel of the program shall maintain the confidentiality of all information and records used in the review and analysis of newborn screening and follow-up, including information that is confidential under Iowa Code chapter 22 or any other provisions of state law.

b. The program shall not release confidential information, except to the following persons and entities under the following conditions:

(1) The parent or guardian of an infant or child or the adult individual for whom the report is made.

(2) A primary health care provider, birthing facility, or submitting laboratory.

(3) A representative of a state or federal agency or agents of tribes and tribal public health authorities to the extent that the information is necessary to perform a legally authorized function of that agency or the department. No data shall be furnished to state or federal agencies or agents of tribes or tribal public health agencies until the department has prepared in writing the conditions under which the data may be used and has received an agreement signed by a responsible agent of the state or federal agency agreeing to meet and conform to such conditions.

(4) A researcher, upon documentation of parental consent obtained by the researcher, and only to the extent that the information is necessary to perform research authorized by the department.

c. Newborn screening information shall not be released to any person or entity for commercial purposes or law enforcement purposes or to establish a database for forensic identification.

4.2(8) *Retention, use and disposition of residual newborn screening specimens.*

a. A newborn screening specimen collection form consists of a filter paper containing the dried blood spots (DBS) specimen and the attached requisition that contains information about the infant and birthing facility or drawing laboratory. The DBS specimen can be separated from the information contained in the requisition form. The INSP is the custodian of the specimens and related data for purposes of newborn screening, quality improvement and quality assurance activities.

- (1) The residual DBS specimen shall be held for five years in a locked area at the SHL.
- (2) The residual DBS specimen shall be stored for the first year at –75 to –80 degrees C.
- (3) After one year, the residual DBS specimen shall be archived for four additional years at room temperature.

- (4) The residual DBS specimen shall be incinerated after completion of the retention period.

b. The program shall not release a residual newborn screening specimen except to the following persons and entities:

- (1) The parent or guardian of the infant or the individual adult upon whom the screening was performed.

- (2) A health care provider acting on behalf of the patient.

- (3) A medical examiner authorized to conduct an autopsy on a child or an investigation into the death of a child.

- (4) A researcher, upon documentation of parental consent obtained by the researcher, and only to the extent that the information is necessary to perform research authorized by the department.

- (5) The newborn screening program, for operations as provided in this rule.

c. Research. A residual newborn screening specimen may be released for research purposes only if written consent has been received by the researcher from a parent or guardian of the child, or the individual adult upon whom the screening was performed, and each of the following conditions is satisfied:

- (1) Investigators shall submit proposals to use residual newborn screening specimens to the department. Any intended use of the requested specimens as part of the research study must be clearly delineated in the proposal.

- (2) Before research can commence, proposals shall be approved by the researcher's institutional review board and the department.

- (3) Research on residual newborn screening specimens shall be allowed only in instances where research would further: newborn screening activities; the health of an infant or child for whom no other specimens are available or readily attainable; general medical knowledge for existing public health surveillance activities; public health purposes; or medical knowledge to advance the public health.

d. Newborn screening program operations. Residual newborn screening specimens and related data may be used for activities, testing, and procedures directly related to the operation of the newborn screening program, including confirmatory testing, laboratory quality control assurance and improvement, equipment calibration, evaluation and improvement of the accuracy of newborn screening tests, and equipment and screening methods validation, and for the use of linked specimens in feasibility studies approved by the council for the purpose of incorporating new tests or evaluating new test methodologies.

e. Prohibited uses. A residual newborn screening specimen shall not be released to any person or entity for commercial purposes or law enforcement purposes or to establish a database for forensic identification.

f. Return or destruction of specimens. A parent or guardian may request return or destruction of the parent's or guardian's newborn's residual newborn screening specimen by contacting the department.

4.2(9) *Newborn screening for critical congenital heart disease.* All newborns and infants born in Iowa shall receive newborn screening for CCHD, by pulse oximetry or other means in accordance with subparagraph 4.2(9)“b”(3). The purpose of newborn screening for CCHD is to identify newborns with structural heart defects usually associated with hypoxia in the newborn period that could have significant morbidity or mortality early in life with the closing of the ductus arteriosus or other physiological changes early in life.

a. Newborn CCHD screening procedure for providers and facilities.

(1) Educating parent or guardian. Before newborn screening for CCHD on an infant is conducted, a parent or guardian shall be informed of the type of screening, how it is performed, the nature of the conditions and disorders for which the infant is being screened, and the follow-up procedure for an abnormal screen result.

(2) Refusal. Should a parent or guardian refuse the screening, said refusal shall be documented in the infant’s medical record, and the parent or guardian shall sign the refusal of screening form. The birthing facility or attending health care provider shall submit the signed refusal form to the central laboratory within six days of the refusal. The birthing facility or attending health care provider may submit refusal forms via the courier service established for the transportation of newborn screening specimen collection forms or via secure fax.

b. Newborn CCHD screening for newborns in low-risk or intermediate nurseries or out-of-hospital births.

(1) Screening should not begin until the newborn is at least 24 hours of age, or as late as possible if earlier discharge is planned, and should be completed on the second day of life.

(2) Screening shall be conducted using pulse oximeters or other means in accordance with subparagraph 4.2(9)“b”(3). Pulse oximeters shall:

1. Be motion tolerant;
2. Report functional oxygen saturation;
3. Be validated in low-perfusion conditions;
4. Be cleared by the Food and Drug Administration (FDA) for use on newborns; and
5. Have a 2 percent root-mean-square accuracy.

Disposable or reusable probes may be used. Reusable probes must be appropriately cleaned between uses according to manufacturer’s instructions.

(3) Newborn CCHD screening shall be conducted by pulse oximetry or other means in accordance with the most recently published guidelines, algorithms, and protocols as outlined by the American Academy of Pediatrics, the American College of Cardiology Foundation and the American Heart Association, or subsequent guidance by the organizations listed in this subparagraph. Materials are available on the department’s website.

c. Newborn CCHD screening for high-risk newborns in neonatal intensive care unit (NICU). Until such time that an evidence-based protocol for CCHD screening in infants discharged from the NICU is available, the attending health care provider shall conduct a comprehensive examination of the newborn to screen the infant for CCHD prior to discharge.

d. Primary health care provider responsibility. The health care provider shall ensure that infants under the provider’s care are screened.

e. Reporting results of newborn CCHD screening. Results of newborn CCHD screening shall be reported in a manner consistent with other newborn screening reporting.

4.2(10) *INSP and IMPSP fees.*

a. In consultation with the department, the SHL shall establish the newborn screening fee schedule in a manner sufficient to support the newborn screening system of care, including but not limited to laboratory screening costs, short-term and long-term follow-up program costs, the newborn screening developmental fund, and the cost of the department’s newborn screening data system.

b. The SHL shall include as part of the INSP fee an amount to fund the provision of special medical formula and foods for eligible individuals with inherited diseases of amino acids and organic acids who are identified through the programs.

c. Funds collected through newborn screening fees will be used for newborn screening program activities only.

d. Funds collected through maternal prenatal screening fees will be used for maternal prenatal screening activities only.

e. In order to support newborn and maternal prenatal screening activities, the department will authorize the expenditure and exchange of newborn screening and maternal prenatal screening developmental funds between the SHL (as designated fiscal agent) and the department.

f. A portion of INSP and IMPSP fees will be distributed to the department to support activities of the INSP and the IMPSP.

4.2(11) *Special medical formula and foods program.*

a. A special medical formula and foods program for individuals with inherited diseases of amino acids and organic acids who are identified through the Iowa newborn screening program is provided by the University of Iowa.

b. Payments received from clients based on third-party payment, sliding fee scales and donations shall be used to support the administration of and the purchase of special medical formula and foods.

c. The funding allocation from the Iowa newborn screening program fee will be used as the funder of last resort after all other available funding options have been pursued by the special medical formula and foods program.

d. Provisions of special medical formula and foods through this funding allocation shall be available to an individual only after the individual has shown that all benefits from third-party payers, including but not limited to health insurers; health maintenance organizations; Medicare; Medicaid; Special Supplemental Food Program for Women, Infants and Children program (WIC); and other government assistance programs have been exhausted. In addition, a full fee and a sliding fee scale shall be established and used for those persons able to pay all or part of the cost. Income and resources shall be considered in the application of the sliding fee scale. Individuals whose income is at or above 185 percent of the federal poverty level shall be charged a fee for the provision of special medical formula and foods. Placement of individuals on the sliding fee scale shall be determined and reviewed at least annually.

e. The SHL will act as the fiscal agent.

f. The University of Iowa Health Care Medical Center under the control of the state board of regents shall not receive indirect costs from state funds appropriated for this program.

[ARC 9319C, IAB 5/28/25, effective 8/1/25]

641—4.3(136A) Iowa maternal prenatal screening program (IMPSP). This program provides comprehensive maternal prenatal screening services for the state.

4.3(1) *Maternal screening.* The IMPSP provides a risk assessment for certain congenital or inherited conditions and disorders of a newborn. The department will identify the minimum conditions included in the assessment on the department's website.

a. If a patient desires this screening test, the health care provider shall direct that a specimen be drawn and submitted to the SHL or a laboratory with the capacity to provide screening for the minimum type of prenatal screening services.

b. As new technologies and tests become available, the department will develop and follow protocols for the addition or deletion of conditions and disorders from the screening program.

4.3(2) *Maternal screening procedure.*

a. *Specimen collection.* A serum or clotted blood specimen shall be collected from the patient within the appropriate gestational range indicated by the requested screen.

b. *Specimen processing.* The SHL will test specimens within three working days of receipt.

c. *Reporting abnormal results.* Abnormal screen results shall be reported within 24 hours to the consulting physician or the physician's designee, who shall then notify the primary health care

provider. On the next working day, this initial report shall be followed by a written report to the primary health care provider.

4.3(3) Consulting physician responsibility. A consulting physician shall be designated by the department to provide interpretation of screen results and consultation to the submitting health care provider. This physician shall provide consultation for abnormal screen results, assist with questions about management of identified cases, provide education and assist with quality assurance measures. The screening program, with assistance from the consulting physician, shall:

a. In collaboration with the SHL, submit a proposed budget and narrative justification for the upcoming fiscal year to the department by January 31 of each year, and

b. Submit a written annual report of the previous calendar year's activity to the department by July 1 of each year. The report will include:

- (1) Number of persons screened,
- (2) Number of repeat screens,
- (3) Number of abnormal results by condition and disorder,
- (4) Number of rejected specimens,
- (5) Results of quality assurance testing, and
- (6) Screening and educational activity details.

4.3(4) SHL responsibility. The SHL will:

a. Contract with a courier service to provide transportation and delivery of maternal prenatal serum specimens.

b. Contact all entities submitting specimens to recommend use of the courier service to transport specimens to the SHL.

c. Test specimens within seven working days of receipt.

d. Distribute specimen collection kits and other materials to health care provider offices and drawing facilities as required.

e. Inform the submitting health care provider or drawing facility of an unacceptable specimen and request another specimen.

f. Provide educational materials concerning specimen collection procedures to health care provider offices.

g. Have available for review a written quality assurance program covering all aspects of its screening activity.

h. Act as a fiscal agent for program charges encompassing the analytical, technical, administrative, educational and follow-up costs for the screening program.

4.3(5) IMPSP fee determination. The department will annually review and determine the fee to be charged for all activities associated with the IMPSP. The review and determination of the fee will be completed at least one month prior to the beginning of the fiscal year.

4.3(6) Information sharing and confidentiality. Reports, records, and other information collected by or provided to the IMPSP relating to a patient's maternal prenatal screening results and follow-up information are confidential records pursuant to Iowa Code section 22.7.

a. Personnel of the program shall maintain the confidentiality of all information and records used in the review and analysis of maternal serum screening and follow-up, including information that is confidential under Iowa Code chapter 22 or any other provisions of state law.

b. The program shall not release confidential information except to the following persons and entities, under the following conditions:

- (1) The patient for whom the report is made.
- (2) A primary health care provider or submitting laboratory.

(3) A representative of a state or federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state or federal agency will be subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa.

c. Maternal prenatal information shall not be released to any person or entity for commercial purposes or law enforcement purposes or to establish a database for forensic identification.

4.3(7) *Retention, use and disposition of residual maternal prenatal screening specimens.* The residual serum specimens shall be held for a specified period of time in a locked area at the SHL in accordance with SHL policy and procedures.

[ARC 9319C, IAB 5/28/25, effective 8/1/25]

641—4.4(136A) Regional genetic consultation service (RGCS). This program provides comprehensive genetic and genomic services statewide through outreach clinics.

4.4(1) Provision of comprehensive genetic and genomic services. The department will contract with the division of medical genetics and genomics within the department of pediatrics at the University of Iowa to provide genetic and genomic health care and education outreach services for individuals and families within Iowa.

4.4(2) The University of Iowa Health Care Medical Center under the control of the state board of regents shall not receive indirect costs from state funds appropriated for this program.

[ARC 9319C, IAB 5/28/25, effective 8/1/25]

641—4.5(136A) Neuromuscular and other related genetic disease program (NMP). This program provides comprehensive services statewide for individuals and families with neuromuscular disorders through outreach clinics and statewide, active surveillance for selected neuromuscular disorders.

4.5(1) Comprehensive service provision. The department will contract with the department of pediatrics at the University of Iowa to provide neuromuscular health care, case management and education outreach services for individuals and families within Iowa.

4.5(2) The University of Iowa Health Care Medical Center under the control of the state board of regents shall not receive indirect costs from state funds appropriated for this program.

[ARC 9319C, IAB 5/28/25, effective 8/1/25]

641—4.6(136A) Iowa registry for congenital and inherited disorders (IRCID). This program provides active statewide surveillance for congenital and inherited conditions and disorders. These may include birth defects, neuromuscular disorders, metabolic disorders, and all stillbirths. The program also may conduct active statewide surveillance of live births without a reportable congenital or inherited condition or disorder to serve as controls for epidemiological surveys. Surveillance activities for specific congenital and inherited conditions and disorders and maternal and congenital infections will be conducted for the period of time that adequate financial support is available.

A reportable congenital or inherited condition or disorder occurring in a miscarriage or pregnancy may be included in the IRCID.

4.6(1) *Surveillance policy.*

a. Congenital conditions and disorders, including birth defects, occurring in Iowa are reportable conditions, and records will be abstracted pursuant to rule 641—1.3(139A) and maintained in the IRCID. Congenital conditions and disorders surveillance will be performed in order to determine the occurrence and trends of such conditions and disorders, to determine co-occurring conditions and treatments through annual follow-up abstraction, to conduct thorough and complete epidemiological surveys to identify environmental and genetic risk factors for congenital conditions and disorders, to contribute to prevention strategies, and to assist in the planning for and provision of services to children with congenital conditions and disorders and their families.

b. Records for neuromuscular disorders will be abstracted pursuant to rule 641—1.3(139A) and maintained in the IRCID. Neuromuscular disorders surveillance for individuals of all ages shall be performed to determine the occurrence and trends of the selected neuromuscular disorders, to determine co-occurring conditions and treatments through annual follow-up abstraction, to conduct thorough and complete epidemiological surveys through annual long-term follow-up, and to assist in the planning for and provision of services to individuals with selected neuromuscular disorders and their families.

c. Stillbirths occurring in Iowa are reportable conditions, and records of these stillbirths will be abstracted pursuant to rule 641—1.3(139A) and maintained in the IRCID. Stillbirth surveillance will be performed to determine the occurrence and trends of stillbirths, to conduct thorough and complete epidemiological surveys to identify environmental and genetic risk factors for stillbirths, and to assist in the planning for and provision of services to prevent stillbirths.

4.6(2) *IRCID activities.*

a. The department will establish an agreement with the University of Iowa to implement the activities of the IRCID.

b. The IRCID will use the birth defects, neuromuscular disorders, and stillbirth coding schemes developed by the Centers for Disease Control and Prevention (CDC).

c. The IRCID staff will review hospital records, clinical charts, physician's records, vital records, prenatal records, and fetal death evaluation protocols pursuant to rule 641—1.3(139A), information from the INSP, RGCS, NMP, and the IMPSP, and any other information that the IRCID deems necessary and appropriate for congenital and inherited conditions and disorders surveillance.

4.6(3) *Department responsibility.*

a. When a live infant's medical records are ascertained by the IRCID, the department or its designee will inform the parent or legal guardian by letter that this information has been collected and provide the parent or guardian with information about services for which the child and family may be eligible.

b. The department and the IRCID will annually release aggregate medical and epidemiological information to medical personnel and appropriate state and local agencies for the planning and monitoring of services for children with congenital or inherited conditions and disorders and their families.

4.6(4) *Confidentiality and disclosure of information.* Reports, records, and other information collected by or provided to the IRCID relating to a person known to have or suspected of having a congenital or inherited condition or disorder are confidential records pursuant to Iowa Code sections 22.7 and 136A.7.

a. Personnel of the IRCID and the department shall maintain the confidentiality of all information and records used in the review and analysis of congenital or inherited conditions and disorders, including information that is confidential under Iowa Code chapter 22 or any other provisions of state law.

b. IRCID staff are authorized pursuant to rule 641—1.3(139A) to gather all information relevant to the review and analysis of congenital or inherited conditions and disorders. IRCID staff are permitted to review hospital records, clinical charts, physician's records, vital records, and prenatal records, information from the INSP, RGCS, NMP, and IMPSP and any other information the IRCID deems necessary and appropriate for live births without a reportable congenital or inherited condition and disorder to serve as controls for epidemiological surveys.

c. No individual or organization providing information to the IRCID in accordance with this rule shall be deemed or held liable for divulging confidential information.

4.6(5) *Access to information in the IRCID.* The IRCID and the department shall not release confidential information except to the following, under the following conditions:

a. The parent or guardian of an infant or child for whom the report is made and who can demonstrate that the parent or guardian has received the notification letter.

b. An Early ACCESS service coordinator or an agency under contract with the department to administer the children with special health care needs program, upon receipt of written consent from the parent or guardian of the infant or child.

c. A local health care provider, upon receipt of written consent from the parent or guardian of the infant or child.

d. A representative of a federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The information provided shall not

include the personal identifiers of an infant or child with a reportable congenital or inherited condition or disorder.

e. Researchers. All proposals for research using the IRCID data to be conducted by persons other than program staff shall first be submitted to and accepted by the researcher's institutional review board. Proposals shall then be reviewed and approved by the department before research can commence.

f. A representative of a state agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state agency will be subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa.

[ARC 9319C, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement Iowa Code chapter 136A.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 7
IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING
ELEMENTARY OR SECONDARY SCHOOLS, LICENSED CHILD CARE CENTERS OR
INSTITUTIONS OF HIGHER EDUCATION

[Prior to 7/29/87, Health Department[470]]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/3/29

641—7.1(139A) Definitions.

“Admitting official” means the superintendent of schools or the superintendent’s designated representative if a public school; if a nonpublic school or licensed child care center, the governing official of the school or child care center.

“Advanced registered nurse practitioner” or *“ARNP”* means an advanced registered nurse practitioner as defined in 655—Chapter 7.

“Applicant” means any person seeking enrollment in a licensed child care center or elementary or secondary school.

“Certified medical assistant” means a person who is certified to practice as a certified medical assistant following completion of a postsecondary medical assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or the Accrediting Bureau of Health Education Schools and successful completion of the certification examination and who is directed by a supervising physician, physician associate, or nurse practitioner.

“Competent private instruction” is as defined in Iowa Code section 299A.1.

“Elementary school” means kindergarten if provided, and grades one through eight or grades one through six when grades seven and eight are included in a secondary school.

“Eligible postsecondary institution” means an institution of higher learning under the control of the state board of regents, a community college established under Iowa Code chapter 260C, or an accredited private institution as defined in Iowa Code section 256.183.

“Enrolled user” means a user of the registry who has completed an enrollment form that specifies the conditions under which the registry can be accessed and who has been issued an identification code and password by the department.

“Health screening” means a vision screen, dental screen, or refugee health screen.

“Immunization registry” or *“registry”* means the department of health and human services’ database of confidential, population-based, immunization and health screening records.

“Institution of higher education” means a postsecondary school.

“Nurse” means a person licensed to practice as a nurse pursuant to Iowa Code chapter 152.

“On-campus residence hall or dormitory” means campus housing for students that is owned or leased by the institution of higher education and located on a recognized campus site.

“Pharmacist” means a person licensed to practice pharmacy pursuant to Iowa Code chapter 155A.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148.

“Physician associate” means a person licensed to practice as a physician associate pursuant to Iowa Code chapter 148C.

“Postsecondary student” means a person who has officially registered with a postsecondary school, as determined by the school, and who physically attends class on the school’s campus. For purposes of these rules, “postsecondary student” does not include a person who is exclusively registered in a correspondence course or continuing education class or who attends class exclusively by means of distance learning or through other means that do not require the person’s physical presence on the school’s campus.

“Screening provider” means an ophthalmologist, optometrist, physician, free clinic, child care center, local public health department, public or accredited nonpublic school, community-based

organization, advanced registered nurse practitioner (ARNP), physician associate, dentist or dental hygienist.

“Secondary school” means:

1. A junior high school comprising grades 7, 8 and 9, and a senior high school;
2. A combined junior-senior high school comprising grades 7 through 12;
3. A junior high school comprising grades 7 and 8 and a high school comprising grades 9 through 12;
4. A high school comprising grades 9 through 12.

“Signature” means an original signature or the authorized use of a stamped signature or electronic signature.

“Student” means an individual who is enrolled in a licensed child care center, elementary school or secondary school.

[ARC 8041C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 6/10/26]

641—7.2(139A) Persons included. The immunization requirements specified elsewhere in these rules apply to all persons enrolled or attempting to enroll in a licensed child care center or a public or nonpublic elementary or secondary school in Iowa including those who are provided competent private instruction.

[ARC 8041C, IAB 5/29/24, effective 7/3/24]

641—7.3(139A) Persons excluded. Exclusions to these rules are permitted on an individual basis for medical and religious reasons pursuant to Iowa Code section 139A.8. Applicants approved for medical or religious exemptions shall submit to the admitting official a valid department certificate of immunization exemption.

7.3(1) To be valid, a medical certificate of immunization exemption shall contain, at a minimum, the applicant’s last name, first name, and date of birth, the vaccine(s) exempted, and an expiration date (if applicable) and shall bear the signature of a physician, nurse practitioner, or physician associate. Language included on the medical certificate of immunization exemption referencing rule 641—7.3(139A) cannot be altered. Any edits or alterations to the medical certificate of immunization exemption referencing rule 641—7.3(139A) will invalidate the certificate.

a. A medical exemption may apply to a specific vaccine(s) or all required vaccines. If, in the opinion of the physician, nurse practitioner, or physician associate issuing the medical exemption, the exemption should be terminated or reviewed at a future date, an expiration date shall be recorded on the certificate of immunization exemption; or

b. A medical exemption may apply when the administration of the required vaccine would violate minimum interval spacing and the exemption shall apply only to an applicant who has not received prior doses of the exempted vaccine. An expiration date, not to exceed 60 calendar days, and the name of the vaccine exempted shall be recorded on the medical certificate of exemption.

7.3(2) A religious exemption may be granted to an applicant if immunization conflicts with a genuine and sincere religious belief. To be valid, a religious certificate of immunization exemption for religious reasons shall contain, at a minimum, the applicant’s last name, first name, and date of birth and shall bear the signature of the applicant or, if the applicant is a minor, of the applicant’s parent or guardian and shall attest that immunization conflicts with a genuine and sincere religious belief and that the belief is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to immunizations. Language included on the religious certificate of immunization exemption referencing rule 641—7.3(139A) cannot be altered. Any edits or alterations to the religious certificate of immunization exemption referencing rule 641—7.3(139A) will invalidate the certificate.

7.3(3) Medical and religious exemptions do not apply in times of emergency or epidemic pursuant to Iowa Code section 139A.8.

[ARC 8041C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 6/10/26]

641—7.4(139A) Required immunizations.

7.4(1) Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements below:

IMMUNIZATION REQUIREMENTS

Applicants enrolled or attempting to enroll shall have received the following vaccines in accordance with the doses and age requirements listed below. If, at any time, the age of the child is between the listed ages, the child must have received the number of doses in the "Total Doses Required" column.

Institution	Age	Vaccine	Total Doses Required
Licensed Child Care Center	Less than 4 months of age	This is not a recommended administration schedule, but contains the minimum requirements for participation in licensed child care. Routine vaccination begins at 2 months of age.	
	4 months through 5 months of age	Diphtheria/Tetanus/Pertussis	1 dose
		Polio ¹	1 dose
		<i>haemophilus influenzae</i> type B	1 dose
		Pneumococcal	1 dose
	6 months through 11 months of age	Diphtheria/Tetanus/Pertussis	2 doses
		Polio ¹	2 doses
		<i>haemophilus influenzae</i> type B	2 doses
		Pneumococcal	2 doses
	12 months through 18 months of age	Diphtheria/Tetanus/Pertussis	3 doses
		Polio ¹	2 doses
		<i>haemophilus influenzae</i> type B	2 doses; or 1 dose received at 15 months of age or older.
		Pneumococcal	3 doses; or 2 doses if both doses were received at 12 months of age or older.
	19 months through 23 months of age	Diphtheria/Tetanus/Pertussis	4 doses
		Polio ¹	3 doses
		<i>haemophilus influenzae</i> type B	3 doses if a dose was received on or after 12 months of age; or 2 doses if the first dose was received on or after 12 months of age; or 1 dose if the dose was received at 15 months of age or older.
		Pneumococcal	4 doses if a dose was received on or after 12 months of age; or 3 doses if 1 or more doses were received on or after 12 months of age; or 2 doses if both doses were received at 12 months of age or older.
		Measles/Rubella	1 dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose; or the applicant has a reliable history of natural disease.
	24 months of age and older	Diphtheria/Tetanus/Pertussis	4 doses
		Polio ¹	3 doses
		<i>haemophilus influenzae</i> type B	3 doses if a dose was received on or after 12 months of age; or 2 doses if the first dose was received on or after 12 months of age; or 1 dose if the dose was received at 15 months of age or older. Hib vaccine is not required for persons 60 months of age or older.
		Pneumococcal	4 doses if a dose was received on or after 12 months of age; or 3 doses if 1 or more doses were received on or after 12 months of age; or 2 doses if the first dose was received on or after 12 months of age; or 1 dose if the dose was received on or after 24 months of age. Pneumococcal vaccine is not required for persons 60 months of age or older.
		Measles/Rubella	1 dose; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Varicella	1 dose; or the applicant has a reliable history of natural disease.
Elementary or Secondary School (K-12)	4 years of age and older	Diphtheria/Tetanus/Pertussis ²	5 doses with at least 1 dose received on or after 4 years of age; or 4 doses if the fourth dose was received on or after 4 years of age; and 1 dose of tetanus/diphtheria/acellular pertussis-containing vaccine (Tdap) received on or after 10 years of age for applicants in grades 7 and above, regardless of the interval since the last tetanus/diphtheria-containing vaccine.
		Polio ¹	4 doses, with at least 1 dose received on or after 4 years of age; or 3 doses if the third dose was received on or after 4 years of age.
		Measles/Rubella	2 doses; or the applicant demonstrates a positive antibody test for measles and rubella from a U.S. laboratory.
		Hepatitis B	3 doses
		Varicella	2 doses; or the applicant has a reliable history of natural disease.
		Meningococcal (A, C, W, Y)	1 dose received on or after 10 years of age for applicants in grades 7 through 11; and 2 doses with 1 dose received on or after 16 years of age for applicants in grade 12; or 1 dose for applicants in grade 12 if the dose was received on or after 16 years of age.

¹ Doses of oral polio vaccine (OPV) administered on or after April 1, 2016, are not valid doses and do not count toward the polio vaccine requirement.

² Applicants 7 through 18 years of age who received the first dose of diphtheria/tetanus/pertussis-containing vaccine at 12 months of age or older should receive a total of 3 doses, with one dose received on or after 4 years of age.

7.4(2) Vaccine doses administered less than or equal to four days before the minimum interval or age shall be counted as valid. Doses administered greater than or equal to five days earlier than the minimum interval or age shall not be counted as valid doses and shall be repeated as appropriate.

7.4(3) For vaccine administration, the minimum age and intervals recommended by the advisory committee on immunization practices shall be followed.

[ARC 8041C, IAB 5/29/24, effective 7/3/24]

641—7.5(139A) Required education. An institution of higher education with an on-campus residence hall or dormitory shall provide vaccination information on meningococcal disease to enrolled students on a student health form pursuant to Iowa Code section 139A.26. For purposes of this rule, student health form(s) means a document(s) prepared by an institution of higher education that contains, at a minimum, information on meningococcal disease, vaccination information and any recommendations issued by the national Centers for Disease Control and Prevention regarding meningococcal disease. The student health form(s) shall also include space for the postsecondary student to indicate whether or not the postsecondary student has received vaccination against meningococcal disease, including, at a minimum, the date of vaccination. The student health form(s) shall also include space for the postsecondary student to indicate whether or not the postsecondary student has received information on meningococcal disease and benefits of vaccine. If a traditional student health form is not utilized by the institution of higher education, any document(s) containing the above information is acceptable.

[ARC 8041C, IAB 5/29/24, effective 7/3/24]

641—7.6(139A) Proof of immunization.

7.6(1) A valid department certificate of immunization shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll. To be valid, the certificate shall be the certificate of immunization issued by the department, a computer-generated copy from the immunization registry, or a certificate of immunization that has been approved in writing by the department. The certificate shall contain, at a minimum, the applicant's last name, first name, and date of birth, the vaccine(s) administered, the date(s) given, and the signature of a physician, a physician associate, a nurse, or a certified medical assistant. A faxed copy, photocopy, or electronic copy of the valid certificate is acceptable. The judgment of the adequacy of the applicant's immunization history should be based on records kept by the person signing the certificate of immunization or on that person's personal knowledge of the applicant's immunization history, or comparable immunization records from another person or agency, or an international certificate of vaccination, or the applicant's personal health records. If personal health records are used to make the judgment, the records shall include the vaccine(s) administered and the date given. Persons validating the certificate of immunization are not held responsible for the accuracy of the information used to validate the certificate of immunization if the information is from sources other than their own records or personal knowledge.

7.6(2) Persons wishing to enroll who do not have a valid department certificate of immunization available to submit to the admitting official shall be referred to a physician, a physician associate, a nurse, or a certified medical assistant to obtain a valid certificate.

[ARC 8041C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 6/10/26]

641—7.7(139A) Provisional enrollment.

7.7(1) Applicants may be granted provisional enrollment pursuant to Iowa Code section 139A.8. A valid department provisional certificate of immunization shall be submitted by the applicant or, if the applicant is a minor, by the applicant's parent or guardian to the admitting official of the school or licensed child care center in which the applicant wishes to enroll. To qualify for provisional enrollment, applicants shall have received at least one dose of each of the required vaccines or be a transfer student from another school system. A transfer student is an applicant seeking enrollment from one United States elementary or secondary school into another. To be valid, the certificate shall be the certificate of immunization issued by the department, a computer-generated copy from the immunization registry, or a certificate of immunization that has been approved in writing by the department. The certificate shall contain, at a minimum, the applicant's last name, first name, and date of birth, the vaccine(s) administered, the date(s) given, the remaining vaccine(s) required, the reason that the applicant qualifies for provisional enrollment, and the signature of a physician, a physician associate, a nurse, or a certified medical assistant. Persons validating the provisional certificate of

immunization are not held responsible for the accuracy of the information used to validate the provisional certificate of immunization if the information is from sources other than their own records or personal knowledge. Persons signing the provisional certificate of immunization shall certify that they have informed the applicant or, if the applicant is a minor, the applicant's parent or guardian of the provisional enrollment requirements.

a. Any applicant seeking provisional enrollment who does not have a valid department provisional certificate of immunization to submit to the admitting official shall be referred to a physician, a physician associate, a nurse, or a certified medical assistant to obtain a valid certificate.

b. Reserved.

7.7(2) The amount of time allowed for provisional enrollment shall be as soon as medically feasible but shall not exceed 60 calendar days. The period of provisional enrollment shall begin on the date the provisional certificate is signed. The person signing the provisional certificate shall assign an expiration date to the certificate and shall indicate the remaining immunizations required to qualify for a certificate of immunization.

7.7(3) The applicant or parent or guardian shall ensure that the applicant receives the necessary immunizations during the provisional enrollment period and shall submit a certificate of immunization to the admitting official by the end of the provisional enrollment period.

7.7(4) If at the end of the provisional enrollment period the applicant or parent or guardian has not submitted a certificate of immunization, the admitting official shall immediately exclude the applicant from the benefits, activities, and opportunities of the school or licensed child care center until the applicant or parent or guardian submits a valid certificate of immunization.

7.7(5) If at the end of the provisional enrollment period the applicant has not completed the required immunizations due to minimum interval requirements, a new department provisional certificate of immunization shall be submitted to the admitting official. The admitting official must maintain all issued certificates of provisional immunization with the original provisional certificate until the applicant submits a certificate of immunization.

[ARC 8041C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 6/10/26]

641—7.8(139A) Records and reporting.

7.8(1) It shall be the duty of the admitting official of a licensed child care center or elementary or secondary school to ensure that the admitting official has a valid department certificate of immunization, certificate of immunization exemption, or provisional certificate of immunization on file for each student by the first day of attendance.

a. The admitting official shall keep the certificates on file in the school or licensed child care center in which the student is enrolled and assist the student or parent or guardian in the transfer of the certificate to another school or licensed child care center upon the transfer of the student to another school or licensed child care center.

b. Unless otherwise requested by the applicant, or parent or guardian, the admitting official shall retain the department certificate of immunization, or certificate of immunization exemption, or provisional certificate of immunization for three years commencing upon the transfer or graduation of the applicant, or the school may choose to provide the permanent immunization record to the student at time of graduation. Included with the immunization record a letter should state that this is an important document that will be needed by the student for college or employment and should be permanently retained.

7.8(2) It shall be the duty of the local boards of health to audit the department certificates of immunization, certificates of immunization exemption, and provisional certificates of immunization in the schools within their jurisdiction to determine compliance with Iowa Code section 139A.8. The local boards of health shall furnish the department within 60 days of the first official day of school a report of the audit. The report shall be submitted for each school within the local board of health's jurisdiction and shall include the enrollment by grade, and the number of department certificates of

immunization, certificates of immunization exemption, and provisional certificates of immunization by grade.

7.8(3) The local board of health and the department shall have the right to have access to the department certificates of immunization, certificates of immunization exemption, and the provisional certificates of immunization of children enrolled in elementary and secondary schools and licensed child care centers within the constraints of the privacy rights of parents and students.

7.8(4) The admitting official of an institution of higher education shall provide to the department by December 1 each year aggregate data regarding compliance with Iowa Code section 139A.26. The data shall be forwarded to the department within 30 days. The data shall include, but not be limited to, the total number of incoming postsecondary freshmen students living in a residence hall or dormitory who have:

- a. Enrolled in the institution of higher education; and
- b. Been provided information on meningococcal disease; and
- c. Been immunized with meningococcal vaccine.

[ARC 8041C, IAB 5/29/24, effective 7/3/24]

641—7.9(139A) Compliance. Applicants not presenting proper evidence of immunization or exemption are not entitled to enrollment in a licensed child care center or elementary or secondary school under the provisions of Iowa Code section 139A.8. It shall be the duty of the admitting official to deny enrollment to any applicant who does not submit proper evidence of immunization and to exclude a provisionally enrolled applicant in accordance with this chapter.

[ARC 8041C, IAB 5/29/24, effective 7/3/24]

641—7.10(22) Statewide registry.

7.10(1) *Statewide registry.* The department shall maintain a statewide immunization and health screening registry.

7.10(2) *Purpose and permitted uses of registry.*

a. The registry shall contain immunization and health screening information, including identifying and demographic data, to allow enrolled users to maintain and access a database of immunization and health screening histories for purposes of ensuring patients are fully immunized and screened.

b. The registry may be used to track inventory or utilization of pharmaceutical agents identified by the department to prepare for or respond to an emergency event.

c. Enrolled users shall not use information obtained from the registry to market services to patients or nonpatients, to assist in bill collection services, or to locate or identify patients or nonpatients for any purpose other than those expressly provided in this rule.

d. The registry shall contain health screening data, including screening results and follow-up information.

7.10(3) *Release of information to the registry.* Enrolled users shall provide immunization and health screening information, including identifying and demographic data, to the registry. Information provided may include, but is not limited to, the following:

- a. Name of patient;
- b. Sex of patient;
- c. Date of birth;
- d. Race;
- e. Ethnicity;
- f. Birth state and birth country;
- g. Address;
- h. Parents' names;
- i. Mother's maiden name;
- j. Type of vaccination administered;
- k. Dose or series number of vaccine;

- l.* Date vaccination was administered;
- m.* Lot number;
- n.* Date of health screening;
- o.* Health screening results;
- p.* Source of health screening;
- q.* Health screening follow-up information;
- r.* Patient comments;
- s.* Provider name, license, and business address; and
- t.* Patient history, including previously unreported doses.

7.10(4) *Confidentiality of registry information.* Immunization and health screening information, including identifying and demographic data maintained in the registry, is confidential and may not be disclosed except under the following limited circumstances:

- a.* The department may release information from the registry to the following:
 - (1) The person or the parent or legal guardian of the person immunized or screened.
 - (2) Enrolled users of the registry who have completed a department enrollment form that specifies the conditions under which the registry can be accessed.
 - (3) Persons or entities requesting immunization or health screening data in an aggregate form that does not identify an individual either directly or indirectly.
 - (4) Agencies that complete an agreement with the department that specifies conditions for access to registry data and how that data will be used. Agencies shall not use information obtained from the registry to market services to patients or nonpatients, to assist in bill collection services, or to locate or identify patients or nonpatients for any purposes other than those expressly provided in this rule.
 - (5) A representative of a state or federal agency, or entity bound by that state or federal agency, to the extent that the information is necessary to perform a legally authorized function of that agency or the department. The state or federal agency is subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa. State or federal agencies shall not use information obtained from the registry to market services to patients or nonpatients, to assist in bill collection services, or to locate or identify patients or nonpatients for any purposes other than those expressly provided in this rule.
 - (6) The admitting official of a licensed child care center, elementary school, secondary school, or postsecondary school; or medical or health care providers providing continuity of care.
 - (7) Users from other states or jurisdictions who have signed and completed enrollment in the state's or jurisdiction's immunization registry.
- b.* Users shall not release data obtained from the registry except to the person or the parent or legal guardian of the person immunized or screened, admitting officials of licensed child care centers and schools, medical or health care providers providing continuity of care, and other enrolled users of the registry.

7.10(5) *Suspend or terminate access.* The department will approve, suspend, terminate, and reinstate user access in accordance with this chapter and department policy.

[ARC 8041C, IAB 5/29/24, effective 7/3/24; ARC 9617C, IAB 10/15/25, effective 12/1/25]

641—7.11(22) Release of immunization and health screening information.

7.11(1) *Between a physician, physician associate, nurse, certified medical assistant, pharmacist, or screening provider and the elementary, secondary, or postsecondary school or licensed child care center that the student attends.* A physician, a physician associate, a nurse, a certified medical assistant, a pharmacist, or a screening provider shall disclose a student's or patient's immunization or health screening information, including the name, date of birth, and demographic information; vaccine(s) administered and the month, day and year of administration; health screening results; and clinic source and location, to an elementary, secondary, or postsecondary school or a licensed child care center upon written or verbal request from the elementary, secondary, or postsecondary school or licensed child care center. Written or verbal permission from a student or parent is not required to

release this information to an elementary, secondary, or postsecondary school or licensed child care center that the student attends.

7.11(2) *Among physicians, physician associates, nurses, certified medical assistants, pharmacists or screening providers.* Immunization or health screening information, including the student's or patient's name, date of birth, and demographic information; vaccine(s) administered and the month, day and year of administration; health screening results; and clinic source and location, shall be provided by a physician, physician associate, nurse, certified medical assistant, pharmacist, or screening provider to another health care provider without written or verbal permission from the student, parent, guardian or patient.

7.11(3) *Among an elementary school, secondary school, postsecondary school, and licensed child care center that the student attends.* An elementary school, secondary school, postsecondary school, and licensed child care center shall disclose a student's immunization or health screening information, including the student's name, date of birth, and demographic information; vaccine(s) administered and the month, day and year of administration; health screening results; and clinic source and location, to another elementary school, secondary school, postsecondary school, and licensed child care center that the student attends. Written or verbal permission from a student, or if the student is a minor, the student's parent or guardian, is not required to release this information to an elementary school, secondary school, postsecondary school, and licensed child care center that the student attends.

7.11(4) *Among the department and a physician, physician associate, nurse, certified medical assistant, pharmacist, screening provider, elementary school, secondary school, postsecondary school, and licensed child care center.* A student's or patient's immunization or health screening information, including name, date of birth, grade, and demographic information; vaccine(s) administered and the month, day and year of administration; and health screening results, clinic source, and location, all in a format specified by the department, shall be disclosed upon written or verbal request among the department, physicians, physician associates, nurses, certified medical assistants, pharmacists, screening providers, elementary schools, secondary schools, postsecondary schools, and licensed child care centers. Written or verbal permission from a student, patient, parent, or guardian is not required to release this information.

7.11(5) *Among the department and physicians, physician associates, nurses, resettlement agencies, federal, state, and local government agencies, and certified medical assistants conducting refugee health screenings.* Refugee health screenings shall be disclosed only as indicated in this rule. Immunization or health screening information, including the patient's name, date of birth, and demographic information; the vaccine(s) administered and the month, day, and year of administration; health screening results; and clinic source and location, shall be disclosed upon written or verbal request among the department, physicians, physician associates, nurses, certified medical assistants, resettlement agencies, federal, state, and local government agencies, or screening providers to another health care provider or the department. Written or verbal permission from the parent, guardian or patient is not required to release this information.

[ARC 8041C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code sections 139A.8, 139A.26 and 22.7(2).

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[Editorial change: IAC Supplement 6/10/26]

◇ Two or more ARCs

CHAPTER 11
HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AND ACQUIRED IMMUNE
DEFICIENCY SYNDROME (AIDS)

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/30

641—11.1(139A,141A) Definitions.

“AIDS” means the same as defined in Iowa Code section 141A.1.

“AIDS-related condition” means the same as defined in Iowa Code section 141A.1.

“Alleged offender” means the same as defined in Iowa Code section 915.40.

“Benefits and drug assistance program” or *“BDAP”* means the Iowa benefits and drug assistance program, a component of the Ryan White program administered by the health and human services department (department).

“Blood bank” means a facility for the collection, processing, or storage of human blood or blood derivatives, or from which or by means of which human blood or blood derivatives are distributed or otherwise made available.

“Blood-borne viral hepatitis” means hepatitis B or hepatitis C.

“Care provider” means the same as defined in Iowa Code section 139A.2.

“CDC” means the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.

“Certification of a significant exposure report” means the determination by an authorized infection preventionist, occupational health professional, or other personnel trained in infection control or infectious disease medicine and designated by a facility to review significant exposure reports that the incident described by the exposed care provider meets the definition of a significant exposure as defined in this rule.

“Confirmed positive test” means a reactive result or detectable quantity on any HIV-related test, including an antibody test, an antigen test, a culture, a nucleic acid amplification test, or other test or combination of tests that is considered to be confirmatory according to prevailing medical technology and algorithms or guidance from CDC. When the confirmed positive test involves more than one test, all test results should be included in any reports to the department.

“Contagious or infectious disease” means hepatitis in any form, meningococcal disease as defined in these rules, AIDS or HIV as defined in Iowa Code section 141A.1, tuberculosis as defined in these rules, and any other disease determined to be life-threatening to a person exposed to the disease based upon a determination by the state epidemiologist or medical director and in accordance with guidelines of the CDC.

“Department of corrections” means the Iowa department of corrections.

“Designated representative” means a person who is designated by a department, agency, division, or service organization to act on behalf of the exposed care provider as a liaison with the facility that received the source patient when the exposure occurred in the field or during patient transport.

“Director of a plasma center, blood bank, clinical laboratory, organ procurement organization, or public health laboratory” means the person responsible for direction and operation of the facility, the medical director, or the person designated by the director or medical director to ensure compliance with applicable regulations and requirements.

“Emergency medical services personnel” means “emergency medical care provider” as defined in Iowa Code section 147A.1.

“Exposure” means the same as defined in Iowa Code section 139A.2.

“HBV” means hepatitis B virus.

“Health care facility” means the same as defined in Iowa Code section 139A.2.

“Health care provider” means the same as defined in Iowa Code section 141A.1.

“Health facility” means the same as defined in Iowa Code section 141A.1.

“HIV” means the same as defined in Iowa Code section 141A.1.

“HIV infection” means having acquired the human immunodeficiency virus.

“HIV-related test” means the same as defined in Iowa Code section 141A.1.

“Home health services” means health care services provided by a care provider in a patient’s home or other residence.

“Identifiable third party” means a sexual partner of or a person who shares drug injecting equipment with a person who has been diagnosed with HIV infection.

“Infectious bodily fluids” means bodily fluids capable of transmitting HIV as listed in “Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis,” dated September 25, 2013, and updated May 23, 2018, published by the U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Atlanta, Georgia 30333, on its website. To prevent HIV and blood-borne viral hepatitis disease transmission, this reference indicates that standard precautions should be followed for exposure to the following infectious bodily fluids: blood, amniotic fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid, cerebrospinal fluid, semen, vaginal secretions, and saliva contaminated with blood. HIV and blood-borne viral hepatitis disease transmission has not occurred from feces, nasal secretions, sputum, sweat, tears, urine, vomitus, and saliva when it is not contaminated with blood.

“Laboratory” means a clinical or public health laboratory, a plasma center, or a blood bank inside or outside the boundaries of Iowa.

“Meningococcal disease” means acute infectious bacterial meningococcal infection presenting as invasive disease characterized by one or more clinical syndromes, including bacteremia, sepsis, or meningitis. “Meningococcal disease” does not include nasopharyngeal colonization by *Neisseria meningitidis*.

“Payer of last resort” means a requirement to coordinate services and seek payment from all other sources before Ryan White program funds are used.

“Physician” means a person currently licensed pursuant to Iowa Code chapter 148.

“Physician associate” means a person currently licensed under Iowa Code chapter 148C.

“Plasma center” means a facility that conducts plasmapheresis.

“Plasmapheresis” means the removal of blood from a human being to obtain plasma with the subsequent reinfusion of the remaining formed elements into the donor but excludes such a procedure performed for the purpose of improving the health of the donor.

“Public health laboratory” means a laboratory operated by an agency of city, county or state government for the purpose of supporting disease control activities.

“Respite care services” means health care services provided by a care provider in a patient’s home or other residence on a short-term, temporary basis as relief to those who are caring for family members.

“Ryan White program” means the Ryan White part B program administered by the department, which provides case management, behavioral health, and other supportive services, and assistance with the costs of housing, health insurance, and treatment medications for eligible low-income individuals diagnosed with HIV.

“Sexually transmitted disease or infection” means “sexually transmitted disease or infection” as defined in rule 641—1.1(139A).

“Significant exposure” means a situation in which there is a risk of contracting disease through exposure to a patient’s infectious bodily fluids in a manner capable of transmitting an infectious agent as determined by CDC. Exposure includes contact with blood or other infectious bodily fluids to which standard precautions apply through percutaneous inoculation or contact with an open wound, nonintact skin, or mucous membranes during the performance of normal job duties. Significant exposures include:

1. Transmission of blood, bloody fluids, or other infectious bodily fluids of the source patient onto a mucous membrane (mouth, nose, or eyes) of the care provider.

2. Transmission of blood, bloody fluids, or other infectious bodily fluids of the source patient onto an open wound or lesion with significant breakdown in the skin barrier, including a needle puncture with a needle contaminated with blood, bloody fluids, or other infectious bodily fluids.

“Significant exposure report” means the Report of Exposure to HIV or Other Infectious Disease form provided by the department. This is the only form authorized to be used to document a significant exposure to infectious bodily fluids such that the source patient is deemed to consent to a test to determine if the patient has a contagious or infectious disease and is deemed to consent to notification of the care provider of the results of the test pursuant to Iowa Code section 139A.19.

“Tuberculosis” means infectious tuberculosis as defined in rule 641—1.1(139A).

[ARC 8409C, IAB 11/27/24, effective 1/1/25; Editorial change: IAC Supplement 6/10/26]

641—11.2(141A) HIV testing—obtaining consent—voluntary HIV-related tests for adults who are not pregnant.

11.2(1) Prior to conducting a voluntary HIV-related test on an adult, the health care provider requesting the test shall provide information to the subject of the test concerning HIV testing and where to obtain additional information regarding HIV infection and risk reduction.

11.2(2) Patient consent for testing must be obtained as detailed in Iowa Code section 141A.6.

11.2(3) Once an adult has been informed of a confirmed positive HIV-related test, no HIV-specific consent for medical procedures and tests shall be required for subsequent medical procedures and tests involved in the care or treatment of the adult with HIV infection.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.3(139A,141A) HIV testing—obtaining consent—voluntary HIV-related tests for minors who are not pregnant.

11.3(1) Patient consent for testing must be obtained as detailed in Iowa Code section 141A.6. A minor shall have the legal capacity to act and give consent pursuant to Iowa Code section 139A.35.

11.3(2) Prior to conducting a voluntary HIV-related test on a minor, the health care provider requesting the test shall provide information to the subject of the test concerning HIV testing and where to obtain additional information regarding HIV infection and risk reduction.

11.3(3) A minor shall be informed prior to testing of requirements for health facilities to inform the minor’s legal guardian of a positive test result pursuant to Iowa Code section 141A.7.

11.3(4) Prior to the test, a minor shall give written consent for performance of the HIV-related test and to the notification of the legal guardian should the test be confirmed as positive.

11.3(5) Once a minor has been informed of a confirmed positive HIV-related test and the legal guardian has been notified, no HIV-specific consent for medical procedures and tests shall be required for subsequent medical procedures and tests involved in the care or treatment of a minor with HIV infection.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.4(141A) HIV testing—obtaining consent—voluntary HIV-related tests for pregnant women.

11.4(1) Health care providers that offer prenatal care to women shall provide HIV testing to all pregnant women as described in Iowa Code section 141A.4. No written or oral consent shall be required.

11.4(2) The testing shall occur as early as possible during each pregnancy.

11.4(3) The health care provider requesting the test shall make information available about HIV prevention, risk reduction, and treatment to all pregnant women pursuant to Iowa Code section 141A.4.

11.4(4) A pregnant woman who is a minor shall be informed prior to testing of requirements for health facilities to inform the minor’s legal guardian of a positive test result as described in Iowa Code section 141A.7.

11.4(5) If a pregnant woman declines the test, the decision shall be documented as described in Iowa Code section 141A.4. A health care provider shall encourage women who decline the test early in prenatal care to be tested at a subsequent visit.

11.4(6) Once a pregnant woman has been informed of a confirmed positive HIV-related test and, if the pregnant woman is a minor, the legal guardian has been notified, no HIV-specific consent for medical procedures and tests shall be required for subsequent medical procedures and tests involved in the care or treatment of a pregnant woman with HIV infection.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.5(141A) HIV test results—posttest counseling. Upon informing the subject of an HIV-related test of a confirmed positive test result, the health care provider who requested the test or other designated personnel shall initiate counseling concerning the emotional and physical health effects of HIV infection as described in Iowa Code section 141A.7.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.6(141A) Reporting of diagnoses and HIV-related tests, events, and conditions to the department.

11.6(1) The following constitute reportable events related to HIV infection:

a. A test result indicating HIV infection, including:

(1) Confirmed positive results on any HIV-related test or combination of tests, including antibody tests, antigen tests, cultures, and nucleic acid amplification tests.

(2) A positive result or report of a detectable quantity on any other HIV detection (non-antibody) tests, and results of all viral loads, including nondetectable levels.

(3) Results of genotypic resistance assays.

b. AIDS and AIDS-related conditions, including all levels of CD4+ T-lymphocyte counts.

c. Birth of an infant to an HIV-infected mother (perinatal exposure) or any (positive, negative, or undetectable) non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger.

d. Death resulting from an AIDS-related condition or death of a person with HIV infection.

11.6(2) Reportable events as described in this rule shall be reported to the department pursuant to Iowa Code section 141A.6. The following reporting requirements are in addition to those described in Iowa Code section 141A.6.

a. Within seven days of the receipt of a person's confirmed positive test result indicating HIV infection, the director of a plasma center, organ procurement organization, or public health laboratory that performed the test or that requested the confirmatory test shall make a report to the department.

b. Within seven days of the birth of an infant to a mother diagnosed with HIV or a receipt of a laboratory result (positive, negative, or undetectable) of a non-antibody detection test (antigen test, viral culture, viral load, or qualitative nucleic acid amplification test) on an infant 18 months of age or younger, the attending physician shall make a report to the department.

11.6(3) The report shall be made on a form provided by the department that includes those form fields described in Iowa Code section 141A.6 unless approval from the department has been obtained for use of other reporting formats.

11.6(4) All persons who experience a reportable event while receiving services in the state, regardless of state of residence, shall be reported.

Rules 641—11.1(139A,141A) through 641—11.6(141A) are intended to implement Iowa Code sections 139A.35, 141A.4, 141A.6, and 141A.7.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.7(141A) Confidentiality of information. In addition to the entities described in Iowa Code section 141A.9, medical information secured pursuant to Iowa Code section 141A.9(1) may be shared between employees and agents of the department and employees and agents of tribes and tribal public health authorities that have a need for the information in the duties related to HIV prevention, disease

surveillance, or care of persons with HIV, only as necessary to administer the program for which the information is collected or to administer a program in the tribe or tribal public health authority. Confidential information transferred to other persons or entities under this rule shall continue to maintain its confidential status as described in Iowa Code section 141A.9.

This rule is intended to implement Iowa Code section 141A.9.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.8(135) HIV and AIDS training programs where occupational exposure to blood or other potentially infectious materials may occur.

11.8(1) *Personnel covered by the rule.*

a. Nonemergency personnel. All supervisory and patient care personnel of any agency listed below:

- (1) A licensed hospice,
- (2) A homemaker-home health aide provider agency that receives state homemaker-home health aide funds, or

- (3) An agency that provides respite care services.

b. Emergency and law enforcement personnel. All personnel from the following agencies:

- (1) Emergency medical services.
- (2) Fire services.
- (3) Law enforcement.

11.8(2) *Topics covered.* Training programs must address the following topics, consistent with standards from the Occupational Safety and Health Administration of the U.S. Department of Labor:

- a.* Symptoms and modes of transmission of blood-borne diseases, including human immunodeficiency virus and viral hepatitis,
- b.* Location and handling of personal protective equipment,
- c.* Information on the hepatitis B vaccine, and
- d.* Follow-up procedures in the event of an exposure.

11.8(3) *Timing of training.* Training must occur before an initial assignment of tasks where occupational exposure to blood or other potentially infectious materials may take place and at least annually thereafter.

This rule is intended to implement Iowa Code section 135.11.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.9(139A,141A) Partner notification program.

11.9(1) The department will maintain a partner notification program for persons known to have tested positive for sexually transmitted diseases or infections pursuant to the procedures described in Iowa Code sections 141A.5 and 139A.33.

11.9(2) Services provided include but are not limited to counseling about the disease or infection, risk reduction techniques, linkage to medical care and treatment, assessment and referral to social and prevention services, and elicitation of exposed partners' names and contact information for referral to testing, as described in the Partner Services Program Manual dated December 2023, adopted and incorporated by this reference. The manual contains the policies and procedures utilized in the implementation of the program. The manual is updated annually. A copy of the manual is available on the department website.

11.9(3) The department may delegate its partner notification duties under this rule for persons who have tested positive for HIV or other sexually transmitted diseases to a local health authority or a physician or other health care provider unless the authority or physician or other health care provider refuses or neglects to conduct the partner notification program in a manner deemed to be effective by the department.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.10(141A) Direct notification of an identifiable third party by a physician, physician associate or the department.

11.10(1) Direct notification shall be used when a person diagnosed with HIV is having continuing contact with a sexual or needle-sharing partner who is unaware of the person's infection and when both of the following situations exist:

a. A physician or physician associate for the person diagnosed with HIV is of the good-faith opinion that the nature of the continuing contact through sexual intercourse or the sharing of drug injecting equipment poses an imminent danger of HIV transmission to the third party.

b. When the physician or physician associate believes in good faith that the person diagnosed with HIV, despite strong encouragement, has not and will not warn the third party and will not participate in the voluntary partner notification program.

11.10(2) The department or a physician or a physician assistant may reveal the identity of a person diagnosed with HIV pursuant to this rule only to the extent necessary to protect a third party from the direct threat of transmission. Notification of a person pursuant to this rule shall be made confidentially. Nothing in this rule shall be interpreted to create a duty to warn third parties of the danger of exposure to HIV through contact with a person diagnosed with HIV.

11.10(3) When the physician or physician associate is of the good-faith opinion and belief that third-party notification should be performed, notification of a person pursuant to this rule shall be made:

a. Directly by the physician or physician associate, or

b. By the department at the request of the physician or physician associate.

11.10(4) Notification by the physician or physician associate. Prior to notification of a third party by the physician or physician associate of a person diagnosed with HIV, the physician or physician associate shall make reasonable efforts to inform, in writing, the person diagnosed with HIV. The written information shall state that, due to the nature of the person's continuing contact through sexual intercourse or the sharing of drug injecting equipment with the third party and the physician's or physician associate's belief that the person diagnosed with HIV, despite strong encouragement, has not and will not warn the third party and will not participate in the voluntary partner notification program, the physician or physician associate is forced to take action to provide notification to the third party. The physician or physician associate, when reasonably possible, shall provide the following information to the person diagnosed with HIV:

a. The nature of the disclosure and the reason for the disclosure.

b. The anticipated date of disclosure.

c. The name of the party or parties to whom disclosure is to be made.

NOTE: Reasonable efforts to inform, in writing, the person diagnosed with HIV shall be deemed satisfied when the physician or physician associate delivers the written notice in person or directs a written notice to the diagnosed person's last-known address by restricted certified mail, return receipt requested, at least five days prior to the anticipated date of disclosure to the third party.

11.10(5) When performed by the diagnosed person's physician or physician associate, notification of the third party and any disclosure concerning the purpose of that notification shall be made in person. However, initial contact with the third party may be made by telephone, mail, or other electronic means to arrange the meeting with the physician or physician associate at the earliest opportunity to discuss an important health matter. The nature of the health matter to be discussed shall not be revealed in the telephone call, letter, or other electronic message.

11.10(6) Notification by the department.

a. The physician or physician associate attending the person diagnosed with HIV shall provide by telephone to the department any relevant information provided by the person diagnosed with HIV regarding any party with whom the person diagnosed with HIV has had sexual relations or has shared drug injecting equipment. The information may include the third party's name, address, telephone number, and any other locating information known to the physician or physician associate.

The department shall use the information in accordance with procedures established for the voluntary partner notification program.

b. Notification of the third party and any disclosure concerning the purpose of that notification shall be made in person. However, initial contact with the third party may be made by telephone, mail, or other electronic means to arrange the meeting with the department representative. The nature of the matter to be discussed shall not be revealed in the telephone call, letter, or other electronic message.

11.10(7) Confidentiality. The physician or physician associate of the person diagnosed with HIV and the department shall protect the confidentiality of the third party and the person diagnosed with HIV. The identity of the person diagnosed with HIV shall remain confidential unless it is necessary to reveal it to the third party so that the third party may avoid exposure to HIV. If the identity of the person diagnosed with HIV is revealed, the third party shall be presented with a statement in writing at the time of disclosure that includes the following or substantially similar language: “Confidential information revealing the identity of a person diagnosed with HIV has been disclosed to you. The confidentiality of this information is protected by state law. State law prohibits you from making any further disclosure of the information without the specific written consent of the person to whom it pertains. Any breach of the required confidential treatment of this information subjects you to legal action and civil liability for monetary damages. A general authorization for the release of medical or other information is not sufficient for this purpose.”

11.10(8) Immunity. A health care provider attending a person diagnosed with HIV has no duty to disclose to or to warn third parties of the dangers of exposure to HIV through contact with the person diagnosed with HIV and is immune from any liability, civil or criminal, for failure to disclose to or warn third parties of the condition of the person diagnosed with HIV.

Rules 641—11.9(139A,141A) through 641—11.10(141A) are intended to implement Iowa Code sections 139A.33 and 141A.5.

[ARC 8409C, IAB 11/27/24, effective 1/1/25; Editorial change: IAC Supplement 6/10/26]

641—11.11(139A,141A) Care provider notification upon exposure to contagious or infectious diseases—exposures in nonclinical settings.

11.11(1) If a care provider sustains a significant exposure from a patient while rendering health care or other services, other than home-health or respite care services, outside of a health care facility or hospital, the care provider shall file a significant exposure report as soon as reasonably possible following the exposure. When the exposure occurred outside a clinical setting, a care provider who has sustained a significant exposure should file this report with the infection control, occupational health, or other designated office of the facility to which the patient was transported.

11.11(2) The source patient to whom the care provider was exposed is deemed to consent to a test to determine if the patient has a contagious or infectious disease and is deemed to consent to notification of the care provider or the designated representative of the results of the test, upon submission of a significant exposure report and certification of the significant exposure by an authorized infection preventionist, occupational health professional, or other professional trained in infectious disease control. No further consent from the source patient is required. However, as soon as is practicable, the source patient shall be notified that an exposure has occurred and shall be told which specific tests have been performed to determine the presence of contagious or infectious diseases. If the source patient is a minor, the minor shall be informed that, upon positive confirmation of an HIV-related test result, the minor’s legal guardian shall be informed of the positive result pursuant to Iowa Code section 141A.7(3).

11.11(3) Hospitals, clinics, or other health care facilities; institutions administered by the department of corrections; and jails shall have written policies and procedures pursuant to Iowa Code section 139A.19. In addition to those policies and procedures required by Iowa Code section 139A.19, hospitals, clinics, or other health care facilities; institutions administered by the department of corrections; and jails shall have written policies and procedures for reviewing and certifying significant exposure report forms, testing a source patient, and notifying a care provider who sustained

a significant exposure while rendering health care services or other services to the source patient when the source patient is delivered to the facility and the exposure occurred prior to the delivery.

11.11(4) The hospital, clinic, or other health care facility to whom the source patient is delivered shall conduct the test. If the source patient is delivered to an institution administered by the department of corrections, the test shall be conducted by the staff physician of the institution. If the source patient is delivered to a jail, the test shall be conducted by the attending physician of the jail or the county medical examiner. If the source patient was deemed to consent upon certification of a significant exposure report, the sample and test results shall only be identified by a number.

11.11(5) If a test result is positive, the hospital, clinic, or other health care facility, or other person performing the test shall notify the source patient and make any required reports to the department pursuant to Iowa Code sections 139A.3 and 141A.6. The report to the department shall include the name of the source patient.

11.11(6) If a source patient is diagnosed or confirmed as having a contagious or infectious disease, the hospital, clinic, or other health care facility, or other person performing the test shall notify the care provider or the designated representative of the care provider who shall then notify the care provider. If the source patient is a minor and is diagnosed with HIV infection, the hospital, clinic, or other health facility, or other person performing the test shall notify the legal guardian of the minor.

11.11(7) The notification shall advise the care provider of possible exposure to a particular contagious or infectious disease and recommend that the provider seek medical attention. The notification shall be provided as soon as reasonably possible following determination that the source patient has a contagious or infectious disease. The notification shall not include the name of the source patient unless the patient consents. If the care provider who sustained a significant exposure determines the identity of a source patient who has been diagnosed or confirmed as having a contagious or infectious disease, the identity of the source patient shall be confidential information and shall not be disclosed by the care provider to any other person unless a specific written release is obtained from the source patient.

11.11(8) This rule does not preclude a hospital, clinic, other health care facility, or a health care provider from providing notification to a care provider under circumstances in which the hospital's, clinic's, other health care facility's, or health care provider's policy provides for notification of the hospital's, clinic's, other health care facility's, or health care provider's own employees of exposure to a contagious or infectious disease that is not life-threatening if the notice does not reveal a source patient's name, unless the patient consents.

11.11(9) The infection control, occupational health, or other designated office of the facility shall maintain a record of all significant exposure reports it receives and shall retain each report for a period of five years.

11.11(10) The significant exposure report form is a confidential record pursuant to Iowa Code section 141A.9.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.12(139A,141A) Care provider notification upon exposure to contagious or infectious diseases—exposures in clinical settings.

11.12(1) If a care provider sustains a significant exposure from a patient while rendering health care services or other services within a hospital, clinic, or other health care facility or while delivering home-health or respite care services, the care provider shall file a report as soon as reasonably possible following the exposure. A care provider who has sustained a significant exposure should file the report with the infection control, occupational health, or other office designated by the facility in which the exposure occurred, or by the facility that has oversight for the delivery of home-health or respite care services.

a. If a general consent form was signed and in effect at the time of the significant exposure and the source patient is an adult, a significant exposure report form shall not be required to document the significant exposure. The health care facility or hospital may use an employee incident report

or other similar form for this purpose. The source patient to whom the care provider was exposed is deemed to consent to a test to determine if the patient has a contagious or infectious disease and is deemed to consent to notification of the care provider or the designated representative of the results of the test, upon submission and review of an employee incident report and certification of the significant exposure by an authorized infection preventionist, occupational health professional, or other professional trained in infectious disease control. No further consent from the source patient is required. However, as soon as is practicable, the source patient shall be notified that an exposure has occurred and shall be told which specific tests have been performed.

b. If no consent form was signed or in effect at the time of the exposure, or if the source patient is a minor, the source patient is deemed to consent to a test to determine if the patient has a contagious or infectious disease and is deemed to consent to notification of the care provider or the designated representative of the results of the test upon submission of a significant exposure report form and certification of the significant exposure by an authorized infection preventionist, occupational health professional, or other professional trained in infectious disease control. As soon as is practicable, the source patient shall be notified that an exposure has occurred and shall be told which specific tests have been performed to determine the presence of contagious or infectious diseases. If the source patient is a minor, the minor shall be informed that, upon positive confirmation of an HIV-related test result, the minor's legal guardian shall be informed of the positive result pursuant to Iowa Code section 141A.7(3).

11.12(2) Hospitals, clinics, or other health care facilities; institutions administered by the department of corrections; and jails shall have written policies and procedures for reviewing and certifying significant exposure report forms or other employee incident report forms, testing a source patient, and notifying a care provider who sustained a significant exposure while rendering health care services or other services to a patient during the admission, care, or treatment of the patient at the facility or while delivering home-health or respite care services.

11.12(3) The hospital, clinic, or other health care facility where exposure occurred or that has oversight for the delivery of home-health or respite care services shall conduct the test. If a general consent form was signed and in effect and the source patient is an adult, the sample and test results shall be identified by name. If the source patient was deemed to consent to a test and to notification of the care provider upon certification of a significant exposure report pursuant to these rules because no general consent was signed and in effect at the time of the exposure or because the source patient is a minor, the sample and test results shall be identified only by a number.

11.12(4) If a test result is positive, the hospital, clinic, or other health care facility or other person performing the test shall notify the source patient and make any required reports to the department pursuant to Iowa Code sections 139A.3 and 141A.6. The reports to the department shall include the name of the source patient.

11.12(5) If a source patient is diagnosed or confirmed as having a contagious or infectious disease, the hospital, clinic, or other health care facility or other person performing the test shall notify the care provider or the designated representative of the care provider who shall then notify the care provider. If the source patient is a minor and is diagnosed with HIV infection, the hospital, clinic, or other health care facility or other person performing the test shall notify the legal guardian of the minor.

11.12(6) The notification shall advise the care provider of possible exposure to a particular contagious or infectious disease and recommend that the provider seek medical attention. The notification shall be provided as soon as reasonably possible following determination that the source patient has a contagious or infectious disease.

11.12(7) The infection control, occupational health, or other designated office of the facility shall maintain a record of all significant exposure reports it receives and shall retain each report for a period of five years.

11.12(8) The significant exposure report form is a confidential record pursuant to Iowa Code section 141A.9.

Rules 641—11.11(139A,141A) through 641—11.12(139A,141A) are intended to implement Iowa Code section 139A.19.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.13(915) Testing, reporting, and counseling of convicted or alleged sexual assault assailants.

11.13(1) Prior to ordering an HIV-related test on a convicted or alleged offender pursuant to Iowa Code sections 915.40 through 915.43, the physician or practitioner shall provide information to the subject of the test concerning testing and where to obtain additional information on HIV transmission and risk reduction pursuant to Iowa Code section 141A.6. The department may be contacted for brochures that may assist in meeting the requirements of Iowa Code section 141A.6.

11.13(2) At any time that the subject of an HIV-related test is informed of confirmed positive test results, the physician or other practitioner who ordered the test shall initiate counseling concerning the emotional and physical health effects of HIV infection, as required under Iowa Code section 141A.7, and shall make any required reports to the department pursuant to Iowa Code section 141A.6.

a. The physician or other practitioner shall encourage a person diagnosed with HIV to participate in the voluntary partner notification program pursuant to rule 641—11.9(139A,141A).

b. The physician or other practitioner may provide to the department any relevant information provided by the person diagnosed with HIV regarding any party with whom the person has had sexual relations or has shared drug injecting equipment.

This rule is intended to implement Iowa Code section 135.11(22).

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

641—11.14(141A) Ryan White program.

11.14(1) *General purpose and incorporation.* The Ryan White program is a state-administered program that provides support services and assistance with the costs of health insurance and treatment medications for eligible low-income individuals diagnosed with HIV when adequate state and federal funding is available for administration of the program.

a. The program is authorized under Part B of Title XXVI of the Public Health Service Act, as amended by the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87). This legislation requires that the Ryan White program, including the benefits and drug assistance program, be the payer of last resort for HIV-related services. The Ryan White program is not an entitlement program and does not create a right to assistance. In the event that funding is exhausted or terminated or there are changes in state or federal guidelines, programs, or regulations that impact funding available to the program, the department reserves the right to close enrollment, cease to provide specific services, or alter eligibility criteria until such time that funding is again sufficient.

b. The Ryan White program will be administered in accordance with the Ryan White Part B Client Services Manual dated December 2023, adopted and incorporated by this reference. The manual contains the policies and procedures utilized in the implementation of the program. The manual is updated annually. A copy of the manual is available at the department website.

c. The benefits and drug assistance program will be administered in accordance with the Benefits and Drug Assistance Program Manual dated December 2023, adopted and incorporated by this reference. The manual contains the policies and procedures utilized in the implementation of the program. The manual is updated annually. A copy of the manual is available at the department website.

11.14(2) *Collaboration with Iowa Medicaid.* To ensure that the Ryan White program is the payer of last resort and to maximize the efficiency and effectiveness of HIV-related prevention and care services, Iowa Medicaid shall grant the department access to client information for persons enrolled in Medicaid.

11.14(3) *Confidentiality.* Applications, assessments, and all other client-level information received or maintained by the department in connection with the Ryan White program shall be considered confidential information in accordance with Iowa Code section 141A.9.

This rule is intended to implement Iowa Code section 141A.3.

[ARC 8409C, IAB 11/27/24, effective 1/1/25]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 12
APPROVAL OF CONFIRMATORY LABORATORIES FOR
PRIVATE SECTOR DRUG-FREE WORKPLACE TESTING

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

641—12.1(730) Definitions. For the purpose of these rules, the following definitions apply:

“Alcohol or drug testing” means analysis of a sample for the purpose of detecting the presence or absence of alcohol or other drugs, or their metabolites, in the sample tested.

“CLIA” means the Clinical Laboratory Improvement Amendments of 1988.

“CMS” means the Centers for Medicare and Medicaid Services.

“GC/MS” means gas chromatography/mass spectrometry.

“Laboratory” means a facility inside or outside the state of Iowa approved to conduct confirmatory testing of samples for the detection of alcohol or other drugs, or their metabolites.

“Sample,” for the purpose of these rules, means the substances determined by the department to be samples from the human body capable of accurately and reliably revealing the presence of alcohol or other drugs, or their metabolites, including hair, urine, saliva, breath, and blood.

“SHL” means the state hygienic laboratory.

“Specimen” means a part taken from a sample to determine the character of the whole sample.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.2(730) Powers and duties. The department is responsible for the following actions:

12.2(1) Processing applications from laboratories requesting approval to conduct confirmatory testing pursuant to Iowa Code section 730.5(7) “f.”

12.2(2) Developing an application package.

a. The department will make an application package available to all laboratories requesting approval to conduct confirmatory testing for alcohol or other drugs, or their metabolites.

b. The package will contain application procedures, a standardized application form and a self-inspection questionnaire.

c. The self-inspection questionnaire will assist the department in assessing the quality of a laboratory’s performance as a confirmatory testing laboratory. This questionnaire will comprise the major but not the sole objective criteria used during the initial on-site inspection conducted by the SHL.

d. The package will be available from the department upon request.

12.2(3) Reviewing each application submitted and determining the adequacy for approval.

12.2(4) Designating the SHL to conduct an on-site inspection of each approved confirmatory laboratory at least once every two years. Inspection may be waived by the director if the laboratory has been inspected and accredited for forensic drug testing by the College of American Pathologists, or if the laboratory has been inspected and certified, licensed, or approved to conduct confirmatory testing by another state whose requirements are at least equal to Iowa’s.

12.2(5) Maintaining and providing upon request an updated list of all approved confirmatory laboratories.

12.2(6) Providing written notice of approval and assigning an expiration date.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.3(730) Application procedures and requirements. Laboratories desiring to conduct confirmatory testing for Iowa’s employers shall apply to the department for approval. Each laboratory requesting Iowa approval to conduct confirmatory testing shall provide the following to the department:

12.3(1) A completed laboratory survey checklist on a form provided by the department.

12.3(2) A completed self-inspection questionnaire provided by the department.

12.3(3) Proof of enrollment in a recognized proficiency testing program. Recognized programs include those approved by CMS.

12.3(4) Acceptable performance over a 12-month period in all appropriate areas of proficiency testing for alcohol or other drugs, or their metabolites, shall be documented and maintained on an ongoing basis. Acceptable performance is as follows:

a. Initial approval shall require at least 80 percent accuracy in the last two graded proficiency test cycles with no false positive results.

b. Renewal shall require at least 80 percent accuracy each year on graded proficiency surveys with no false positive results.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.4(730) Requirements of laboratory personnel involved in confirmatory testing for alcohol or other drugs, or their metabolites.

12.4(1) The laboratory director shall be a pathologist or doctoral level individual who qualifies as a clinical laboratory director under CLIA regulations.

12.4(2) Supervisors of analysts shall possess at least a bachelor of science degree in chemistry, medical technology, or comparable education and two years of analytical alcohol or drug testing experience. Supervisors must also have training in the theory and practice of laboratory procedures and an understanding of quality control concepts. Annual verification of the supervisor's skills must be documented by the laboratory director.

12.4(3) Analysts shall possess the necessary training and skills for assigned tasks. These individuals shall possess at least two years of college education in the physical or biological sciences. At a minimum, analysts shall be graduates of a medical laboratory technician program that is recognized by the department or have at least two years of college with a minimum of nine semester hours in chemistry.

12.4(4) Laboratory directors, supervisors and analysts involved in alcohol or drug testing shall annually complete at least one in-service continuing education program related to alcohol or drug testing. Continuing education programs include formal training programs where continuing education units are awarded, informal in-house training programs, and relevant correspondence courses. Dates, titles and subject matter for each completed course shall be documented and the information shall be available for review.

12.4(5) The following information about each of the laboratory staff involved in alcohol or drug testing shall be retained for two years from date of termination and shall be available for review:

a. Résumé of training and experience.

b. Certificate or license.

c. Job description.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.5(730) Quality assurance program and procedure manual requirements. All approved confirmatory laboratories shall have a written quality assurance program and a procedure manual that encompasses all aspects of the alcohol or drug testing process.

12.5(1) Approved laboratories shall have written procedures for performing alcohol or drug testing that shall include the following:

a. Sample acquisition.

b. Chain of custody.

c. Sample and report security.

d. Test performance.

e. Reporting of results.

f. Confidentiality.

12.5(2) The quality assurance program and procedure manuals shall be available for review during any on-site inspection.

12.5(3) Approved laboratories shall review their performance in each of the above areas every 12 months.

12.5(4) Approved laboratories are responsible for developing the criteria necessary to establish and maintain an effective quality assurance program for confirmatory testing of alcohol or other drugs, or their metabolites.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.6(730) Analytical quality control. The number and position of control specimens tested within a batch and the number of calibrators used for each batch of specimens shall be consistent with generally accepted laboratory practice for the methodology used to conduct confirmatory testing.

12.6(1) Positive and negative controls shall be used in testing each batch of specimens.

12.6(2) Procedures shall be implemented and documented to ensure that carryover from a positive specimen does not contaminate other subsequent specimens in that batch.

12.6(3) Approved laboratories shall develop criteria for the detection and rejection of adulterated samples.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.7(730) Sample security and confidentiality of test results. Samples and reports must never be left unattended or unsecured.

12.7(1) Complete chain of custody documentation shall be maintained for each sample from the time of collection from the employee or prospective employee to the time the sample is discarded. Each time the sample is handled or transferred, the individual receiving the sample, the time and date of transfer, and the recipient or destination of the sample shall be documented.

12.7(2) If the first portion of the sample yielded a confirmed positive test result, the laboratory shall store the second portion of that sample until receipt of a confirmed negative test result or for a period of at least 45 calendar days following the completion of the initial confirmatory testing. Urine and blood samples shall be retained in secure storage at freezing temperatures.

12.7(3) All samples for which a negative test result was reported shall be disposed of within five working days after issuance of the negative test result report.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.8(730) Confirmatory testing.

12.8(1) Reports for alcohol shall be confirmed by gas chromatography, or a test that is recognized by the department as an equivalent test before being reported as positive (or negative).

12.8(2) Reports for drugs or their metabolites, other than alcohol, shall not be issued in the absence of confirmation by GC/MS or a scientifically equivalent test approved by the department.

12.8(3) Complete chain of custody procedures shall be used for referred samples.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.9(730) Documentation of the confirmatory testing process. The following documents shall be retained for at least two years and, if requested, made available for inspection.

12.9(1) Chain of custody documentation shall be maintained for each sample tested with the identification of the sample, the person(s) handling and testing the sample, the storage of the sample, and the eventual disposal of the sample.

12.9(2) Documents regarding the following: analytical information for each batch assayed, instrument identification, calibration records, identification of reagent lot numbers and expiration dates, quality control results, and any other pertinent information.

12.9(3) Copies of proficiency testing results for ongoing monitoring and evaluation of laboratory performance. Approved confirmatory laboratories inspected by the SHL shall submit copies of proficiency testing results to the SHL or shall ensure that proficiency testing programs submit copies of proficiency testing results directly to the SHL on their behalf.

12.9(4) Current procedure manuals must be maintained for all procedures.

12.9(5) An annual review of manuals shall be performed and documented. Alterations and additions to procedures shall be incorporated into manuals and approved by the laboratory director before implementation.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.10(730) Reporting of confirmed positive test results to the medical review officer.

12.10(1) Each report shall identify the alcohol or other drugs, or their metabolites, being tested with the results of positive/negative or detected/nondetected clearly recorded.

12.10(2) Approved confirmatory laboratories shall have available a written summary of the established sensitivity levels used for the confirmatory tests conducted for alcohol or other drugs, or their metabolites. However, this information need not be issued with each report.

12.10(3) Approved confirmatory laboratories shall have written procedures for making both written and telephone reports to the medical review officer.

12.10(4) All test results must be reviewed and signed by the laboratory director, or a qualified designee, before being reported to the medical review officer.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.11(730) Reporting requirements to department. Pursuant to Iowa Code section 730.5(16), approved confirmatory laboratories shall file a report with the department by March 1 of each year. The report shall include the number of positive and negative drug or alcohol test results for the previous calendar year for the following if available to the laboratory:

1. Employees who work in non-safety-sensitive positions,
2. Employees who work in safety-sensitive positions,
3. Employees during and after completion of drug or alcohol rehabilitation,
4. Employees as a consequence of reasonable suspicion drug or alcohol testing,
5. Prospective employees,
6. As a consequence of federal law or regulation, or by law enforcement,
7. As a consequence of accident investigation in the workplace,
8. The types of drugs that were found in the positive drug tests,
9. All significant available demographic factors relating to the positive test pool, and
10. Total number of positive and negative drug or alcohol test results for the previous calendar year for all employees and prospective employees who were tested.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.12(730) Approval, renewal, and inspection fees. At the time of initial application and each year thereafter, laboratories shall remit to the department a fee in an amount sufficient to reimburse the department for expenses incurred in administering the confirmatory laboratory approval program. All fees shall be made payable to the department and are as follows:

12.12(1) *Approval.* An administration fee of \$600 is required for new applications, including applicants seeking approval through reciprocity.

12.12(2) *Renewal.* An administration fee of \$300 is required to renew laboratory approval.

12.12(3) *Inspections by the SHL.* Reimbursement for actual on-site inspection and related expenses shall be assessed to each laboratory after the completion of each inspection. Expenses related to the on-site inspection shall be reimbursed to the SHL. These expenses shall reflect the actual cost incurred for personnel time and travel expenses consistent with state of Iowa travel reimbursement policies and procedures. These expenses shall also include the time necessary for SHL inspection staff to:

- a. Review the application and related laboratory materials in preparation for the on-site inspection,
- b. Generate the written laboratory report regarding inspection findings,
- c. Conduct postinspection follow-up activities, if any, and
- d. Review proficiency test results on an ongoing basis.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.13(730) Renewal. Laboratories wishing to continue confirmatory testing for alcohol or other drugs, or their metabolites, in Iowa must renew their certification annually. The request for renewal shall include the following:

1. Name and address of laboratory.
2. Renewal fee.
3. Information that reflects any changes that occurred during the current approval period.
4. Copy of supporting documents if the laboratory is accredited for forensic drug testing by the College of American Pathologists or if it is certified, licensed, or approved through reciprocity.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.14(730) Reciprocity.

12.14(1) Confirmatory laboratories certified, licensed, or approved by another state to conduct testing for alcohol or other drugs, or their metabolites, may request Iowa approval through reciprocity by:

- a. Completing and submitting the department's application package, and
- b. Including a copy of their current certificate, license, or approval document from the state whose requirements are at least equal to Iowa's.

12.14(2) Laboratories approved through reciprocity that lose their certification, license or approval from another state shall notify the department within five working days.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.15(730) Changes during approval periods. The following changes that occur during an approval period shall be submitted to the department within five working days from the date the change took place:

1. Change in laboratory director.
2. Change of address.
3. Change in supervisor.
4. Change in confirmation procedures.
5. Change in proficiency testing program.
6. Addition or subtraction of alcohol or other drugs, or their metabolites, being tested.
7. Change of ownership.
8. Loss of accreditation for forensic drug testing by the College of American Pathologists.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.16(730) Enforcement. Upon a determination of noncompliance by the director that these rules have been violated, the director may immediately move to suspend, modify, or revoke any approval issued under these rules.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.17(730) Denial, suspension, modification or revocation of approval. Any one of the following can result in denial, suspension, modification or revocation of approval. Failure of the confirmatory laboratory to:

1. Remain in compliance with the requirements of these rules.
2. Provide required documentation, including documentation of laboratory personnel and proficiency test results.
3. Maintain confidentiality.
4. Meet proficiency testing criteria.
5. Provide correct information.
6. Satisfactorily complete the two most recent and relevant graded proficiency test reports from a recognized proficiency testing program (for initial approval).
7. Correctly represent facts on a self-inspection questionnaire or other application documents.

8. Pass an on-site inspection conducted by the College of American Pathologists for forensic drug testing, or by another state whose requirements are at least equal to Iowa's, or by the SHL.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.18(730) Restoration of approval. A confirmatory laboratory whose approval has been suspended, modified, or revoked may be reinstated within 90 days following the receipt of the following:

1. Documentation of actions that correct the reasons for suspension, modification, or revocation.
2. Documentation of a successful on-site inspection, if necessary, conducted by the College of American Pathologists for forensic drug testing, or by another state whose requirements are at least equal to Iowa's, or by the SHL.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

641—12.19(730) Appeals process.

12.19(1) Denial, suspension, modification, or revocation. The department will send written notice of denial, suspension, modification, or revocation by certified mail, return receipt requested, pursuant to 441—Chapter 16. The adverse action will become effective 30 days after receipt of the notice unless the applicant, within 90 days, gives written notice to the department requesting a hearing. In that event, the notice will be deemed to be suspended.

12.19(2) Contested cases. The procedures for contested cases as set out in Iowa Code chapter 17A and the rules adopted by the department in 441—Chapter 2506 will be followed in all cases where proper notice has been made to the department of the intent to formally contest any denial, suspension, modification, or revocation of approval.

[ARC 9167C, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

641—12.20(730) Complaints.

12.20(1) The department will accept complaints of alleged problems relating to confirmatory laboratory procedures. The information shall state in as specific a manner as possible the basis for the complaint. The complaint shall be presented to the department in writing, in person or by telephone.

12.20(2) Within 20 working days of the receipt of the complaint, the department will communicate with the laboratory director for initial evaluation of the specific matters alleged in the complaint. The complainant will be informed of the results of the action taken by the department.

[ARC 9167C, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 730.5.

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[Filed 3/9/06, Notice 2/1/06—published 3/29/06, effective 5/3/06]

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[Filed ARC 9167C (Notice ARC 8485C, IAB 12/11/24), IAB 4/30/25, effective 7/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 24
PRIVATE WELL TESTING, RECONSTRUCTION, AND PLUGGING—IOWA PRIVATE WELL
GRANTS

[Prior to 3/29/06, see 567—Ch 47]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/3/29

641—24.1(455E,135) Grant procedures.

24.1(1) The department has adopted policies to administer the awarding of grants for the grants to counties program. Grants will be awarded pursuant to Iowa Code section 455E.11.

24.1(2) The department will:

- a.* Determine program objectives;
- b.* Set eligible and ineligible grant costs for which the department will reimburse county programs;
- c.* Define performance requirements for grant recipients that set minimum standards to be met by all county programs;
- d.* Develop a grant application and a grant application submission procedure;
- e.* Terminate a grant found to be obtained by fraud or misrepresentation regardless of whether grant moneys have already been given to the grantee;
- f.* Allow for an applicant to appeal the denial of a properly submitted grant application. Appeals shall be governed by 441—Chapter 2506.

This rule is intended to implement Iowa Code sections 455E.11 and 135.11(26).

[ARC 8042C, IAB 5/29/24, effective 7/3/24; Editorial change: IAC Supplement 6/10/26]

[Filed 3/9/06, Notice 2/1/06—published 3/29/06, effective 7/1/06]

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[Filed ARC 8042C (Notice ARC 7367C, IAB 1/24/24), IAB 5/29/24, effective 7/3/24]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 51 DENTAL SCREENING

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/1/30

641—51.1(135) Definitions.

“Admitting official” means the superintendent of schools or the superintendent’s designated representative if a public school; if an accredited nonpublic school, the governing official of the school.

“Applicant” means any person seeking first-time enrollment in kindergarten or ninth grade in a public or accredited nonpublic elementary school or high school in Iowa.

“Dental hygienist” means a person licensed to practice as a dental hygienist.

“Dentist” means a person licensed to practice as a dentist.

“Electronic signature” means a confidential personalized digital key, code, or number that is used for secure electronic data transmission and that identifies and authenticates the signatory.

“Elementary school” means kindergarten through grade six in an Iowa school district or accredited nonpublic school.

“Gum infection” means that gum (gingival) tissue is red, bleeding, or swollen.

“High school” means grades 9 through 12 in an Iowa school district or accredited nonpublic school.

“Injury” means soft tissue laceration or a broken or dislodged tooth.

“I-Smile” means the department program designed to increase access to dental care for children and to ensure a dental home.

“I-Smile coordinator” means a designated dental hygienist who is employed by or under contract with a local public health agency to administer the I-Smile dental home program.

“Local board of health” means a county, city, or district board of health as defined in Iowa Code section 137.102.

“Needs dental care” means that tooth decay or a white spot lesion is suspected in one or more teeth or that gum infection is suspected.

“Needs urgent dental care” means that obvious tooth decay is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

“No obvious problems” means a child’s hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

“Nurse” means a person licensed to practice as a registered nurse or advanced registered nurse practitioner.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery.

“Physician associate” means a person licensed to practice as a physician associate.

“Recorder” means a dentist, dental hygienist, physician, physician associate, or nurse who is authorized to record screening information and sign the Certificate of Dental Screening form.

“Severe infection” means excessive bleeding, swelling, or pus discharge; or an abscess.

“Signature” means an original signature, or authorized use of stamped signature, or electronic signature of a dentist, dental hygienist, physician, physician associate, or nurse.

“Tooth decay” means a visible cavity or hole in a tooth with brown or black coloration, or a retained root.

“White spot lesion” means a demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gum line. A white spot lesion is considered an early indicator of tooth decay, especially in primary teeth.

[ARC 9321C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

641—51.2(135) Persons included. The dental screening requirements specified in this chapter apply to all persons seeking first-time enrollment in kindergarten or ninth grade in a public or accredited nonpublic elementary school or high school in Iowa.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.3(135) Persons excluded. Exclusions to these rules are permitted on an individual basis for religious and financial hardship reasons. Applicants approved for a religious or financial hardship exemption shall submit to the admitting official a valid department certificate of dental screening exemption.

51.3(1) Religious exemption. A religious exemption may be granted to an applicant if the dental screening conflicts with a genuine and sincere religious belief.

a. The certificate of dental screening exemption for religious reasons shall attest that the dental screening conflicts with a genuine and sincere religious belief and that the belief is in fact religious and not based merely on philosophical, scientific, moral, personal, or medical opposition to dental screenings.

b. The certificate of dental screening exemption for religious reasons shall be signed and dated by the applicant or, if the applicant is a minor, by the parent or guardian.

c. To be valid, the certificate of dental screening exemption for religious reasons shall be the department certificate or a form approved in writing by the department.

51.3(2) Financial hardship exemption. A financial hardship exemption may be granted to an applicant who is unduly burdened by the cost of a dental screening.

a. The certificate of dental screening exemption for financial hardship reasons shall attest that dental screening would cause a genuine financial burden to the applicant.

b. The certificate of dental screening exemption for financial hardship reasons shall be signed and dated by a dentist, dental hygienist, physician, physician associate, or nurse.

c. The certificate of dental screening exemption for financial hardship reasons shall include the provider type and the provider's name, business address, and telephone number.

d. To be valid, the certificate of dental screening exemption for financial hardship reasons shall be the department certificate or a form approved in writing by the department.

51.3(3) A faxed copy, photocopy, or electronic copy of the valid certificate of dental screening exemption is acceptable.

[ARC 9321C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

641—51.4(135) Dental screening components.

51.4(1) A dental screening is a visual assessment and is noninvasive and nondiagnostic.

51.4(2) Dental instrumentation is not needed for a dental screening.

51.4(3) A dental screening can identify obvious or suspected oral health conditions that need or that might need examination by a dentist.

51.4(4) The dental screening shall include the following steps:

a. Visual inspection of the soft tissues, including the lips, cheeks, gums, tongue, floor of mouth, and roof of mouth, to assess infection or injury.

b. Visual inspection of all tooth surfaces to assess tooth decay, white spot lesions, or injury.

c. Documentation of the screening and treatment needs according to rule 641—51.8(135).

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.5(135) Dental screening providers.

51.5(1) Elementary school. A dental screening for elementary school enrollment shall be performed by a licensed dentist, a licensed dental hygienist, a licensed physician, a licensed physician associate, or a licensed nurse.

51.5(2) High school. A dental screening for high school enrollment shall be provided by a licensed dentist or a licensed dental hygienist.

[ARC 9321C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

641—51.6(135) Timeline for valid dental screening.

51.6(1) Elementary school. To be valid, a minimum of one dental screening shall be performed on an applicant no earlier than three years of age but no later than four months after the enrollment date.

51.6(2) High school. To be valid, a minimum of one dental screening shall be performed on an applicant no earlier than one year prior to the enrollment date and no later than four months after the enrollment date.

51.6(3) A dental screening may also be deemed valid by the department if the department determines that the applicant has substantially complied with the dental screening requirements.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.7(135) Proof of dental screening. The applicant or, if a minor, the parent or guardian of a child enrolled in elementary school or high school shall submit a valid department certificate of dental screening to the admitting official of the school district or accredited nonpublic elementary school in which the applicant wishes to enroll.

51.7(1) To be valid, the certificate of dental screening shall be the department certificate or a form approved in writing by the department.

a. The Certificate of Dental Screening form is available on the department's website or by calling the department.

b. The certificate of dental screening shall include all information required by rule 641—51.8(135).

c. The certificate of dental screening may also be deemed valid by the department if the department determines that the information on the certificate substantially complies with the dental screening requirements.

51.7(2) A faxed copy, photocopy, or electronic copy of the valid certificate of dental screening is acceptable.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.8(135) Dental screening documentation.

51.8(1) *Student information.* A person authorized to perform a dental screening required by this chapter shall record the following student information or ensure that such information is recorded on the certificate of dental screening provided or approved in writing by the department in cooperation with the department of education:

a. Name (first and last); and

b. Birth date.

51.8(2) *Screening information.* A person authorized to perform a dental screening required by this chapter shall record the following screening information on the certificate of dental screening provided or approved in writing by the department in cooperation with the department of education:

a. Date of dental screening;

b. Treatment needs (no obvious problems, needs dental care, needs urgent dental care);

c. Provider type;

d. Provider name and telephone number; and

e. Provider or recorder signature and credentials.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.9(135) Ensuring dental screening services. Each public and accredited nonpublic school, in collaboration with the department, shall ensure that the parent or guardian of a student enrolled in the school has complied with the dental screening requirement. Parents or guardians of students who do not have a valid certificate of dental screening shall be provided with community dental screening referral resources, including contact information for the I-Smile coordinator, the department, or a dental society.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.10(135) Records. It shall be the duty of the admitting official of an elementary school or a high school to ensure that a valid certificate of dental screening or certificate of dental screening exemption is on file for each child enrolled.

51.10(1) The admitting official shall ensure that all certificates of dental screening are properly completed according to rule 641—51.7(135).

51.10(2) The admitting official shall ensure that all certificates of dental screening exemption are properly completed according to subrules 51.3(1) and 51.3(2).

51.10(3) The admitting official shall keep the certificates of dental screening or certificates of dental screening exemption on file at the school in which the applicant is enrolled and assist the applicant or the applicant's parent or guardian.

51.10(4) The local board of health or its designee, the department of education, and the department or its designee shall have the right to have access to the certificates of dental screening and certificates of dental screening exemption of students enrolled in elementary schools and high schools.
[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.11(135) Reporting.

51.11(1) It shall be the duty of each local board of health or its designee to audit the certificates of dental screening and certificates of dental screening exemption in the schools within the local board's jurisdiction to determine compliance with Iowa Code section 135.17.

51.11(2) By May 31 annually, each local board of health shall furnish the department with evidence for the preceding school year that each child enrolled in any public or accredited nonpublic school within the local board's jurisdiction met the dental screening requirement.

51.11(3) The evidence shall be in the form of a report that includes:

- a. Name of school,
- b. Enrollments by grade,
- c. The number of valid certificates of dental screening by grade,
- d. The number of valid certificates for religious exemptions by grade, and
- e. The number of valid certificates for financial hardship exemptions by grade.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.12(135) Release of dental screening information.

51.12(1) *Between a dentist, dental hygienist, physician, physician associate, or nurse, and the elementary school or high school that the child attends.* A dentist, dental hygienist, physician, physician associate, or nurse shall disclose a student's dental screening information, including the student's name and date of birth; the name of the student's parent or guardian; the month, day and year of the screening; and the screening results and treatment needs to an elementary school or a high school upon written or verbal request from the elementary school or high school. Written or verbal permission from a student or the student's parent or guardian is not required to release this information to an elementary school or a high school.

51.12(2) *Among dentists, dental hygienists, physicians, physician associates, or nurses.* Dental screening information, including the student's name, date of birth, name of parent or guardian, the month, day and year of the screening, and the screening results and treatment needs shall be provided by one dentist, dental hygienist, physician, physician associate, or nurse to another health care provider without written or verbal permission from the student or the student's parent or guardian.

[ARC 9321C, IAB 5/28/25, effective 8/1/25; Editorial change: IAC Supplement 6/10/26]

641—51.13(135) Referral requirements. Parents or guardians of students who need dental care or need urgent dental care shall be referred to the parent's or guardian's dentist of choice. Students without a dentist or who have difficulty accessing dental care shall be referred to a local I-Smile coordinator or local public health agency for assistance with completion of dental care. This assistance may include locating dentists, scheduling appointments, and identifying payment sources.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

641—51.14(135) Provider training. For the purpose of quality assurance and consistency, the department will make training and training materials available for dental screening providers.

[ARC 9321C, IAB 5/28/25, effective 8/1/25]

These rules are intended to implement Iowa Code section 135.17.

[Filed 7/10/08, Notice 5/21/08—published 7/30/08, effective 9/3/08]

[Filed Emergency After Notice ARC 8980B, IAB 8/11/10, effective 7/14/10]

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[Filed ARC 9321C (Notice ARC 8507C, IAB 12/11/24), IAB 5/28/25, effective 8/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 52 VISION SCREENING

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

641—52.1(135) Definitions.

“Advanced registered nurse practitioner” or *“ARNP”* means the same as defined in rule 655—7.1(17A,124,147,152).

“Autorefractor” means a method of vision screening involving skiascopy methods or wave-front technology to evaluate the refractive error of each eye. Depending on the autorefractor being used, this method allows for immediate results interpreted by the operator or the instrument as a pass or fail.

“Community-based organization” means a public or private nonprofit organization of demonstrated effectiveness that is representative of a community or significant segments of a community and that provides educational or related services to individuals in the community that include utilizing approved age-appropriate, acceptable child vision screening tests approved by the department.

“Comprehensive eye examination” means a clinical diagnostic assessment performed by an optometrist or ophthalmologist to assess a person’s level of vision and to detect any abnormality or diseases.

“Elementary school” means an Iowa public or accredited nonpublic school that a kindergarten or third grade student would attend.

“Iowa KidSight” means a joint project of the lions clubs of Iowa and the university of Iowa, department of ophthalmology and visual sciences, dedicated to enhancing the early detection and treatment of vision impairments in Iowa’s young children (target population six months of age through kindergarten age) through screening and public education.

“IRIS” means the immunization registry information system as established in 641—Chapter 7.

“Online vision screening” means a vision screening test administered from the internet to a child to assess vision and includes vision test results and recommendations.

“Ophthalmologist” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148 and board-certified in ophthalmology as a specialist in medical and surgical eye problems.

“Optometrist” means a person licensed to practice optometry pursuant to Iowa Code chapter 154.

“Photoscreening” means a method of vision screening employing an automated technique that uses the red reflex of the eye to screen for eye problems and produces immediate readable results and a timely report of the results thereafter.

“Physician” means a person licensed to practice medicine and surgery or osteopathic medicine and surgery pursuant to Iowa Code chapter 148.

“Physician associate” means a person licensed to practice as a physician associate pursuant to Iowa Code chapter 148C.

“Potential vision impairment” means that a child’s vision appears to be compromised and there is reason for the child to be seen by an ophthalmologist or optometrist.

“Student vision card” means a card distributed by the Iowa optometric association to all schools in Iowa pursuant to Iowa Code section 280.7A. The student vision card recommends children receive a complete eye health examination.

“Vision screening” means an eye testing program that is age and developmentally appropriate and that assesses visual acuity or other risk factors contributing to refractive errors and other vision conditions.

[ARC 9269C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

641—52.2(135) Persons included and persons excluded.

52.2(1) The child vision screening requirements specified in this chapter apply to all persons seeking first-time enrollment in kindergarten and third grade in a public or accredited nonpublic elementary school in Iowa.

52.2(2) Persons shall be included or excluded as established in Iowa Code section 135.39D.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

641—52.3(135) Child vision screening components.

52.3(1) The requirement for a child vision screening may be satisfied pursuant to Iowa Code section 135.39D.

52.3(2) All vision screening methods, including emerging vision screening technologies, shall be age-appropriate and will be approved by the department. A list of acceptable child vision screening tests will be reviewed and updated annually by the department and will be listed on the department's website.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

641—52.4(135) Timeline for valid vision screening.

52.4(1) *Kindergarten.* To be valid, a minimum of one child vision screening shall be performed on a child no earlier than one year prior to the date of the child's enrollment in kindergarten and no later than six months after the date of the child's enrollment in kindergarten.

52.4(2) *Grade three.* To be valid, a minimum of one child vision screening shall be performed on a child no earlier than one year prior to the date of the child's enrollment in the third grade and no later than six months after the date of the child's enrollment in the third grade.

52.4(3) *Substantial compliance.* A child vision screening may also be deemed valid by the department if the department determines the child has substantially complied with the child vision screening requirements.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

641—52.5(135) Proof of child vision screening.

52.5(1) The parent or guardian of a child enrolled in kindergarten or third grade shall ensure that evidence of a child vision screening is submitted to the school district or accredited nonpublic elementary school in which the child is enrolled either electronically through IRIS pursuant to subrule 52.5(2) or in hard copy or electronic form pursuant to subrule 52.5(3).

52.5(2) If the child's vision screening results were electronically submitted to IRIS, the parent or guardian may notify the school district or accredited nonpublic elementary school of such submission to satisfy the requirement for evidence of a child vision screening.

52.5(3) If evidence of the child vision screening is not electronically submitted to IRIS, the parent or guardian shall provide evidence of the child vision screening in hard copy or electronic form directly to the school. Hard copy or electronic evidence of the vision screening shall include the child's first name, last name, date of birth and ZIP code; evidence of the vision screening, including the date of screening, left eye results, right eye results (if available), vision screening result of "pass" or "fail," and designation of "yes" or "no" for referral made; and the name of the provider who performed the vision screening.

52.5(4) Submission of a faxed copy, photocopy, or electronic copy of the child vision screening results is acceptable.

52.5(5) If a parent or guardian chooses for a child to receive a comprehensive eye examination completed by an ophthalmologist or optometrist in lieu of a vision screening, the parent or guardian may submit a completed student vision card to satisfy the requirement of this rule.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

641—52.6(135) Child vision screening reporting.

52.6(1) A person authorized to perform a child vision screening required by this chapter shall report results of the child vision screening to the department.

a. An ophthalmologist or optometrist shall report the results in written form, either electronically or by hard copy, to the parent or guardian to be forwarded to the department via the school or shall report the results via IRIS if available.

b. A pediatrician's or family practice physician's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization or an ARNP or physician associate shall report the results in written form, either electronically or by hard copy, to the parent or guardian to be forwarded to the department via the school or shall report the results via IRIS if available.

c. Results from an online vision screening administered from the internet shall be generated in an electronic or hard-copy report to the parent or guardian to be forwarded to the department via the school or the results shall be reported via IRIS if available.

d. The results of an autorefractor or photostereopsis vision screening, including those performed by Iowa KidSight, shall be reported to the parent or guardian in written form, either electronically or by hard copy, to be forwarded to the department via the school or shall be reported via IRIS if available.

52.6(2) The department will collect and maintain results of the vision screenings submitted electronically, via hard copy or through IRIS.

[ARC 9269C, IAB 5/14/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

641—52.7(135) School requirements.

52.7(1) Each public and accredited nonpublic elementary school, in collaboration with the department, shall provide the parents or guardians of students enrolled in the school with vision screening referral resources prior to enrollment or during the enrollment period.

52.7(2) Each public and accredited nonpublic elementary school shall provide to parents or guardians of students for whom evidence of a child vision screening is not submitted community eye health referral resources, including but not limited to contact information for the local public health department, maternal and child health agency, Iowa KidSight, the department, or an optometric or ophthalmology society.

52.7(3) Each public and accredited nonpublic elementary school shall arrange for the following to be forwarded to the department:

a. Child vision screening results or comprehensive eye examination results provided by parents or guardians;

b. A list of students whose parents or guardians indicate that the students' results were reported through IRIS; and

c. Any other evidence of vision screening or comprehensive eye examination provided to the school.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

641—52.8(135) Iowa's child vision screening database module and follow-up. The department may develop and maintain a statewide child vision screening database module in IRIS to collect and maintain child vision screening results, to ensure students receive the required vision screening, and to monitor eye health.

52.8(1) The database module will consist of vision screening information, including identifying and demographic data.

52.8(2) Database module reporting will comply with rule 641—52.6(135).

52.8(3) Unauthorized uses of database module. The database module information shall not be used to:

a. Market services to students or nonstudents;

b. Assist in bill collection services; or

c. Locate or identify students or nonstudents for any purpose other than those expressly provided in this rule.

52.8(4) Confidentiality of database module information. Child vision screening information, including identifying and demographic data maintained in the database module, is confidential and may not be disclosed except under the following limited circumstances:

a. The department may release information from the database module to the following:

(1) The person who received the child vision screening or the parent or guardian of the person who received the child vision screening;

(2) Users of the database module that complete an agreement with the department that specifies the conditions under which the database module can be accessed and that have been issued an organization code and username by the department;

(3) Persons or entities requesting child vision screening data in an aggregate form that does not identify an individual either directly or indirectly;

(4) Agencies that complete an agreement with the department that specifies conditions for access to database module information and how that information will be used;

(5) A representative of a state or federal agency, or an entity bound by that state or federal agency, to the extent the information is necessary to perform a legally authorized function of the agency or the department. The state or federal agency is subject to confidentiality regulations that are the same as or more stringent than those in the state of Iowa; or

(6) Licensed health care providers, agencies, and other persons involved with vision screenings, eye examinations, follow-up services, and intervention services as necessary to administer this chapter.

b. Approved database module users shall not release child vision screening data except to the person who received the child vision screening; the parent or guardian of the person who received the child vision screening; health records staff of schools; medical, optometry, ophthalmology or health care providers providing continuity of care; and other approved users of the database module.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

641—52.9(135) Referral requirements.

52.9(1) If a vision screening identifies a potential vision impairment in a child, the person who performed the vision screening or the person's designee shall, if the person is not an ophthalmologist or optometrist, refer the child to an ophthalmologist or optometrist for a comprehensive eye examination.

52.9(2) Persons performing vision screenings or the persons' designee shall contact parents or guardians of children identified as having potential vision impairment based on the results of a vision screening required pursuant to this chapter or a comprehensive eye examination required pursuant to subrule 52.9(1) in order to provide information on obtaining necessary vision correction.

[ARC 9269C, IAB 5/14/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 135.39D.

[Filed ARC 1924C (Notice ARC 1838C, IAB 1/21/15), IAB 4/1/15, effective 5/6/15]

[Filed ARC 9269C (Notice ARC 8528C, IAB 12/11/24), IAB 5/14/25, effective 7/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/31

641—56.1(135) Definitions. For purposes of this chapter, the following definitions apply:

“Assessment” means the review of the member’s current functioning with regard to the member’s situation, needs, strengths, abilities, desires and goals.

“Brain injury services waiver” means the same as defined in Iowa Code section 135.22B.

“Cost share” means the portion an individual is responsible to pay for services received by the individual.

“Countable income,” when determining initial and ongoing eligibility for the brain injury services program, means all earned and unearned income unless specifically exempted in 441—subrule 86.2(2).

“Family size,” for purposes of establishing initial and ongoing eligibility under the brain injury services program, means all persons living together who are children and who are parents of those children as defined in 441—subrule 86.2(3).

“Member” means an individual who has applied for and been found eligible to participate in the waiver-eligible component or the cost-share component of the brain injury services program.

“Program” means the department’s brain injury services program.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.2(135) Waiver-eligible component. Persons eligible for the brain injury services waiver and on the waiting list for the waiver are eligible for the waiver-eligible component. The program may provide funding for the nonfederal share of the cost of services if the appropriation for the medical assistance program does not have sufficient funding designated to do so.

56.2(1) Provision of funding under this component is not an entitlement and is subject to funding availability.

56.2(2) A person who receives support under the waiver-eligible component of the program is not eligible to receive support under the cost-share component of the program.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.3(135) Cost-share component. Persons determined ineligible for the brain injury services waiver due to fiscal or functional criteria or persons who are eligible for the waiver but for whom funding was not authorized or available to provide waiver eligibility are eligible for the cost-share component of the program.

56.3(1) An individual must meet all of the following requirements:

- a.* The individual is aged one month through 64 years.
- b.* The individual has a brain injury as defined in Iowa Code section 135.22.
- c.* The individual is a resident of Iowa and either a United States citizen or a qualified alien as defined in 8 U.S.C. Section 1641 as amended to August 1, 2025.
- d.* The individual meets the cost-share component’s financial eligibility requirements and is willing to pay a cost share for the cost-share component.

56.3(2) Financial eligibility and cost share. The department will use countable income to determine initial and ongoing eligibility for the program. Cost share will be as follows:

- a.* Individuals who are at 300 percent or below the federal poverty level for a family of the same size will not be assessed a cost share.
- b.* Individuals whose countable income is between 301 percent and 350 percent of the federal poverty level for a family of the same size will be assessed a 10 percent cost share for services that will be payable to the service provider.

c. Individuals whose countable income is between 351 percent and 400 percent of the federal poverty level for a family of the same size will be assessed a 20 percent cost share for services that will be payable to the service provider.

d. Individuals whose countable income is above 400 percent of the federal poverty level for a family of the same size will be assessed a 30 percent cost share for services that will be payable to the service provider.

56.3(3) The cost-share component must be the source of last resort for payment; the program will not pay for services when the provision of those services is mandated by law or administrative rule to be the responsibility of another governmental unit, private agency or program. Brain injury cost-share services are not available to an individual who receives services or funding under any type of medical assistance home- and community-based services waiver.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.4(135) Application process.

56.4(1) The department will provide the application materials, including the waiver application and any denial letter, financial assessment, and functional assessment regarding the person in an agreed-upon format.

56.4(2) The department will determine eligibility within 45 days of receipt of complete application materials.

a. After determining if the applicant's service needs fit within the scope of the program, the department will inform the discharge planner or case manager on behalf of the applicant or the applicant's legal representative of the applicant's eligibility.

b. The case manager will establish an interdisciplinary team for each member and, with the team, identify the member's plan based on the member's needs and desires as well as the availability and appropriateness of services. The case manager will notify the department of the service plan.

c. The date of eligibility for applicants deemed eligible for the cost-share component will be the date when both the service eligibility and financial eligibility assessments have been completed.

d. The department will notify the applicant or the applicant's legal representative within seven days of the date eligibility determination is completed.

56.4(3) After determining an applicant's eligibility, if no payment slot is available, the program will enter the applicant on a waiting list according to the following:

a. The date a completed application is date-stamped in a county office of the department. If more than one application is received on the same date, applicants will be entered on the waiting list on the basis of the applicant's month of birth, with January designated as month one.

b. As slots become available, applicants will be selected from the waiting list based on their order on the waiting list to maintain the number of persons approved for participation in the program.

56.4(4) The member or the member's legal representative shall complete and sign a Brain Injury Functional Assessment form indicating the member's choice of caregiver.

56.4(5) The member's case manager will initiate development of the consumer's service plan and commencement of services. All service plans must be approved by the program.

56.4(6) The department will not pay the cost of services provided to a member prior to approval of eligibility.

56.4(7) The program will make the final determination as to whether program funding will be authorized under the cost-share component.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.5(135) Service providers and reimbursement.

56.5(1) A service provider must either be certified to provide services under the brain injury services waiver or have a contract with a county to provide services and apply to become certified to provide services under the brain injury services waiver within 90 days of the date that services commence.

56.5(2) The reimbursement rate payable for the cost of a service provided under the cost-share component is the rate payable under the medical assistance program. However, if the service provider does not have a medical assistance program reimbursement rate, the rate will be the amount payable under the county contract.

56.5(3) All service providers must contract with the department and will be paid retroactively to the date of service eligibility.

56.5(4) Service providers will be responsible for billing and collection of any cost share from an individual as determined by the department.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.6(135) Available services/service plan.

56.6(1) Services available will be consistent with the services offered through the Medicaid home- and community-based services waiver.

56.6(2) Service plans must reflect use of all services, including non-cost-shared services, to ensure that no duplication of services occurs.

56.6(3) All service plans must be submitted, either electronically or in hard-copy format, to the program for approval prior to implementation.

56.6(4) Any change to the service plan must be approved by the program.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.7(135) Redetermination.

56.7(1) The department will annually conduct a complete financial redetermination of continuing eligibility for the program after consultation with the case manager and the interdisciplinary team.

56.7(2) The department will also conduct a redetermination of continuing eligibility when a change in financial or functional circumstances occurs that affects eligibility.

[ARC 9705C, IAB 11/12/25, effective 1/1/26]

641—56.8(135) Appeal rights. Any individual denied funding under either the waiver-eligible or the cost-share component of the program may appeal pursuant to 441—Chapter 2506.

[ARC 9705C, IAB 11/12/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 135.22B.

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[Filed ARC 9705C (Notice ARC 9527C, IAB 9/3/25), IAB 11/12/25, effective 1/1/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 88
VOLUNTEER HEALTH CARE PROVIDER PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/1/31

641—88.1(135) Definitions. For the purpose of these rules, the following definitions will apply:

“Charitable organization” means the same as defined in Iowa Code section 135.24.

“Defend” means that the office of the attorney general will provide the individual volunteer health care provider and protected clinic with legal representation at no cost to the individual volunteer health care provider or protected clinic.

“Field dental clinic” means the same as defined in Iowa Code section 135.24.

“Free clinic” means the same as defined in Iowa Code section 135.24.

“Health care facility” means a residential care facility, a nursing facility, or an intermediate care facility for persons with an intellectual disability.

“Health care provider” means the same as defined in Iowa Code section 135.24.

“Health care services” means services received from a health care provider at a protected clinic or sponsor entity, as provided in Iowa Code section 135.24 and these rules, and approved in a protection agreement or sponsor entity agreement. The agreement covers “health care services” that are volunteer, uncompensated services. For those services to qualify as volunteer, uncompensated services under this chapter, the individual volunteer health care provider, health care provider, protected clinic, or sponsor entity will receive no compensation for any services provided under the agreement and shall not bill or accept compensation from the person, or any public or private third-party payor, for the specific services provided.

“Indemnify” means that the state of Iowa will pay all sums that the individual volunteer health care provider or protected clinic holding a protection agreement with the VHCPP is legally obligated to pay as damages because of any claim made against the individual volunteer health care provider or protected clinic that arises out of the provision of free health care services rendered or that should have been rendered by the individual volunteer health care provider or protected clinic.

“Individual volunteer health care provider” means any one of the health care providers defined in Iowa Code section 135.24 who has a fully executed protection agreement with the VHCPP.

“License” means a license, certification or registration issued to a person by a licensing authority that evidences the granting of authority to engage in a profession or occupation.

“Major surgical procedure” means a surgical procedure not ordinarily performed in a private provider’s office, free clinic, or specialty health care provider office and includes the surgery performed in a hospital as defined in Iowa Code section 135B.1(3) or an organized outpatient health facility.

“Minor surgical procedure” means a surgical procedure ordinarily performed in a private provider’s office, free clinic, or specialty health care provider office.

“Organized outpatient health facility” means a facility defined in Iowa Code section 10A.711.

“Permanent site” means a site at which free health care services will be provided on a continuous basis.

“Protected clinic” means field dental clinic, free clinic, or specialty health care provider office providing free care to the uninsured and underinsured. Each protected clinic has a signed protection agreement that provides for defense and indemnification of the protected clinic. The protection agreement will allow the protected clinic to deliver health care services to uninsured and underinsured persons as an agent of the state.

“Protection agreement” means a signed contract providing for defense and indemnification between an individual volunteer health care provider or protected clinic and the VHCPP. This agreement will allow the individual health care provider or protected clinic to deliver health care services to uninsured and underinsured persons as an agent of the state. The agreement covers “health care services” that are volunteer, uncompensated services. For those services to qualify as

volunteer, uncompensated services under this chapter, the individual volunteer health care provider, health care provider, and protected clinic will receive no compensation for any services provided under the agreement and will not bill or accept compensation from the person, or any public or private third-party payor, for the specific services provided by the individual volunteer health care provider covered by the agreement.

“Specialty health care provider office” means the same as defined in Iowa Code section 135.24.

“Sponsor entity” or *“sponsor entity clinic”* means a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, organized outpatient health facility, or field dental clinic. Each sponsor entity has a fully executed sponsor entity agreement. The sponsor entity agreement will allow an individual volunteer health care provider to deliver health care services to uninsured and underinsured persons as an agent of the state.

“Sponsor entity agreement” means a signed contract between the VHCPP and a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, organized outpatient health facility, or field dental clinic allowing an individual volunteer health care provider to deliver free health care services through the VHCPP at the sponsor entity location.

“Temporary site” means a site at which free health care services will be provided for a short period of time not to exceed three days. “Temporary site” includes but is not limited to temporary health fairs, flu shot clinics, and temporary sites that provide back-to-school physicals.

“Underinsured” means that a person does not have adequate insurance, which is determined on cost-exposure to family income with at least one of three indicators: (1) out-of-pocket medical expenses equal to or greater than 10 percent of income; (2) out-of-pocket medical expenses equal to or greater than 5 percent of income if income is less than 200 percent of the federal poverty level; and (3) health plan deductibles equal to or greater than 5 percent of income.

“Volunteer health care provider program” or *“VHCPP”* means the volunteer health care provider program of the department.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.2(135) Eligibility for the volunteer health care provider program.

88.2(1) *Individual volunteer health care provider eligibility.* To be eligible for protection as an employee of the state under Iowa Code chapter 669 for a claim arising from covered health care services, an individual volunteer health care provider shall satisfy each of the following conditions at the time of the act or omission allegedly resulting in injury:

a. The individual volunteer health care provider must hold an active unrestricted license, registration, or certification to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A. The individual volunteer health care provider shall provide a sworn statement attesting that the license, registration, or certification to practice is free of restrictions. The statement shall describe any disciplinary action that has ever been taken against the individual volunteer health care provider by any professional licensing, registering, or certifying authority or health care facility, including any voluntary surrender of license, registration, or certification or other agreement involving the individual volunteer health care provider’s license, registration, or certification to practice or any restrictions on practice, suspension of privileges, or other sanctions. The statement shall also describe any malpractice suits that have been filed against the individual volunteer health care provider. The statement provided by a pharmacist shall also describe any disciplinary action that has ever been taken against any pharmacy in which the pharmacist has ever been owner, partner, or officer.

b. Application. The applicant shall submit the following information on forms provided by the VHCPP:

(1) The individual volunteer health care provider’s current licensure identification number and expiration date;

(2) The health care services to be voluntarily provided meet all of the following:

1. The services fall under the individual volunteer health care provider's licensed scope of practice;

2. The services are covered health care services listed in paragraph 88.4(1) "d"; and

3. The individual volunteer health care provider applicant is willing to voluntarily provide the health care services to those persons who are uninsured and underinsured for the public health purpose of improved health, prevention of illness/injury, and disease management.

c. Agreement. The individual volunteer health care provider shall have a signed and current protection agreement with the VHCPP that identifies the covered health care services within the respective scope of practice and conditions of defense and indemnification as provided in rules 641—88.4(135) and 641—88.5(135).

- (1) The protection agreement is only valid during the time that the individual volunteer health care provider maintains a current unrestricted license and only for voluntary services provided in conjunction with a sponsor entity or protected clinic that has its own valid VHCPP protection agreement in effect at the time of service provision.

- (2) The protection agreement with the VHCPP will provide that the individual volunteer health care provider shall:

1. Perform only those health care services identified and approved by the VHCPP;

2. Promptly notify the VHCPP of any changes in licensure status;

3. Maintain proper records of the health care services provided;

4. Make no representations concerning eligibility for the VHCPP or eligibility of services for indemnification by the state except as authorized by the department;

5. Cooperate fully with the state in the defense of any claim or suit relating to participation in the VHCPP, including attending hearings, depositions and trials and assisting in securing and giving evidence, responding to discovery and obtaining the attendance of witnesses;

6. Accept financial responsibility for personal expenses and costs incurred in the defense of any claim or suit related to participation in the VHCPP, including travel, meals, compensation for time and lost practice, and copying costs, and agree that the state will not compensate the individual volunteer health care provider for the individual volunteer health care provider's expenses or time needed for the defense of the claim or suit;

7. Receive no direct monetary compensation of any kind for services provided in the VHCPP; and

8. Comply with the protection agreement with the VHCPP concerning approved health care services.

88.2(2) Protected clinic eligibility. To be eligible for protection as a state agency under Iowa Code chapter 669 for a claim arising from the provision of covered health care services at a protected clinic, the protected clinic will satisfy each of the following conditions at the time of the act or omission allegedly resulting in injury:

- a. The protected clinic will comply with subrules 88.3(1) through 88.3(5).

- b. The protected clinic will, upon request from the department, provide to the department a list of all health care providers who provided health care services at the protected clinic at the time of a claim made against the individual health care provider or protected clinic that arises out of the provision of free health care service rendered or that should have been rendered by the individual volunteer health care provider or protected clinic.

- c. The protected clinic will only be covered under the VHCPP for the provision of covered health care services by a health care provider providing health care services at the protected clinic who either:

- (1) Holds a current individual volunteer health care provider protection agreement with the VHCPP, or

- (2) Holds current professional liability insurance coverage and an active unrestricted license, registration, or certification to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A.

d. The protected clinic will submit a list of the clinic board of directors and contact information for the board of directors, if applicable.

e. If the protected clinic is a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, the protected clinic will provide proof of Section 501(c)(3) status to the VHCPP.

f. A protected clinic may allow health care profession students to volunteer at the protected clinic provided that the following conditions are satisfied:

(1) The college, university, or other health care profession educational institution provides professional liability insurance that covers the students;

(2) The protected clinic or the health care profession institution provides general liability and professional liability insurance that covers the students; and

(3) The students provide only those services or activities as are authorized by the education agreement, and such services and activities are provided under the on-site supervision of a health care provider.

88.2(3) *Sponsor entity or sponsor entity clinic.* As a condition of sponsoring individual volunteer health care providers in the VHCPP, a hospital, clinic, free clinic, health care facility, health care referral program, charitable organization, specialty health care provider office, organized outpatient health facility, or field dental clinic shall comply with subrules 88.3(1) through 88.3(5).

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.3(135) Sponsor entity and protected clinic.

88.3(1) Licensure. The sponsor entity or protected clinic shall be licensed to the extent directed by law for the facility in question.

88.3(2) If the sponsor entity or protected clinic is a charitable organization within the meaning of Section 501(c)(3) of the Internal Revenue Code, the sponsor entity or protected clinic shall provide proof of Section 501(c)(3) status to the VHCPP.

88.3(3) Application. The sponsor entity or protected clinic shall submit the following information on forms provided by the VHCPP:

- a. By category, the patient groups to be served;
- b. The health care services to be provided;
- c. The site where free health care services are to be provided;
- d. Classification of each site as a permanent site or temporary site; and
- e. The services that will be provided to those persons who are uninsured and underinsured for the public health purpose of improved health, prevention of illness/injury, and disease management.

88.3(4) Agreement. A signed and current sponsor entity agreement or protected clinic agreement will exist with the VHCPP that will:

- a. Provide that the individual volunteer health care provider or health care provider within a protected clinic and the individual volunteer health care provider within a sponsor entity will perform only those health care services identified and approved by the VHCPP;
- b. Identify by category the patient groups to be served;
- c. Identify the sites at which the free health care services will be provided;
- d. Identify as a permanent site or temporary site for the provision of free health care services through the VHCPP;
- e. Provide that the sponsor entity or protected clinic will maintain proper records of health care services for a period of seven years from the date of service or, in the case of a minor, for a period of one year after the minor has reached the age of majority; and
- f. Provide that the sponsor entity agrees that only the individual volunteer health care provider or protected clinic covered under a current VHCPP protection agreement at the time of the service provision in a claim is afforded protection under Iowa Code section 135.24 and that the state assumes no obligation to the sponsor entity, its employees, officers, or agents. The sponsor entity or protected

clinic shall submit a statement, that will be submitted on forms provided by the VHCPP, attesting that the sponsor entity or protected clinic and its staff, employees and volunteers agree to:

(1) Cooperate fully with the state in the defense of any claim or suit relating to participation in the VHCPP, including attending hearings, depositions and trials and assisting in securing and giving evidence, responding to discovery and obtaining the attendance of witnesses;

(2) Accept financial responsibility for the sponsor entity's or protected clinic's expenses and costs incurred in the defense of any claim or suit related to participation in the VHCPP, including travel, meals, compensation for time and lost practice, and copying costs, and agree that the state will not compensate the sponsor entity or protected clinic for expenses or time needed for the defense of the claim or suit;

(3) Receive no direct monetary compensation of any kind for health care services provided in the sponsor entity or protected clinic; and

(4) Comply with the sponsor entity agreement or protected clinic agreement with the VHCPP concerning approved health care services.

88.3(5) General liability insurance. The sponsor entity or protected clinic shall submit proof of general liability insurance for the clinic site.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.4(135) Covered health care services. An individual volunteer health care provider holding a current protection agreement with the VHCPP will be afforded the protection of an employee of the state under Iowa Code chapter 669, and a protected clinic holding a current protection agreement with the VHCPP will be afforded protection as an agency of the state under Iowa Code chapter 669, only for claims for injury alleged to have been proximately caused by an individual volunteer health care provider's provision of covered health care services or solely on the basis of the individual volunteer health care provider's participation in the sponsor entity or protected clinic.

88.4(1) Covered health care services are only those that are:

- a. Identified in the protection agreement with the VHCPP;
- b. In compliance with these rules;
- c. Provided by or under the direct supervision of the individual volunteer health care provider;
- d. Health care services of:

(1) Advanced registered nurse practitioners for: well-child examinations; annual adult examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; immunizations; and minor surgical procedures. Certified registered nurse anesthetists may provide anesthesia services for major surgical procedures only if the following conditions are satisfied:

1. The surgery is performed in a hospital as defined in Iowa Code section 135B.1(3) or an organized outpatient health facility;

2. The hospital or organized outpatient health facility at which the surgery is performed has executed a sponsor entity agreement;

3. The physician performing the surgery provides or ensures the provision of adequate presurgical and postsurgical care, including any follow-up necessary to address postoperative complications; and

4. The physician performing the surgery is an individual specialty health care provider or part of a group of specialty health care providers that has registered with the department as a specialty health care provider office.

(2) Audiologists for: testing, measurement and evaluation related to hearing and hearing disorders and associated communication disorders for the purpose of nonmedically identifying, preventing, modifying or remediating such disorders and conditions including the determination and use of appropriate amplification; patient instruction/counseling; patient habilitation/rehabilitation; and referrals.

(3) Bachelor social workers for: psychosocial assessment and intervention through direct contact with clients; referral to other qualified resources for assistance; performance of social histories; problem identification; establishment of goals and monitoring of progress; interviewing techniques; counseling; social work administration; supervision; evaluation; interdisciplinary consultation and collaboration.

(4) Chiropractors for: examinations; diagnosis and treatment; health education; and health maintenance.

(5) Dental assistants for: intraoral services; extraoral services; infection control; radiography; and removal of plaque or stain by toothbrush, floss, or rubber cup coronal polish.

(6) Dental hygienists for: assessments and screenings; health education; health maintenance; and preventive services (cleaning, X-rays, sealants, fluoride treatments, fluoride varnish).

(7) Dentists for: dental examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; and minor surgical procedures.

(8) Emergency medical care providers for: airway/ventilation/oxygenation; assisted medications—patient's; cardiovascular/circulation; immobilization; IV initiation/maintenance/fluids; and medication administration—routes.

(9) Independent social workers for: psychosocial assessment, diagnosis, and treatment; performance of psychosocial histories; problem identification; evaluation of symptoms and behavior; assessment of psychosocial and behavioral strengths and weaknesses and effects of the environment on behavior; psychosocial therapy; differential treatment planning; and interdisciplinary consultation.

(10) Licensed practical nurses for: supportive or restorative care.

(11) Marital and family therapists for: marital and family therapy; and application of counseling techniques in the assessment and resolution of emotional conditions.

(12) Master social workers for: psychosocial assessment, diagnosis, and treatment; performance of psychosocial histories; problem identification; evaluation of symptoms and behavior; assessment of psychosocial and behavioral strengths and weaknesses and effects of the environment on behavior; psychosocial therapy; differential treatment planning; and interdisciplinary consultation.

(13) Mental health counselors for: mental health counseling; and counseling services involving assessment, referral and consultation.

(14) Occupational therapists for: evaluation and treatment of problems interfering with functional performance in persons impaired by physical illness or injury, emotional disorder, congenital or developmental disability or the aging process.

(15) Optometrists for: examinations; diagnosis and treatment of the human eye and adnexa; health education; and health maintenance.

(16) Pharmacists for: drug dispensing; patient counseling; health screenings and education; and immunizations.

(17) Physical therapists for: interpretation of performance, tests, and measurements; evaluation and treatment of human capabilities and impairments; use of physical agents, therapeutic exercises, and rehabilitative procedures to prevent, correct, minimize, or alleviate a physical impairment; establishment and modification of physical therapy program; treatment planning; and patient instruction/education.

(18) Physicians and physician associates for: well-child examinations; annual adult examinations; diagnosis and treatment of acute and chronic conditions; health education; health maintenance; immunizations; and minor surgical procedures. Physicians may perform major surgical procedures only if the following conditions are satisfied:

1. The surgery is performed in a hospital as defined in Iowa Code section 135B.1(3) or an organized outpatient health facility;

2. The hospital or organized outpatient health facility at which the surgery is performed has executed a sponsor entity agreement;

3. The physician provides or ensures the provision of adequate presurgical and postsurgical care, including any follow-up necessary to address postoperative complications; and

4. The physician performing the surgery is an individual specialty health care provider or part of a group of specialty health care providers that has registered with the department as a specialty health care provider office.

(19) Podiatrists for: examinations; diagnosis and treatment; health education; health maintenance; and minor surgical procedures.

(20) Psychologists for: counseling and the use of psychological remedial measures with persons with adjustment or emotional problems.

(21) Registered nurses for: well-child examinations; annual adult examinations; treatment of acute and chronic conditions; health education; health maintenance; and immunizations.

(22) Respiratory therapists for: diagnostic and therapeutic use of administration of medical gases, aerosols, and humidification, not including general anesthesia; pharmacologic agents relating to respiratory care procedures; bronchopulmonary hygiene; specific diagnostic and testing techniques employed in the medical management of patients to assist in diagnosis, monitoring, treatment, and research of cardiopulmonary abnormalities; and pulmonary function testing.

(23) Speech pathologists for: testing, measurement and evaluation related to the development and disorders of speech, fluency, voice or language for the purpose of nonmedically preventing, ameliorating, modifying or remediating such disorders and conditions; patient instruction/counseling; patient habilitation/rehabilitation; and referrals.

88.4(2) Experimental procedures or procedures and treatments that lack sufficient evidence of clinical effectiveness are excluded from the VHCPP.

[ARC 9956C, IAB 1/7/26, effective 3/1/26; Editorial change: IAC Supplement 6/10/26]

641—88.5(135) Defense and indemnification. The state will defend and indemnify an individual volunteer health care provider or a protected clinic for a claim arising from the VHCPP only to the extent provided by Iowa Code chapter 669 and section 135.24. Persons or entities other than the participating individual volunteer health care provider or protected clinic are not considered state employees or state agencies under Iowa Code chapter 669. Defense and indemnification of the individual volunteer health care provider or a protected clinic under Iowa Code chapter 669 and section 135.24 will occur only if all of the following are met:

88.5(1) The claim involves medical injury alleged to have been proximately caused by health care services that were identified and approved in the protection or sponsor agreement with the VHCPP and then only to the extent the health care services were provided by or under the direct supervision of the individual volunteer health care provider, including claims based on negligent delegation of health care, or the individual volunteer health care provider is named as a defendant solely because of the individual volunteer health care provider's participation in the protected clinic or sponsor entity clinic.

88.5(2) The claim arises from covered health care services that were performed at a site identified and approved in the protection agreement with the VHCPP.

88.5(3) The claim arises from covered health care services provided through a protected clinic or sponsor entity clinic identified and approved in the individual volunteer health care provider's protection agreement with the VHCPP and that meets the necessities of rule 641—88.2(135).

88.5(4) The individual volunteer health care provider, health care provider, protected clinic, or sponsor entity clinic that provided the health care services receives no direct monetary compensation of any kind and no promise to pay compensation for the health care services that allegedly resulted in medical injury.

88.5(5) The health care services are provided to a patient who is a member of a patient group identified in the sponsor entity or protected clinic protection agreement with the VHCPP.

88.5(6) The individual volunteer health care provider, protected clinic, or sponsor entity clinic is eligible and registered as provided in rule 641—88.2(135) or the care is provided by a health care provider who holds current professional liability insurance coverage and an active unrestricted license

to practice in Iowa under Iowa Code chapter 147A, 148, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 153, 154, 154B, 154C, 154D, 154F, or 155A and has been approved by the VHCPP.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.6(135) Term of agreement.

88.6(1) *Individual volunteer health care provider.* The protection agreement with the VHCPP will expire five years from the date of execution. Individual volunteer health care providers may apply for renewal by filing an application at least 30 days prior to expiration of the protection agreement.

88.6(2) *Protected clinic.* The protection agreement with the VHCPP will expire five years from the date of execution. The protected clinic may apply for renewal by filing an application at least 30 days prior to expiration of the protection agreement. It is anticipated that temporary sites may change over the five-year period. An updated list of temporary site location or service provision changes will be provided to the department for review and acceptance at least one week prior to service provision at the temporary site. Location or service provision changes to permanent sites will necessitate a protection agreement amendment.

88.6(3) *Sponsor entity.* The sponsor entity agreement with the VHCPP will expire five years from the date of execution. Sponsor entities may apply for renewal by filing an application at least 30 days prior to expiration of the sponsor entity agreement. It is anticipated that temporary sites may change over the five-year period. An updated list of temporary site location or service provision changes will be provided to the department for review and acceptance at least one week prior to service provision at the temporary site. Location or service provision changes to permanent sites will necessitate a protection agreement amendment.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.7(135) Reporting necessities and duties.

88.7(1) Upon obtaining knowledge or becoming aware of any injury allegedly arising out of the negligent rendering of, or the negligent failure to render, covered health care services under the VHCPP, a participating individual volunteer health care provider, protected clinic, or sponsor entity will provide to the VHCPP, as soon as practicable, written notice containing, to the extent obtainable, the circumstance of the alleged injury, the names and addresses of the injured, and any other relevant information.

88.7(2) Upon obtaining knowledge or becoming aware of an injury as defined in subrule 88.7(1), the participating protected clinic or sponsor entity will promptly take all reasonable steps to prevent further or other injury from arising out of the same or similar incidents, situations or conditions.

88.7(3) A participating individual volunteer health care provider, protected clinic, or sponsor entity will immediately notify the Iowa Department of Justice, Special Litigation Division, Hoover State Office Building, Des Moines, Iowa 50319, of service or receipt of an original notice, petition, suit or claim seeking damages from the individual volunteer health care provider, protected clinic or sponsor entity related to participation in the VHCPP.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.8(135) Revocation of agreement. The VHCPP may deny, suspend, revoke, or condition the agreement of an individual volunteer health care provider, protected clinic or sponsor entity for cause, including but not limited to:

1. Failure to comply with the protection agreement or sponsor entity agreement with the VHCPP.
2. Violation of state law governing the respective scope of practice or other law governing the health care services provided under the VHCPP.
3. Making false, misleading, or fraudulent statements in connection with the VHCPP, including determination of eligibility of the individual volunteer health care provider, protected clinic, or sponsor entity or handling of a claim against the individual volunteer health care provider, protected clinic, sponsor entity or the state.

4. Evidence of substance abuse or intoxication affecting the provision of health care services under the VHCPP.

5. Reasonable grounds to believe that the individual volunteer health care provider or health care provider may have provided incompetent or inadequate care to a patient under the VHCPP or is likely to do so.

6. Reasonable grounds to believe that the individual volunteer health care provider's, protected clinic's, or sponsor entity's participation in the VHCPP may expose the state to undue risk.

7. Failure to immediately notify the VHCPP of any disciplinary action brought against the individual volunteer health care provider by the applicable state licensing board.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.9(135) Procedure for revocation of agreement. A proceeding for revocation of an individual volunteer health care provider's protection agreement or a protected clinic's protection agreement or a sponsor entity's agreement for participation will be conducted as a contested case proceeding pursuant to Iowa Code chapter 17A. Iowa Code section 17A.18 does not preclude emergency summary suspension of a protection agreement or a sponsor entity agreement. The VHCPP will immediately notify the appropriate licensing board and the appropriate protected clinic or sponsor entity of revocation of an individual volunteer health care provider's protection agreement.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.10(135) Effect of suspension or revocation. If the VHCPP suspends or revokes an individual volunteer health care provider's protection agreement, sponsor entity protection agreement, or protected clinic's protection agreement, the action will suspend or revoke future protection but will not negate defense and indemnification coverage for covered acts or omissions that occurred during the effective dates of the protection agreement.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.11(135) Protection denied.

88.11(1) *Protection denied—appeal procedure.* An applicant who has been denied protection by the VHCPP may appeal the decision according to the provisions set forth in 441—Chapter 2506.

88.11(2) Reserved.

[ARC 9956C, IAB 1/7/26, effective 3/1/26; Editorial change: IAC Supplement 6/10/26]

641—88.12(135) Board notice of disciplinary action. The applicable state licensing board will notify the VHCPP of the initiation of a contested case against a protected individual volunteer health care provider or the imposition of disciplinary action, including providing copies of any contested case decision or settlement agreement with the protected individual volunteer health care provider upon request of the VHCPP.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.13(135) Effect of eligibility protection. A fully executed protection agreement of an individual volunteer health care provider or protected clinic as eligible for participation in the VHCPP by the applicable state licensing board and the department is solely a determination that the state will defend and indemnify the individual volunteer health care provider or the protected clinic to the extent provided by Iowa Code section 135.24 and these rules. The protection is not an approval or indication of ability or competence and will not be represented as such. The protected clinic or sponsor entity through which the individual volunteer health care provider provides free health care services will retain responsibility for determining that health care personnel are competent and capable of adequately performing the health care services to be provided.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

641—88.14(135) Reporting by a protected clinic or sponsor entity. A reporting form will be provided by the VHCPP to the participating protected clinic or sponsor entity at the time the protected

clinic or sponsor entity agreement is approved by the VHCPP. Within 60 days following each calendar quarter, the protected clinic or sponsor entity will provide a report to the VHCPP. At a minimum, the report will include the number of clinic patients receiving free health care services and patient demographics by age, ethnicity, and insurance status.

[ARC 9956C, IAB 1/7/26, effective 3/1/26]

These rules are intended to implement Iowa Code section 135.24.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 94
CHILD PROTECTION CENTER GRANT PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 11/1/30

641—94.1(135) Definitions. For the purposes of these rules, the following definitions apply:

“*Child abuse*” means the same as defined in Iowa Code section 232.68(2).

“*Child protection center*” or “*child advocacy center*” means a comprehensive, child-focused program, designed by communities to meet their needs, based in a facility that allows law enforcement, child protection professionals, prosecutors, and the mental health and medical communities to work together to handle child abuse cases. “Child advocacy center” is synonymous with “child protection center.”

“*Department service area*” means one of the five geographic areas designated by the department for the provision of family well-being and protection services.

[ARC 9563C, IAB 9/17/25, effective 11/1/25]

641—94.2(135) Goals. A child protection center’s goals for victims of child abuse allegations shall be:

1. To provide consistent and expedient response and follow-up to abuse reports.
2. To coordinate activities to investigate, prosecute, and treat child abuse.
3. To advocate for medical and mental health resources to effectively help the child and the child’s family.
4. To reduce the number of interviews and interactions with a victim.
5. To provide consistent and compassionate support for the child and the child’s family.
6. To ensure that the child is not further victimized by the system designed to protect the child.
7. To increase successful prosecutions.

[ARC 9563C, IAB 9/17/25, effective 11/1/25]

641—94.3(135) Review process.

94.3(1) The department will establish a request for proposal and application process for organizations eligible to receive funding. The department will establish a process to review applications, including receiving input from a review committee. The review process and review criteria will be described in the request for proposals.

94.3(2) The director will create a committee to review proposals and make recommendations to the director. At a minimum, committee membership will be in accordance with Iowa Code section 135.118(3).

94.3(3) While implementation of the grant program is subject to the availability of funding, if sufficient funding is available, the department will, at a minimum, award a grant to a child protection center in or available to each department service area.

[ARC 9563C, IAB 9/17/25, effective 11/1/25]

641—94.4(135) Eligibility and criteria. To be eligible for a child protection center grant, an organization shall:

94.4(1) Have acquired partial membership rank as a child advocacy center from the National Children’s Alliance and shall identify a plan to acquire full membership rank within one year of receiving a state grant.

94.4(2) Have in place an interagency memorandum of understanding that meets the requirements of Iowa Code section 135.118. The applicant shall provide in the application written information in the following areas:

- a. Data, statistics and facts from an assessment of need and assets in the community to support a child protection center for children.

- b.* Identification of barriers to the child protection center to reach the purpose and goals for children as may exist in federal, state, or local rules, regulations, codes, policies, or procedures.
- c.* A plan to request and advocate waivers of federal, state, or local rules, regulations, codes, policies, or procedures to remove or reduce barriers.
- d.* The child protection center's access to information regarding all suspected or confirmed child abuse/neglect victims in the identified service area.
- e.* The child protection center's provision of 24-hour access to center staff for support, questions, and referrals regarding child abuse.
- f.* Identification of matching local funds to support and sustain the child protection center in the community.
- g.* A plan for community education on prevention of child abuse and neglect.
- h.* Collaboration agreements with providers of human services, child health services, early education services, and all other potential community partners to support the purpose and goals of the child protection center.
- i.* The child protection center's ability to access and utilize alternate funds for activities provided.

[ARC 9563C, IAB 9/17/25, effective 11/1/25]

641—94.5(135) Appeals. An applicant may appeal the denial of a properly submitted grant application. Appeals will be governed by 441—Chapter 2506.

[ARC 9563C, IAB 9/17/25, effective 11/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 135.118.

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IAB 9/17/25, effective 11/1/25]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 95
VITAL RECORDS: GENERAL ADMINISTRATION
[Prior to 12/12/12, see [641] Ch 96, 98.1, Chs 103, 104]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

641—95.1(144) Definitions. For the purpose of 641—Chapters 95 through 100, the following definitions apply:

“Administrative costs” means costs for the registration, collection, preservation, modification and certification of records, including but not limited to costs related to copying, regular mailing, searching, staffing, and maintenance of systems.

“Advanced registered nurse practitioner” or *“ARNP”* means the same as defined in Iowa Code section 152.1.

“Age of majority” means the chronological moment when a child legally assumes majority control over the child’s own person and actions and decisions, thereby terminating the legal control and legal responsibilities of the child’s parents over and for the child. The period of minority extends to the age of 18 years, but every minor attains majority by marriage.

“Amendment” means a change made by the state registrar upon request from an entitled person as described in rule 641—95.8(144) to an obvious error, omission, or transposition of letters in a word of common knowledge one year or more after the event.

“Birth center” means a facility or institution, that is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy.

“Birthing institution” means a private or public hospital licensed pursuant to Iowa Code chapter 135B that has a licensed obstetric unit or is licensed to provide obstetric services.

“Burial-transit permit” means the same as described in Iowa Code section 144.32.

“Certificate” or *“record”* means the written or electronic legal document containing the facts of an event.

“Certificate of birth resulting in stillbirth” means the same as described in Iowa Code section 144.31A.

“Certificate of nonviable birth” means a document issued based upon a nonviable birth.

“Certified copy” means an official copy of a registered vital record that is authenticated by the state registrar or county registrar. A certified copy contains a statement certifying the facts are true and accurate as recorded, is printed on security paper, and has authentication seals and signatures. A certified copy excludes all entries indicated as confidential or for statistical information.

“Commemorative certificate” means the same as described in Iowa Code section 144.45A.

“Competent and disinterested person” means an individual of legal age who is acquainted with both applicants who plan to marry.

“Confidential information” means data or information that is on a vital record, is not considered public information, and is restricted as to its release pursuant to Iowa Code chapter 144 or other provision of federal or state law.

“Correction” means a change made by the state registrar upon observation, upon query, or upon request from an entitled person as described in rule 641—95.8(144) to an obvious error, omission, or transposition of letters in a word of common knowledge within one year and prior to the first anniversary of the event.

“County registrar” means the same as described in Iowa Code section 331.601(4). If the office of the county recorder has been abolished, “county registrar” means the office to which the duties are assigned by the county board of supervisors.

“County resident copy” means a properly filed, clearly marked working copy of a decedent’s death certificate that is sent to and recorded by the county registrar of the county of the decedent’s residence in the event the death occurred outside the county of the decedent’s residence.

“Court of competent jurisdiction” means the appropriate court for the type of action. When used to refer to inspection of an original certificate of birth based upon an adoption, “court of competent jurisdiction” means the court in which the adoption was ordered.

“Cremated remains” means the same as defined in Iowa Code section 144.1.

“Cremation” means the same as defined in Iowa Code section 144.1.

“Custody” means guardianship or control of vital records, including both physical possession, referred to as physical custody, and legal responsibility, referred to as legal custody, unless one or the other is specified. The state registrar will not transfer legal custody of vital records to another agency for purposes of granting public access until all the records have been purged of all confidential information.

“Day” means calendar day.

“Dead body” means the same as defined in Iowa Code section 144.1.

“Death” means the condition as defined in Iowa Code section 702.8.

“Declaration of paternity registry” means a registry for a putative father to declare paternity pursuant to Iowa Code section 144.12A. The declaration does not constitute an affidavit of paternity filed pursuant to Iowa Code section 252A.3A.

“Delayed birth record” means the registration of a live birth event occurring in Iowa one or more years after the date of birth that is clearly marked as delayed and shall show on its face the date of the delayed registration.

“Delayed death record” means the registration of a death event occurring in Iowa one or more years after the date of death that is clearly marked as delayed and shall show on its face the date of the delayed registration.

“Delayed marriage record” means the registration of a marriage event occurring in Iowa one or more years after the event that is clearly marked as delayed and shall show on its face the date of the delayed registration.

“Disinterment permit” means a permit that allows the removal of a dead human body or fetus from its original place of burial, entombment, or interment for the purpose of autopsy or reburial.

“Electronic access” means authority given by the state registrar to a county registrar to access electronic vital records through the electronic statewide vital records system for purposes of retrieving information. The state registrar will provide guidelines for electronic access and the retrieval of information from the electronic statewide vital records system.

“Electronic statewide vital records system” means the combined vital records system for registration of birth records, registration of death records, issuance of certified copies of vital records by the state registrar and county registrar, and fee accounting.

“Emancipated minor” means a person younger than 18 years of age who has obtained the age of majority by court order.

“Fetal death” means the same as defined in Iowa Code section 144.1.

“Filing” means the same as defined in Iowa Code section 144.1.

“Final disposition” means the same as defined in Iowa Code section 144.1.

“Foundling” means a living infant of unknown parentage whose place of birth is where the infant is found and whose date of birth shall be determined by approximation.

“Funeral director” means a person licensed in Iowa to practice mortuary science pursuant to Iowa Code chapter 156.

“Gestational surrogate arrangement” or *“surrogate mother arrangement”* means the same as defined in Iowa Code section 710.11.

“Health care provider” means the same as defined in Iowa Code section 144.29A.

“Hospital” means the same as defined in Iowa Code section 135B.1.

“Induced termination of pregnancy” means the same as defined in Iowa Code section 144.29A.

“Institution” means a facility as defined in Iowa Code section 144.1(9), including “hospital” as defined in Iowa Code section 135B.1(3) but not including “birth center” as defined in Iowa Code section 10A.711(3).

“Institutional health facility” means a hospital as defined in Iowa Code section 135B.1, including a facility providing medical or health services that is open 24 hours per day, seven days per week and that is a hospital emergency room or a health care facility as defined in Iowa Code section 135C.1.

“Jurisdiction” means the state or county to which legal authority for the system of vital statistics has been granted by statute.

“Last name” means surname.

“Lineal consanguinity” means the existence of a line of descent in which one person is descended in a direct lineal relationship to another: as between the registrant and the registrant’s parent, grandparent, great-grandparent, and so upward, in the direct ascending line; or between the registrant and the registrant’s child, grandchild, great-grandchild and so downward in the direct descending line; or any siblings of the registrant.

“Live birth” means the same as defined in Iowa Code section 144.1.

“Marriage license valid date” means the day on which the marriage license becomes valid and on or after which the parties are authorized to marry. When the marriage license valid date is computed, the date of application shall be excluded. The marriage license shall become valid after the expiration of three calendar days after the date of application unless earlier validated by a court of competent jurisdiction.

“Medical certification” means a statement that attests that the medical information reported on the certificate of death or fetal death is accurate to the best of the medical certifier’s knowledge.

“Medical certifier” means an Iowa-licensed physician, physician associate, advanced registered nurse practitioner, or medical examiner who attests that the death event has taken place and who determines the cause and manner of death.

“Medical examiner” means the medical legal officer who makes the determination of the cause of death in nonroutine deaths such as nonnatural, sudden, or unattended deaths or other deaths that affect the public interest.

“Modification” means any change made to a record that has been accepted and registered, such as a correction, an amendment, a change after adoption or paternity determination, or any other change.

“Mutual consent voluntary adoption registry” means a registry that authorizes adult adopted children, adult siblings, and the biological parents of adult adoptees to register to obtain identifying birth information.

“Natural cause of death” means a death due to a disease or the aging process and not due to external causes.

“Newborn safe haven registration” means the registration of the birth of a living infant of unknown parentage who has been abandoned or left at some unknown time after birth in a location other than the place of delivery.

“Non-birthing institution” means a private or public hospital licensed pursuant to Iowa Code chapter 135B that does not have a licensed obstetric unit or is not licensed to provide obstetric services but may provide obstetric services on an emergency basis.

“Non-institution birth” means a live birth that occurs outside of an institution and not en route to an institution.

“Nonnatural cause of death” means the same as defined in Iowa Code section 144.28(1).

“Nonviable birth” means an unintentional, spontaneous fetal demise occurring after demonstration of a doppler-detected heartbeat and prior to the twentieth week of gestation during a pregnancy that has been verified by a health care provider.

“Notification of record search” means the document issued to the applicant when the record requested cannot be located through a search of registered records. The document contains a certification statement, is printed on security paper, and has authentication seals and signatures.

“Officiant” means:

1. A judge of the Iowa supreme court, court of appeals, or district court, including a district associate judge, an associate juvenile judge, or a judicial magistrate, and including a senior judge as defined in Iowa Code section 602.9202(3), or

2. A person ordained or designated as a leader of the person's religious faith.

"Physician" means an individual licensed pursuant to Iowa Code chapter 148.

"Physician associate" means an individual licensed pursuant to Iowa Code chapter 148C.

"Presumptive death" means a death event presumed to have occurred in Iowa where no human body is found and a court of competent jurisdiction has determined the death has occurred.

"Putative father" means a man who is alleged to be or who claims to be the biological father of a child born to a woman to whom the man is not married at the time of the conception or birth of the child or at any time during the period between the conception and birth of the child.

"Record of death" means the compilation of those entries of a death, whether electronic or paper, that are contained in indexed systems that record the death event occurring in Iowa. "Record of death" includes the certificate of death.

"Record of fetal death" means the compilation of those entries of a fetal death, whether electronic or paper, that are contained in indexed systems that record a fetal death event occurring in Iowa. "Record of fetal death" includes the certificate of fetal death.

"Record of foreign-born adoption" means the compilation of those entries of a live birth event for a child born in a foreign country and adopted by an Iowa resident. "Record of foreign-born adoption" includes the certificate of foreign birth and shall not constitute U.S. citizenship.

"Record of live birth" means the compilation of those entries of a live birth event, whether electronic or paper, that are contained in indexed systems that record a live birth event occurring in Iowa. "Record of live birth" includes the certificate of live birth.

"Record of marriage" means the compilation of those entries of a marriage event, whether electronic or paper, that are contained in indexed systems that record a marriage event occurring in Iowa. "Record of marriage" includes the certificate of marriage.

"Registrant" means the person named on the certificate as the person who was born, died, or was married.

"Registration" means the same as defined in Iowa Code section 144.1.

"Report of dissolution or annulment" means the statistical report of dissolution or annulment, whether electronic or paper, excluding all entries indicated as confidential or for statistical information only.

"Report of termination of pregnancy" means the aggregated compilation of the information received by the department on terminations of pregnancies for each information item listed, with the exception of the report tracking number, the health care provider code, and any set of information for which the number is so small that the confidentiality of any person to whom the information relates may be compromised.

"Research" means the systematic investigation designed primarily to develop or contribute to scientific, medical, public health or psychosocial disciplines and generalized knowledge and not for private gain.

"Sealed" means the removal from inspection of any copy of an original certificate in the custody of the county registrar and the state registrar.

"Security paper" means standardized paper for issuing certified copies of vital record events that meets, at a minimum, national requirements for security features embedded within the paper to deter tampering, counterfeiting, photocopying, or imaging in order to help prevent fraudulent use of the certified copy and prevent identity theft.

"Single parent birth" means any record of live birth for which there is a reference or statement on the certificate or entry that directly indicates "no" regarding "born in wedlock" or "married"; or any record of live birth for which there is reference or statement on the certificate or entry that either parent is "unknown" or "anonymous"; or any certificate or entry that reflects the omission or absence of the name of the father of the child.

"Spontaneous termination of pregnancy" means the same as defined in Iowa Code section 144.29A(7) "c."

“Standard birth registration” means a vital record of a live birth event that occurred in Iowa that was submitted and accepted for registration within one year of the event.

“State registrar” means the director of the department or the director’s designee.

“Stillbirth” means the same as defined in Iowa Code section 136A.2.

“System of vital statistics” or *“system”* means the same as defined in Iowa Code section 144.1.

“Uncertified copy” means an unofficial copy of a registered vital record that is not printed on security paper and that does not contain any authentication by the issuing jurisdiction. Uncertified copies shall contain an overstamp such as: “Not for Legal Purposes,” “Administrative Use Only,” “Deceased,” “For Genealogical Purposes Only,” “Working Copy,” or any other overstamp as authorized by the state registrar.

“Vital records” means certificates or reports of birth, death, fetal death, marriage, dissolution, annulment, and related data.

“Vital statistics” means data derived from reports, certificates, and records of live birth, death, fetal death, induced termination of pregnancy, marriage, dissolution of marriage or annulment, and data related thereto.

[ARC 0142D, IAB 3/18/26, effective 7/1/26; Editorial change: IAC Supplement 6/10/26]

641—95.2(144) Vital records and statistics. The department will install, maintain, and operate the system of vital statistics throughout the state. No official system for the registration of births, deaths, fetal deaths, adoptions, marriages, dissolutions, and annulments shall be maintained in the state or any of its political subdivisions other than the one provided for in Iowa Code chapter 144, including but not limited to a system maintained by any agency or private entity.

95.2(1) No person shall prepare or issue any certificate that purports to be an original certified copy or a copy of a certificate of birth, death, fetal death, adoption, marriage, dissolution, or annulment except as provided for in Iowa Code chapter 144 and authorized by the state registrar.

95.2(2) The state registrar and the county registrar will not maintain or issue copies of any vital record of an event occurring outside the state registrar’s or county registrar’s jurisdiction except as provided for in Iowa Code chapter 144 and authorized by the state registrar.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.3(144) Forms—property of department. All forms, certificates and reports pertaining to the registration of vital events are the property of the department and shall be surrendered to the state registrar upon demand. Official designated forms used for the express purpose of creating a vital record event will not be accessible to the general public unless authorized by rule.

95.3(1) The forms supplied or approved for reporting vital events will be used for official purposes as provided for by law, rules and instructions of the state registrar.

95.3(2) No forms, except those furnished or approved by the state registrar, can be used in the reporting of vital events or the making of copies of vital records.

95.3(3) Security paper used to report vital events will be maintained in a secure location accessible only to the state and county registrars and their employees for administrative purposes.

95.3(4) Security paper will be used to issue certified copies of Iowa vital records and will be maintained in a secure location accessible only to the state and county registrars and their employees for administrative purposes.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.4(144) Information by others.

95.4(1) Any person having knowledge of the facts shall furnish information the person possesses regarding any birth, death, fetal death, adoption, marriage, dissolution, or annulment, upon demand of the state registrar.

95.4(2) Every person in charge of an institution, or the person’s designee, shall maintain a record of personal particulars and data concerning each person admitted or confined to the institution pursuant to Iowa Code section 144.47. This record shall include information required by the standard

certificate of birth, death, and fetal death forms issued under the direction of the state registrar. The record shall be made at the time of admission based on the information provided by such person, but when information cannot be obtained from the person, it shall be obtained from the most knowledgeable relative or person acquainted with the facts. The name and address of the person providing the information shall be a part of the record.

95.4(3) Records maintained under this rule shall be retained for a period of not less than ten years and shall be made available for inspection by the state registrar upon demand.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.5(144) Handling of vital records.

95.5(1) State equipment and state vital records shall not be handled or accessed except by the state registrar, the state registrar's employees, or other authorized personnel for administrative purposes.

95.5(2) The county registrar will provide assistance to the public in accessing vital records designated as public records in the custody of the county registrar.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.6(144) Fees.

95.6(1) *Fees for services provided by state registrar or county registrar.* The following fees will be charged and remitted for the various services provided by the state registrar or the county registrar.

a. The state registrar or county registrar, as applicable, will charge a fee of \$20 for a certified copy of a vital record. If, following a search, no record is found and no certified copy is printed, the \$20 fee may be retained.

b. The state registrar will charge a fee of \$15 to prepare an adoption certificate, amend a certificate, amend a certificate of live birth to reflect a legal change of name, prepare a delayed certificate, process other administrative or legal actions, prepare a noncertified copy of an original certificate of birth pursuant to Iowa Code sections 144.23A and 144.24A, or prepare copies of supporting documents on file in the state registrar's office. No fee will be charged for establishment of paternity.

c. The state registrar will charge a fee of \$25 to file a completed application for the mutual consent voluntary adoption registry.

d. The state registrar will charge a fee of \$5 to update applicant information maintained in the mutual consent voluntary adoption registry and the declaration of paternity registry.

e. The state registrar will charge a fee of \$15 to amend an abstract or other legal documentation in support of the preparation of a new certificate.

f. The state registrar will charge a fee of \$35 to issue a commemorative copy of a certificate of birth or a certificate of marriage pursuant to Iowa Code section 144.45A. Fees collected will be deposited in the emergency medical services fund established in Iowa Code section 135.25.

g. The state registrar will charge a fee of \$15 for the purpose of issuing an uncertified copy of a certificate of birth resulting in stillbirth pursuant to Iowa Code section 144.31A.

h. The state registrar will charge a fee of \$15 for the purpose of issuing a certificate of nonviable birth pursuant to Iowa Code section 144.31B.

95.6(2) *Overpayments.* Any overpayment of \$5 or less received by the state registrar for the copying of vital records or for the preparation or amending of a certificate will not be refunded and will be retained by the department.

95.6(3) *Certified copy of modified vital record.* When an individual is in possession of a previously issued certified copy of a vital record and the original record is subsequently modified, the individual may request and receive a certified copy of the modified record without charge if the certified copy prior to modification is relinquished to the registrar's office that issued the certified copy, unless otherwise directed by the state registrar.

95.6(4) *Search of county registrar's records—fee for uncertified copy.* A person who is requesting an uncertified copy of a vital record in the custody of the county registrar shall conduct the

search of the county files to locate the record. If a copy is requested, the county registrar may charge a fee pursuant to Iowa Code section 22.3. The fee will be retained by the county.

95.6(5) *Distribution of fees.*

a. All fees collected by the county registrar and the state registrar will be distributed as follows:

(1) For fees collected by a county registrar, the county registrar will retain \$4 of each \$20 fee collected by that office. The remaining fees will be sent to the state registrar and will be divided as follows:

1. For a birth certificate or a marriage certificate, the state registrar will receive \$13, and \$3 will be deposited in the general fund of the state, except for the fee collected pursuant to paragraph 95.6(1) “f.”

2. For a death certificate, the state registrar will receive \$1, the office of the state medical examiner will receive \$13, and \$2 will be deposited in the general fund of the state.

(2) Fees collected by the state registrar will be divided as follows:

1. For a birth certificate or a marriage certificate, the state registrar will retain \$14 and \$6 will be deposited in the general fund of the state.

2. For a death certificate, the state registrar will retain \$4, the office of the state medical examiner will receive \$13, and \$3 will be deposited in the general fund of the state.

b. All fees retained by the state registrar will be added to the vital records fund established by the department pursuant to Iowa Code section 144.46A.

c. All fees received by the office of the state medical examiner will be added to the operating budget established for the operation of that office.

95.6(6) *Fee for search to verify vital statistics record.* A fee will be charged by the state registrar for each search conducted for the purpose of providing verification of vital statistics data to an agency authorized to receive such data under subrule 95.12(2).

a. The amount of the fee will be determined in an agreement with the department and will be dependent on the nature and scope of the project and the resources needed to obtain the data requested.

b. The state registrar will retain the full amount of all fees collected under this subrule in the vital records fund established pursuant to Iowa Code section 144.46A.

95.6(7) *Fee for researcher access to vital statistics data.* A fee shall be charged to each researcher who is provided access to vital statistics data in accordance with Iowa Code section 144.44 and the required agreement executed with the department. The amount of the fee will be based on the nature and scope of the research project and resources required to obtain the data requested.

a. The state registrar will allocate the fees for copies of birth, marriage, and death certificates provided to researchers pursuant to the distribution of fees set forth in subrule 95.6(5).

b. The state registrar will retain in the vital records fund established pursuant to Iowa Code section 144.46A the full amount of fees collected from researchers for searching files or records to create a data file.

95.6(8) *Service member who died while on active duty—waiver of fee.* The certified copy fee for a birth certificate or a death certificate of a service member, as defined in Iowa Code section 29A.90, who died while on active duty will be waived for a period of one year from the date of death. Application for the certified copy shall be made by an entitled family member as described in rule 641—95.8(144) of the deceased service member or the entitled family member’s legal representative. Documentation shall be submitted at the time of application to substantiate the date of death and active duty status.

95.6(9) *Retention of applications and reports.* An application for a certified copy of a vital record in Iowa will be retained by the county registrar for a minimum of six months from date of issuance of the certified copy. All financial reports for vital records fees will be retained by the county registrar for a minimum of three calendar years.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.7(144) General public access of vital records in the custody of the county registrar. A vital record may be in the custody of the county registrar if the event occurred in that county and the record is not excluded by statute or definition for purposes of confidentiality.

95.7(1) There will be public access and the right to inspect all vital records in the custody of the county registrar after the vital records are purged of confidential information pursuant to rule 641—95.11(144). The county registrar will allow the general public access to the electronic statewide vital records system to search as a public user as a right under Iowa Code chapter 22 for events that occurred in that county.

95.7(2) Information inspected and copied shall not be used to establish an official system for the registration of vital statistics except as authorized by Iowa Code chapter 144.

95.7(3) County registrars may issue uncertified copies of vital records held in the registrars' physical custody or accessible through the electronic statewide vital records system, except those records excluded by statute. Uncertified copies issued by the county registrar will be issued on plain white paper and clearly stamped "not for legal purposes." Security paper provided by the state registrar shall not be used to produce uncertified copies.

95.7(4) For records available in the electronic statewide vital records system, the state registrar will send to the county registrars a list of all records that have been modified. County registrars shall, as directed by the state registrar, remove all forms of any vital record in their physical custody from the county vital records system if the vital record appears on the list of modified records.

95.7(5) For records not available in the electronic statewide vital records system, the state registrar will send a copy of any modified vital record to the county of event and, if the record is a death record, to the county of residence.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.8(144) Direct tangible interest in and entitlement to a vital record. Certified copies of vital records may be issued by the state registrar or county registrar upon written application, payment of the required fee pursuant to paragraph 95.6(1) "a," and demonstration of a verifiable, direct tangible interest and entitlement.

95.8(1) The following persons shall be considered to have a direct tangible interest and entitlement and are authorized to obtain a certified copy of a vital record:

a. The registrant, if the registrant is of legal age, has reached the age of majority, or is an emancipated minor.

b. A member of the registrant's immediate legal family, including:

- (1) Current spouse or surviving spouse;
- (2) Children;
- (3) Mother or father if listed on the registrant's birth certificate;
- (4) Sibling, if sibling has reached the age of majority;
- (5) Maternal grandparents, or paternal grandparents if the father is listed on the birth certificate;

or

(6) Step-parent or step-child if:

1. Legal parent and step-parent are currently married at the time of application; or
2. Step-parent is the surviving spouse of the legal parent and not remarried.

c. The documented legal representative of the registrant or the registrant's immediate legal family, including:

- (1) An attorney;
- (2) A court-appointed guardian;
- (3) A foster parent;
- (4) A funeral director, for up to one year following the decedent's date of death; or
- (5) A legal executor.

d. Other persons who demonstrate a direct tangible interest and entitlement when it is shown that the certified copy is needed to determine or protect a personal or property interest and the interest is for the benefit of the registrant.

95.8(2) The following persons shall not be deemed to have direct tangible interest and entitlement or be authorized to secure vital records:

- a.* Biological parents of adopted persons in the absence of a court order from the court of competent jurisdiction;
- b.* Biological family members of adopted persons;
- c.* Adopted persons requesting biological family records; or
- d.* Commercial firms or agencies requesting lists of vital record events, or lists of names, or lists of addresses, or that are not legal representatives requesting records on behalf of entitled individuals.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.9(144) Search and issuance of a certified copy of a vital record. The search and issuance of a certified copy of a vital record shall be requested from the state registrar or county registrar.

95.9(1) Only entitled applicants as described in rule 641—95.8(144) may submit requests for certified copies of vital records.

95.9(2) A person requesting a search and issuance of a certified copy of a vital record shall provide in writing the following:

- a.* The name of the person or persons whose vital record is to be searched;
- b.* The purpose of such request;
- c.* The relationship to the registrant of the person making the request; and
- d.* The notarized signature and the address of the person making the request.

95.9(3) In addition to a completed written application, the applicant shall provide:

- a.* A current, legible government-issued photo identification of the applicant making the request or other identification documents acceptable to the state registrar; and
- b.* Payment of the required fee before the search is conducted.

95.9(4) The state registrar and county registrar will have the authority to mandate additional supporting documents to prove direct tangible interest and entitlement pursuant to rule 641—95.8(144).

95.9(5) If, after the search is conducted, no record is on file and the state registrar or county registrar issues a “notification of record search” on certified paper, the fee for the search will be retained pursuant to paragraph 95.6(1) “*a.*”

95.9(6) If a certified copy of a vital record is issued and sent to the applicant using a mail service and the applicant does not receive the certified copy, the state registrar or the county registrar may replace the certified copy without an additional fee using an Affidavit of Non-Receipt. The applicant must contact the issuing registrar within 90 days of the date of request. A minimum of 30 days must have elapsed from the time the certified copy was mailed. The applicant shall read the instructions, complete the Affidavit of Non-Receipt and have the applicant’s signature notarized. The original Affidavit of Non-Receipt and a photocopy of the applicant’s driver’s license must be reviewed by the issuing registrar before the certified copy can be replaced for no additional fee. The state registrar or county registrar may refuse any Affidavit of Non-Receipt when the state registrar or county registrar determines proof of receipt, fraud or misrepresentation. The state registrar will give to the registrant a notice in writing of the state registrar’s reason and intention to refuse the Affidavit of Non-Receipt.

95.9(7) If printed from the electronic statewide vital records system by a county registrar, the certified copy of a vital record will be stamped by the issuing county registrar to reflect the county in which the certified copy was issued.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.10(144) Search and issuance for genealogy or family history. The search and issuance of a vital record for genealogy may be requested from the state registrar or county registrar upon written application and payment of the required fee pursuant to paragraph 95.6(1) “*a.*”

95.10(1) The state registrar or county registrar may issue certified copies of a vital record for genealogy or family history to an applicant who can satisfactorily demonstrate a line of direct lineal consanguinity and to aunts, uncles, and cousins not past twice removed.

95.10(2) All certified copies issued for genealogy or family history will be clearly marked “for genealogical purposes only.”

95.10(3) No certified copy will be issued for genealogy or family history if the registrant is known to be living.

95.10(4) If, after the search is conducted, no record is on file, the state registrar or county registrar will issue a “notification of record search” on certified paper, and the fee for the search will be retained pursuant to paragraph 95.6(1) “a.”

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.11(144) Registrars’ responsibility for maintenance of confidentiality.

95.11(1) The state registrar and county registrar will maintain the confidentiality of the following material, records, and information:

a. Entries indicated as confidential or statistical in nature on the face of the record or otherwise confidential by law;

b. Any record that is ordered sealed by the state registrar or pursuant to a court order.

95.11(2) The county registrar will take all necessary steps to ensure that confidential information reflected on vital records has been redacted from general public access. If confidential information is included with accessible information, only accessible information will be made available to the general public for examination.

95.11(3) The county registrar will employ at a minimum all of the following methods to ensure confidentiality:

a. Permanently cover or remove, by appropriate means, confidential information;

b. Promptly process the notice to seal a record as directed by the state registrar; and

c. Seal and not reproduce confidential information when copies of vital records are made.

95.11(4) The county registrar may charge reasonable administrative costs to reflect the expenses for efforts needed to allow general public access, examination and the assurance of confidentiality of this material and information pursuant to the authority of Iowa Code chapter 22.

a. The administrative cost is to be paid by persons who request the services provided by the county registrar, including supervising, copying or providing a suitable place for such work.

b. The county registrar will retain all administrative costs collected to allow general public access, examination, and the assurance of confidentiality of the vital record and information pursuant to the authority of Iowa Code chapter 22.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.12(144) Disclosure of data.

95.12(1) The state registrar may disclose data from the system of vital statistics to federal, state, county or municipal agencies of government that request such data in the conduct of their official duties, subject to conditions the state registrar may impose to ensure that the use of the data is limited to official purposes.

a. The aforementioned agencies shall not provide the certified copy or a copy of the vital record, or release information contained therein, to the person named on the certificate, a member of the person’s legal family, or the person’s legal representative.

b. Certified copies issued to the aforementioned agencies will be appropriately stamped, for example, “administrative purposes only” or “for veteran affairs purposes only.”

95.12(2) Confidential verifications of the facts contained in vital records may be furnished by the state registrar to any federal, state, county or municipal government agency or other entity in the conduct of the agency’s or entity’s official duties, subject to conditions the state registrar may impose to ensure that the verification is limited to official purposes. Confidential verification of the facts contained in vital records may be furnished by a county registrar to another county office, within the

county jurisdiction, in the conduct of the county's official duties, subject to conditions the state and county registrar may impose to ensure that the verification is limited to official purposes.

a. Such confidential verifications will be on forms prescribed and furnished by the state registrar or on forms furnished by the requesting agency or entity and acceptable to the state registrar, or the state registrar may authorize the verification in other ways.

b. The aforementioned agencies and entities shall not provide the original or a copy of the verified certificate, or release information contained therein, to the person named on the certificate, a member of the person's legal family, or the person's legal representative.

95.12(3) The state registrar may permit the use of data from vital statistics for research purposes subject to conditions the state registrar may impose to ensure the use of the data is limited to such research purposes. No data will be furnished from vital statistics for research purposes until the state registrar has prepared in writing the conditions under which the data may be used and has received an agreement signed by a responsible agent of the research organization agreeing to meet and conform to such conditions.

95.12(4) The state registrar may transmit to the county registrar data needed to produce certified copies of vital records pursuant to rule 641—95.8(144).

95.12(5) The state registrar may transmit to the statewide immunization registry information from birth certificates for the sole purpose of identifying those children in need of immunizations. The state registrar may impose conditions to ensure that the use of the information is limited to official purposes.

95.12(6) The state medical examiner or the county medical examiner may request an uncertified copy of a death certificate before the death certificate is accepted and filed at the county registrar's office.

a. The copy will be clearly stamped "administrative purposes only."

b. The death certificate shall be for the sole use of the state medical examiner or county medical examiner and shall not be used as a legal document, be distributed, be copied or be maintained other than to be made a part of the investigatory file.

c. If the state medical examiner or any county medical examiner determines the death does not warrant further investigation, the state medical examiner or county medical examiner shall destroy the uncertified copy of the death certificate.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.13(144) Preparation of certified copies. Certified copies of vital records may be prepared and issued by the state registrar or the county registrar pursuant to rules 641—95.3(144) and 641—95.9(144).

95.13(1) Certified copies of vital records may be made by mechanical, electronic, or other reproductive processes, except for confidential information. Certified copies will be issued using security paper that is prescribed by the state registrar.

95.13(2) When a certified copy is issued, each certification will contain a statement certifying that the facts are the true facts recorded in the issuing office, the date issued, the name of the issuing office, the registrar's signature or an authorized copy thereof, and the seal of the issuing office.

95.13(3) No person shall prepare or issue any certificate that purports to be an original, certified copy, or copy of a certificate of birth, death, fetal death, or marriage.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.14(144) Access to original certificate of birth prior to adoption. Notwithstanding any provision of law to the contrary, an adopted person who was born in this state and whose original certificate of birth was substituted with a new certificate of birth pursuant to Iowa Code section 144.24 based upon the adoption, or an entitled person, may apply for and obtain a noncertified copy of the original certificate of birth of the adopted person who is the subject of the original certificate of birth in accordance with this rule, including with any mandatory redaction of personally identifiable information pursuant to Iowa Code section 144.24A(2).

95.14(1) Entitlement.

a. If an adopted person who is the subject of the original certificate of birth is submitting the application, the adopted person shall be at least 18 years of age at the time the application is filed.

b. If an entitled person is submitting the application, the adopted person who is the subject of the original certificate of birth must be deceased at the time the application is filed.

95.14(2) The adopted person or the entitled person requesting a noncertified copy of the original certificate of birth shall file a written application with the state registrar on a form and in the manner prescribed by the state registrar.

95.14(3) Upon receipt of the written application, proof of identification pursuant to paragraph 95.9(3)“*a*,” and payment of a fee pursuant to paragraph 95.6(1)“*b*,” the state registrar will issue a noncertified copy of the original certificate of birth to the applicant in accordance with this rule, including with any mandatory redaction of personally identifiable information pursuant to Iowa Code section 144.24A(2). At the time of such issuance, the state registrar will also provide to the applicant any contact preference form or medical history form completed and submitted to the state registrar including with any mandatory redaction of personally identifiable information pursuant to Iowa Code section 144.24A(2).

a. A biological parent may file a contact preference form prescribed by the state registrar in accordance with the provisions outlined in Iowa Code section 144.24A(2) and state the biological parent’s preference for contact by an adopted person or an entitled person following application for and issuance of the noncertified copy of the original certificate of birth under this rule. The contact preference form will be provided to the biological parent in accordance with Iowa Code section 600A.4. A contact preference form may be completed or updated by the biological parent at any time at the request of the biological parent.

b. A biological parent may file a medical history form prescribed by the state registrar in accordance with the provisions outlined in Iowa Code section 144.24A(3) and provide medical history of the biological parent and any blood relatives. The medical history form will be provided to the biological parent in accordance with Iowa Code section 600A.4. A medical history form may be completed or updated by the biological parent at any time at the request of the biological parent.

c. Upon receipt of a completed contact preference form or medical history form, the state registrar will attach any such completed form to the original certificate of birth.

d. For the purposes of this rule, “entitled person” means the spouse of the adopted person who is deceased or an adult related to the adopted person who is deceased within the second degree of consanguinity.

e. An application may be submitted under this rule by an adopted person or an entitled person to obtain a noncertified copy of an adopted person’s original certificate of birth in accordance with this rule, if the adopted person who is the subject of the original certificate of birth was born before January 1, 1971.

f. An application may be submitted under this rule by an adopted person or an entitled person to obtain a noncertified copy of an adopted person’s original certificate of birth in accordance with this rule, notwithstanding the date of birth of the adopted person who is the subject of the original certificate of birth prescribed under paragraph 95.14(3)“*b*.”

This rule is intended to implement Iowa Code sections 144.24A and 600A.4.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.15(144) Certificate of nonviable birth.

95.15(1) A health care provider who attends or diagnoses a nonviable birth or a hospital at which a nonviable birth occurs shall advise a patient who experiences a nonviable birth that the patient may request a certificate of nonviable birth as provided in this section and, upon request by the patient, shall provide a letter certifying the nonviable birth to the patient on the form prescribed by the state registrar.

95.15(2) The department will issue a certificate of nonviable birth to a patient within 60 days of receipt of a request and certification letter. The request shall be made on the form prescribed by the state registrar.

95.15(3) The certificate of nonviable birth will contain all of the following:

a. The date of the nonviable birth.

b. The name and sex of the baby, if known.

(1) If the name is not furnished by the patient, the department will complete the certificate with the name “baby boy” or “baby girl” and the last name of the patient.

(2) If the sex is unknown, the department will complete the certificate with the name “baby” and the last name of the patient.

c. The name of the patient and, if married, the patient’s spouse.

d. The statement: “This certificate is not proof of live birth.”

95.15(4) The fees collected will be remitted to the treasurer of state for deposit in the general fund of the state and the vital records fund in accordance with Iowa Code section 144.46A.

95.15(5) A certificate of nonviable birth shall not be filed or registered with the department. The department will not register the nonviable birth associated with a certificate issued under this section or use the nonviable birth in calculating live birth statistics.

95.15(6) A certificate of nonviable birth shall not be used to establish, bring, or support a civil cause of action seeking damages against any person for bodily injury, personal injury, or wrongful death for a nonviable birth.

95.15(7) This rule will only apply to, and a certificate of nonviable birth may be requested and issued for, nonviable births occurring on or after January 1, 2000.

This rule is intended to implement Iowa Code section 144.31B.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.16(144) Cancellation of fraudulent records.

95.16(1) When the state registrar determines that a certificate was registered through fraud or misrepresentation, the state registrar will give to the registrant a notice in writing of the state registrar’s intention to cancel the certificate.

95.16(2) The notice of cancellation will give the registrant an opportunity to appear and show cause why the certificate should not be canceled.

a. The notice may be served on the registrant, or, in the case of a minor or incompetent person, on the parent or guardian, by the forwarding of the notice by certified mail to the last-known address on file in the office of the state registrar.

b. The certificate shall not be available for certification unless the registrant, parent or guardian within 30 days after the date of mailing the notice shows cause satisfactory to the state registrar why the certificate should not be canceled.

95.16(3) Upon presentation to the state registrar of a court order stating a marriage certificate was registered through fraud or misrepresentation, the state registrar will remove the record from the vital statistics system. The state registrar will order the county registrar to remove any record related to the marriage.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.17(144) Unlawful acts.

95.17(1) *Serious misdemeanors.* Any person who reports information required under Iowa Code chapter 144 and who commits any of the following acts is guilty of a serious misdemeanor:

a. Willfully and knowingly makes any false statement in a report, record, or certificate required to be filed or in an application for an amendment or willfully and knowingly supplies false information intending that such information be used in the preparation or amendment of any such report, record, or certificate.

b. Without lawful authority and with the intent to deceive, makes, alters, amends, or mutilates any report, record, or certificate required to be filed or a certified copy of such report, record, or certificate.

c. Willfully and knowingly uses or attempts to use or furnish to another for use for any purpose of deception any certificate, record, or report or certified copy thereof.

d. Willfully and knowingly alters, amends, or mutilates any copy, certified copy, record or report.

e. Willfully, with the intent to deceive, uses or attempts to use any certificate of birth or certified copy of a record of birth knowing that such certificate or certified copy was issued based upon a record that is false in whole or in part or that relates to the birth of another person.

f. Willfully and knowingly furnishes a certificate of birth or certified copy of a record of birth with the intention that it be used by a person other than the person to whose birth the record relates.

g. Disinterring a body in violation of Iowa Code section 144.34.

h. Knowingly violates a provision of Iowa Code section 144.29A.

95.17(2) *Simple misdemeanors.* Any person committing any of the following acts is guilty of a simple misdemeanor:

a. Knowingly transports or accepts for transportation, interment, or other disposition a dead body without an accompanying permit as provided in Iowa Code sections 144.32, 144.33, and 144.34.

b. Refuses to provide information required by Iowa Code chapter 144.

c. Willfully violates any of the provisions of Iowa Code chapter 144 or refuses to perform any of the duties imposed upon the person.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

641—95.18(144) Enforcement assistance.

95.18(1) The department will report cases of alleged violations to the proper county attorney, with a statement of the facts and circumstances, for such action as is appropriate.

95.18(2) Upon request of the department, the attorney general will assist in the enforcement of the provisions of Iowa Code chapter 144.

[ARC 0142D, IAB 3/18/26, effective 7/1/26]

These rules are intended to implement Iowa Code chapter 144.

[Filed ARC 0483C (Notice ARC 0376C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]¹

[Filed ARC 1074C (Notice ARC 0926C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]²

[Filed ARC 1402C (Notice ARC 1294C, IAB 1/22/14), IAB 4/2/14, effective 5/7/14]

[Filed ARC 2275C (Notice ARC 2155C, IAB 9/30/15), IAB 12/9/15, effective 1/13/16]

[Filed ARC 2933C (Notice ARC 2821C, IAB 11/23/16), IAB 2/1/17, effective 3/8/17]³

[Filed ARC 4398C (Notice ARC 4127C, IAB 11/21/18), IAB 4/10/19, effective 5/15/19]

[Filed ARC 5199C (Notice ARC 5087C, IAB 7/15/20), IAB 10/7/20, effective 11/11/20]

[Filed ARC 6108C (Notice ARC 5926C, IAB 9/22/21), IAB 12/29/21, effective 2/2/22]

[Filed ARC 6849C (Notice ARC 6648C, IAB 11/16/22), IAB 2/8/23, effective 3/15/23]

[Filed ARC 8043C (Notice ARC 7507C, IAB 1/24/24), IAB 5/29/24, effective 7/3/24]

[Filed ARC 9617C (Notice ARC 9491C, IAB 8/20/25), IAB 10/15/25, effective 12/1/25]

[Filed ARC 0142D (Notice ARC 9948C, IAB 1/7/26), IAB 3/18/26, effective 7/1/26]

[Editorial change: IAC Supplement 6/10/26]

¹ January 16, 2013, effective date of the rescission of Chapter 95 and the adoption of new Chapter 95 [ARC 0483C] delayed until adjournment of the 2013 General Assembly by the Administrative Rules Review Committee at its meeting held January 8, 2013; delay lifted at the meeting held March 8, 2013.

² January 1, 2014, effective date of 95.6(2) [ARC 1074C, Item 2] delayed 70 days by the Administrative Rules Review Committee at its meeting held October 8, 2013.

- ³ March 8, 2017, effective date of 95.2, 95.7 and 95.10 [ARC 2933C] delayed 70 days by the Administrative Rules Review Committee at its meeting held February 10, 2017.

CHAPTER 97
DEATH REGISTRATION AND DISPOSITION OF DEAD HUMAN BODIES
[Prior to 12/12/12, see [641] 98.2, Chs 99, 101]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

641—97.1(144) Definitions. For the purpose of this chapter, the definitions in 641—Chapter 95 apply.
[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.2(144) Forms—property of department. All forms, certificates and reports pertaining to the registration of death events are the property of the department and will be surrendered to the state registrar upon demand.

97.2(1) The forms supplied or approved for reporting death events will be used for official purposes as provided for by law, rules and instructions of the state registrar.

97.2(2) No forms, except those furnished or approved by the state registrar, can be used in the reporting of death events or the making of copies of vital records.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.3(144) Standard registration of death—up to one year. Iowa death records submitted for registration within one year from the date of death will be prepared on the standard Certificate of Death form.

97.3(1) The county in which the death occurs or in which the dead human body is found is the county of death.

97.3(2) If the death occurs in a moving conveyance, the county in which the dead human body is first removed from the conveyance is the county of death.

97.3(3) Each person with a duty related to death certificates shall participate in the electronic death record system. A person with a duty related to a death certificate includes but is not limited to a physician as defined in Iowa Code section 135.1, a physician associate, an advanced registered nurse practitioner, a funeral director and a county recorder.

[ARC 0144D, IAB 3/18/26, effective 7/1/26; Editorial change: IAC Supplement 6/10/26]

641—97.4(144) Standard registration of fetal death—up to one year. Iowa fetal death records submitted for registration within one year from the date of fetal death shall be prepared on the standard Certificate of Fetal Death form. A fetal death certificate shall not be filed after one year from the date of the event. A fetal death record shall not be entered into the electronic death record system.

97.4(1) When a fetal death occurs in an institution, the person in charge of the institution or the person's designee, the physician in attendance at or after delivery, or a medical examiner may assist in preparation of the Certificate of Fetal Death form as directed by the state registrar.

97.4(2) In cases in which a fetus has reached the gestation period of 20 completed weeks or more or a weight of 350 grams or more, a Certificate of Fetal Death form shall be:

- a. Registered and maintained solely at the state registrar's office; and
- b. Filed within three days after delivery and prior to final disposition of the fetus.

97.4(3) The county in which the dead human fetus is found is the county of death. The certificate of fetal death shall be filed within three days after the fetus is found.

97.4(4) If the fetal death occurs in a moving conveyance, the county in which the fetus is first removed from the conveyance is the county of death.

97.4(5) A blank Certificate of Fetal Death form shall be used only by the state registrar or authorized agents.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.5(144) Preparation of the certificate of death or fetal death.

97.5(1) The funeral director or person other than the funeral director who first assumes custody of a dead human body or fetus for the purposes of disposition shall:

- a. Obtain the personal data from the next of kin or the best-qualified person or source available;
- b. Obtain the medical certification of cause of death from the medical certifier; and
- c. Within three days after the death and prior to final disposition of the dead human body, file the completed certificate of death using the electronic statewide vital records system or, within three days after delivery and prior to disposition of the fetus, file the completed certificate of fetal death with the state registrar.

97.5(2) The funeral director or person other than the funeral director who first assumes custody of the dead human body for the purposes of disposition shall prepare the certificate of death using the electronic statewide vital records system.

97.5(3) The funeral director or person other than the funeral director who first assumes custody of the dead fetus for the purposes of disposition shall prepare the certificate of fetal death on the official form and paper issued by the state registrar.

97.5(4) Unless otherwise directed by the state registrar, a certificate of fetal death will be accepted for filing and registration only when:

- a. All names are documented in the spaces provided;
- b. All items are completed as required;
- c. No alterations or erasures are apparent;
- d. All signatures are original and genuine and are in dark blue or black ink;
- e. The certificate presented for registration is on the approved form and official paper prescribed by the state registrar;
- f. Data are consistent with the facts of death; and
- g. The form is prepared in conformity with these rules or instructions issued by the state registrar.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.6(144) Medical certification of death. The funeral director shall submit the completed fact of death portion of the certificate of death to the physician, physician associate, advanced registered nurse practitioner, or medical examiner for the completion of the medical portion.

97.6(1) For a natural cause of death, the physician, physician associate or advanced registered nurse practitioner in charge of the patient's care for the illness or condition that resulted in death shall complete and sign the medical certification within 72 hours after receipt of the death certificate from the funeral director or individual who initially assumed custody of the body.

97.6(2) If there is a non-natural cause of death, the state medical examiner or county medical examiner shall be notified and shall conduct an investigation.

97.6(3) If the decedent was an infant or child and the cause of death is not known, a medical examiner shall conduct an investigation and an autopsy shall be performed as necessary to exclude a non-natural cause of death.

97.6(4) If upon investigation into a death, the state medical examiner or county medical examiner determines that a preexisting natural disease or condition was the likely cause of death and that the death does not affect the public interest as described in Iowa Code section 331.802(3), the state medical examiner or county medical examiner may elect to defer to the physician, physician associate or advanced registered nurse practitioner in charge of the patient's preexisting condition the certification of the cause of death.

97.6(5) When an investigation is required by the state medical examiner or county medical examiner, the state medical examiner or county medical examiner shall investigate the cause and manner of death and shall complete and sign the medical certification within 72 hours after determination of the cause and manner of death.

97.6(6) The medical certifier completing the medical certification of cause of death shall attest to the accuracy of the medical certification either by signature or by an electronic process approved by the state registrar.

[ARC 0144D, IAB 3/18/26, effective 7/1/26; Editorial change: IAC Supplement 6/10/26]

641—97.7(144) Medical certification of fetal death.

97.7(1) The medical certification for a fetal death shall be completed by the physician in attendance at or after delivery of the fetus within 72 hours after delivery, except when an investigation is required by a medical examiner.

97.7(2) When an investigation by a medical examiner is required, or when a fetal death occurs without medical attendance upon the mother at or after delivery, the medical examiner shall investigate the cause of fetal death and shall complete the medical certification of the fetal death within 72 hours after taking charge of the case.

97.7(3) The physician or medical examiner completing the medical certification of fetal death shall attest to the accuracy either by signature or by an electronic process approved by the state registrar.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.8(144) Medical certifier.

97.8(1) Only an Iowa-licensed physician, physician associate, advanced registered nurse practitioner, or medical examiner shall certify to the cause and manner of death.

97.8(2) If the medical certifier is unavailable, an alternate Iowa-licensed medical certifier may complete the cause and manner of death when:

- a.* The alternate medical certifier has access to the medical history of the case;
- b.* The alternate medical certifier views the deceased at the time of death or after death has occurred; and
- c.* The death is from natural causes.

97.8(3) In all other cases in which a medical certifier is unavailable, the medical examiner shall prepare the medical certification of cause of death.

97.8(4) The medical certifier who signs the medical certification on a certificate of death shall be entitled to view the death record through the electronic statewide vital records system for up to one year from the date of death.

[ARC 0144D, IAB 3/18/26, effective 7/1/26; Editorial change: IAC Supplement 6/10/26]

641—97.9(144) Report of autopsy findings.

97.9(1) In cases in which an autopsy is to be performed, it shall not be necessary to defer the entry of the cause of death pending a full report of microscopic or toxicological studies.

97.9(2) In any case in which the gross findings of an autopsy are inadequate to determine the cause of death, the medical certifier shall mark the cause of death as “pending investigation” on the certificate and sign the certificate. Immediately after the medical data necessary for determining the cause of death have been made known, the medical certifier shall provide to the state registrar a signed statement that identifies the decedent and the cause of death.

97.9(3) In any case in which the autopsy findings significantly change the medical diagnosis of cause of death, the medical certifier shall make a report of the cause of death and submit it to the state registrar as soon as the findings are available. Such report shall be a signed statement that identifies the decedent and the revised cause of death. Such report shall amend the original certificate, and the report shall be maintained in a sealed file.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.10(144) Extension of time. If the medical certifier is unable to complete the medical certification of cause of death or if the funeral director is unable to obtain the personal information about the deceased within the statutory time period, the funeral director shall file the certificate of death or fetal death with all available information.

97.10(1) Such certificate of death or fetal death shall be considered appropriate authority to issue a burial-transit permit.

97.10(2) As soon as possible, the person responsible for completing the information missing from the original certificate shall report the missing information to the state registrar.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.11(144) Removal of a dead human body or fetus.

97.11(1) A person assuming custody of a dead human body shall:

a. Contact the attending physician, physician associate, or advanced registered nurse practitioner and receive confirmation the death was from natural causes and that the physician, physician associate, or advanced registered nurse practitioner will assume responsibility for certifying the cause of death; or

b. Contact the medical examiner and receive authorization to remove the dead human body if the case is within the jurisdiction of the medical examiner.

97.11(2) A person assuming custody of a dead human fetus shall:

a. Contact the attending physician and receive confirmation the death was from natural causes and that the physician will assume responsibility for certifying to the cause of fetal death; or

b. Contact the medical examiner and receive authorization to remove the dead human fetus if the case is within the jurisdiction of the medical examiner.

97.11(3) A person other than a funeral director, medical examiner, or emergency medical service provider who assumes custody of a dead human body or fetus shall first contact the state registrar for instructions for registering the certificate of death or fetal death. After review and registration of the certificate of death or fetal death, the state registrar will issue a burial-transit permit pursuant to rule 641—97.12(144) prior to removal of the dead human body or fetus from the place of death.

[ARC 0144D, IAB 3/18/26, effective 7/1/26; Editorial change: IAC Supplement 6/10/26]

641—97.12(144) Burial-transit permit. If a person other than a funeral director, medical examiner, or emergency medical service assumes custody of a dead human body or fetus, the person is mandated to secure a burial-transit permit pursuant to rule 641—97.11(144) and Iowa Code section 144.32. Pursuant to Iowa Code chapter 144, an unlicensed employee of the funeral establishment shall be considered an agent of the funeral director.

97.12(1) The burial-transit permit will be issued upon a form prescribed by the state registrar and will state:

- a.* The name of the decedent;
- b.* The date and place of death;
- c.* If the death was from a communicable disease;
- d.* The name and location of the cemetery, crematory, or other location where final disposition of the remains is to be made;
- e.* The method of disposition;
- f.* That a certificate of death or fetal death has been filed; and
- g.* That permission is granted to inter, remove or otherwise dispose of the dead human body or fetus.

97.12(2) To be valid, a burial-transit permit will not be issued prior to the presentation of the completed and registered certificate of death or certificate of fetal death. The burial-transit permit must be issued by the county medical examiner, a funeral director, or the state registrar. The burial-transit permit shall be obtained prior to the removal of the dead human body or fetus from the place of death and shall accompany the body or fetus to the place of final disposition. The person responsible for obtaining the burial-transit permit shall provide the permit to the person in charge of the place of final disposition.

97.12(3) The person in charge of the place of final disposition shall ensure that all of the requirements of this chapter relative to the burial-transit permit have been complied with before the final disposition of the remains. Such person shall retain the burial-transit permit for a period of one year from the date of the final disposition.

97.12(4) A burial-transit permit will not be issued to a person other than a licensed funeral director if the death or fetal death was caused by a suspected or known “communicable disease” as defined by Iowa Code section 139A.2.

97.12(5) In cases in which a fetus has reached the gestation period of 20 completed weeks or more, or a weight of 350 grams or more, a burial-transit permit will be obtained prior to the final disposition of the fetus.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.13(144) Transportation and disposition of a dead human body or fetus.

97.13(1) A dead human body or fetus shall be transported only after enclosure in a container for transfer that will control odor and prevent leakage of body fluids unless the body or fetus has been embalmed or is being transported by a licensed funeral director, emergency medical service provider or medical examiner. The transport of a dead human body or fetus shall be in a manner that is respectful of the dead, the feelings of relatives, and the sensibilities of the community.

97.13(2) When a dead human body or fetus is transported from the state for final disposition, the burial-transit permit shall accompany the body or fetus. When a dead human body or fetus is brought into the state for final disposition, a burial-transit permit under the law of the state in which the death occurred shall accompany the body or fetus.

97.13(3) If the final disposition of a dead human body or fetus is cremation at a licensed cremation establishment, scattering of cremated remains shall be subject to the local ordinances of the political subdivision and any and all regulations of the cemetery, if applicable, in which the scattering site is located. However, such local ordinances and cemetery regulations shall not allow the scattering of cremated remains upon public property or upon private property without the property owner's consent. In the absence of an applicable local ordinance or cemetery regulation, the scattering of cremated remains shall not be allowed upon any public property or upon private property without the property owner's consent. Cremation shall be considered final disposition by the department, and no further burial-transit permit shall be needed.

97.13(4) If the final disposition of a dead human body or fetus is burial, interment, or entombment, local ordinances of the political subdivision in which the final disposition site is located and any and all regulations of the cemetery, if applicable, shall apply. In the absence of an applicable local ordinance, the depth of the grave at its shallowest point shall be at least three feet from the top of the burial container.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.14(144) Disinterment permits.

97.14(1) A disinterment permit may be issued as follows:

a. Disinterment of a dead human body or fetus, without a court order, shall be allowed for the purpose of autopsy or reburial only and then only if supervised by a funeral director.

b. Disinterment of cremated remains, without a court order, shall be allowed but only if supervised by a funeral director.

c. The state registrar, without a court order, will not issue a permit without the consent of the person authorized to control the decedent's remains under Iowa Code section 144C.5.

d. Disinterment of a dead body or fetus for the purpose of reburial may be allowed by court order only upon a showing of substantial benefit to the public and then only if supervised by a funeral director.

e. Disinterment of a dead body or fetus for the purpose of autopsy by court order shall be allowed only when reasonable cause is shown that someone is criminally or civilly responsible for such death, after hearing, upon reasonable notice prescribed by the court to the person authorized to control the decedent's remains under Iowa Code section 144C.5 and then only if supervised by a funeral director.

f. Disinterment of a dead body or fetus for the purpose of cremation may be allowed by court order if supervised by a funeral director. Subsequent to the disinterment, cremation of the body will only be allowed upon a determination by the state or county medical examiner that the death was due to natural causes.

97.14(2) A permit for disinterment will be issued by the state registrar according to rules adopted pursuant to Iowa Code chapter 17A or when ordered by the district court of the county in which such body is buried. A person authorized to control final disposition of a decedent's remains under Iowa Code section 144C.5 is an interested person and shall be entitled to notice prior to the obtaining of a court order.

97.14(3) Disinterment permits are mandated for any relocation above ground or below ground of remains from the original site of interment. Disinterment permits will be valid for 30 days after the date the permit is signed by the state registrar. Disinterment permits are issued on a form as prescribed by the state registrar with copies to be distributed as follows:

- a.* One copy filed with the sexton or person in charge of the cemetery in which disinterment is to be made;
- b.* One copy to be used during transportation of the remains;
- c.* One copy filed with the sexton or person in charge of the cemetery of reburial; and
- d.* One copy to be returned to the state registrar by the funeral director within ten days after the date of disinterment.

97.14(4) When removed from the vault for final burial, a dead human body or fetus, properly embalmed and placed in a receiving vault, shall not be considered a disinterment.

97.14(5) The following persons who are competent adults may acquire a disinterment permit without a court order pursuant to Iowa Code sections 144.34 and 144C.5 in the following descending order:

- a.* A designee, or alternate designee, acting pursuant to the decedent's declaration.
- b.* The surviving spouse of the decedent, if not legally separated from the decedent, whose whereabouts are reasonably ascertainable.
- c.* A surviving child of the decedent or, if there is more than one surviving child, a majority of the surviving children whose whereabouts are reasonably ascertainable.
- d.* The surviving parent or parents of the decedent whose whereabouts are reasonably ascertainable.
- e.* A surviving grandchild of the decedent or, if there is more than one surviving grandchild, a majority of the surviving grandchildren whose whereabouts are reasonably ascertainable.
- f.* A surviving sibling of the decedent or, if there is more than one surviving sibling, a majority of the surviving siblings whose whereabouts are reasonably ascertainable.
- g.* A surviving grandparent of the decedent or, if there is more than one surviving grandparent, a majority of the surviving grandparents whose whereabouts are reasonably ascertainable.
- h.* A person in the next degree of kinship to the decedent in the order named by law to inherit the estate of the decedent under the rules of inheritance for intestate succession or, if there is more than one such surviving person, a majority of such surviving persons whose whereabouts are reasonably ascertainable.
- i.* A person who knows the identity of the decedent and who signs an affidavit affirming the identity of the decedent and assuming the right to control final disposition of the decedent's remains and the responsibility to pay any expense associated with such final disposition. A person who affirms the identity of the decedent pursuant to this paragraph is liable for all damages that result, directly or indirectly, from that affirmation.
- j.* The county medical examiner, if responsible for the decedent's remains.

97.14(6) A funeral director may await a court order before proceeding with disinterment of a decedent's remains if the funeral director is aware of a dispute among:

- a.* Persons who are members of the same class of persons described in subrule 97.14(5); or
- b.* Persons who are authorized under subrule 97.14(5) and the executor named in the decedent's will or personal representative appointed by the court.

97.14(7) Due consideration under this rule shall be given to the public health, the preferences of a person authorized to control final disposition of a decedent's remains under Iowa Code section 144C.5, and any court order.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.15(144) Delayed death registration—one year or more after event. Iowa deaths registered one year or more after the date of death shall be prepared on a Delayed Certificate of Death form developed by the state registrar. The state registrar will require documentary evidence to prove the facts of the death pursuant to Iowa Code section 144.16. The delayed certificate of death will be registered and maintained solely at the state registrar's office.

97.15(1) Application. Registration of a delayed certificate of death may be requested by the surviving next of kin of the deceased, or the surviving next of kin's legal representative, in the following descending order:

- a. Executor of the decedent's estate;
- b. Spouse, if not legally separated from the decedent;
- c. Child or legal guardian of the child if the child is under the age of majority;
- d. Parent;
- e. Grandchild or legal guardian of the grandchild if the grandchild is under the age of majority;
- f. Sibling;
- g. Grandparent; or
- h. Funeral director responsible for the disposition of the decedent.

97.15(2) Facts to be established.

a. The applicant shall submit a notification of record search certified by the state registrar that will indicate that no prior certificate of death is on file for the person whose delayed death record is to be filed. The notification of record search will be returned to the applicant and will not be exchanged for a certified copy of the delayed certificate of death.

b. The applicant shall substantiate the following with documentary evidence:

- (1) The full legal name and sex of the deceased at the time of the death;
- (2) The date and place of birth;
- (3) The date and time of death;
- (4) The place of death, including the type of place and location where the death occurred;
- (5) The method and location of the final disposition;
- (6) The full name and address of the person responsible for the final disposition;
- (7) Cause and manner of death; and
- (8) The full name, address, and relationship to the decedent of the person applying to register the delayed certificate of death.

97.15(3) Documentary evidence.

a. The application to register the delayed certificate of death shall be supported by a minimum of the following:

- (1) An affidavit of the person filing the certificate attesting to the accuracy of the information on the certificate; and
- (2) Three dated documents from independent sources that consistently support the information necessary pursuant to subrule 97.15(2). The documents shall be in the form of the original record, a certified copy thereof, or a notarized statement from the custodian of the record or document on the custodian's letterhead. Personal affidavits are not acceptable.

b. The state registrar may require additional documentary evidence to prove the facts of the death event.

97.15(4) Abstraction and certification by the state registrar. The state registrar will abstract on the Delayed Certificate of Death form a description of each document submitted to support the facts of death. This description will include:

- a. The title or description of the document;
- b. The name and address of the custodian who attested to the facts on the original documents in the custodian's custody;
- c. The date of the original filing of the document being abstracted; and

d. The information regarding the death for delayed registration.

97.15(5) *Acceptance of documentary evidence for registration.* All documents submitted in support of the delayed registration will be returned to the applicant after review, abstraction, and registration. The state registrar will by signature certify that:

- a. No prior certificate of death is on file for the decedent;
- b. The evidence has been reviewed and substantiates the facts of death; and
- c. The abstract of the evidence appearing on the delayed certificate of death accurately reflects the nature and content of the documents.

97.15(6) *Denial of registration.* In the absence of adequate substantiating evidence or if the state registrar finds reason to question the validity or adequacy of the evidence necessary to establish a delayed certificate of death, the state registrar will not register the delayed record.

- a. The written notice of rejection from the state registrar will include:
 - (1) The Delayed Certificate of Death form stamped “rejected”; and
 - (2) The Delayed Evidence Refusal form.
- b. Applications for a delayed certificate of death that have not been completed within one year from the date of application may be dismissed at the discretion of the state registrar. Upon dismissal, the state registrar will advise the applicant, and all documents submitted in support of such registration will be returned to the applicant.

97.15(7) *Duties of county registrar.* The county registrar may assist the applicant in the completion and notarization of the Delayed Certificate of Death form, excluding the portion restricted for state use only. The county registrar may forward the partially completed Delayed Certificate of Death form, documents and fees to the state registrar for final review and possible acceptance.

97.15(8) *Fees.* Administrative and certified copy fees will be charged as provided in rule 641—95.6(144).

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.16(144) Registration of presumptive death.

97.16(1) A petition shall be filed with the district court in the county where the presumptive death occurred and shall be supported with the completed Affidavit of Personal Knowledge of a Missing Person form. The form shall be completed by the surviving next of kin of the deceased, or the surviving next of kin’s legal representative, in the following descending order:

- a. Spouse, if not legally separated from the decedent;
- b. Child or the child’s legal guardian if the child is under the age of majority;
- c. Parent;
- d. Grandchild or the grandchild’s legal guardian if the grandchild is under the age of majority;
- e. Sibling;
- f. Grandparent;
- g. Aunt or uncle;
- h. Niece or nephew; or
- i. A person in the next degree of kinship to the decedent in the order named by law to inherit the estate of the decedent pursuant to Iowa Code sections 633.210 through 633.226.

97.16(2) In addition to the Affidavit of Personal Knowledge of a Missing Person form or in the absence of the next of kin, the petition may be supported by the following:

- a. Affidavit by Employer for an Employee Who Was Working at Time of Disappearance form;
- b. Affidavit by Government Official for a Government Employee Missing While Involved in Rescue Efforts form; or
- c. Affidavit by Reliable Informant of Missing Person form.

97.16(3) The state registrar will provide the affidavit forms and the certificate of presumptive death. The affidavits and the certificate of presumptive death will be registered and maintained solely at the state registrar’s office.

97.16(4) Upon presentation of a certified copy of a court order, the state registrar will file a certificate of presumptive death pursuant to Iowa Code sections 633.517 through 633.520. The order from the district court shall only establish the presumptive death record.

97.16(5) In cases under the jurisdiction of the medical examiner, the certified copy of the court order and the completed supporting affidavits listed in subrules 97.16(1) and 97.16(2) shall be delivered to the medical examiner. The medical examiner will complete the certificate of presumptive death and certify to the cause of death.

97.16(6) The certificate of presumptive death will be registered and maintained solely at the state registrar's office.

97.16(7) The certificate of presumptive death will be recorded based on the date of the court order and shall not be registered as a delayed certificate of death.

97.16(8) If the missing person is located and found to be alive, the certificate of presumptive death will be voided and removed from the vital records system of registration. Any issued certified copies shall be surrendered to the state registrar.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.17(144) Release or final disposition of a dead human body or fetus by an institution.

97.17(1) When a dead human body or fetus is released by an institution, the person in charge of the institution shall maintain a record showing:

- a. Name of the deceased;
- b. Date, time, and place of death;
- c. Name, title, and license number of person who pronounced death;
- d. Name and address of the medical certifier;
- e. Name and address of the person to whom the dead human body or fetus is released; and
- f. Date of removal of the dead human body or fetus from the institution.

97.17(2) When a dead human body or fetus is released or final disposition is completed by an institution, the person in charge of the institution shall keep a record showing the date, place, and manner of release or final disposition.

97.17(3) At the direction of the state registrar, the institution shall provide the information listed in subrule 97.17(1) to the funeral director or person acting as such who assumes custody of the dead human body for purposes of final disposition.

97.17(4) Records maintained under this rule will be retained for a period of not less than ten years and will be made available for inspection by the state registrar upon demand.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

641—97.18(144) Additional record by funeral director.

97.18(1) In addition to filing any certificate or other form required by Iowa Code chapter 144, a funeral director or other person who removes from the place of death or transports or completes final disposition of a dead human body or fetus shall maintain a record that shall identify the following:

- a. Name of the deceased;
- b. Date, time, and place of death;
- c. Name and address of the person to whom the dead human body or fetus is released;
- d. Name of institution or other place of death releasing the dead human body or fetus;
- e. Date of removal from the place of death; and
- f. Place and method of final disposition of the dead human body or fetus.

97.18(2) Records maintained under this rule shall be retained for a period of not less than ten years at the funeral establishment responsible for disposition and shall be made available for inspection by the state registrar upon demand.

[ARC 0144D, IAB 3/18/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 135.11(7), 144.12, 144.16 through 144.18, 144.26 through 144.29, 144.30 through 144.35, 144.47, 144.49 through 144.51, 144C.5, 331.802(3) and 633.517 through 633.520.

[Filed ARC 0483C (Notice ARC 0376C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]¹
[Filed ARC 2276C (Notice ARC 2156C, IAB 9/30/15), IAB 12/9/15, effective 1/13/16]
[Filed ARC 5199C (Notice ARC 5087C, IAB 7/15/20), IAB 10/7/20, effective 11/11/20]
[Filed ARC 9617C (Notice ARC 9491C, IAB 8/20/25), IAB 10/15/25, effective 12/1/25]
[Filed ARC 0144D (Notice ARC 9946C, IAB 1/7/26), IAB 3/18/26, effective 7/1/26]
[Editorial change: IAC Supplement 6/10/26]

¹ January 16, 2013, effective date of Chapter 97 [ARC 0483C] delayed until the adjournment of the 2013 General Assembly by the Administrative Rules Review Committee at its meeting held January 8, 2013; delay lifted at the meeting held March 8, 2013.

CHAPTER 99
VITAL RECORDS MODIFICATIONS
[Prior to 12/12/12, see [641] Chs 100, 102]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/31

641—99.1(144) Definitions. For the purpose of this chapter, the definitions in 641—Chapter 95 apply.
[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.2(144) Forms—property of department. All forms, certificates and reports pertaining to the registration of vital events are the property of the department and shall be surrendered to the state registrar upon demand.

99.2(1) The forms supplied or approved for reporting vital events will be used for official purposes as provided for by law, rules and instructions of the state registrar.

99.2(2) No forms, except those furnished or approved by the state registrar, can be used in the reporting or modification of vital events or the making of copies of vital records.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.3(144) Forms used in the establishment of new records. The standard certificate form for reporting of live birth, death, fetal death, or marriage in use at the time of the event will be used to prepare a new certificate.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.4(144) Corrections of minor errors in vital record—within one year of event.

99.4(1) Corrections of minor errors may be made by the state registrar within one year and prior to the first anniversary of the date of the event upon observation, upon request of the data provider, upon query, or upon request from an entitled person. Minor errors include obvious errors, omissions, or transpositions of letters in words of common knowledge.

99.4(2) For a certificate of live birth, entitled persons include in the following descending order of priority:

- a. Either parent as shown on the child's certificate of live birth; or
- b. The legal guardian or agency having legal custody of the child.

99.4(3) For a certificate of death or fetal death other than the medical certification, entitled persons include in the following descending order of priority:

- a. The surviving spouse as shown on the certificate of death;
- b. A parent as shown on the certificate of death or fetal death;
- c. The informant as shown on the certificate; or
- d. The data provider in the case of a data entry error.

99.4(4) For a certificate of marriage, entitled persons include:

- a. The county registrar that issued the license to marry; or
- b. Either of the parties married.

99.4(5) Entitled persons requesting a correction shall submit to the state registrar:

a. A notarized statement and a legible copy of current government-issued photo identification or other identification documents acceptable to the state registrar; and

b. Supporting evidence if requested by the state registrar.

(1) The state registrar will determine a priority of best evidence and may, at the state registrar's discretion, require additional documentary evidence to support the requested correction.

(2) The state registrar will evaluate the evidence submitted in support of any correction, and when there is reason to question the validity or adequacy of the evidence, the state registrar may reject the request for correction and will advise the applicant of the reasons for this action.

99.4(6) Only the state registrar will make corrections on a vital record. The source of information and the date of correction will be documented on the record but will not appear on the certified copy.

99.4(7) There are no administrative fees required to correct a certificate pursuant to this rule.

99.4(8) Certificates corrected pursuant to this rule will not be marked “amended.”

99.4(9) Any certified copies of the incorrect certificate shall be surrendered to the state registrar for replacement at no cost pursuant to 641—subrule 95.6(3). Additional certified copies of the corrected certificate may be obtained upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to 641—paragraph 95.6(1) “a.”

99.4(10) The corrected certificate will be on file at the county registrar’s office pursuant to rule 641—95.7(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.5(144) Amendment of certificate of live birth to add first or middle given name—within one year of event.

99.5(1) The first or middle given name for a child whose birth was reported without a first or middle given name may be amended to add the first or middle given name within one year and prior to the first anniversary of the date of the live birth based upon a completed and notarized Affidavit to Add Child’s Given Name form as provided by the department pursuant to Iowa Code section 144.38. The affidavit shall be submitted to the state registrar by entitled persons in the following descending order of priority:

- a. The single parent or both parents as shown on the child’s certificate of live birth;
- b. The mother, in the case of the death or incapacity of the second parent;
- c. The second parent if listed on the birth certificate, in the case of the death or incapacity of the mother; or
- d. The legal guardian or agency having legal custody of the child.

99.5(2) A first or middle given name may be added to the certificate of live birth once in this manner. Thereafter, a first or middle given name shall be changed only upon submission of a court order for a legal change of name from a court of competent jurisdiction pursuant to Iowa Code chapter 674.

99.5(3) An administrative fee shall be charged and remitted pursuant to 641—paragraph 95.6(1) “b.”

99.5(4) The original certificate will be marked “amended” and will be endorsed on the certified copy. The date of amendment and a summary description of the evidence submitted in support of the amendment will be made a part of the record.

99.5(5) The certificate will be on file at the county registrar’s office pursuant to rule 641—95.7(144).

99.5(6) Any certified copies of the incorrect certificate shall be surrendered for replacement at no cost. Additional certified copies of the amended certificate may be obtained upon the state registrar’s receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar, and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.6(144) Amendment of vital record—one year or more after the event.

99.6(1) Amendments of vital records may be made by the state registrar one year or more after the date of the event upon request from an entitled person or by an order to amend the record by a court of competent jurisdiction. Amendments include the correction of obvious errors, omissions, or transposition of letters in words of common knowledge.

99.6(2) For a certificate of live birth, entitled persons include in the following descending order of priority:

a. The registrant, if the registrant is of legal age, has reached the age of majority or is an emancipated minor;

b. Either parent as shown on the child's certificate of live birth; or

c. The legal guardian or agency having legal custody of the child.

99.6(3) For a certificate of death or fetal death other than the medical certification, entitled persons include:

a. The surviving spouse as shown on the certificate of death;

b. A parent as shown on the certificate of death or fetal death; or

c. The informant as shown on the certificate of death or fetal death.

99.6(4) Amendment of a medical certification of cause of death or fetal death shall be requested solely by the medical certifier listed on the certificate of death or fetal death.

99.6(5) For a certificate of marriage, entitled persons include either of the parties married.

99.6(6) Entitled persons requesting an amendment shall submit the following to the state registrar:

a. A completed and notarized amendment request on the applicable form as follows:

(1) Amendment to Certificate of Live Birth form.

(2) Amendment to Certificate of Death or Fetal Death form.

(3) Amendment to Certificate of Marriage form;

b. A legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar;

c. Certified copies of one or more pieces of documentary evidence supporting the amendment; and

d. The required fees pursuant to rule 641—95.6(144).

99.6(7) The documentary evidence shall have been established at least five years prior to the date of the application or within seven years of the date of the event.

a. The state registrar will determine a priority of best evidence and may, at the state registrar's discretion, require additional documentary evidence to support the requested amendment.

b. The state registrar will evaluate the evidence submitted in support of any amendment, and when there is reason to question the validity or adequacy of the evidence, the state registrar may reject the amendment and will advise the applicant of the reasons for this action and provide information related to the applicant's right of appeal to the district court pursuant to Iowa Code section 144.38.

c. If a request to amend a certificate of birth is rejected under the provisions of Iowa Code section 144.38, a petition may be filed with the district court for an order amending a vital record. The petition shall:

(1) Be made on a form prescribed and furnished by the state registrar.

(2) Allege that diligent efforts by the petitioner have failed to obtain the evidence required in accordance with Iowa Code section 144.38.

(3) Allege the state registrar has refused to amend the certificate of vital record.

(4) Include such other allegations as may be required.

(5) Be accompanied by a statement of the registration official made in accordance with Iowa Code section 144.38 and all documentary evidence that was submitted to the registration official in support of such registration.

(6) Be verified by the petitioner.

99.6(8) An administrative fee will be charged and remitted pursuant to rule 641—95.6(144).

99.6(9) The original certificate will be clearly marked "amended," and the date of the amendment will be endorsed on the certified copy. A summary description of the evidence submitted in support of the amendment will be made a part of the record.

99.6(10) The amended certificate will be on file at the county registrar's office pursuant to rule 641—95.7(144).

99.6(11) Any certified copies of the incorrect certificate shall be surrendered for replacement at no cost. Additional certified copies of the amended certificate may be obtained upon the state

registrar's receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.7(144) Method of amendment of vital records.

99.7(1) Records not on the electronic vital records system will be amended by drawing a single line through the incorrect item and inserting the correct or missing data immediately above or to the side of the item or by completing a blank item. In all cases in which a line must be drawn through an original entry, the line must not obliterate the original entry. The following will be endorsed on or made a part of the record:

- a. The word “amended” and the date of the amendment action; and
- b. A summary of the evidence submitted in support of the amendment.

99.7(2) Records on the electronic vital records system will be amended by correction of the incorrect item. The following will be endorsed on or made a part of the record:

- a. The word “amended” and the date of the amendment action;
- b. A statement identifying the amendment; and
- c. A summary of the evidence submitted in support of the amendment.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.8(144) Correction or amendment of same item more than once. After a correction or an amendment is made on a vital record, that entry will not be corrected again unless:

99.8(1) It can be proven that an error was made in processing the first correction or amendment; or

99.8(2) A court order is received from a court of competent jurisdiction to correct or amend the item. If a court order for a correction or an amendment is received, an administrative fee will be charged and remitted pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.9(144) Other amendments to certificate of live birth.

99.9(1) The parent's name or both parents' names as reported by the parent or parents on the birth worksheet used to establish the certificate of live birth shall only be amended if the amendment is supported by a certified copy of a vital record or amended by an order from a court of competent jurisdiction.

99.9(2) Certificates of live birth of deceased persons shall only be amended if the amendment is supported by a certified copy of a vital record or amended by an order from a court of competent jurisdiction.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.10(144) Correction or substitution of medical certification of cause of death.

99.10(1) Corrections or substitutions of the medical certification of cause of death shall be requested solely by the medical certifier listed on the certificate of death or fetal death.

a. In the event the medical certifier listed on the certificate of death or fetal death is no longer licensed to practice in the state of Iowa, an authorized medical certifier may request correction or substitution of the medical certification of cause of death.

b. For the purposes of this rule, “authorized medical certifier” means an Iowa-licensed physician, physician associate, advanced registered nurse practitioner, or medical examiner who has knowledge of and access to the medical records associated with the decedent's care at the time of death.

99.10(2) The medical certifier may correct the medical certification of cause of death within 12 months of the date of death or fetal death. The request shall be submitted to the state registrar

with supporting evidence on official letterhead signed and dated by the medical certifier listed on the certificate of death or fetal death or by an authorized medical certifier.

99.10(3) A correction to the medical certification of the cause of death and substitution of a death certificate requested solely by the medical certifier or by an authorized medical certifier after 12 months from the date of death or fetal death shall be made by order of a court of competent jurisdiction and considered an amendment. However, the medical certification of cause of death may be amended at any time upon submission of a report of autopsy or toxicological findings or additional findings by the county or state medical examiner.

99.10(4) No fee will be charged for correction, substitution or amendment made pursuant to this rule.

[ARC 0146D, IAB 3/18/26, effective 7/1/26; Editorial change: IAC Supplement 6/10/26]

641—99.11(144) Correction or amendment to a certificate of marriage.

99.11(1) The request to correct a certificate of marriage during the first year may be made by the county registrar who issued the license to marry. The written request shall be submitted to the state registrar with supporting evidence.

99.11(2) The request to correct or amend a certificate of marriage may be made by either of the parties married. The written request shall be submitted to the state registrar with supporting evidence.

99.11(3) An order from a court of competent jurisdiction is required to correct or amend a legal name after marriage.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.12(144) Correction to a report of dissolution of marriage or annulment.

99.12(1) A written notice to correct a report of dissolution of marriage or annulment may be submitted to the state registrar by the clerk of district court maintaining the record from which the original report was prepared. The notice shall state in what manner the report shall be corrected.

99.12(2) Those items appearing on the Report of Dissolution of Marriage or Annulment form that are not a part of the divorce decree may be corrected either by query or upon application of either party to the dissolution of marriage or annulment or the legal representative.

99.12(3) Corrections to the report of dissolution of marriage or annulment will be accepted only within the first year from the date of dissolution of marriage or annulment.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.13(144) Minimum information required to establish a new certificate of live birth.

99.13(1) A request to establish a new certificate of live birth shall be submitted to the state registrar and include, at a minimum, the following information:

- a. The full name of the child as stated on the original certificate of live birth;
- b. The full name of the child to be listed on the new certificate of live birth;
- c. The date and place of birth as stated on the original certificate of live birth;
- d. The full name of the parent or parents as listed on the original certificate of live birth; and
- e. The full name, place of birth, date of birth, and complete residential address of the parent or parents to be listed on the new certificate of live birth.

99.13(2) The new certificate of live birth will contain the same state file number and registration file date as were assigned to the original certificate of live birth.

99.13(3) The clerk of the court shall, within 30 days of issuance, deliver one certified copy of any adoption decree, any contact preference form or medical history form associated with the certified copy of any adoption decree for the purposes of Iowa Code section 144.24A, and the fee pursuant to rule 641—95.6(144) to the state registrar of vital statistics to prepare a certificate of birth as prescribed in Iowa Code section 144.19.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.14(144) Establishment of new certificate of live birth following adoption.

99.14(1) Upon receipt of a completed Certificate of Adoption Report form or a certified copy of the decree of adoption from a court of competent jurisdiction and the information required pursuant to rule 641—99.13(144), the state registrar will establish a new certificate of live birth for a person who was born in Iowa and has been adopted.

99.14(2) The new certificate of live birth will not be marked “amended.”

99.14(3) When a new certificate of live birth is established, the actual date and place of birth will be shown on the certificate.

99.14(4) The county registrar and state registrar will seal the original certificate of live birth. The state registrar will place the original certificate of live birth and all related adoption information in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24 or as provided in Iowa Code section 144.24A.

99.14(5) In accordance with Iowa Code section 144.23A, an adopted person may apply to the state registrar to have the adopted person’s original certificate of birth prior to adoption reestablished to include the name of an omitted biological parent.

99.14(6) The new certificate of live birth after adoption shall not be on file at the county registrar’s office.

99.14(7) The state registrar will reveal the date of the adoption and the name and address of the court that issued the adoption decree upon the receipt of a completed, notarized Revelation of County of Adoption form from an adult adopted person, a biological parent, an adoptive parent, or the legal representative of the adult adopted person, the biological parent, or the adoptive parent pursuant to Iowa Code section 144.24.

99.14(8) Administrative and certified copy fees will be charged and remitted pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.15(144) Establishment of new certificate of live birth following a birth by gestational surrogate arrangement.

99.15(1) All live births shall be considered the product of the woman who delivered the live infant and shall be filed in the standard manner, with that woman named as the birth mother on the original record submitted for registration.

99.15(2) For the purpose of filing for registration the record of a live birth by a gestational surrogate, the institution’s or non-institution’s person responsible for filing the certificate of live birth shall:

a. Notify the state registrar of the birth of a child pursuant to a gestational surrogate arrangement;

b. Follow directives for completion of the official birth worksheet;

c. Submit the birth record for registration based on the birth mother’s information; and

d. Notify the state registrar when the birth record has been submitted for registration.

99.15(3) In addition, the institution’s or non-institution’s person responsible for filing the record for registration shall:

a. Provide the prenatal and medical data on the medical portion of the birth worksheet pertinent to the pregnancy and the birth mother’s prenatal care;

b. Waive all birth registration and copy fees as collected on behalf of the state registrar;

c. Indicate on the registration that the birth mother does not have custody of the infant;

d. Assist in advising the intended parents of the procedures required to file the original birth record for registration and to reestablish the record to reflect the intended parents’ information; and

e. Advise the birth mother to complete the mother’s portion of the birth worksheet and to mark “no” for the social security card for the child.

99.15(4) Two intended parents—both intended parents are biological parents to the child. If the intended mother is the egg donor and the intended father is the sperm donor to the child being carried by the gestational surrogate:

a. After the birth of the child, the intended parents shall petition a court of competent jurisdiction to establish legal paternity and maternity of the child.

b. The court shall enter an order requiring the state registrar to reestablish the certificate of live birth naming the intended mother and father as the legal mother and father and requiring the state registrar to seal the original birth certificate and all related documentation.

c. The court order shall:

- (1) Identify the child's full name as stated on the original certificate of live birth;
- (2) State the child's date of birth and place of birth;
- (3) Identify the full names of the birth mother and her legal spouse, if married;
- (4) Disestablish the birth mother and her legal spouse, if married, as the legal parents of the child; and
- (5) Identify the intended parents' full names prior to any marriage, full current legal names, dates of birth, birthplaces, social security numbers, and full current residential address, including county.

d. The intended parents or their legal representative shall:

- (1) Submit a certified copy of the court order to the state registrar;
- (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and
- (3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

99.15(5) Two intended parents—intended mother is biological mother to the child; her legal spouse is not a biological parent. If the intended mother is the egg donor but her legal spouse is not the sperm donor, the intended mother shall petition a court of competent jurisdiction after the birth of the child to establish legal maternity.

a. The court shall enter an order requiring the state registrar to reestablish the certificate of live birth naming the intended mother as the legal mother and shall require the state registrar to seal the original certificate of live birth and all related documents.

b. The court order establishing legal maternity shall:

- (1) Identify the child's full name as stated on the original certificate of live birth;
- (2) State the child's date of birth and place of birth;
- (3) Identify the full names of the birth mother and her legal spouse, if married;
- (4) Disestablish the birth mother and her legal spouse, if married, as the legal parents of the child; and
- (5) Identify the intended mother's full name prior to any marriage, full current name, date of birth, birthplace, social security number, and full current residential address, including county.

c. The intended mother or her legal representative shall:

- (1) Submit a certified copy of the court order to the state registrar;
- (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and
- (3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

99.15(6) Two intended parents—intended father is biological father to the child; his legal spouse is not a biological parent.

a. If the surrogate birth mother is unmarried and the intended father is the sperm donor, the unmarried surrogate birth mother and the intended father may complete a Voluntary Paternity Affidavit form after the child's birth to place the intended father's name and information on the certificate of live birth.

b. If the surrogate birth mother is married and the intended father is the sperm donor, the married surrogate birth mother and the intended father shall by court order disestablish the surrogate birth mother's legal spouse as the legal parent and may complete a Voluntary Paternity Affidavit form pursuant to Iowa Code section 144.13.

c. The court order that disestablishes the married surrogate birth mother's legal spouse and the completed Voluntary Paternity Affidavit form shall be submitted to the state registrar.

d. If a certified copy of the certificate of live birth is requested, a notarized written request shall also be submitted to the state registrar with the certified copy fee and mailing instructions.

e. There is no administrative fee to process the completed Voluntary Paternity Affidavit form.

f. Adoption laws shall be followed to reestablish the certificate of live birth by establishing the nonbiological parent on the certificate of live birth pursuant to Iowa Code chapter 600.

99.15(7) Two intended parents—neither biological parent to the child. If the intended parents are neither the egg donor nor sperm donor, adoption laws shall be followed to reestablish the certificate of live birth by disestablishing the birth mother and her legal spouse, if any, and establishing the nonbiological parents on the certificate of live birth pursuant to Iowa Code chapter 600.

99.15(8) One female intended parent—biological mother to the child. If the intended mother is the egg donor to the child being carried by the gestational surrogate:

a. After the birth of the child, the intended mother shall petition a court of competent jurisdiction to establish legal maternity of the child.

b. The court shall enter an order requiring the state registrar to reestablish the certificate of live birth naming the intended mother as the legal mother and requiring the state registrar to seal the original certificate of live birth and all related documentation.

c. The court order shall:

(1) Identify the child's full name as stated on the original certificate of live birth;

(2) State the child's date of birth and place of birth;

(3) Identify the full names of the birth mother and her legal spouse, if married;

(4) Disestablish the birth mother and her legal spouse, if married, as the legal parents of the child; and

(5) Identify the intended parent's full name prior to any marriage, full current legal name, date of birth, birthplace, social security number, and full current residential address, including county.

d. The intended parent or her legal representative shall:

(1) Submit a certified copy of the court order to the state registrar;

(2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and

(3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

99.15(9) One male intended parent—biological father to the child.

a. If the surrogate birth mother is unmarried and the intended father is the sperm donor, the unmarried surrogate birth mother and the intended father may complete a Voluntary Paternity Affidavit form after the child's birth to place the intended father's name and information on the certificate of live birth.

b. If the surrogate birth mother is married and the intended father is the sperm donor, the married surrogate birth mother and the intended father shall by court order disestablish the surrogate birth mother's legal spouse as the legal parent and may complete a Voluntary Paternity Affidavit form pursuant to Iowa Code section 144.13.

c. The court order that disestablishes the married surrogate birth mother's legal spouse and the completed Voluntary Paternity Affidavit form shall be submitted to the state registrar.

d. If a certified copy of the certificate of live birth is requested, a notarized written request shall also be submitted to the state registrar with the certified copy fee and mailing instructions.

e. There is no administrative fee to process the completed Voluntary Paternity Affidavit form.

f. If the intended father has been established as the legal father pursuant to paragraph 99.15(9)“a” or “b” and the surrogate birth mother and the intended father wish to remove the surrogate birth mother as the legal mother from the certificate of live birth, the parties shall seek a court order. The court order disestablishing legal maternity shall:

(1) Identify the child's full name as stated on the original certificate of live birth;

(2) State the child's date of birth and place of birth;

- (3) Identify the full name of the birth mother; and
 - (4) Disestablish the birth mother as the legal parent of the child.
- g. The intended parent or his legal representative shall:
- (1) Submit a certified copy of the court order to the state registrar;
 - (2) Remit administrative and certified copy fees pursuant to rule 641—95.6(144); and
 - (3) Include a notarized written request with mailing instructions for the certified copy of the certificate of live birth.

99.15(10) One intended parent—not biological parent to the child. If the intended parent is neither the egg donor nor sperm donor, adoption laws shall be followed to reestablish the certificate of live birth by disestablishing the birth mother and her legal spouse, if any, and establishing the nonbiological parent on the certificate of live birth pursuant to Iowa Code chapter 600.

99.15(11) The state registrar will seal the original certificate of live birth. The state registrar will place the original certificate of live birth and all related documents in a sealed file, and the file shall not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

99.15(12) The new certificate of live birth will not be marked “amended.”

99.15(13) The new certificate of live birth will not be on file at the county registrar’s office pursuant to rule 641—95.7(144).

99.15(14) A certified copy fee and an administrative fee to replace a parent’s information on a certificate of live birth will be charged and remitted pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.16(144) Certificate of live birth following voluntary paternity affidavit.

99.16(1) If the birth mother was legally married at the time of conception or birth or at any time during the period between conception and birth, the name of her spouse shall be entered on the certificate of live birth as a parent pursuant to Iowa Code section 144.13.

99.16(2) If the birth mother was not legally married at the time of conception or birth or at any time during the period between conception and birth, the birth mother and the alleged biological father may:

- a. Complete a Voluntary Paternity Affidavit form after the birth of the child; and
- b. Submit the completed form to the state registrar.

99.16(3) If the birth mother was legally married at the time of conception or birth or at any time during the period between conception and birth, and her legal spouse is not the biological father, the birth mother and the alleged biological father may:

- a. Complete a Voluntary Paternity Affidavit form after the birth of the child;
- b. Obtain a court order that disestablishes her legal spouse as a parent; and
- c. Submit the completed form and a certified copy of the court order to the state registrar.

99.16(4) If the birth mother and the biological father of an Iowa-born child subsequently marry each other after a voluntary affidavit of paternity has been processed, the parents may submit a second completed Voluntary Paternity Affidavit form with a certified copy of the parents’ certificate of marriage to establish a new certificate changing the child’s last name to that of the father.

99.16(5) If another man is shown as the father on the original certificate of live birth, a new certificate of live birth may be established only when a determination of paternity is made by a court of competent jurisdiction.

99.16(6) There is no age limitation and no fee for filing a completed Voluntary Paternity Affidavit form.

99.16(7) The county registrar and the state registrar will seal the original certificate of live birth. The state registrar will place the original certificate of live birth and all related documents in a sealed file, and the file will not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

99.16(8) A copy of the completed and processed Voluntary Paternity Affidavit form may be acquired by either parent or either parent's legal representative upon notarized application and payment of the fee pursuant to rule 641—95.6(144). The notarized application shall include, at a minimum, the following items:

- a. The child's full name;
- b. The child's date and place of birth;
- c. The mother's full name prior to any marriage; and
- d. The full name and mailing address of the applicant.

99.16(9) The new certificate of live birth will not be marked "amended."

99.16(10) The new certificate of live birth will be on file at the county registrar's office pursuant to rule 641—95.7(144).

99.16(11) The birth mother and the biological father shall surrender any incorrect certified copies of the child's certificate of live birth for replacement at no cost. Additional certified copies of the new certificate of live birth shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.17(144) Certificate of live birth following court determination of paternity.

99.17(1) If the birth mother was married at the time of conception or birth or at any time during the period between conception and birth, the name of her spouse will be entered on the certificate of live birth as a parent unless paternity has been determined otherwise by a court of competent jurisdiction pursuant to Iowa Code section 144.13.

99.17(2) Upon receipt of a certified copy of the court determination of paternity order from a court of competent jurisdiction or the completed Abstract from Court Determination of Paternity form, the state registrar will establish a new certificate of live birth to be filed in place of the original certificate of live birth.

99.17(3) The new certificate of live birth will list the name of the child as stated in the court determination of paternity order.

99.17(4) Child support services may not change the child's name.

99.17(5) After a court determination of paternity has been completed, the parents as listed on the court order may submit a completed Voluntary Paternity Affidavit form to change the child's last name to that of the established father.

99.17(6) The county registrar and the state registrar will seal the original certificate of live birth. The state registrar will place the original certificate of live birth and all related documents in a sealed file, and the file will not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

99.17(7) The new certificate of live birth will not be marked "amended."

99.17(8) The new certificate of live birth will be on file at the county registrar's office pursuant to rule 641—95.7(144).

99.17(9) There are no administrative fees required to establish a new certificate of live birth following a court determination of paternity.

99.17(10) Any incorrect certified copy of the child's certificate of live birth shall be surrendered for replacement at no cost. Additional certified copies of the new certificate of live birth shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.18(144) Certificate of live birth following rescission of paternity affidavit or disestablishment of paternity.

99.18(1) An application to rescind a voluntary paternity affidavit shall be made on the Rescission of Paternity Affidavit form by either the birth mother or the putative father who originally completed and signed the Voluntary Paternity Affidavit form pursuant to Iowa Code section 252A.3A.

a. The completed Rescission of Paternity Affidavit form shall be notarized and received by the state registrar within the earlier of either 60 days from the latest notarized parental signature on the original Voluntary Paternity Affidavit form or entry of a court order regarding the child by child support services pursuant to Iowa Code section 252A.3A.

b. Acceptance of the completed Rescission of Paternity Affidavit form shall remove the alleged biological father's information from the certificate of live birth and rescind the voluntary paternity affidavit.

c. The child's last name shall revert to the last name as it was listed on the certificate of live birth prior to the voluntary paternity affidavit.

d. The state registrar will send a written notice of the rescission to the last-known address of the signatory of the voluntary paternity affidavit who did not sign the Rescission of Paternity Affidavit form.

e. After the completed Rescission of Paternity Affidavit form has been accepted and processed, the state registrar will not accept any subsequent Voluntary Paternity Affidavit forms signed by the same mother and putative father relating to the same child pursuant to Iowa Code section 252A.3A.

99.18(2) Upon receipt of a court-ordered disestablishment of paternity, which shall include court-ordered language directing the state registrar to add or remove the father from the certificate of live birth, the father's information will be removed from the certificate of live birth. The child's last name shall revert to the last name as it was listed on the certificate of live birth prior to the establishment of paternity.

99.18(3) An administrative fee will be charged and remitted pursuant to rule 641—95.6(144).

99.18(4) The county registrar and the state registrar will seal the original certificate of live birth. The state registrar will place the rescission of paternity information in the same sealed file as the original certificate of live birth and all previous related documents. The file will not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

99.18(5) The new certificate of live birth will not be marked "amended."

99.18(6) The new certificate of live birth will be on file at the county registrar's office pursuant to rule 641—95.7(144).

99.18(7) Any incorrect certified copies of the child's certificate of live birth shall be surrendered for replacement at no cost. Additional certified copies of the new certificate of live birth shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.19(144) Certificate of live birth following court-ordered change of name.

99.19(1) For a court-ordered name change, a certified copy of an order from a court of competent jurisdiction pursuant to Iowa Code chapter 674 or an Abstract to Change Registrant's Legal Name form completed by the clerk of district court changing the name shall be submitted to the state registrar.

99.19(2) Only the person named on the record, parent or parents if the registrant is a minor child, legal guardian, or legal representative may request a court-ordered change of name.

99.19(3) The court order or abstract shall contain:

- a.* The registrant's full name as it appears on the original certificate of live birth;
- b.* The registrant's date and place of birth;

c. The mother's full maiden name and father's full name as it appears on the original certificate of live birth;

d. The registrant's full new name; and

e. The certification of the clerk of district court.

99.19(4) The certified copy of a certificate of live birth after a legal change of name will be clearly marked "legal change of name" and note the following:

a. The registrant's full name as shown on the original certificate;

b. Any previous legal name changes;

c. The registrant's full new name according to the court order;

d. The date the legal change of name order was granted; and

e. The name of the court that ordered the name change pursuant to Iowa Code chapter 674.

99.19(5) A parent cannot be added to the certificate of live birth with a court-ordered change of name.

99.19(6) The county registrar and the state registrar will seal the original certificate of live birth. The state registrar will place the original certificate of live birth and all related documents in a sealed file, and the file will not be opened and inspected except by the state registrar for administrative purposes or upon an order from a court of competent jurisdiction pursuant to Iowa Code section 144.24.

99.19(7) After the court-ordered change of name, the certificate of live birth will not be on file at the county registrar's office pursuant to rule 641—95.7(144).

99.19(8) An administrative fee will be charged and remitted pursuant to rule 641—95.6(144).

99.19(9) Any incorrect certified copies of the certificate of live birth shall be surrendered for replacement at no cost. Additional certified copies of the new certificate shall be acquired upon receipt of a notarized application, legible copy of a current government-issued photo identification or other identification documents acceptable to the state registrar and payment of the fee pursuant to rule 641—95.6(144).

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

641—99.20(144) Disestablishment of parentage.

99.20(1) To disestablish parentage of a mother, father, or both on a certificate of live birth, the court will submit an abstract from court determination to disestablish parentage to the state registrar.

99.20(2) Upon receipt of a court-ordered abstract from court determination to disestablish parentage, which shall include court-ordered language directing the state registrar to remove the parent or parents from the certificate of live birth, the parent's or parents' information will be removed from the certificate of live birth.

99.20(3) The state registrar will prepare a new certificate of live birth to be filed in place of the original birth certificate.

99.20(4) The new birth certificate will bear the name of the child after the judgment and disestablish the parent's or parents' information as determined by the court.

[ARC 0146D, IAB 3/18/26, effective 7/1/26]

These rules are intended to implement Iowa Code sections 144.19 through 144.21, 144.23, 144.24, 144.25A, 144.38 through 144.41, 252A.3A, 600.15, 600.16A, 674.2, 674.7 and 674.9.

[Filed ARC 0483C (Notice ARC 0376C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]¹

[Filed ARC 1075C (Notice ARC 0925C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]

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[Filed ARC 0146D (Notice ARC 9944C, IAB 1/7/26), IAB 3/18/26, effective 7/1/26]

[Editorial change: IAC Supplement 6/10/26]

- ¹ January 16, 2013, effective date of the rescission of Chapter 99 and the adoption of new Chapter 99 [ARC 0483C] delayed until adjournment of the 2013 General Assembly by the Administrative Rules Review Committee at its meeting held January 8, 2013; delay lifted at the meeting held March 8, 2013.

CHAPTER 107
BOARD-CERTIFIED BEHAVIOR ANALYST AND BOARD-CERTIFIED ASSISTANT
BEHAVIOR ANALYST (BCBA/BCaBA) GRANTS PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 3/1/31

641—107.1(135) Definitions. For the purposes of these rules, the following definitions will 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.

“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 9957C, IAB 1/7/26, effective 3/1/26]

641—107.2(135) Eligibility criteria. To be eligible for a grant, the applicant shall:

107.2(1) Be an Iowa resident or nonresident.

107.2(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.

107.2(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.

107.2(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.

107.2(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 9957C, IAB 1/7/26, effective 3/1/26]

641—107.3(135) Priority in grant awards. Priority in the awarding of a grant will be given to resident applicants.

[ARC 9957C, IAB 1/7/26, effective 3/1/26]

641—107.4(135) Amount of a grant. The department will award funds based upon the amount set aside in the special fund as identified in Iowa Code section 135.181. Moneys appropriated to, and all other moneys specified for deposit in, the fund will be dedicated to the BCBA/BCaBA grants program as established in Iowa Code section 135.181. These rules will be implemented only to the extent that funding is available. The amount of funding awarded to each applicant will 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 will 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 9957C, IAB 1/7/26, effective 3/1/26]

641—107.5(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 9957C, IAB 1/7/26, effective 3/1/26]

641—107.6(135) Review process.

107.6(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 will follow the requirements for competitive bid appeals contained in 441—Chapter 2506.

107.6(2) The department will establish an application process for applicants eligible to receive funding. The application review process and review criteria for preference in awarding the grants will be described in a request for proposals.

107.6(3) An applicant may appeal the denial of a properly submitted grant application. Appeals will be governed by the provisions set forth in 441—Chapter 2506.

[ARC 9957C, IAB 1/7/26, effective 3/1/26; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 135.181.

[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]

[Filed ARC 9957C (Notice ARC 9665C, IAB 11/12/25), IAB 1/7/26, effective 3/1/26]

[Editorial change: IAC Supplement 6/10/26]

CHAPTER 109
PRESCRIPTION DRUG DONATION REPOSITORY PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/31

641—109.1(135M) Definitions. For purposes of this chapter, the following definitions apply:

“*Centralized repository*” means an entity approved by the contractor and licensed pursuant to applicable regulations of the board of pharmacy that accepts donated drugs, conducts a safety inspection of the drugs, and ships the donated drugs to a local repository to be dispensed in compliance with this chapter and federal and state laws, rules and regulations.

“*Contractor*” means the third party approved by the department to implement and administer the prescription drug donation repository program.

“*Controlled substance*” means the same as defined in Iowa Code section 124.101.

“*Indigent*” means the same as defined in Iowa Code section 135M.2.

“*Local repository*” means a pharmacy or medical facility that elects to accept and dispense donated drugs and that meets the eligibility requirements of rule 641—109.2(135M).

“*Medical facility*” means the same as defined in Iowa Code section 135M.2.

“*NDC #*” means the unique national drug code number that identifies a specific approved drug.

“*Nurse practitioner*” means an advanced registered nurse practitioner as defined in 481—Chapter 621.

“*Pharmacist*” means the same as defined in Iowa Code section 155A.3.

“*Pharmacy*” means the same as defined in Iowa Code section 155A.3.

“*Physician*” means an individual licensed under Iowa Code chapter 148.

“*Physician associate*” means an individual licensed under Iowa Code chapter 148C.

“*Prescription drug*” means the same as defined in Iowa Code section 155A.3 and includes cancer drugs and antirejection drugs but does not include controlled substances.

“*Supplies*” means the same as defined in Iowa Code section 135M.2.

“*USP*” means United States Pharmacopoeia.

[ARC 9765C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

641—109.2(135M) Eligibility criteria for program participation by medical facilities and pharmacies.

109.2(1) To be eligible for participation in the prescription drug donation repository program, a medical facility or pharmacy shall be in compliance with all applicable federal and state laws, including laws applicable to the storage and distribution of drugs and the appropriate licensure standards, and shall hold active, nonrestricted, state-issued licenses or registrations in good standing.

109.2(2) Participation in the prescription drug donation repository program is voluntary.

109.2(3) A pharmacy or medical facility may elect to participate in the prescription drug donation repository program by providing, on a form prescribed by the department and available on the department’s website, written notification to the centralized repository of all of the following:

a. The name, street address, and telephone number of the pharmacy or medical facility and any state-issued license or registration number issued to the pharmacy or medical facility, including the name of the issuing agency.

b. The name and telephone number of the responsible pharmacist, physician, physician associate or nurse practitioner who is employed by or under contract with the pharmacy or medical facility.

c. A statement, signed and dated by the responsible pharmacist, physician, physician associate or nurse practitioner, indicating that the pharmacy or medical facility meets the eligibility requirements under this rule and shall comply with the requirements of this chapter.

109.2(4) A pharmacy or medical facility may withdraw from participation in the prescription drug donation repository program at any time by providing written notice to the centralized repository on a form prescribed by the department and available on the department’s website.

[ARC 9765C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

641—109.3(135M) Standards and procedures for accepting donated prescription drugs and supplies.

109.3(1) Any individual who is 18 years of age or older may donate legally obtained prescription drugs or supplies to the centralized repository or a local repository if the drugs or supplies meet the requirements of this rule as determined by a pharmacist who is employed by or under contract with a drug repository.

109.3(2) No drugs that need storage temperatures other than normal room temperature as specified by the manufacturer or USP shall be donated or accepted as part of the prescription drug donation repository program. Drugs that need storage temperatures other than normal room temperature as specified by the manufacturer or USP shall not be donated or accepted because of the increased potential for these drugs to become adulterated. Excluded from this restriction are drugs donated directly from a drug manufacturer.

109.3(3) Controlled substances shall not be donated or accepted. Pursuant to federal and state laws, a controlled substance cannot be returned or reused once the drug has been dispensed to a patient.

109.3(4) The centralized repository or a local repository may accept a prescription drug only if all of the following requirements are met:

a. The drug is in its original sealed and tamper-evident packaging. However, a drug in a single-unit dose or blister pack with the outside packaging opened may be accepted if the single-unit-dose packaging is undisturbed;

b. The drug has been stored according to manufacturer or USP storage requirements;

c. The packaging contains the lot number and expiration date of the drug. If the lot number is not retrievable, all specified medications will be destroyed in the event of a recall, pursuant to board of pharmacy rules;

d. The drug has an expiration date that is more than six months after the date that the drug was donated. However, a donated prescription drug bearing an expiration date that is six months or less after the date the prescription drug was donated may be accepted and distributed if the drug is in high demand and can be dispensed for use prior to the drug's expiration date;

e. The drug does not have any physical signs of tampering or adulteration, and there is no reason to believe that the drug is adulterated;

f. The packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity or adulteration; and

g. All drugs shall be inventoried at the centralized repository or a local repository. The inventory shall include the name of the drug, strength of the drug, quantity of the drug, and the date of donation if the drug has been continually under the control of a health care professional. If the drug has not been continually under the control of a health care professional, the repository shall collect a donation form provided by the prescription drug donation repository program that is signed by the person making the donation or that person's authorized representative.

109.3(5) A repository may accept supplies necessary to administer the prescription drugs donated only if all of the following requirements are met:

a. The supplies are in their original, unopened, sealed packaging;

b. The supplies are not adulterated or misbranded; and

c. The supplies are inventoried at the centralized repository or a local repository. The inventory shall include a description of the supplies and the date donated. Such inventory shall be recorded on a form provided by the department.

109.3(6) Drugs and supplies may be donated on the premises of a participating centralized repository or a local repository to a person designated by the repository. A drop box will not be used to deliver or accept donations.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

641—109.4(135M) Standards and procedures for inspecting and storing donated prescription drugs and supplies.

109.4(1) A licensed pharmacist employed by or under contract with the centralized repository or a local repository shall inspect donated prescription drugs and supplies to determine, to the extent reasonably possible in the judgment of the pharmacist, that the drugs and supplies are not adulterated or misbranded, are safe and suitable for dispensing, and are not ineligible drugs or supplies. The pharmacist who inspects the drugs shall sign an inspection record stating the above and attach it to the copy of the inventory or donor record provided with the drugs. If a local repository receives drugs and supplies from the centralized repository, the local repository does not need to reinspect the drugs and supplies.

109.4(2) The centralized repository and local repositories shall store donated drugs and supplies in a secure storage area under environmental conditions appropriate for the drugs or supplies being stored. Donated drugs and supplies will not be stored with nondonated inventory. When donated drugs are not inspected immediately upon receipt, a repository shall quarantine the donated drugs separately from all dispensing stock until the donated drugs have been inspected and approved for dispensing under the program.

109.4(3) Repositories shall destroy donated noncontrolled substances that are not suitable for dispensing and make a record of such destruction according to rules of the board of pharmacy. The destruction record shall be made in the same manner as prescribed for the record of return or destruction of a controlled substance in subrule 109.4(4).

109.4(4) Controlled substances shall not be accepted for donation.

a. Controlled substances submitted for donation shall be documented and returned immediately to the donor or the donor's representative that provided the drugs.

b. In the event controlled substances enter the centralized repository or a local repository and it is not possible or practicable to return the controlled substances to the donor or the donor's representative due to inability to identify the donor or the donor's representative or due to refusal by the donor or the donor's representative to receive them, abandoned controlled substances shall be documented and destroyed beyond reclamation pursuant to rules of the board of pharmacy. Such destruction shall be performed by a pharmacist or other person who has authority to dispense controlled substances and shall be witnessed by another responsible adult employee of the repository.

109.4(5) If a repository receives a recall notification, the repository shall perform a uniform destruction of all of the recalled prescription drugs in the repository and complete the destruction information form for all donated drugs destroyed. If a recalled drug has been dispensed, the repository shall immediately notify the recipient of the recalled drug pursuant to established drug recall procedures.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

641—109.5(135M) Standards and procedures for dispensing donated prescription drugs and supplies.

109.5(1) Donated drugs and supplies may be dispensed only if the drugs or supplies are prescribed by a health care practitioner for use by an eligible individual and are dispensed by a licensed pharmacist, physician, physician associate or nurse practitioner.

109.5(2) A repository shall prioritize dispensing to an individual requesting drugs through the program as follows:

- a.* First, to an indigent individual;
- b.* Second, to an individual who has no active third-party prescription drug reimbursement coverage for the drug prescribed; and
- c.* Third, to any other individual if an indigent or uninsured individual is unavailable.

109.5(3) A repository shall dispense donated prescription drugs in compliance with applicable federal and state laws and regulations for dispensing prescription drugs, including all requirements relating to packaging, labeling, recordkeeping, drug utilization review, and patient counseling.

109.5(4) The centralized repository and a local repository shall remove the original donor's identification and the name of the dispensing pharmacy from the package prior to dispensing the drugs or supplies.

109.5(5) The centralized repository and a local repository shall be responsible for drug recalls and shall have an established mechanism to notify recipients in the event of a drug recall.

109.5(6) Prescription drugs or supplies donated under this program shall not be resold.

109.5(7) The participating centralized repository and local repositories may distribute drugs and supplies donated under this program to other participating repositories for use pursuant to the program. The repository distributing the drugs or supplies shall complete a transfer form.

[ARC 9765C, IAB 11/26/25, effective 1/1/26; Editorial change: IAC Supplement 6/10/26]

641—109.6(135M) Eligibility criteria for individuals to receive donated prescription drugs and supplies.

109.6(1) An individual who requests drugs from the prescription drug donation repository program shall certify to the repository that the individual is a resident of Iowa and meets one or both of the following criteria:

- a.* Is indigent; and
- b.* Has no active third-party prescription drug reimbursement coverage for the drug prescribed.

109.6(2) The local repository shall collect from each individual recipient a signed intake collection form provided by the department or its contractor.

a. The intake collection form shall attest that:

- (1) The individual is a resident of the state of Iowa;
- (2) The individual's income does not exceed 200 percent of the federal poverty level (FPL);
- (3) The individual is uninsured and has no prescription coverage or is underinsured and has no prescription coverage;

(4) The individual acknowledges that the drugs may have been donated; and
(5) The individual consents to a waiver of the requirement for child resistant packaging of the Poison Prevention Packaging Act (as amended to August 1, 2025).

b. The intake collection form will include an identification card to be given to the recipient for continued use for one year.

109.6(3) The identification card is valid for one year or until the new federal poverty guidelines have been published for all prescriptions and supplies.

109.6(4) A summary of data taken from the intake collection form is to be sent via regular mail, email or facsimile to the centralized repository for data collection.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

641—109.7(135M) Forms and recordkeeping.

109.7(1) The following forms developed for the administration of this program shall be utilized by participants of the program and are available on the department's website:

- a.* Prescription drug donation repository program notice of participation or withdrawal.
- b.* Prescription drug donation repository program donation, transfer, inventory or destruction record.
- c.* A record of medications dispensed.

109.7(2) The prescription drug donation repository program recipient data collection form and identification card are given to the recipient by the local repository, and the completed data collection form is collected from the recipient by the local repository.

109.7(3) Recordkeeping requirements.

a. All records required to be maintained as a part of the prescription drug donation repository program shall be maintained for a minimum of five years by participating pharmacies and medical facilities.

b. Records required as part of this program shall be maintained pursuant to all current applicable practice acts.

c. Data collected by the prescription drug donation repository program from all participating repositories shall be submitted quarterly or upon request to the centralized repository.

d. The centralized repository and the contractor shall submit reports to the department as required by the contract or upon request of the department.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

641—109.8(135M) Handling fee. A repository may charge the recipient of a donated drug a handling fee, not to exceed a maximum of 200 percent of the Medicaid professional dispensing fee as established by rule. A prescription drug dispensed through the prescription drug donation repository program shall not be eligible for reimbursement under the medical assistance program.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

641—109.9(135M) List of drugs and supplies program will accept. All prescription drugs, excluding controlled substances, that have been approved for medical use in the United States, that are listed in the USP or National Formulary (USP/NF), and that meet the criteria for donation established by these rules may be accepted for donation under the prescription drug donation repository program.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

641—109.10(135M) Prescription drug donation repository in disaster emergencies. The following are the requirements for the department to receive and distribute prescription drugs and supplies in preparation for a disaster emergency proclaimed by the governor or in preparation for a public health disaster.

109.10(1) The department may receive prescription drugs and supplies directly from the prescription drug donation repository contractor and dispense prescription drugs and supplies through licensed personnel during or in preparation for a disaster emergency proclaimed by the governor pursuant to Iowa Code section 29C.6 or during or in preparation for a public health disaster as defined in Iowa Code section 135.140(5).

109.10(2) The department may receive and distribute prescription drugs and supplies as outlined in Iowa Code section 135.142 to any Iowan who has been a victim of a disaster emergency proclaimed by the governor.

[ARC 9765C, IAB 11/26/25, effective 1/1/26]

These rules are intended to implement Iowa Code chapter 135M.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 127
COUNTY MEDICAL EXAMINERS
[Prior to 7/29/87, Health Department [470] Ch 127]

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/31

641—127.1(144,331,691) Definitions.

“Autopsy” means the external and internal postmortem examination of a deceased person.

“Cause of death” means the disease or injury that sets in motion the chain of events that eventually results in the death of a person. The physician shall consider “but for” this injury or disease the person would still be living.

“County medical examiner” or *“CME”* means a medical or osteopathic physician or surgeon licensed in the state of Iowa and appointed by the board of supervisors to serve in this capacity.

“County medical examiner investigator” or *“CME-I”* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to serve under the supervision of a county medical examiner to assist in death investigations.

“County of appointment” means the county that requests a medical examiner to conduct an investigation, perform or order an autopsy, or prepare a report(s) in a death investigation case. The request may be authorized by the county attorney or the county medical examiner. The county of appointment shall be the county in which the death occurred.

“Cremation” means the technical process, using heat and flame, that reduces human remains to bone fragments.

“Cremation permit” means an electronic cremation permit approved by the medical examiner.

“Day” means calendar day.

“Death” means the condition as described in Iowa Code section 702.8.

“Death affecting the public interest” means any death of a human being in which the circumstances are sudden, unexpected, violent, suspicious, or unattended, including but not limited to those deaths listed in Iowa Code sections 331.802(3) and 144.29.

“Deputy county medical examiner” or *“DCME”* means an individual appointed by a county medical examiner, with approval by the board of supervisors and the state medical examiner, to assist the county medical examiner in the performance of the county medical examiner’s duties.

“EMER” means the electronic medical examiner report.

“External examination” means a close inspection of the exterior of a deceased human body for the purpose of locating, describing, and delineating any and all injuries or other abnormalities. External examination of a body does not constitute an autopsy, even if toxicology samples are obtained.

“Fee” means an amount to be paid to a county medical examiner’s office as determined by the board of supervisors of the county of appointment for completion of an investigation, autopsy, or report(s). Fees for services provided by the state medical examiner’s office are established in rule 641—126.3(691).

“Manner of death” means the circumstances under which the cause of death occurred and may be specified as follows: natural, accident, suicide, homicide, undetermined, or pending.

“Medical care provider” means an individual licensed or certified in any medical profession, including but not limited to a physician, physician associate, nurse, emergency medical care provider, certified nurse’s aide, pharmacist, physical therapist, and medical technologist.

“Medical examiner” means the state medical examiner, deputy state medical examiner, county medical examiner, or deputy county medical examiner.

[ARC 0076D, IAB 2/18/26, effective 4/1/26; Editorial change: IAC Supplement 6/10/26]

641—127.2(331,691) Duties of medical examiners—jurisdiction over deaths that affect the public interest.

127.2(1) Jurisdiction. Upon receiving notification of a death that affects the public interest, a medical examiner shall notify any appropriate law enforcement agency not otherwise notified and take

charge of the body of the decedent. The body shall not be disturbed or removed from the position in which it was found without authorization from the medical examiner except for the purpose of preserving the body from loss or destruction or permitting the passage of traffic on a highway, railroad, or airport, or unless the failure to remove the body might endanger life, safety, or health.

127.2(2) Investigation. A county medical examiner shall conduct a preliminary investigation of the cause and manner of death and utilize the investigative protocol outlined in the County Medical Examiner's Handbook as amended to August 1, 2025, available from the state medical examiner's office. A medical examiner may perform or authorize performance of any scientific study to assist in identifying the cause, circumstances, and manner of death. A medical examiner shall cooperate with other investigating officials and agencies involved and share reports, information, and conclusions with these officials and agencies.

127.2(3) Reports required.

a. EMER.

(1) Preparation and filing. A county medical examiner shall electronically enter the examiner's findings in the Preliminary Medical Examiner Report in the EMER system. A county medical examiner must complete and submit the EMER within 14 days of the date of death and file a copy of the EMER with the county attorney within 14 days of the date of the death and retain a copy for the county medical examiner's records.

(2) Content. The EMER shall be completed as fully as possible in light of all available information and may be signed by either a county medical examiner or a county medical examiner investigator acting under the supervision of a county medical examiner. If the cause or manner of death, identity of the decedent, or other information is unknown or pending at the time of filing, "unknown" or "pending" may be written in the appropriate area of the form. If additional information becomes available, this information shall be forwarded to the state medical examiner in written form at such time as it becomes available to be added as a supplement to the file.

b. Jurisdiction declined or terminated. An EMER with designated, abbreviated, or minimal information shall be completed and submitted in accordance with subparagraphs 127.2(3)"a"(1) and "a"(2) in cases reported to the county medical examiner where jurisdiction is terminated or declined.

127.2(4) Disposition of body. After an investigation, including an autopsy if one was performed, the body of the decedent shall be made available to the funeral home designated by a relative or friend of the decedent for burial or appropriate disposition. A medical examiner cannot use influence in favor of a particular funeral director or funeral home. If no one claims a body, it shall be disposed of as provided in Iowa Code chapter 142.

127.2(5) Coverage.

a. When an individual is required to report a death to a medical examiner and the county medical examiner cannot be located or is not available, the individual must contact a county medical examiner from any adjacent Iowa county to perform those duties outlined in this chapter. The responding medical examiner has full authority to conduct any procedures necessary to the investigation of the cause and manner of death. If an adjacent county medical examiner is not available, the state medical examiner shall be contacted and may act in the capacity of a county medical examiner.

b. The responding county medical examiner will be reimbursed by the county for which the service is provided for all fees and expenses at the rate that is customarily paid by the county for which the service is provided or at a rate agreed upon by the medical examiner and the board of supervisors of the county for which the service is provided.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.3(331,691) Autopsies.

127.3(1) Autopsy required. A county medical examiner shall order that an autopsy be performed in the following cases:

- a.* All cases of homicide or suspected homicide, irrespective of the period of survival following injury.
- b.* All cases in which the manner of death is undetermined.
- c.* All cases involving unidentified bodies.
- d.* All deaths of children under the age of two when there is not a clear cause of death, including suspected cases of unexpected or unexplained death.
- e.* All work- and farm-related deaths unless there is an obvious natural cause of death.
- f.* All drowning deaths.
- g.* All deaths of commercial vehicle drivers that occur during the performance of their job duties.
- h.* Deaths due to poisoning.
- i.* Deaths of airplane pilots who die as a result of an airplane crash. The National Transportation Safety Board and the Federal Aviation Administration should be contacted prior to the autopsy to request specimen kit(s).
- j.* Deaths due to a natural disaster, including tornadoes and floods.
- k.* Deaths in a prison, jail or correctional institution or under police custody, where there is not a natural disease process that accounts for the death.

127.3(2) *Autopsy recommended.* It is recommended that a county medical examiner should perform an autopsy or order that an autopsy be performed in the following cases:

- a.* Deaths of adolescents less than 18 years of age when there is not a natural cause of death.
- b.* All cases that involve a motor vehicle crash.
- c.* Deaths from suicide.
- d.* All pedestrian, bicycle, motorcycle, snowmobile, boating, watercraft, three- or four-wheeler or all-terrain vehicle fatalities.
- e.* Deaths due to failure of a consumer product.
- f.* Deaths due to a possible public health hazard.
- g.* Deaths due to drug or alcohol abuse or overdose.
- h.* Electrical- and lightning-related deaths.
- i.* Deaths from burns or smoke or soot inhalation.
- j.* All deaths related to exposure, such as hypothermia and hyperthermia.
- k.* All sport-related deaths, including but not limited to deaths from auto racing and deaths resulting from injuries sustained in football, basketball, baseball, softball, soccer, or other games or sports.

127.3(3) *Other deaths.* For those deaths not listed in subrule 127.3(1) or 127.3(2), a county medical examiner will determine whether the public interest requires an autopsy and order that an autopsy be performed. A county medical examiner may consult with the state medical examiner to assist in determining the need for an autopsy.

127.3(4) *Performance of autopsy.*

a. Who may authorize. Autopsies may be authorized by the state medical examiner, the county medical examiner for the county in which the death occurred or the county where any injury contributing to or causing the death was sustained, or the county attorney who would have jurisdiction in any criminal proceeding related to the death.

b. Who may perform. An autopsy must be performed by a pathologist trained or with experience in forensic pathology, licensed to practice medicine and surgery or osteopathic medicine and surgery in the state of Iowa and board-certified by the American Board of Pathology, or under the direct supervision of a physician with these qualifications. The following types of deaths shall be transported to the office of the state medical examiner for autopsy unless otherwise approved by the state medical examiner:

- (1) Deaths of adolescents through 18 years of age when there is not a known or preexisting natural cause of death.

(2) All cases of homicide or suspected homicide, irrespective of the period of survival following injury.

(3) Deaths of children under the age of two years if death results from an unknown cause or is unexpected.

(4) All suspicious suicides.

(5) All high-profile deaths, including but not limited to deaths of elected officials in municipal, state or federal government.

(6) All deaths of inmates occurring in any institutions under the department of corrections as outlined in Iowa Code section 904.102, excluding those deaths that result from a pre-existing medical condition.

c. Permit required—EMER. A medical examiner must complete the EMER. All reasonable efforts must be made to complete the EMER prior to the performance of an autopsy.

127.3(5) Autopsy report. A complete record of the findings of the autopsy shall be submitted to the state medical examiner's office, the county attorney of the county where the death occurred and the county attorney of the county where the injury contributing to or causing the death was sustained within 90 days following the date of death unless unusual circumstances requiring further investigation or testing exist. The report filed shall include transcriptions of the autopsy observations and opinions and toxicology reports.

127.3(6) Out-of-state autopsy. The body of a decedent may be sent out of state for an autopsy or postmortem examination only if the county medical examiner certifies in writing that the out-of-state autopsy or examination is necessary for any of the following reasons:

a. A forensic pathologist practicing in the state of Iowa is unavailable;

b. Requiring an in-state autopsy would cause financial hardship; or

c. Requiring an in-state autopsy would delay the funeral or burial more than three days.

127.3(7) Retention and disposal of tissues, organs, and bodily fluids. The office of the state medical examiner will retain tissues, organs, and bodily fluids as necessary to determine the cause and manner of death or as deemed advisable by the state medical examiner for medical or public health investigation, teaching, or research. Tissues, organs, and bodily fluids will be retained at a minimum for the time periods established by the National Association of Medical Examiners and may be retained for a longer time period at the discretion of the state medical examiner. Tissues, organs, and bodily fluids retained under this subrule will be disposed of without the specific consent or notification of the legal next of kin and in accordance with applicable federal and state regulations, including but not limited to OSHA-recommended biohazard and blood-borne pathogen standards. The anatomical material must be removed from the laboratory premises through use of a contracted, licensed, and bonded medical waste removal service to a medical waste processing center for final disposition.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.4(331,691) Fees.

127.4(1) Payment of fee and expenses.

a. A medical examiner receives from the county of appointment or the county of the decedent's residence a fee for each preliminary investigation and report submitted in a case in which a death affects the public interest. A county medical examiner shall also receive from the county of appointment or the county of the decedent's residence the examiner's actual expenses. The fee and expenses are submitted by the county medical examiner to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the county medical examiner. If the county medical examiner does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.

b. A pathologist or other physician who performs an autopsy under medical examiner authorization shall be paid for the services by the county of appointment.

c. Invoices produced for services performed by a county medical examiner, deputy county medical examiner or county medical examiner investigator must be submitted as a joint invoice to the county of appointment when services were rendered in a case by multiple county medical examiner staff.

127.4(2) Reimbursement.

a. *County of residence different from county of appointment—Iowa resident.* The county of the decedent's residence shall reimburse the county of appointment for the fee and expenses paid by the county of appointment.

b. *Death caused by criminal defendant.* If the person's death is caused by a criminal defendant who has been convicted and sentenced for murder, voluntary manslaughter, involuntary manslaughter, or homicide by vehicle, the county of the person's residence may recover from the defendant the fee and expenses.

c. *Out-of-state resident—law enforcement involvement.* The fee and expenses of a county medical examiner who performs an investigation or autopsy of a person who dies after being brought into the state for emergency medical treatment by or at the direction of an out-of-state law enforcement officer or public authority will be paid by the state. A claim for payment shall be filed with the state appeal board.

d. *Out-of-state resident—no law enforcement involvement.* The fee and expenses of a county medical examiner who performs an investigation or autopsy of an out-of-state resident shall be paid by the county of appointment.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.5(144,331,691) Death certificates—deaths affecting the public interest.

127.5(1) Completion. The funeral director to whom the body is released shall complete the personal data on the death certificate. The medical examiner must complete the manner of death and cause of death sections of the death certificate within 72 hours after determination of the cause and manner of death. If an autopsy is performed by the state medical examiner, the death certificate medical certifier sections will be completed by the state medical examiner's office.

127.5(2) Filing. The funeral director shall file the certificate with the county registrar in the county in which the death occurred. A death certificate shall be filed prior to the issuance of a burial transit permit and prior to disposal of the body.

127.5(3) Extension of time. If a medical examiner is unable to complete the manner of death and cause of death sections of the death certificate within the 24-hour time period, the funeral director must file a death certificate form completed with all available information. Such certificate is authority for the issuance of a burial transit permit. Within 15 days, a supplemental report shall be filed with the local registrar that provides the information missing from the original certificate.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.6(331,691) Cremation.

127.6(1) Permit obtained prior to cremation—cremation permit. A permit for cremation must be obtained from a county medical examiner or state medical examiner prior to cremation of a body of a decedent. Cremation permits must be completed in the electronic death registry system. For the purposes of this requirement, a hard copy or facsimile of a hard copy shall only be utilized if the electronic death registry system is off-line for four or more hours.

127.6(2) Requirements for issuance of permit. A county medical examiner shall direct an inquiry into the cause and manner of death and determine whether the death is one that affects the public interest prior to issuing a cremation permit.

a. *Death that affects the public interest.* If the death occurred in a manner specified in Iowa Code section 331.802(3) or if reasonable suspicion that the death occurred in such a manner exists, a medical examiner shall view the body, make a personal inquiry into the cause and manner of death, and complete or cause to be completed all necessary autopsy or postmortem examinations prior to issuing a cremation permit.

b. Death that does not affect the public interest. If, following an inquiry into the cause and manner of death, the county medical examiner determines that the death did not occur in a manner specified in Iowa Code section 331.802(3), a medical examiner is not required to view the body prior to issuing a cremation permit. A county medical examiner must certify on the Cremation Permit in the electronic death registry system that the medical examiner's inquiry into the cause and manner of death did not disclose evidence that the death occurred in a manner specified in Iowa Code section 331.802(3).

127.6(3) Fee. A fee for the Cremation Permit by Medical Examiner shall be paid by the family, next of kin, guardian of the decedent, or other person authorized to act on behalf of the decedent.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.7(331,691) County medical examiner investigators.

127.7(1) Appointment. A county medical examiner may appoint one or more county medical examiner investigators upon approval by the board of supervisors and the state medical examiner.

127.7(2) Qualifications.

a. Prior to appointment, a CME-I should possess a minimum of two years of experience as a licensed or certified nurse or medical care provider. A certified peace officer may be appointed to the position of CME-I if a nurse or medical care provider is not available.

b. A CME-I shall satisfy the following criteria:

(1) Prior to or within two years of appointment, attend the St. Louis University School of Medicine Basic Medicolegal Death Investigation Course or its state medical examiner-approved equivalent; and

(2) Prior to or within five years of appointment, obtain certification at the registry level as a death investigator by the American Board of Medicolegal Death Investigators.

c. A CME-I is not required to meet the requirements of paragraph 127.7(2) "a" or "b" if the individual has functioned in the capacity of a CME-I for a period of five years.

d. If a CME is unable to appoint a CME-I who possesses the qualifications required by paragraph 127.7(2) "a," "b," or "c," the CME may request a waiver. Waiver requests must be submitted in writing to the state medical examiner and include the efforts undertaken by the CME to locate a CME-I who meets the above qualifications; the qualifications of the individual willing to serve in the capacity of a CME-I; and the period of time for which the waiver is requested, not to exceed two years. The state medical examiner has sole discretion to waive the requirements of this rule and may withdraw or modify a waiver request upon a finding that the CME-I has failed to adequately perform the duties of the position or for other good cause.

e. If a CME-I is unable to meet the eligibility requirements for obtaining registry certification due to the small number of cases requiring investigation in the county of appointment, then a waiver must be obtained from the state medical examiner in order for the investigator to continue the investigator's duties. The county medical examiner must submit a request for a waiver in writing with documentation of the number of deaths occurring in the county of appointment that require death investigation. The waiver must be renewed every five years if the required number of investigations has still not been achieved.

127.7(3) Duties. A CME-I shall assist in death investigations. A CME-I acting under the supervision of a county medical examiner may sign the EMER. A CME-I cannot sign a certificate of death or a cremation permit.

127.7(4) Supervision. A CME-I shall serve under the supervision of a county medical examiner. A CME-I provides services under the direction of a county medical examiner or state medical examiner's office. A CME-I can perform services in a manner that is consistent with the protocol outlined in this chapter.

127.7(5) Fees. Fees for the services provided by a CME-I shall be paid by the county of appointment or by the county of the decedent's residence. A CME-I shall receive from the county of appointment or the county of the decedent's residence reimbursement for actual expenses. The fee and

expenses must be submitted by the CME-I to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the CME-I. If the CME-I does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment shall pay the invoice.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.8(331,691) Deputy county medical examiners.

127.8(1) *Appointment.* A county medical examiner may appoint one or more DCMEs upon approval by the board of supervisors and the state medical examiner.

127.8(2) *Qualifications.* A DCME must be licensed in the state of Iowa as a medical or osteopathic physician or surgeon.

127.8(3) *Duties.* A DCME serves at the direction of the county medical examiner and may perform any duty of a county medical examiner that is delegated by the county medical examiner to the DCME.

127.8(4) *Fees.* Fees for the services provided by a DCME are paid by the county of appointment or by the county of the decedent's residence. A DCME receives from the county of appointment or the county of the decedent's residence reimbursement for actual expenses. The fee and expenses will be submitted by the DCME to the county of appointment, which may immediately pay the invoice or forward the invoice to the county of the decedent's residence for payment to the DCME. If the DCME does not receive payment from the county of the decedent's residence within 60 days of receiving the invoice, the county of appointment pays the invoice.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.9(331,691) Failure to comply with rules. If a county medical examiner, deputy county medical examiner, county medical examiner investigator, pathologist, or other physician fails to comply with these rules, the state medical examiner may provide written notice of the failure to comply to that individual, the appropriate county medical examiner, and the appropriate county board of supervisors. Within 30 days of the date of the notice, the individual to whom the notice was provided shall submit a written response to the state medical examiner, outlining a proposed corrective action plan. If no response is received within the 30 days or if the proposed corrective action plan is unacceptable, the state medical examiner will forward copies of the notice and all pertinent correspondence and information to the board of supervisors for the county that appointed the individual, notifying the board of the individual's failure to comply with these rules.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.10(331,691,22) Confidentiality. Records and reports of a medical examiner may be confidential records pursuant to Iowa Code section 22.7(2), 22.7(5), and 22.7(41) and other provisions of Iowa law. Prior to releasing a medical examiner record or report to a member of the public, a county medical examiner may inform the appropriate law enforcement agency, the county attorney, and the state medical examiner to determine whether release is authorized under Iowa law.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

641—127.11(331,691,670) Indemnification. A board of supervisors shall defend, hold harmless, and indemnify a county medical examiner and any properly appointed staff members to the extent provided in Iowa Code chapter 670.

[ARC 0076D, IAB 2/18/26, effective 4/1/26]

These rules are intended to implement Iowa Code chapters 331 and 691.

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CHAPTER 131
EMERGENCY MEDICAL SERVICES—PROVIDERS—INITIAL
CERTIFICATION—RENEWAL AND REACTIVATION—AUTHORITY—COMPLAINTS
AND INVESTIGATIONS

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—131.1(147A,147D,272C) Definitions. For the purpose of these rules, the following definitions apply:

“*Advanced emergency medical technician*” or “*AEMT*” means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the Department or NREMT testing requirements for the AEMT, and is currently certified by the department as an AEMT.

“*CAPCE*” means the Commission on Accreditation for Prehospital Continuing Education, the accrediting body charged with the review and accreditation of EMS continuing education.

“*CEH*” means continuing education hour, which is based upon a minimum of 50 minutes of training per hour.

“*Certification*” or “*certificate*” means a document issued by the department authorizing a person to practice as an emergency medical care provider in Iowa.

“*Certification period*” means the length of time an emergency medical care provider certificate is valid. The certification period is two years from initial issuance or from renewal unless otherwise specified on the certificate or unless sooner suspended or revoked.

“*Certification status*” means the status of an individual EMS certificate holder.

1. “*Active*” means the holder of the certification has the authority to function as an emergency medical care provider at the level certified in accordance with subrule 131.4(1).

2. “*Probation*,” which is an active certification, means the holder of the certification has the authority to function as an emergency medical care provider at the level certified in accordance with subrule 131.4(1) and under the conditions of probation.

3. “*Denied*” means the certificate is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

4. “*Inactive*” means the certificate is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

5. “*Revoked*” means the certification is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

6. “*Surrendered*” means the certification is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

7. “*Suspended*” means the certification is inactive and the holder of the certification has no authority to function as an emergency medical care provider.

“*Certified*” means being officially recognized as meeting department-approved testing and training standards and being issued a certificate by the department in accordance with Iowa Code chapters 272C and 147A to practice as an emergency medical care provider in the state of Iowa.

“*Compact*” means the emergency medical services personnel licensure interstate compact according to Iowa Code chapter 147D.

“*Complete criminal record*” includes the complaint and judgment of conviction for each offense of which the applicant has been convicted, regardless of whether the offense is classified as a felony or a misdemeanor, and regardless of the jurisdiction in which the offense occurred.

“*Conviction*” means a finding, plea, or verdict of guilt made or returned in a criminal proceeding, even if the adjudication of guilt is deferred, withheld, or not entered. “*Conviction*” includes Alford pleas and pleas of nolo contendere.

“Core continuing education” means education obtained during a certification period to renew certification. Core continuing education will have an assigned sponsor number from CAPCE, an authorized EMS training program, the board of nursing, the board of medicine or the department.

“Critical care paramedic” or *“CCP”* means a currently certified paramedic who has successfully completed a critical care course of instruction approved by the department and has received endorsement from the department as a critical care paramedic.

“Disqualifying offense” means a conviction directly related to the duties and responsibilities of the profession. A conviction is directly related to the duties and responsibilities of the profession if either (1) the actions taken in furtherance of an offense are actions customarily performed within the scope of practice of a certified profession, or (2) the circumstances under which an offense was committed are circumstances customary to a certified profession.

“Emergency medical care” means any medical procedure authorized by Iowa Code chapter 147A and these rules.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“Emergency medical care student” means an individual registered with the department and enrolled in an EMS training program with an active EMS student registration.

“Emergency medical responder” or *“EMR”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the EMR, and is currently certified by the department as an EMR.

“Emergency medical services” or *“EMS”* means an integrated medical care delivery system to provide emergency and nonemergency medical care at the scene or during out-of-hospital patient transportation in an ambulance.

“Emergency medical technician” or *“EMT”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the EMT, and is currently certified by the department as an EMT.

“Emergency medical technician-defibrillation” or *“EMT-D”* means an individual who has successfully completed an approved program and is currently certified by the department as an EMT-D.

“EMS clinical guidelines” or *“minimum EMS clinical guidelines”* means a minimum clinical standard approved by the department upon which a service program’s medical director will base service program protocols.

“EMS instructor” or *“EMS-I”* means an individual who has successfully completed an EMS instructor curriculum approved by the department and is currently endorsed by the department as an EMS-I.

“Endorsement” or *“endorsed”* means an approval granted by the department authorizing an individual to serve as an EMS-I or CCP.

“Fees” means those fees received pursuant to Iowa Code chapters 147A and 147D.

“First responder” or *“FR”* means an individual who has successfully completed an approved program and is currently certified by the department as an FR.

“First responder-defibrillation” or *“FR-D”* means an individual who has successfully completed an approved program and is currently certified by the department as an FR-D.

“NREMT” means the National Registry of Emergency Medical Technicians. The NREMT provides a valid, uniform process to assess the knowledge and skills required for competent practice by EMS professionals.

“Paramedic” or *“PM”* means an individual who has successfully completed a course of study based on the U.S. Department of Transportation’s National Emergency Medical Services Education Standards (December 2021), has passed the department or NREMT testing requirements for the paramedic, and is currently certified by the department as a paramedic.

“Patient” means an individual who is sick, injured, or otherwise incapacitated and has been evaluated or provided treatment by an emergency medical care provider.

“Patient abandonment” means a termination of the provider/patient relationship at a time when a continuous level of care is needed. Patient abandonment does not occur when a scene is unsecured, deteriorates or becomes too dangerous for the emergency medical care provider to safely function. Patient abandonment does not occur when patient care is transferred to another emergency medical care provider following assessment or triage.

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician associate” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Protocols” means written directions and orders approved by a service program’s medical director utilizing the EMS clinical guidelines.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Service program” or *“service”* means any transport service or nontransport service, inclusive of associated satellites and service program affiliates, that has received full or conditional authorization from the department.

[ARC 9123C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—131.2(147A,272C) Initial certification.

131.2(1) An individual who has successfully completed the training program requirements at the EMR, EMT, AEMT or paramedic level and has a valid certification with NREMT shall submit the following to the department for initial Iowa emergency medical care provider certification:

- a. A completed EMS certification application.
- b. An NREMT active certification number.
- c. Payment of the initial application fee.
- d. Two completed fingerprint cards for background checks.
- e. Payment of the background check fee.

131.2(2) The individual seeking an Iowa emergency medical provider care certification shall submit all application materials within two years from the Iowa training program course completion date.

131.2(3) If the individual is unable to complete the requirements within two years due to medical reasons or military obligation, an extension may be granted upon submission of a signed statement from an appropriate medical or military authority and approval by the department.

131.2(4) Fees may be waived in accordance with provisions in Iowa Code chapter 272C.

131.2(5) Use of criminal convictions in eligibility determinations and initial licensing decisions.

a. *License application.* Unless an applicant for licensure petitions the department for an eligibility determination pursuant to paragraph 131.2(7)“b,” the applicant’s convictions will be reviewed when the department receives a completed license application.

(1) An applicant must disclose all convictions on a license application. Failure to disclose all convictions is grounds for license denial or disciplinary action following license issuance.

(2) An applicant with one or more convictions shall submit the complete criminal record for each conviction and a personal statement regarding whether each conviction directly relates to the practice of the profession in order for the license application to be considered complete.

(3) An applicant must submit as a part of the license application all evidence of rehabilitation that the applicant wishes to be considered by the department.

(4) The board may deny a license if the applicant has a disqualifying offense unless the applicant demonstrates by clear and convincing evidence that the applicant is rehabilitated pursuant to Iowa Code section 272C.15.

(5) An applicant with one or more disqualifying offenses who has been found rehabilitated must still satisfy all other requirements for licensure.

(6) Any application fees paid will not be refunded if the license is denied.

b. Eligibility determination. An individual who has not yet submitted a completed license application may petition the department for a determination of whether one or more of the individual's convictions are disqualifying offenses that would render the individual ineligible for licensure. An individual with a conviction is not required to petition the department for an eligibility determination prior to applying for licensure. To petition the department for an eligibility determination of whether one or more of the petitioner's convictions are disqualifying offenses, a petitioner shall submit all of the following:

- (1) A completed petition for eligibility determination form;
- (2) The complete criminal record for each of the petitioner's convictions;
- (3) A personal statement regarding whether each conviction directly relates to the duties and responsibilities of the profession and why the department should find the petitioner rehabilitated;
- (4) All evidence of rehabilitation that the petitioner wishes to be considered by the department; and
- (5) Payment of a nonrefundable fee of \$25.

c. Appeal. A petitioner deemed ineligible or an applicant denied a license because of a disqualifying offense may appeal the decision in accordance with 441—Chapter 2506.

d. Future petitions or applications. If a final order determines a petitioner is ineligible, the petitioner may not submit a subsequent petition for eligibility determination or a license application prior to the date specified in the final order. If a final order denies a license application, the applicant may not submit a subsequent license application or a petition for eligibility determination prior to the date specified in the final order.

[ARC 9123C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—131.3(147A) Background check results. All criminal history records are confidential and will only be used in accordance with this policy to determine eligibility. All background check records will be stored in a secure location. Background check records will not be redisseminated by the department.

[ARC 9123C, IAB 4/16/25, effective 6/1/25]

641—131.4(147A) Authority.

131.4(1) Authority of emergency medical care provider. An emergency medical care provider who holds an active Iowa certification issued by the department or has permission to practice in Iowa pursuant to Iowa Code chapter 147D may:

a. As a member of a responding authorized service program, render emergency medical care and perform emergency medical care without contacting medical direction if written protocols have been approved by the service program medical director.

b. Function in any hospital or any other entity in which health care is ordinarily provided only when:

(1) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided when under the direct supervision of a physician as a member of an authorized service program, or in an individual capacity, by rendering lifesaving services in the facility in which employed or assigned pursuant to the emergency medical care provider's certification and under direct supervision of a physician, physician associate, or registered nurse. An emergency medical care provider shall not routinely function without the direct supervision of a physician, physician associate, or registered nurse. However, when the physician, physician associate, or registered nurse cannot directly assume emergency care of the patient, the emergency medical care provider may perform, without direct supervision, emergency medical care procedures for which certified, if the life of the patient is in immediate danger and such care is required to preserve the patient's life;

(2) Employed by or assigned to a hospital or other entity in which health care is ordinarily provided when under the direct supervision of a physician, as a member of an authorized service program, or in an individual capacity, to perform nonlifesaving procedures for which certified and designated in a written job description. Such procedures may be performed after the patient is

observed by and when the emergency medical care provider is under the supervision of the physician, physician associate, or registered nurse and where the procedure may be immediately abandoned without risk to the patient.

131.4(2) *Scope of practice.*

a. Emergency medical care providers shall perform only those skills and procedures that are authorized within the scope of practice for which an emergency medical care provider is certified.

b. The Iowa Emergency Medical Care Provider Scope of Practice (September 2019) is hereby incorporated and adopted by reference for emergency medical care providers. For any differences that may occur between the scope of practice adopted by reference and these rules, the rules prevail.

c. The Iowa Emergency Medical Care Provider Scope of Practice (September 2019) is available on the department's website.

d. The department may grant a waiver for changes to the scope of practice that have not yet been adopted by reference in these rules pursuant to 441—Chapter 2504.

[ARC 9123C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—131.5(147A) Renewal standards, reactivation procedures, fees, and continuing education.

131.5(1) *Renewal of certification.*

a. An emergency medical care provider shall submit an application for renewal of an active Iowa EMS certification within 90 days prior to the certification expiration date.

b. The renewal application and process are completed online via an individual Iowa EMS provider account. The electronic portal to access individual accounts may be accessed through the department's website.

c. Renewal notifications will be sent to Iowa emergency medical care providers who have an active certification set to expire in 90 days. The notification will be sent by email to the address on file in the emergency medical care provider's electronic profile.

d. It is the emergency medical care provider's responsibility to ensure the electronic profile information, including the email address, is updated and correct within 30 days of any change.

e. A renewal certificate is valid for two years from the current expiration date unless sooner surrendered, suspended or revoked.

f. A lower-level certificate may be renewed if the individual voluntarily chooses to move from a higher level to a lower level by completing all applicable continuing education requirements for the lower level during the certification period and submitting a change of status request, available from the department upon request.

g. A certification status becomes inactive if the certificate has not been renewed by the certification expiration date unless the emergency medical care provider is granted an extension as described in subrule 131.5(3).

h. An emergency medical care provider may request an inactive status. The request must be made by submitting a change of status request, available from the department upon request. A request for inactive status, when accepted in connection with a disciplinary investigation or proceeding, has the same effect as an order of revocation.

131.5(2) *Late renewal of certification.*

a. An emergency medical care provider who has completed the required continuing education during the certification period but fails to submit the EMS renewal of certification application and applicable fees prior to the certification expiration date is eligible for late renewal of the inactive certification.

b. The emergency medical care provider shall complete the EMS renewal of certification application, submit a late fee in addition to the applicable renewal fee and submit an audit report form provided by the department. The fee and audit report form shall be submitted before the last day of the month following the certification expiration date. If the late renewal submission is not completed by the last day of the month following the certification expiration date, the certification remains inactive.

c. An emergency medical care provider who has not completed the required continuing education during the certification period is not eligible for late renewal. The certification is inactive.

131.5(3) *Extension of certification.*

a. An emergency medical care provider who is unable to attain all continuing education requirements within the certification period may request a 45-day extension. To complete the extension process, the provider shall:

(1) Submit a request for extension application, available from the department upon request, at least 7 days prior to the certification expiration date, but no more than 90 days prior to the certification expiration date, and payment of the extension fee.

(2) Complete the continuing education requirements.

(3) Complete and submit the EMS affirmative renewal of certification application, with all applicable renewal fees, to the department prior to the extended expiration date.

(4) Submit an audit report form provided by the department.

b. If an emergency medical care provider fails to submit any of the items required in subparagraphs 131.5(3)“a”(2) and (3) by the 45th day of the extended certification period, the certification will be inactive.

c. The emergency medical care provider may not use continuing education completed during the extension period in the subsequent renewal period.

131.5(4) *Reactivation of an inactive certification.*

a. *Certification inactive up to 24 months.* An emergency medical care provider may apply to reactivate an inactive certification up to 24 months after the certification became inactive.

(1) An individual will submit to the department an EMS certification reactivation application, which is available from the department upon request.

(2) If the department approves the application, the individual must submit an audit report form with 36 core continuing education hours prorated per lapsed year by core topic area and the reactivation fee.

(3) Upon receipt and approval of the items required in subparagraphs 131.5(4)“a”(1) and (2), the department may issue a new certification.

(4) An emergency medical care provider who fails to complete the reactivation process within 12 months from the date of application approval must reapply for reactivation of the inactive certification.

b. *Certification inactive from 25 months to 48 months.* An emergency medical care provider may apply to reactivate an inactive certification that has been inactive for 25 months but no more than 48 months.

(1) An individual will submit to the department an EMS certification reactivation application, which is available from the department upon request.

(2) If the department approves the application, the individual must submit documentation of successful completion of an approved EMS refresher course that includes successful completion of department or NREMT testing requirements. In addition, the individual must:

1. Complete fingerprint requirements.

2. Submit reactivation and background check fees.

3. Upon receipt and approval of the items required in subparagraphs 131.5(4)“b”(1) and (2), the department may issue a new certification.

4. An emergency medical care provider who fails to complete the reactivation process within 12 months from the date of application approval must reapply for reactivation of the inactive certification.

c. *Certification inactive for more than 48 months.* An emergency medical care provider may not apply to reactivate a certification that has been inactive for more than 48 months.

131.5(5) *Reactivation of revoked or suspended certification.*

a. Any person whose certification to practice has been revoked or suspended may apply to the department for reactivation in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the certification is permanently revoked.

b. If the order of revocation or suspension did not establish terms and conditions upon which reactivation might occur or if the certification was voluntarily surrendered, an initial application for reactivation may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender.

c. All proceedings for reactivation shall be initiated by the person whose certification has been revoked or suspended in accordance with subrule 131.5(4). An application for reactivation shall allege facts that, if established, will be sufficient to enable the department to determine that the basis for the revocation or suspension of the person's certification no longer exists and that it will be in the public interest for the certification to be reinstated. The burden of proof to establish such facts is on the person whose certification has been suspended or revoked.

d. An order denying or granting reactivation shall be based upon a decision that incorporates findings of facts and conclusions of law.

131.5(6) Fees. The nonrefundable fees are as follows:

- a.* Application for initial Iowa certification at all certification levels: \$30.
- b.* Reactivation of a certification to practice: \$30.
- c.* Renewal of a certification to practice as a first responder, EMR: no fee.
- d.* Renewal of a certification to practice as an EMT: no fee.
- e.* Renewal of a certification to practice as an AEMT: \$10.
- f.* Renewal of a certification to practice as a paramedic: \$25.
- g.* Late renewal of a certification to practice: \$30.
- h.* Returned payment due to insufficient funds: \$15.
- i.* Extension of certification: \$50.

131.5(7) Continuing education renewal.

a. The table below illustrates the minimum number of core continuing education hours (CEHs) by topic area for each level of emergency medical care provider to renew an Iowa EMS certification.

Core Topics	EMR/FR	EMT/EMT-D	AEMT	PM
Airway, Respirations, Ventilations	1	1	2	3
Cardiology	2	6	7	9
Trauma	1	2	3	3
Medical	3	6	8	9
Operations	1	5	5	6
Totals	8	20	25	30

b. All core continuing education hours used to renew an Iowa EMS certification must have a sponsor number by an authorized Iowa training program, the department, the board of nursing, the board of medicine, or CAPCE before the emergency medical care provider attends the offering.

c. An emergency medical care provider who is registered with the NREMT may renew the provider's Iowa EMS certification by meeting the NREMT's requirements. The emergency medical care provider must submit the Iowa affirmative renewal of certification application and all appropriate fees.

d. An emergency medical care provider is deemed to have complied with the continuing education requirements during periods in which the provider serves honorably on active duty in the military services or for periods in which the provider is a government employee working as an emergency medical care provider and assigned to duty outside the United States. The emergency medical care provider must submit the Iowa affirmative renewal of certification application, all appropriate fees and documentation of assignment.

e. The emergency medical care provider must maintain a file containing documentation of CEHs accrued during each certification period for four years from the end of each certification period.

f. A group of emergency medical care providers will be audited for each certification period. Emergency medical care providers to be audited will be chosen in a random manner or at the discretion of the department. Falsifying reports or failure to comply with the audit request may result in formal disciplinary action. Those audited must submit a department-provided audit report form within 45 days of the request. If audited, the emergency medical care provider must provide the following information:

- (1) Date of program.
- (2) Program sponsor number.
- (3) Title of program.
- (4) Number of approved hours.

131.5(8) Continuing education approval. The following standards apply for approval of continuing education:

a. CEHs will have an assigned sponsor number from CAPCE, an authorized EMS training program, the board of nursing, the board of medicine or the department.

b. Human health-related college courses may be approved in advance by the department at one quarter credit equal to 10 CEHs, one semester credit equal to 15 CEHs.

131.5(9) Out-of-state continuing education. Out-of-state continuing education courses will be accepted for CEHs if all criteria in subrule 131.5(7) are met and if the courses have been approved for emergency medical care personnel in the state in which the courses were held. A copy of course completion certificates (or other verifying documentation) shall, upon request, be submitted to the department.

[ARC 9123C, IAB 4/16/25, effective 6/1/25]

641—131.6(147A,272C) Discipline—denial, citation and warning, probation, suspension, or revocation of certificates or renewal.

131.6(1) This rule is not subject to waiver pursuant to 441—Chapter 2504 or any other provision of law.

131.6(2) Prohibited grounds for discipline. The department will not suspend or revoke the certification of a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

131.6(3) Methods of discipline.

a. The department has the authority to impose the following disciplinary sanctions against an emergency medical care provider:

- (1) Issue a citation and warning.
- (2) Impose a civil penalty not to exceed \$1,000.
- (3) Require reexamination.
- (4) Require additional education or training.
- (5) Impose a period of probation under specific conditions.
- (6) Prohibit permanently, until further order of the department, or for a specific period, a provider's ability to engage in specific procedures, methods, acts or activities incident to the practice of the profession.
- (7) Suspend a certificate until further order of the department or for a specific period.
- (8) Deny an application for certification.
- (9) Revoke a certification.
- (10) Impose such other sanctions as allowed by law and as may be appropriate.

b. A request for inactive status in connection with a disciplinary investigation or proceeding has the same effect as an order of revocation.

c. A citation and warning, denial, probation, restriction, suspension, revocation, or civil penalty imposed upon an individual certificate holder by the department will be considered applicable to all certificates and endorsements issued to that individual by the department.

d. An emergency medical care provider who has knowledge of an emergency medical care provider, service program or training program that has violated Iowa Code chapter 147A or these rules shall report such information to the department within 30 days.

131.6(4) The department may deny an application for issuance or renewal of an emergency medical care provider certificate, including endorsement, or may impose any of the disciplinary sanctions provided in subrule 131.6(3) when it finds that the individual or certificate holder has committed any of the following acts or offenses:

- a. Negligence in performing emergency medical care.
- b. Failure to follow the directions of supervising physicians or their designees.
- c. Rendering treatment not authorized under Iowa Code chapter 147A.
- d. Patient abandonment.
- e. Fraud in procuring certification or renewal, including but not limited to:

(1) An intentional perversion of the truth in making application for a certification to practice in this state;

(2) False representations of a material fact, whether by word or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed when making application for a certification in this state; or

(3) Attempting to file or filing with the department or training program any false or forged diploma or certificate or affidavit or identification or qualification in making an application for a certification in this state.

f. Professional incompetency. Professional incompetency includes but is not limited to:

(1) A substantial lack of knowledge or ability to discharge professional obligations within the scope of practice.

(2) A substantial deviation from the standards of learning or skill ordinarily possessed and applied by other emergency medical care providers in the state of Iowa acting in the same or similar circumstances.

(3) A failure to exercise the degree of care that is ordinarily exercised by the average emergency medical care provider acting in the same or similar circumstances.

(4) Failure to conform to the minimal standard of acceptable and prevailing practice of certified emergency medical care providers in this state.

(5) A substantial lack of knowledge or ability to discharge professional obligations within the minimum clinical standards approved by the department.

g. Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established. Acts that may constitute unethical conduct include but are not limited to:

(1) Verbally or physically abusing a patient, coworker or any other individual encountered while a certified emergency medical care provider.

(2) Improper sexual contact with or making suggestive, lewd, lascivious or improper remarks or advances to a patient, coworker or any other individual encountered while certified as an emergency medical care provider in the state of Iowa.

(3) Betrayal of a professional confidence.

(4) Engaging in a professional conflict of interest.

(5) Falsification of medical records, official documents or other writings or records.

h. Engaging in any conduct that subverts or attempts to subvert a department investigation.

i. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.

- j.* Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.
- k.* Failure to report another emergency medical care provider to the department for any violations listed in these rules pursuant to Iowa Code chapter 147A.
- l.* Knowingly aiding, assisting or advising a person to unlawfully practice EMS.
- m.* Representing oneself as an emergency medical care provider when one's certification has been suspended or revoked or when one's certification is lapsed or has been placed on inactive status.
- n.* Permitting the use of a certification by a noncertified person for any purpose.
- o.* Mental or physical inability reasonably related to and adversely affecting the emergency medical care provider's ability to practice in a safe and competent manner as determined by an evaluation from a licensed evaluator of the provider's mental or physical status.
- p.* Being adjudged mentally incompetent by a court of competent jurisdiction.
- q.* Sexual harassment of a patient, student, coworker or any other individual encountered while certified as an emergency medical care provider in the state of Iowa. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature communicated in person, in writing, via a third person or through electronic communication.
- r.* Habitual intoxication or addiction to drugs.
 - (1) The inability of an emergency medical care provider 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 that may impair an emergency medical care provider's ability to practice with reasonable skill or safety.
 - (3) Obtaining, possessing, attempting to obtain or possess, or administering controlled substances without lawful authority.
- s.* Fraud in representation as to skill, ability or certification.
- t.* Willful or repeated violations of Iowa Code chapter 147A or these rules.
- u.* Conviction of a disqualifying offense. A copy of the guilty plea or order of conviction constitutes conclusive evidence of conviction.
- v.* Having certification to practice emergency medical care suspended or revoked or having other disciplinary action taken by a licensing or certifying authority of this state or another state, territory or country. A copy of the record or order of suspension, revocation or disciplinary action is conclusive or prima facie evidence.
- w.* Falsifying certification renewal reports or failure to comply with the renewal audit request.
- x.* Acceptance of any fee by fraud or misrepresentation.
- y.* Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.
- z.* Violating privacy and confidentiality. An emergency medical care provider shall not disclose or be compelled to disclose patient information unless disclosure is required or authorized by law.
 - aa.* Discrimination. An emergency medical care provider shall not practice, condone, or facilitate discrimination against a patient, student, or any other individual encountered while acting as certified as an emergency medical care provider in the state of Iowa on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability, diagnosis, or social or economic status.
 - ab.* Practicing emergency medical services or using a designation of certification or otherwise holding oneself out as practicing emergency medical services at a certain level of certification when the emergency medical care provider is not certified at such level.
 - ac.* Failure to respond within 30 days of receipt, unless otherwise specified, to communication from the department that was sent by registered or certified mail.

641—131.7(147A) Certification denial. An individual who has been denied certification by the department may appeal the denial and request a hearing on the issues related to the licensure denial pursuant to 441—Chapter 2506.

[ARC 9123C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—131.8(147A) Emergency adjudicative proceedings. To the extent necessary to prevent or avoid immediate danger to the public health, safety or welfare and consistent with the Constitution and other provisions of law, the department may issue a written order in compliance with Iowa Code section 17A.18 to suspend a certificate in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the department by emergency adjudicative order.

131.8(1) Before issuing an emergency adjudicative order, the department will consider factors, including but not limited to the following:

- a.* Whether there has been a sufficient factual investigation to ensure that the department is proceeding on the basis of reliable information;
- b.* Whether the specific circumstances that pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
- c.* Whether the individual 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; and
- e.* Whether the specific action contemplated by the department is necessary to avoid the immediate danger.

131.8(2) Issuance of order.

a. An emergency adjudicative order will contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the department's decision to take immediate action. The order is a public record.

b. The written emergency adjudicative order will be immediately delivered to the individual who is required to comply with the order. Delivery will be made by 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) Fax. Fax may be used as the sole method of delivery if the individual required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the department will select the procedure for providing written notice that best ensures prompt, reliable delivery.

d. Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the department will make reasonable immediate efforts to contact by telephone the individual who is required to comply with the order.

e. After the issuance of an emergency adjudicative order, the department will proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

f. Issuance of a written emergency adjudicative order will include notification of the date on which department proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further department proceedings to a later date will be granted only in compelling circumstances upon application in writing unless the individual who is required to comply with the order is the party requesting the continuance.

[ARC 9123C, IAB 4/16/25, effective 6/1/25]

641—131.9(147A) Complaints, investigations and appeals.

131.9(1) This rule is not subject to waiver pursuant to 441—Chapter 2504 or any other provision of law.

131.9(2) All complaints regarding emergency medical care personnel, training programs or continuing education providers, or those purporting to be or operating as the same shall be reported to the department in writing.

131.9(3) An emergency medical care provider who has knowledge of an emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall report such information to the department.

131.9(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

131.9(5) A determination of mental incompetence by a court of competent jurisdiction automatically suspends a certificate for the duration of the certificate unless the department orders otherwise.

131.9(6) Notice of denial, issuance of a citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of 441—Chapter 16 and may be appealed pursuant to 441—Chapter 2506.

131.9(7) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, the news media or employer.

[ARC 9123C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapters 147A and 147D and section 272C.4.

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CHAPTER 132
EMERGENCY MEDICAL SERVICES—SERVICE PROGRAM AUTHORIZATION

[Joint Rules pursuant to 147A.4]
[Prior to 7/29/87, Health Department[470] Ch 132]

Chapter rescission date pursuant to Iowa Code section 17A.7: 5/21/30

641—132.1(147A) Definitions. For the purpose of these rules, the following definitions apply:

“Advanced emergency medical technician level service” or *“AEMT level service”* means a service program that provides emergency medical care that does not exceed the scope of practice of a certified AEMT provider as outlined in 641—subrule 131.5(2).

“Advanced registered nurse practitioner” or *“ARNP”* means a nurse licensed pursuant to 655—7.1(152) with current licensure as a registered nurse in Iowa who is registered in Iowa to practice in an advanced role.

“Ambulance” means any privately or publicly owned ground, fixed-wing or rotor-wing vehicle equipped with life-support systems and specifically designed to transport the sick or injured who require emergency medical care.

“Applicant” means an owner of a transport or nontransport program or service program that is applying to the department for authorization as a service program or renewal of current authorization as a service program.

“Biomedical hazardous waste” means waste product that may be contaminated with a biological material that is an infectious disease transmission risk.

“Communication system” means but is not limited to a telecommunication system, radio communication system, or mobile data communication system.

“Conditional service level authorization” means an enhanced service program authorization under which a service program may provide an advanced level of service from that routinely provided under the service program’s full authorization level, on an intermittent basis with department and medical director approval.

“Continuous quality improvement” or *“CQI”* means a program that is an ongoing process to monitor standards at all EMS operational levels.

“Credentialing” means a clinical determination that is the responsibility of a physician medical director. It is the employer or affiliating organization’s responsibility to act on the clinical credentialing status of EMS personnel in making employment or deployment decisions.

“Critical care transport” or *“CCT”* means a paramedic level service program that has received an endorsement from the department to provide specialty care patient transportation and that is staffed by one or more paramedics with a critical care paramedic endorsement from the department or that is staffed by other health care professionals in an appropriate specialty area.

“Deficiency” means noncompliance with Iowa Code chapter 147A or these administrative rules.

“Emergency medical care” means any medical procedure authorized by Iowa Code chapter 147A and 641—Chapter 131.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“Emergency medical responder level service” or *“EMR level service”* means a nontransport service program that provides emergency medical care that does not exceed the scope of practice of a certified EMR provider as outlined in 641—subrule 131.5(2).

“Emergency medical services” or *“EMS”* means the same as defined in Iowa Code section 147A.1.

“Emergency medical technician” or *“EMT”* means the same as defined in 641—Chapter 131.

“Emergency medical technician level service” or *“EMT level service”* means a service program that provides emergency medical care that does not exceed the scope of practice of a certified EMT provider as outlined in 641—subrule 131.5(2).

“Emergency medical transportation” means transportation of a patient by an ambulance.

“Emergency vehicle driver” or *“driver”* means a currently licensed driver rostered with the service program or other emergency response personnel with emergency vehicle driving training.

“EMS clinical guidelines” or *“minimum EMS clinical guidelines”* means a minimum clinical standard approved by the department upon which a service program’s medical director will base service program protocols.

“Endorsement” means an approval granted by the department authorizing a paramedic level service program to provide critical care transport (CCT).

“FAA” means Federal Aviation Administration.

“Fixed-wing ambulance” means any privately or publicly owned fixed-wing aircraft specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated who are in need of out-of-hospital emergency medical care or whose condition requires treatment or continuous observation while being transported.

“First response vehicle” means any privately or publicly owned vehicle that is not an ambulance and that is used solely for the transportation of personnel and equipment to and from the scene of an emergency.

“Full authorization” means a service program authorization under which a service is authorized to provide and routinely provides a specific level of emergency medical care for initial 911 or emergency calls 24 hours per day, seven days per week.

“Hospital” means any hospital licensed under the provisions of Iowa Code chapter 135B.

“Medical direction” means direction, advice, or orders provided by a medical director, supervising physician, PA, or ARNP to emergency medical care personnel.

“Medical director” means a physician designated by the service program and responsible for providing medical direction and overall supervision of the medical aspects of the service program.

“Nontransport service” means any privately or publicly owned service program that does not provide patient transportation and provides emergency medical care at the scene of an emergency.

“Paramedic” or *“PM”* means the same as defined in 641—Chapter 131.

“Paramedic level service” or *“PM level service”* means a service program that provides emergency medical care that does not exceed the scope of practice of a certified paramedic provider as outlined in 641—subrule 131.4(2).

“Patient” means any individual who is sick, injured, or otherwise incapacitated.

“Patient care report” or *“PCR”* means a report that documents the assessment and management of the patient by the emergency care provider.

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician associate” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Primary response ambulance” means any ambulance utilized by a service program and dispatched as the initial ambulance response to a 911 or emergency call.

“Protocols” means written directions and orders approved by a service program’s medical director utilizing the EMS clinical guidelines.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Rotorcraft ambulance” means any privately or publicly owned rotorcraft specifically designed, modified, constructed, equipped, staffed and used regularly to transport the sick, injured or otherwise incapacitated who are in need of out-of-hospital emergency medical care or whose condition requires treatment or continuous observation while being transported.

“Service director” means an individual designated by the service program who is responsible for the operation and administration of a service program.

“Service program” or *“service”* means any ground or air medical transport service or nontransport service, inclusive of associated satellites, that has received full or conditional authorization from the department.

“Service program affiliate” or *“affiliate”* means an independently owned service program affiliated with one or more service programs or a separate management entity.

“Service program affiliate agreement” or *“affiliate agreement”* means a written agreement executed between one or more service programs or one or more management entities and filed with the department that clearly defines the responsibilities of each service program to ensure compliance with these rules.

“Service program base of operation” means the physical location from which a service program responds and at which the service program houses emergency medical care personnel and equipment.

“Service program ownership” means the legal owner of the service program responsible for providing emergency medical care and compliance with Iowa Code chapter 147A and these rules.

“Service program satellite” or *“satellite”* means one or more additional service program locations owned by the same service program.

“Student” means any individual enrolled in a training program and participating in the didactic, clinical, or field experience portions.

“Tiered response” means a rendezvous between service programs to allow the transfer, continuation, or enhancement of patient care.

“Transport agreement” means a written agreement executed between two or more service programs and filed with the department that ensures response and transportation for initial 911 or emergency calls. A transport agreement may be a component of an affiliate agreement.

“Transport service” means any privately or publicly owned service program that utilizes ambulances in order to provide patient transportation.

[ARC 9124C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/10/26]

641—132.2(147A) Service program—authorization and renewal procedures and inspections.

132.2(1) Requirements for initial service program authorization.

a. An entity that desires to provide emergency medical care services in the out-of-hospital setting in this state shall apply to the department for service program full authorization.

b. Information for initial authorization can be found on the department’s website or upon request.

c. Transport service—full authorization. An entity seeking authorization as a transport service program shall apply for full authorization at a minimum of the EMT level or the level of care that will be provided by the service program or through a transport agreement for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

d. Transport service—conditional service level authorization. An entity seeking authorization as a transport service that is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) AEMT.
- (2) Paramedic.

e. Nontransport service—full authorization. An entity seeking authorization as a nontransport service program shall apply for full authorization at a minimum of the EMR level or at the level of care that will be provided for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMR.
- (2) EMT.
- (3) AEMT.
- (4) Paramedic.

The nontransport service program shall have an executed written transport agreement ensuring simultaneous dispatch with an authorized transport service program for all 911 or emergency calls.

f. Nontransport service—conditional service level authorization. An entity seeking authorization as a nontransport service program that has an executed written transport agreement ensuring simultaneous dispatch with an authorized transport service program for all 911 or emergency calls and is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) EMT.
 - (2) AEMT.
 - (3) Paramedic.
- g.* Conditional service level authorization requirements.

(1) A service program that has been granted conditional service level authorization shall only advertise or otherwise hold itself out to the public as an authorized service program at the level of full authorization.

(2) A service program authorized to operate at a conditional service level shall operate at such level only when an emergency medical care provider certified at the advanced certification level is listed on the service roster, physically present and directly responsible for patient care.

h. Initial service program authorization is valid for a period of one year from its effective date unless otherwise specified on the certificate of authorization or unless sooner suspended or revoked or surrendered.

i. An applicant shall provide evidence of liability insurance coverage for the service program and emergency medical care provider staff. Any change in insurance status must be reported to the department no later than 30 days from the change.

j. An applicant seeking endorsement must submit a department-approved application.

132.2(2) *Requirements for renewal of service program authorization.*

a. A service program seeking renewal of current authorization shall submit all required documentation to the department at least 90 days prior to the current authorization expiration date.

b. Transport service—full authorization. An entity seeking renewal authorization as a transport service program shall apply for full authorization at a minimum of the EMT level or the level of care that will be provided by the service program or through a transport agreement for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

c. Transport service—conditional service level authorization. An entity seeking renewal authorization as a transport service that is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) AEMT.
- (2) Paramedic.

d. Nontransport service—full authorization. An entity seeking renewal authorization as a nontransport service program shall apply for full authorization at a minimum of the EMR level or at the level of care that will be provided for initial 911 or emergency calls 24 hours per day, seven days per week at the following EMS service levels:

- (1) EMR.
- (2) EMT.
- (3) AEMT.
- (4) Paramedic.

e. Nontransport service—conditional service level authorization. An entity seeking renewal authorization as a nontransport service program that is capable of providing emergency medical care beyond the full authorization level on an intermittent basis may apply for conditional service level authorization at one or more of the following conditional service levels:

- (1) EMT.
- (2) AEMT.
- (3) Paramedic.

f. Air medical requirements.

(1) Staff fixed-wing ambulances, at a minimum on each flight request, with the following staff while a patient is being transported:

1. One health care clinician who is certified or licensed in the state from which the aircraft launches and is certified as an EMT or higher level; and
2. One FAA-certified commercial pilot who is appropriately rated in the aircraft being used for the transport.

(2) Staff rotorcraft ambulances, at a minimum on each flight request, with the following staff while a patient is being transported:

1. Two health care clinicians who are certified or licensed in the state from which the aircraft launches, one of whom must at a minimum be certified as a paramedic; and
2. One FAA-certified commercial pilot who is appropriately rated in the aircraft being used for the transport.

(3) Medical crew members trained in the following areas:

1. Patient care limitations in flight.
2. Altitude physiology.
3. Appropriate utilization of air medical services.
4. Air medical communication systems.
5. Aircraft operations and safety.
6. Emergency safety and survival.
7. Prehospital scene response and safety.
8. Crew resource management.
9. Program flight risk assessment procedures.

g. Conditional service level authorization requirements.

(1) A service program that has been granted conditional service level authorization shall only advertise or otherwise hold itself out to the public as an authorized service program at the level of full authorization.

(2) A service program authorized to operate at a conditional service level shall operate at such level only when an emergency medical care provider certified at the advanced certification level is listed on the service roster, physically present and directly responsible for patient care.

h. A service program that has submitted to the department fewer than 100 data reports per year for each of the previous two consecutive calendar years shall only be eligible for renewal of current authorization as an affiliate. The department will provide technical assistance in developing affiliations.

i. A service program shall be fully operational upon the effective date specified on the certificate of authorization and shall ensure compliance with Iowa Code chapter 147A and these rules.

j. A service program renewal authorization is valid for a period not to exceed three years from its effective date unless otherwise specified on the certificate of authorization or unless sooner revoked or suspended or surrendered.

132.2(3) *Reinstatement of service program authorization.*

a. A service program whose full authorization or conditional service level authorization has been revoked or suspended or surrendered may apply to the department for reinstatement in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the authorization is permanently revoked.

b. If the authorization was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender.

132.2(4) Out-of-state service programs.

a. An emergency medical service program authorized and based in another state shall provide the department with verification of current state authorization upon request and may provide emergency medical care to patients in Iowa.

b. A service program authorized and based in another state shall meet all requirements of Iowa Code chapter 147A and these rules and must be authorized by the department to respond to 911 requests in Iowa to transport patients in Iowa to locations within Iowa.

132.2(5) Service program inspections.

a. The department, at a minimum, will complete an inspection of each base of operations, all associated satellites, and all affiliate locations prior to initial authorization or renewal of current full authorization or conditional service level to ensure compliance with Iowa Code chapter 147A and these rules.

b. The department without prior notification may make additional inspections at times, at places and under such circumstances as it deems necessary to ensure compliance with Iowa Code chapter 147A and these rules.

c. Service program inspection forms are available on the department's website.

d. A service program shall correct deficiencies identified during a service program inspection within the time period specified by the department on the inspection form. Failure to correct identified deficiencies within the specified time period may result in disciplinary action.

e. The department may request additional information from or may inspect the records of any service program or associated satellite or associated affiliate that is currently authorized or that is seeking authorization to ensure continued compliance or to verify the validity of any information presented on the application for initial service program authorization or renewal of current authorization.

f. The department may inspect the patient care records of a service program to verify compliance with Iowa Code chapter 147A and these rules.

g. No person shall interfere with the inspection activities of the department or its agents pursuant to Iowa Code section 135.36.

h. Interference with or failure to allow an inspection by the department or its agents may be cause for disciplinary action.

[ARC 9124C, IAB 4/16/25, effective 5/21/25]

641—132.3(147A) Service program operations.**132.3(1) Ownership.**

a. Each service program will have a unique authorization number assigned by the department.

b. A service program with satellites will have a single authorization number assigned by the department for all locations.

c. A service program owner shall ensure compliance with Iowa Code chapter 147A and these rules.

d. A service program shall report any change in ownership to the department at least seven days prior to the change.

e. A service program changing ownership shall apply to the department at least seven days prior to the change in ownership for initial authorization in accordance with 132.2(1).

132.3(2) Medical director.

a. Each service program shall have a designated medical director at all times.

b. A medical director shall:

(1) Be accessible for medical direction 24 hours per day, seven days per week or ensure accessibility to alternate medical direction.

(2) Ensure that all duties and responsibilities of the medical director are not relinquished before a new or temporary replacement is functioning in that capacity.

(3) Complete a department-sponsored medical director training within one year of assuming duties as a medical director and at a minimum once every three years thereafter.

(4) Develop, approve, and update service program protocols that meet or exceed the minimum EMS clinical guidelines approved by the department.

(5) Ensure that the emergency medical care providers rostered with the service program are credentialed in the emergency medical skills to be provided and the duties of the emergency medical care provider do not exceed the provider's scope of practice as referenced in 641—subrule 131.4(2) and the service program's EMS service level of authorization.

(6) Be available for individual evaluation and consultation with service program personnel.

(7) Have authority to restrict a service program's authorized functional EMS service level.

(8) Have the authority to permanently or temporarily restrict a service program member to function within a lower level scope of practice or prohibit a service program member from providing patient care.

(9) Approve the service program's CQI program.

(10) Perform or complete, or appoint a designee to perform or complete, the medical audits in the service program's established CQI policy.

(11) Randomly audit (on at least a quarterly basis) documentation of calls where emergency medical care was provided.

(12) Randomly review audits performed by the qualified appointee.

c. A medical director may:

(1) Make additions to the department-approved EMS clinical guidelines when developing service protocols, provided the additions are within the service program's level of authorization, the EMS provider's scope of practice, and acceptable medical practice.

(2) Request that service program providers provide additional emergency medical care skills on a limited pilot project basis. The pilot project applications are available from the department upon request.

(3) Approve the physician, PA and RN exception form identifying the level of EMS provider equivalency not to exceed the service program's EMS service level authorization for each physician, PA and RN who will be providing emergency medical care as part of the service program.

d. A medical director who receives no compensation for the performance of the director's volunteer duties under this chapter is considered a state volunteer as provided in Iowa Code section 669.24 while performing volunteer duties as an emergency medical services medical director. Compensation does not include payments for reimbursement of expenses.

e. A medical director, supervising physician, PA, or ARNP who gives orders to an emergency medical care provider is not subject to criminal liability by reason of having issued the orders and is not liable for civil damages for acts or omissions relating to the issuance of the orders unless the acts or omissions constitute recklessness.

f. Nothing in these rules requires or obligates a medical director, supervising physician, PA, or ARNP to approve requests for orders received from an emergency medical care provider.

g. A service program medical director who fails to comply with Iowa Code chapter 147A or these rules may be referred to the Iowa board of medicine.

132.3(3) Service director.

a. Each service program shall have a designated service director at all times.

b. A service director shall:

(1) Be accessible 24 hours per day, seven days per week or ensure accessibility to a service director designee.

(2) Be responsible for providing direction and overall supervision of the administrative and operational aspects of the service program.

(3) Ensure that all duties and responsibilities of the service director are not relinquished before a new or temporary replacement is functioning in that capacity.

(4) Complete a department-sponsored training within one year of assuming duties as a service director and at a minimum once every three years thereafter.

(5) Ensure the service program is in compliance with service program policy, Iowa Code chapter 147A and these rules.

(6) Ensure that duties of the service program's emergency medical care providers do not exceed the providers' scope of practice as referenced in 641—subrule 131.4(2) or the service program's EMS service level of authorization.

132.3(4) *Service program requirements.*

a. A service program shall:

(1) Not advertise or otherwise imply or hold itself out to the public as a service program unless currently authorized by the department.

(2) Only advertise at or otherwise hold itself out as having the level of full authorization.

(3) Select a new or temporary medical director if the current medical director cannot or no longer wishes to serve in that capacity. Selection shall be made before the current medical director relinquishes the duties and responsibilities of that position.

(4) Notify the department in writing within seven days prior to any change in medical director or any reduction or discontinuance of operations.

(5) Select a new or temporary service director if the current service director cannot or no longer wishes to serve in that capacity. Selection shall be made before the current service director relinquishes the duties and responsibilities of that position.

(6) Notify the department in writing within seven days prior to any change in service director or any reduction or discontinuance of operations.

(7) Notify the department within seven days prior to any change in location of a service program base of operations, administrative office, satellite, or affiliate.

(8) Notify the department within seven days when entering into agreements with one or more service programs or a management entity to form multiservice systems for shared service program management, administration, data submission, or other services to ensure compliance with these rules.

(9) Report the termination or resignation in lieu of termination of an emergency medical care provider due to negligence, professional incompetency, unethical conduct, substance use, or violation of any of these rules to the department in writing within seven days.

(10) Report theft of drugs to the department in writing within 48 hours following the occurrence of the incident.

(11) Develop a notification process for service members in the event of a motor vehicle collision involving a first response vehicle, ambulance, rescue vehicle or personal vehicle when used by a service program member responding as a member of the service program.

(12) Notify the department in writing within 48 hours of a motor vehicle collision resulting in personal injury or death.

(13) Ensure a response to an initial 911 or emergency call request to the service program, 24 hours per day, seven days per week.

(14) Utilize protocols developed and approved by the service program medical director that meet or exceed the minimum EMS clinical guidelines approved by the department.

(15) Ensure alterations to the minimum EMS clinical guidelines by the service program's medical director are approved by and filed with the department.

(16) Maintain a communication system at a minimum between medical direction, receiving facility, and other emergency responders.

(17) Maintain a current personnel roster utilizing a department-approved registry system. Ensure all rostered personnel are currently certified as active EMS providers in the state of Iowa.

(18) Maintain files with the medical director and department-approved physician, PA and RN exception forms for appropriate personnel. Physician, PA and RN forms are available on the department's website.

(19) Ensure all service program members who operate motorized emergency response vehicles, ambulances, and rescue vehicles when used by a service member responding as a member of the service have a valid driver's license and attend driver training prior to driving an emergency vehicle.

(20) Develop, maintain and follow a written driver training policy that includes a review of Iowa laws regarding emergency vehicle operations (Iowa Code section 321.231), frequency of service required driver training, a review of service program policies and criteria for response with lights or sirens or both, speed limits, procedure for approaching intersections, and use of the service program communications equipment.

(21) Ensure the emergency medical care provider with the highest level of certification attends the patient unless otherwise indicated by patient assessment and approved by the service program's guidelines.

b. A ground transport service program shall:

(1) Provide as a minimum, on initial 911 or emergency calls, the following staff on each primary response ambulance:

1. One currently certified emergency medical care provider certified at the service program full level of authorization.

2. One driver.

(2) Provide as a minimum on each subsequent call or nonemergency call, when responding, the following staff:

1. One currently certified EMT.

2. One driver.

(3) Establish a transport decision policy that requires a complete assessment of a patient in order to determine transport needs. The service transport decision policy shall include:

1. The Out-of-Hospital Trauma and Triage Destination Decision Guideline, as amended to August 1, 2024, and described in 641—Chapter 135.

2. Time critical condition considerations for transport to facilities that specialize in conditions such as cardiac conditions or stroke.

3. A process for a service program provider to determine transportation to a hospital, medical clinic, extended care facility, or other facilities where health care is routinely provided.

4. A process for patient refusal or nontransport if emergency transport is not warranted. The service program provider will obtain a signed transport/treatment refusal document or liability release if transport is not required.

5. A process by which a service program provider may make arrangements for alternate transport if emergency transport is not needed and remain with the patient until alternate transport arrives unless the provider is called to respond to another emergency.

c. Air transport service programs.

(1) An air transport service program operating fixed wing ambulances shall, at a minimum on each flight request, staff fixed wing ambulances with the following staff while a patient is being transported:

1. One health care clinician who is certified or licensed in the state from which the aircraft launches and is certified as an EMT or higher level; and

2. One FAA-certified commercial pilot who is appropriately rated in the aircraft being used for the transport.

(2) An air transport service program operating rotorcraft ambulances shall, at a minimum on each flight request, staff rotorcraft ambulances with the following staff while a patient is being transported:

1. Two health care clinicians who are certified or licensed in the state from which the aircraft launches, one of whom must at minimum be certified as a paramedic; and

2. One FAA-certified commercial pilot who is appropriately rated in the aircraft being used for the transport.

d. Nontransport service programs.

(1) Nontransporting service programs, when responding to 911 or emergency calls, shall provide as a minimum one currently certified emergency medical care provider certified at the service program full level of authorization.

(2) Nontransport service programs shall have an executed written transport agreement ensuring simultaneous dispatch with an authorized transport service program for all 911 or emergency calls.

(3) Nontransport service programs may transport patients in an ambulance only in an emergency situation when lack of transporting resources would cause an unnecessary delay in patient care.

e. Service programs electing to diagnose or treat police service dogs. A service program that elects to have rostered emergency medical care providers diagnose or treat severely injured police service dogs shall develop, maintain, and follow policies and procedures for diagnosing or treating police service dogs. The policies and procedures shall be developed in consultation with a veterinarian holding an active license to practice veterinary medicine in Iowa pursuant to Iowa Code chapter 169.

132.3(5) *Data reporting.*

a. A service program shall report data electronically to the department.

b. A service program shall submit data in a format approved by the department.

c. A service program shall submit reportable data to the department no later than the last day of the month following the month services were provided.

d. The data collected by the EMS data 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 that individually identifies patients shall not be disclosed, and state and federal law regarding patient confidentiality shall apply.

e. 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.

(2) The department has given administrative approval for the proposal.

(3) The confidentiality of patients is protected pursuant to Iowa Code section 22.7 and chapter 147A.

(4) The department may require those requesting the data to pay any or all of the reasonable costs associated with furnishing the reportable data.

f. For the purpose of ensuring the completeness and quality of reportable data, the department or authorized representative may examine all or part of the data record as necessary to verify or clarify all reportable data submitted by a service program.

g. To the extent possible, activities under this subrule shall be coordinated with other health data collection methods.

h. A service program will develop, maintain and follow a written data submission policy.

132.3(6) *Patient care reporting.*

a. Each service program, satellite, and affiliate shall complete and maintain a patient care report documenting the care provided to each patient.

b. The patient care report is a confidential document and is exempt from disclosure pursuant to Iowa Code section 22.7(2) and shall not be accessible to the general public. Information contained in these reports, however, may be utilized by any of the indicated distribution recipients and may appear in any document or public health record in a manner that prevents the identification of any patient or person named in these reports.

c. To facilitate the continuum of care, transport service programs shall provide at a minimum, upon delivery of a patient to a receiving facility, a verbal patient care report that contains details of the assessment and care provided.

d. Transport service programs shall provide a final patient care report within 24 hours to the receiving facility. Transport services and receiving facilities must work together to initiate reasonable

and realistic mechanisms (including but not limited to paper, secure email, secure links, secure electronic system retrieval, and access to printers at the receiving facility) to ensure the delivery of the patient care report.

- e. A service program will develop, maintain, and follow a written patient care report policy.

132.3(7) *Continuous quality improvement (CQI).*

- a. A service program shall develop, maintain, and follow a CQI program that follows a written CQI policy.

- b.* The CQI program shall include medical audits that review patient care provided.

- c. The CQI program shall be utilized to identify deficiencies or potential deficiencies regarding medical knowledge or skill or procedure performance.

- d. The CQI program shall review at a minimum 911 response and scene times.

- e. The CQI program shall develop a written plan that monitors, identifies and documents at a minimum continuing education, credentialing of skills and procedures, and personnel performance for the service program's emergency medical care providers, drivers, physicians, PA and RN exceptions.

- f. The CQI program shall establish measurable outcomes that reflect the goals and standards of the service program.

- g. The CQI program shall ensure completion of loop closure/resolution of identified areas of concern.

132.3(8) *Medications in service programs.*

- a. A service program shall have written pharmacy agreements in accordance with the Iowa board of pharmacy's 657—Chapter 11.

- b. A service program shall maintain all medications in accordance with the rules of the Iowa board of pharmacy's 657—Chapters 10 and 11.

- c. A service program shall develop, maintain, and follow a written pharmacy policy.

132.3(9) *Vehicle standards, supplies, equipment and maintenance.*

- a. All service programs, regardless of their designation as governmentally owned, not-for-profit, or privately operated, shall, at a minimum, annually systematically inspect, repair, and maintain, or cause to be systematically inspected, repaired, and maintained, all ambulances operated by the service program.

- b. Ground transport and nontransport service programs shall utilize a vehicle inspection report approved by the department to record the results of an ambulance safety inspection. Safety inspection forms that comply with the requirements of 49 CFR 396 as amended to August 1, 2024, shall be approved by the department. A sample vehicle inspection form that complies with the reporting requirements of 49 CFR 396 as amended to August 1, 2024, can be found on the department's website.

- c. All service programs shall ensure individuals performing safety inspections are qualified and capable of performing an inspection by reason of experience, training, or both.

- d. All service programs shall not use an ambulance that fails to meet or maintain the requirements of this subrule to transport patients.

- e. Ground transport and nontransport service programs shall house primary response ambulances in a garage or other enclosed facility that is maintained in a clean, safe condition, free of debris or other hazards; is temperature controlled; and has an unobstructed exit to the street.

- f. All service programs shall secure all equipment stored in the ambulance patient compartment so the patient and service program personnel are not injured by moving equipment.

- g. For ground transport and nontransport service programs, new ambulances manufactured and placed into service shall meet at a minimum either the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances, as amended to August 1, 2024, or the National Fire Protection Association (NFPA) Standard for Automotive Ambulances (NFPA 1917) as amended to August 1, 2024.

h. All service programs shall maintain first response and rescue vehicles in safe operating condition and provide regular maintenance. Vehicles shall have the exterior clean and the interior clean and disinfected.

i. All service programs shall ensure medical and patient care supplies are monitored for expiration dates, cleaned, laundered or disinfected. All medical supplies shall be stored in clean environments.

j. All service programs shall ensure personal protection equipment and supplies are available to ensure emergency medical care responder safety during every response.

k. All service programs shall ensure supplies to properly dispose of biomedical hazardous waste are available in all response vehicles, and all waste shall be disposed of according to accepted biomedical waste practices.

l. All service programs shall ensure medical equipment is maintained per manufacturer requirements for safe emergency medical care provider and patient use.

m. All service programs will develop, maintain, and follow vehicle standards, supplies, and equipment maintenance policies.

[ARC 9124C, IAB 4/16/25, effective 5/21/25; ARC 9958C, IAB 1/7/26, effective 3/1/26]

641—132.4(147A) Waivers. If during a period of authorization, a service program is unable to maintain compliance with Iowa Code chapter 147A and these rules, the department may grant a waiver.

132.4(1) The department may grant waivers of these rules to a currently authorized service program.

132.4(2) Requests for waivers shall apply only to the service program requesting the waiver and shall apply only to those requirements and standards for which the department is responsible.

132.4(3) A service program shall apply for a waiver in accordance with 441—Chapter 2504.

[ARC 9124C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/10/26]

641—132.5(147A) Complaints and investigations—denial, citation and warning, probation, suspension or revocation of service program authorization or renewal.

132.5(1) All complaints regarding the operation of authorized emergency medical care service programs, or those purporting to be or operating as the same, shall be reported to the department.

132.5(2) Complaints and the investigative process will be treated as confidential in accordance with Iowa Code section 22.7 and chapter 272C. An emergency medical care provider who has knowledge of an emergency medical care provider, service program or training program that has violated Iowa Code chapter 147A or these rules shall report such information to the department within 30 days following knowledge of the violation.

132.5(3) Service program authorization may be denied, issued a civil penalty not to exceed \$1,000, issued a citation and warning, placed on probation, suspended, revoked, or otherwise disciplined by the department in accordance with Iowa Code section 147A.5(3) for any of the following reasons:

- a.* Knowingly allowing the falsifying of a patient care report (PCR).
- b.* Failure to submit required reports and documents.
- c.* Delegating professional responsibility to a person when the service program knows that the person is not qualified by training, education, experience or certification to perform the required duties.
- d.* Practicing, condoning, or facilitating discrimination against a patient, student or employee based on race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability diagnosis, or social or economic status.
- e.* Knowingly allowing sexual harassment of a patient, student or employee. Sexual harassment includes sexual advances, sexual solicitations, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

f. Failure or repeated failure of the applicant or alleged violator to meet the requirements or standards established pursuant to Iowa Code chapter 147A or the rules adopted pursuant to that chapter.

g. Obtaining or attempting to obtain or renew or retain service program authorization by fraudulent means or misrepresentation or by submitting false information.

h. Engaging in conduct detrimental to the well-being or safety of the patients receiving or who may be receiving emergency medical care.

i. Failure to correct a deficiency within the time frame required by the department.

j. Engaging in any conduct that subverts or attempts to subvert a department investigation.

k. Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.

l. Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.

m. Knowingly aiding, assisting or advising a person to unlawfully practice EMS.

n. Acceptance of any fee by fraud or misrepresentation.

o. Repeated failure to comply with standard precautions for preventing transmission of infectious diseases as issued by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services.

p. Violating privacy and confidentiality. A service program shall not disclose or be compelled to disclose patient information unless disclosure is required or authorized by law.

q. Practicing emergency medical services or using a designation of certification or otherwise holding itself out as practicing emergency medical services at a certain level of authorization when the service program is not authorized at such level.

r. Failure to respond within 30 days of receipt, unless otherwise specified, of communication from the department that was sent by registered or certified mail.

132.5(4) The department will notify the applicant of the granting or denial of authorization or renewal, or will notify the alleged violator of action to issue a citation and warning, place on probation or suspend or revoke authorization or renewal pursuant to Iowa Code sections 17A.12 and 17A.18.

132.5(5) Appeal rights. Notice of the right to appeal the denial, citation and warning, probation, suspension or revocation of service program authorization or renewal will be given in accordance with 441—Chapter 16 and may be appealed pursuant to 441—Chapter 2506.

[ARC 9124C, IAB 4/16/25, effective 5/21/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 147A and 2024 Iowa Acts, House File 2507.

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¹ See IAB, Inspections and Appeals Department.

² Rescission of paragraph 132.14(2) “f” inadvertently omitted from 2/2/05 Supplement.

CHAPTER 133
WHITE FLASHING LIGHT AUTHORIZATION

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—133.1(321) Definitions. For the purpose of these rules, the following definitions shall apply:

“*Ambulance*” means the same as defined in rule 641—132.1(147A).

“*Authorization certificate*” means a permit issued to an emergency medical care provider that authorizes the use of a white flashing light.

“*Authorized vehicles*” means any vehicles owned by members of the service program that are authorized by the department to use white flashing lights.

“*Emergency medical care provider*” means the same as defined in Iowa Code section 147A.1.

“*First response vehicle*” means the same as defined in rule 641—132.1(147A).

“*Medical director*” means the same as defined in rule 641—132.1(147A).

“*Member*” means any individual utilized by an ambulance or nontransport service to provide emergency medical care.

“*Nontransport service*” means the same as defined in rule 641—132.1(147A).

“*Rescue vehicle*” means the same as defined in Iowa Code section 321.1.

“*Service director*” means the same as defined in rule 641—132.1(147A).

“*Service program*” or “*service*” means the same as defined in Iowa Code section 147A.1.

“*White light*” means a white or clear rotating, flashing, or strobe lighting device utilized for identification purposes only. Any such lighting device shall not display a constant white or clear light to the rear of the vehicle.

[ARC 9075C, IAB 4/2/25, effective 6/1/25]

641—133.2(321) Purpose.

133.2(1) White flashing lights may be used on emergency vehicles or other authorized vehicles utilized by emergency medical care providers and service programs for identification purposes only.

133.2(2) White flashing lights shall be used only on an authorized vehicle and shall not be used except in any of the following circumstances:

- a. When responding to an emergency in the line of duty requiring the services of the member.
- b. When at the scene of an emergency.
- c. When transporting a patient during a disaster situation.

133.2(3) Owners and operators of authorized vehicles are responsible for ensuring that the lighting devices are utilized in a safe manner. This includes but is not limited to ensuring that lighting devices do not:

- a. Obstruct the view of the vehicle operator.
- b. Overburden the electrical system of the vehicle.
- c. Interfere with the vision of the vehicle operator, passengers, or drivers of other vehicles.

133.2(4) Operators of authorized vehicles shall ensure that the authorization certificate is carried in the vehicle.

[ARC 9075C, IAB 4/2/25, effective 6/1/25]

641—133.3(321) Application.

133.3(1) Authorization certificates will be issued by the service director for service vehicles and vehicles owned by emergency medical care providers who are members in good standing with the service. Authorization certificates are available from the department upon request. Vehicle authorization is limited to:

- a. Vehicles owned or exclusively operated by the ambulance or nontransport service.
- b. Vehicles owned or operated by emergency medical care provider members of the ambulance or nontransport service.
- c. Vehicles owned or operated by the service program’s medical director.

d. One authorization certificate per vehicle.

133.3(2) Nothing in these rules prevents the use of white flashing lights on vehicles that are authorized to use red or blue flashing lights.

133.3(3) The service director shall provide, upon request of the department or its agents, issued authorization certificates.

133.3(4) The authorization expires five years from the date issued unless sooner suspended or revoked.

133.3(5) The department may issue authorization certificates for vehicles used by employees of the department when responding to emergencies or disasters.

[ARC 9075C, IAB 4/2/25, effective 6/1/25]

641—133.4(321) Approval, denial, probation, suspension and revocation of authorization.

133.4(1) The service director or the department may approve or deny an application and the department may place on probation, suspend or revoke an authorization certificate if the service director or the department finds reason to believe that the applicant or certificate holder:

- a.* Has failed to meet all applicable requirements of these rules.
- b.* Has been convicted of a moving violation while using white flashing lights.
- c.* Has utilized a white flashing light without obtaining an authorization certificate.
- d.* Does not have a valid driver's license.
- e.* Does not have a current vehicle registration.

133.4(2) The authorization certificate shall be surrendered upon the request of the department or its agents.

133.4(3) An emergency medical care provider or service director who has knowledge of any emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall, within 30 days, report that information to the department.

133.4(4) A denial, probation, suspension or revocation ordered by the department shall be effected in accordance with 441—Chapter 16 and may be appealed according to the provisions set forth in 441—Chapter 2506.

[ARC 9075C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 321.423.

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CHAPTER 134
TRAUMA CARE FACILITY CATEGORIZATION AND VERIFICATION

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—134.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“*ACS-COT*” means the American College of Surgeons Committee on Trauma.

“*Categorization*” means the same as defined in Iowa Code section 147A.21.

“*Certificate of verification*” means a document awarded by the department that identifies a hospital or emergency care facility’s level and term of verification as a trauma care facility.

“*Criteria deficiency*” or “*deficiency*” means a failure to meet criteria requirements as outlined in subrule 134.2(3).

“*Emergency care facility*” means the same as defined in Iowa Code section 147A.21.

“*Emergency medical care provider*” means emergency medical care provider as defined in Iowa Code section 147A.1.

“*Final report*” means the verification report issued by the department following a verification review conducted by trauma survey team members and department staff.

“*Governing body*” means a group of individuals responsible for the governance of a hospital, including but not limited to a board of directors or board of trustees.

“*Hospital*” means any hospital licensed under Iowa Code chapter 135B.

“*On-site verification survey*” means an on-site survey conducted by the department or survey team members to assess a hospital or emergency care facility’s ability to meet the level of categorization requested.

“*Persistently occurring deficiencies*” means deficiencies identified in two sequential verification reviews.

“*Trauma*” means the same as defined in Iowa Code section 147A.21.

“*Trauma care facility*” means the same as defined in Iowa Code section 147A.21.

“*Trauma survey team*” means a group of health care providers contracted by the department to assist in verifying trauma care facilities’ compliance with trauma criteria adopted in subrule 134.2(3).

“*Type I criteria*” or “*type I criteria deficiency*” indicates criteria requirements that may significantly impact a trauma care facility’s ability to provide optimal care for trauma patients.

“*Type II criteria*” or “*type III criteria deficiency*” indicates criteria that are required but have a less critical impact on the trauma care facility’s ability to provide optimal care for trauma patients than type I criteria.

“*Verification*” means the same as defined in Iowa Code section 147A.21.

[ARC 9125C, IAB 4/16/25, effective 6/1/25]

641—134.2(147A) Trauma care facility categorization and verification. Categorization and verification of trauma care facilities will be made by the department in accordance with Iowa Code section 147A.23.

134.2(1) Categorization applications shall be submitted by all hospitals. New hospitals and emergency care facilities shall submit a categorization application no later than 90 days after licensing by the department of inspections, appeals, and licensing.

134.2(2) Categorization levels for trauma care facilities shall be identified as:

- a. Level I.
- b. Level II.
- c. Level III.
- d. Level IV.

134.2(3) Adoption by reference. Criteria specific to level I, II, and III trauma care facilities identified in the “Resources for Optimal Care of the Injured Patient” 2022 Standards published by the American College of Surgeons (ACS) is incorporated and adopted by reference for level I, II, and

III hospital and emergency care facility categorization criteria. Criteria specific to level IV trauma care facilities identified in the “Resources for Optimal Care of the Injured Patient 2014” published by the ACS is incorporated and adopted by reference for level IV hospital and emergency care categorization criteria. For any differences that may occur between the adopted references and these administrative rules, the administrative rules shall prevail.

134.2(4) Categorization shall not be construed to imply any guarantee on the part of the department as to the level of trauma care services available at a trauma care facility.

134.2(5) A verified trauma care facility may apply to the department for a change in level of categorization through submission of a self-assessment categorization application.

134.2(6) Verification of a trauma care facility will be determined by the department upon successful completion of the categorization application and completion of a verification survey. All categorized hospitals and emergency care facilities shall be verified. Each hospital location operating on a single hospital license must provide the same level of trauma care or be verified separately to the level of trauma care services at that location.

a. Level I and II trauma care facilities shall be verified by the ACS-COT.

b. Trauma care facilities verified by the ACS-COT will be accepted by the department as equivalent for categorization and verification as a trauma care facility in Iowa provided that all policy, reporting, and administrative rules have been met. The department may issue a certification of verification provided that the trauma care facility has been verified by the ACS-COT. The facility shall provide the department documentation including but not limited to a current copy of the ACS-COT verification.

c. A level I or II trauma care facility that fails to attain ACS-COT verification shall submit an application to the department to be verified as a level III or IV trauma care facility to ensure compliance with Iowa Code section 147A.23(2)“a.”

d. Level III and IV trauma care facilities will be verified by the department in consultation with the trauma survey team.

134.2(7) The department will conduct a verification survey for categorized hospitals or emergency care facilities.

a. Type I and II criteria deficiencies identified during the verification process shall be resolved in accordance with the trauma care facility’s final report. Failure to rectify deficiencies in accordance with the trauma care facility’s final report may result in disciplinary action.

b. The department may conduct electronic review or on-site verification that criteria deficiencies have been resolved as outlined in final reports or disciplinary actions.

c. The department will notify the applicant in writing as to the approval or denial of verification as a trauma care facility within 90 days after the completion of a verification survey.

d. Verification cannot be construed to imply any guarantee on the part of the department as to the level of trauma care services available at a hospital or emergency care facility.

e. Trauma care facility verification is valid for a period of three years from the effective date unless otherwise specified on the certificate of verification or unless sooner suspended or revoked.

f. Trauma care facilities shall be fully operational at their verified level upon the effective date specified on the certificate of verification.

g. Trauma care facilities that are unable to maintain their categorization or verification, or both, must notify the department within 48 hours.

h. The director, pursuant to 441—Chapter 2504, may grant a waiver from the requirements of rules adopted under this chapter for any trauma care facility.

i. Proceedings, records, and reports developed pursuant to this chapter constitute peer review records under Iowa Code section 147.135 and are not subject to discovery by subpoena or admissible as evidence. All information and documents received from a hospital, emergency care facility, or trauma care facility under Iowa Code chapter 147A are confidential pursuant to Iowa Code section 272C.6(4).

[ARC 9125C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—134.3(147A) Complaints, investigations and appeals.

134.3(1) The department may deny verification as a trauma care facility or may give a citation and warning, place on probation, suspend, or revoke existing verification if the department finds reason to believe that the facility has not been operating or will not be operated in compliance with Iowa Code section 147A.23 and these administrative rules or that there is insufficient assurance of adequate protection for the public.

134.3(2) All complaints regarding the operation of a trauma care facility, or those purporting to be or operating as the same, shall be reported to the department.

134.3(3) Complaints and the investigative process shall be treated as confidential to the extent that they are protected by Iowa Code section 22.7 and chapter 272C.

134.3(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

134.3(5) Notice of denial, citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of 441—Chapter 16 and appealed pursuant to 441—Chapter 2506.

134.3(6) Final decisions of the department relating to disciplinary proceedings may be transmitted to the appropriate professional associations, news media or employer.

[ARC 9125C, IAB 4/16/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

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CHAPTER 135
TRAUMA TRIAGE AND TRANSFER PROTOCOLS

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—135.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“Out-of-Hospital Trauma Triage Destination Decision Protocols” means written directives to assist in trauma and triage decision-making, established and approved by the department, to be followed by the service program.

“Service program” or *“service”* means the same as defined in Iowa Code section 147A.1.

“Transfer” means the process of a patient being transferred from the scene of an injury to a trauma care facility or from one trauma care facility to another.

“Trauma care facility” means the same as defined in Iowa Code section 147A.21.

“Trauma triage and transfer” means to determine the trauma care facility destination.

[ARC 9076C, IAB 4/2/25, effective 6/1/25]

641—135.2(147A) Trauma triage and transfer protocols. Trauma triage and transfer protocols approved by the department assist personnel from each service program and trauma care facility. These protocols do not preclude service programs or trauma care facilities from making emergency revisions of the approved triage and transfer protocols when an incident overburdens medical care resources, causing an unnecessary delay in patient care.

135.2(1) Adoption by reference. The 2021 National Guideline for the Field Triage of Injured Patients, as amended to August 1, 2024, is incorporated by reference and adopted as the Out-of-Hospital Trauma Triage Destination Decision Protocol for the state of Iowa.

135.2(2) Revisions and modifications to the protocols adopted by reference in subrule 135.2(1) may be made upon recommendation to and approval of the department.

[ARC 9076C, IAB 4/2/25, effective 6/1/25]

641—135.3(147A) Offenses and penalties. The department may deny verification as a trauma care facility or deny authorization as a service program or may give a citation and warning, place on probation, suspend, or revoke existing trauma care facility verification or service program authorization if the department finds reason to believe that the facility or service program has not been or will not be operated in compliance with Iowa Code section 147A.27 and these administrative rules. The denial, citation and warning, period of probation, suspension, or revocation shall be effected in accordance with 441—Chapter 16 and may be appealed in accordance with the requirements of 441—Chapter 2506.

[ARC 9076C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 136 TRAUMA REGISTRY

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—136.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“Health care providers” for the purpose of this chapter includes licensed physicians, advanced registered nurse practitioners, physician associates, and registered nurses.

“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 and definitions determined by the department to be reported to the trauma registry on trauma patients meeting the inclusion criteria.

“Trauma care facility” means the same as defined in Iowa Code section 147A.21.

“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 approved by the department to collect and analyze reportable patient data on the incidence, severity, and causes of trauma, and that serves as the central registry for brain and spinal cord injuries described in rule 641—21.1(135) and farm-related injuries.

“Trauma survey team” means a group of health care providers contracted by the department to assist in verifying trauma care facilities’ compliance with trauma criteria adopted by reference in 641—subrule 134.2(3).

[ARC 9077C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—136.2(147A) Trauma registry.

136.2(1) Trauma care facilities shall submit reportable patient data electronically to the department. Data shall be submitted in the trauma registry format approved by the department. 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(2) Quality assurance of reported data.

a. For the purpose of ensuring the completeness and quality of reportable patient data, the department or its designated trauma survey team may examine medical records to validate the accuracy of data submitted by a trauma care facility.

b. Review of medical records by the department or its designated trauma survey team may be scheduled in advance with the trauma care facility.

[ARC 9077C, IAB 4/2/25, effective 6/1/25]

641—136.3(147A) Offenses and penalties. All complaints, offenses and penalties will be addressed pursuant to rule 641—134.3(147A).

[ARC 9077C, IAB 4/2/25, effective 6/1/25]

These rules are intended to implement Iowa Code section 147A.26.

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CHAPTER 137
TRAUMA EDUCATION AND TRAINING

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—137.1(147A) Definitions. For the purposes of these rules, the following definitions apply:

“Advanced registered nurse practitioner” or *“ARNP”* means a nurse as defined in rule 655—7.1(152).

“Formal education” means education in standardized educational settings with a curriculum.

“Licensed practical nurse” or *“LPN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician associate” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Practitioner” means a person who practices medicine or one of the associated health care professions.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Trauma” means the same as defined in Iowa Code chapter 147A.

“Trauma care facility” means the same as defined in Iowa Code chapter 147A.

“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.

“Verification” means the same as defined in Iowa Code chapter 147A.

[ARC 9078C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—137.2(147A) Initial trauma education requirements.

137.2(1) Trauma education is required of physicians, physician associates, advanced registered nurse practitioners, registered nurses, and licensed practical nurses who are identified or defined as trauma team members by a trauma care facility and who participate directly in the initial resuscitation of the trauma patient.

137.2(2) Requirements for initial trauma education. Specific requirements for initial trauma education for each provider category are as follows:

a. Physicians, PAs and ARNPs shall comply with education criteria specific to the level for which the trauma care facility is verified. Physicians, PAs and ARNPs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. Physicians, PAs and ARNPs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

b. RNs and LPNs shall comply with education criteria specific to the level for which the trauma care facility is verified. RNs and LPNs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. RNs and LPNs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

[ARC 9078C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—137.3(147A) Continuing trauma education requirements. Specific requirements for continuing trauma education for each provider category are as follows:

137.3(1) Physicians, PAs and ARNPs shall comply with education criteria specific to the level for which the trauma care facility is verified. Physicians, PAs and ARNPs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. Physicians, PAs

and ARNPs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

137.3(2) RNs and LPNs shall comply with education criteria specific to the level for which the trauma care facility is verified. RNs and LPNs at verified level I, II, and III trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of Injured Patients 2022 Standards” published by the American College of Surgeons. RNs and LPNs at verified level IV trauma care facilities shall comply with criteria according to the “Resources for Optimal Care of the Injured Patient 2014” published by the American College of Surgeons.

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CHAPTER 139
EMERGENCY MEDICAL SERVICES—TRAINING
PROGRAMS—STUDENTS—COMPLAINTS AND INVESTIGATIONS

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—139.1(147A) Definitions.

“Advanced emergency medical technician” or *“AEMT”* means the same as defined in rule 641—131.1(147A,147D,272C).

“CAAHEP” means the same as defined in rule 641—131.1(147A,147D,272C).

“CAPCE” means the same as defined in rule 641—131.1(147A,147D,272C).

“CEH” means the same as defined in rule 641—131.1(147A,147D,272C).

“Certification” or *“certificate”* means the same as defined in rule 641—131.1(147A,147D,272C).

“Certified” means the same as defined in rule 641—131.1(147A,147D,272C).

“CoAEMSP” means Committee on Accreditation for the EMS Professions.

“Core continuing education” means the same as defined in rule 641—131.1(147A,147D,272C).

“Course completion date” means the date of the final classroom session of an emergency medical care provider course.

“Course coordinator” means an individual who has been assigned by the training program to coordinate the activities of an emergency medical care provider course.

“Critical care paramedic” or *“CCP”* means the same as defined in rule 641—131.1(147A,147D,272C).

“Emergency medical care” means any medical procedure authorized by Iowa Code chapter 147A and 641—Chapter 131.

“Emergency medical care provider” means the same as defined in Iowa Code section 147A.1.

“Emergency medical care student” or *“student”* means any individual enrolled in an EMS training program.

“Emergency medical responder” or *“EMR”* means the same as defined in rule 641—131.1(147A,147D,272C).

“Emergency medical services” or *“EMS”* means the same as defined in Iowa Code section 147A.1.

“Emergency medical technician” or *“EMT”* means the same as defined in rule 641—131.1(147A,147D,272C).

“EMS evaluator” or *“EMS-E”* means an individual who has successfully completed an EMS evaluator curriculum approved by the department and is currently endorsed by the department as an EMS-E.

“EMS instructor” or *“EMS-I”* means the same as defined in rule 641—131.1(147A,147D,272C).

“EMS training program” or *“training program”* means a program offered by an Iowa college approved by the Higher Learning Commission, an Iowa hospital, or a service program that has received authorization from the department to conduct emergency medical care training.

“Endorsement” or *“endorsed”* means the same as defined in rule 641—131.1(147A,147D,272C).

“Higher Learning Commission” means the independent corporation that accredits degree-granting postsecondary institutions in the north central region of the United States.

“NREMT” means the same as defined in rule 641—131.1(147A,147D,272C).

“Out-of-state student” means any individual participating in clinical or field experience as a student in an approved out-of-state training program.

“Out-of-state training program” means an EMS training program located outside the state of Iowa that is approved by the authorizing agency of the program’s home state to conduct initial EMS training for EMR, EMT, AEMT, paramedic or other levels certified by the department.

“Outreach course coordinator” means an individual assigned by the training program to coordinate the activities of an emergency medical care provider course held outside the training program facilities.

“Paramedic” or *“PM”* means the same as defined in rule 641—131.1(147A,147D,272C).

“Physician” means an individual licensed under Iowa Code chapter 148.

“Physician associate” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Preceptor” means an individual assigned by the training program, clinical facility or service program to supervise EMS students while the students are completing their clinical or field experience. A preceptor shall be an emergency medical care provider certified at the level at which the preceptor is providing supervision or at a higher level or be licensed as a physician, physician associate or registered nurse.

“Primary instructor” means an individual who is responsible for teaching the majority of an emergency medical care provider course.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Service program” or *“service”* means the same as defined in Iowa Code section 147A.1.

“Training program director” means a health care professional (full-time educator or practitioner of emergency or critical care) assigned by the training program to direct the operation of the training program.

“Training program medical director” means a physician licensed under Iowa Code chapter 148 who is responsible for providing medical oversight to an EMS training program.

[ARC 9079C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—139.2(147A) Initial application, renewal application, inspection and approval.

139.2(1) *Initial application, inspection and approval.*

a. An applicant seeking initial authorization as an EMS training program shall complete and submit to the department an Iowa EMS training program self-assessment application. The application is available from the department upon request.

b. The department will perform an on-site inspection of the applicant’s facilities and clinical resources. The purpose of the inspection is to examine educational objectives, patient care practices, facilities and administrative practices.

c. A training program’s initial authorization is for one year.

d. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for denial of authorization.

139.2(2) *Renewal application, inspection and approval.*

a. A training program seeking renewal as an EMS training program shall complete and submit to the department the Iowa EMS training program self-assessment renewal application. The application is available from the department upon request.

b. EMS training program renewal applications will be submitted at least 90 days before the end of the current authorization period.

c. The department will complete an on-site inspection and review the self-assessment prior to the end of the current authorization period.

d. Following the on-site inspection, the department will provide the training program a renewal application report detailing the status of the application.

e. The department will authorize the training program or determine timelines for the correction of deficiencies in the renewal application.

f. If the deficiencies are not corrected within the time period established by the department, the training program is subject to disciplinary action as described in rule 641—139.8(147A).

g. A training program’s approved renewal authorization will not exceed four years.

h. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for denial of authorization.

[ARC 9079C, IAB 4/2/25, effective 6/1/25]

641—139.3(147A) Training program standards, student requirements and waivers.**139.3(1) Education standards.** A training program shall:

- a. Have a sponsoring institution that has received authorization from the department to conduct emergency medical care services training.
- b. Use the U.S. Department of Transportation's National Emergency Medical Services Education Standards (December 2021) for any courses leading to Iowa certification.
- c. Use the Iowa CCP curriculum (January 2024) for courses leading to the CCP endorsement.
- d. Be accredited by CAAHEP or have a letter of review from CoAEMSP if graduating students at the paramedic certification level.
- e. Document equivalent training and what portions of any course have been waived for equivalency. A training program may waive portions of the required emergency medical care provider training for students currently certified as emergency medical care providers or licensed in other health care professions, including but not limited to physician, nursing, physician associate, respiratory therapist, dentistry, and military.

139.3(2) Clinical or field experience resources. Training programs shall:

- a. Have a mechanism to clearly identify students in the clinical or field setting, or both.
- b. Ensure that clinical experiences available are consistent with the needs of the curriculum and adequate for the number of students enrolled.
- c. Ensure that clinical affiliations that are outside of the sponsoring training program are established and confirmed in written agreements with institutions or agencies that provide clinical experience under appropriate medical direction and clinical supervision.
- d. Only allow students to perform skills and procedures in the clinical or field setting for which the students have received training with direct supervision by a preceptor designated and approved by the training program.

139.3(3) Staff. Training programs shall:

- a. Have a training program director who is a health care professional (full-time educator or practitioner of emergency or critical care) assigned by the training program to direct the operation of the training program.
- b. Have a training program medical director who shall, at a minimum, review the educational content of each training program curriculum, evaluate the quality of medical instruction, and supervise delivery of the curriculum by the faculty members.
- c. Have qualified faculty through academic preparation, training, and experience to teach and evaluate the courses or topics to which they are assigned. At a minimum, each course coordinator, outreach course coordinator, and primary instructor utilized by the training program shall be endorsed as an Iowa EMS instructor.

139.3(4) Student eligibility. Training programs shall ensure that emergency medical care students meet the following requirements:

- a. Be at least 17 years of age on the date of enrollment.
- b. Have a high school diploma or its equivalent if enrolling in an AEMT or paramedic course.
- c. Be able to speak, write and read English.
- d. Be able to meet the minimum requirements for the department- or NREMT-approved testing requirements with reasonable and appropriate accommodations for those persons with documented disabilities, as required by the Americans with Disabilities Act (ADA) as amended to August 1, 2024.
- e. Be currently certified, at a minimum, as an EMT if enrolling in an AEMT or paramedic course.
- f. Be a current emergency medical care provider, RN, PA, or physician when applying for the EMS instructor endorsement.

139.3(5) Students. Training programs shall:

- a. Have defined processes for review of academic history, criminal history, and health-related issues for the admission of students.

- b. Have a process to evaluate students on a recurring basis and with sufficient frequency to provide both the student and training program faculty with valid and timely indicators of the student's progress and achievement of the competencies and objectives stated within the program's curriculum.
- c. Have student guidance procedures that include documentation of regular and timely discussions with qualified faculty or counselors.
- d. Maintain student records for each student enrolled in each program.
- e. Notify the NREMT of each student's successful completion of a training course to ensure NREMT cognitive examination eligibility.
- f. Verify that a student completes all training program requirements before being eligible to attempt the department- or NREMT-approved testing requirements.
- g. Ensure that students only perform skills or procedures learned in the training program until an Iowa emergency medical care provider certification is obtained.
- h. Ensure that a student is not substituted for the regular personnel of any affiliated medical facility or service program but may be employed while enrolled in the training program.

139.3(6) *Financing and administration.* Training programs shall:

- a. Have sufficient equipment and supplies to be used in the provision of instruction. The equipment and supplies shall be available and consistent with the needs of the curriculum and adequate for the number of students enrolled.
- b. Have sufficient classrooms, laboratories, and administrative offices and facility design to accommodate the number of students in the program and the supporting faculty.
- c. Notify the department, in writing, of any change in ownership or control of the training program.
- d. Have liability insurance or offer liability insurance to enrolled students.

[ARC 9079C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—139.4(147A) Out-of-state training programs.

139.4(1) *Application, inspection and approval.*

- a. An out-of-state training program shall complete and submit to the department for review and approval the out-of-state training program self-assessment application. The application is available from the department upon request.
- b. An out-of-state training program's approval by the department shall not exceed four years.
- c. An out-of-state training program seeking initial or renewal approval must be accredited by CAAHEP or have a letter of review from CoAEMSP if graduating students at the paramedic certification level.
- d. An out-of-state training program shall be limited to utilization of clinical sites or field sites, or both, within Iowa.
- e. An authorized out-of-state training program shall provide the department with a current roster of students who will be participating in the clinical or field experience within the state of Iowa and, for each program, the sites where the students will be participating. This roster will be provided prior to commencement of any clinical or field experience.
- f. An out-of-state training program shall provide documentation of liability insurance for each student participating in the clinical or field setting within the state of Iowa.
- g. Failure to comply with these requirements may lead to disciplinary action or denial of utilization of clinical or field sites in Iowa.
- h. The department may perform an on-site inspection of the out-of-state training program's facilities and clinical and field resources as part of the initial or renewal review process.
- i. The department, without prior notification, may make inspections at times, at places and under such circumstances as it deems necessary to ensure compliance with Iowa Code chapter 147A and these rules.

j. No person shall interfere with the inspection activities of the department or its agents. Interference with or failure to allow an inspection may be cause for disciplinary action regarding training program approval.

k. Representatives of the training program may be required to meet with the department at the time the application and inspection report are discussed.

l. A written report of department action and the department inspection report will be sent to the training program.

m. A training program shall notify the department, in writing, of any change in ownership or control within 30 days.

139.4(2) Reserved.

[ARC 9079C, IAB 4/2/25, effective 6/1/25]

641—139.5(147A) Failure to comply with rules. Failure of a training program to comply with these rules may result in disciplinary action according to rule 641—139.8(147A).

[ARC 9079C, IAB 4/2/25, effective 6/1/25]

641—139.6(147A) Temporary waivers. If during a period of authorization there is some occurrence that temporarily causes a training program to be in noncompliance with these rules, the department may grant a temporary waiver.

139.6(1) Waivers of these rules may be granted by the department to a currently authorized training program.

139.6(2) Requests for waivers apply only to the training program requesting the waiver and apply only to those requirements and standards for which the department is responsible.

139.6(3) A training program can apply for a waiver in accordance with 441—Chapter 2504.

[ARC 9079C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—139.7(147A) Continuing education providers—approval, recordkeeping and inspection.

139.7(1) A training program may conduct or authorize other entities to provide continuing education courses.

139.7(2) Each training program shall assign a sponsor number to each core continuing education course using an assignment system approved by the department.

139.7(3) Course approval shall be completed prior to the course being offered.

139.7(4) Each training program shall maintain a participant record that includes, at a minimum, each participant's:

- a.* Name.
- b.* Address.
- c.* Certification number.
- d.* Course sponsor number.
- e.* Course instructor.
- f.* Date of course.
- g.* CEHs awarded.

139.7(5) The department may request additional information or inspect the records of any continuing education provider who is currently approved or who is seeking approval.

[ARC 9079C, IAB 4/2/25, effective 6/1/25]

641—139.8(147A) Discipline—denial, citation and warning, probation, suspension, or revocation of training program approval or renewal.

139.8(1) This rule is not subject to waiver pursuant to 441—Chapter 2504 or any other provision of law.

139.8(2) Method of discipline. The department has the authority to impose the following disciplinary sanctions against a training program:

- a.* Issue a citation and warning.

- b.* Impose a period of probation under specific conditions.
- c.* Prohibit permanently, until further order of the department, or for a specific period, a program's ability to engage in specific procedures, methods, acts or activities incident to the practice of the profession.
- d.* Suspend an authorization until further order of the department or for a specific period.
- e.* Deny an application for authorization.
- f.* Revoke an authorization.
- g.* Impose such other sanctions as allowed by law and as may be appropriate.

139.8(3) The department may impose any of the disciplinary sanctions provided in subrule 139.8(2) when it finds that the training program or applicant has failed to meet the applicable provisions of these rules or has committed any of the following acts or offenses:

- a.* Fraud in procuring approval or renewal.
- b.* Falsification of training or continuing education records or failure to document training or continuing education.
- c.* Suspension or revocation of approval to provide emergency medical care training or other disciplinary action taken pursuant to Iowa Code chapter 147A. A certified copy of the record or order of suspension, revocation or disciplinary action is conclusive or prima facie evidence.
- d.* Engaging in any conduct that subverts or attempts to subvert a department investigation.
- e.* Failure to respond within 30 days of receipt of communication from the department that was sent by registered or certified mail.
- f.* Failure to comply with a subpoena issued by the department or failure to cooperate with an investigation of the department.
- g.* Failure to comply with the terms of a department order or the terms of a settlement agreement or consent order.
- h.* Submission of a false report of continuing education.
- i.* Knowingly aiding, assisting or advising a person to unlawfully practice EMS.
- j.* Representing itself as an approved training program or continuing education provider when approval has been suspended or revoked or when approval has lapsed or has been placed on inactive status.
- k.* Using an unqualified individual as an instructor or evaluator.
- l.* Allowing verbal or physical abuse of a student or staff.
- m.* Failing to verify registration of a student with the department within the timeline established by the department or allowing an unregistered student to function in a clinical environment.
- n.* Sexually harassing a patient, student or coworker. Sexual harassment includes sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature communicated in person, in writing, via a third person or through electronic communication.
- o.* Betrayal of a professional confidence.
- p.* Engaging in a professional conflict of interest.
- q.* Discrimination. A training program or continuing education provider shall not practice, condone, or facilitate discrimination against a patient, student, or supervisee on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, mental or physical disability, diagnosis, or social or economic status.
- r.* Failure to comply with the 2015 Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions published by the Commission on Accreditation of Allied Health Education Programs.

[ARC 9079C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—139.9(147A) Complaints, investigations and appeals.

139.9(1) All complaints regarding an emergency medical care student, training programs or continuing education providers or those purporting to be or operating as the same shall be reported to the department in writing.

139.9(2) Any emergency medical care provider, emergency medical care student, training program or continuing education provider who has knowledge of an emergency medical care provider or service program that has violated Iowa Code chapter 147A, 641—Chapter 132 or these rules shall report such information to the department.

139.9(3) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

139.9(4) A determination of mental incompetence by a court of competent jurisdiction automatically suspends a certificate for the duration of the certificate unless the department orders otherwise.

139.9(5) Notice of denial, issuance of a citation and warning, probation, suspension or revocation shall be effected in accordance with the requirements of 441—Chapter 16 and can be appealed pursuant to 441—Chapter 2506.

[ARC 9079C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code chapter 147A.

[Filed ARC 5143C (Notice ARC 4857C, IAB 1/15/20), IAB 8/12/20, effective 9/16/20]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 142
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/1/30

641—142.1(144A) Definitions. For the purpose of these rules, the following definitions apply:

“Adult” means an individual 18 years of age or older.

“Attending physician” means a physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

“Attending physician associate” means the physician associate selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

“Comfort care” means care within the scope of the health care provider’s training and certification to alleviate pain and suffering but does not include resuscitative measures.

“Emergency medical care” means such medical procedures as:

1. Administration of intravenous solutions.
2. Intubation.
3. Performance of cardiac defibrillation and synchronized cardioversion.
4. Administration of emergency drugs as provided by rule by the department.
5. Any other medical procedure approved by the department, by rule, as appropriate to be performed by emergency medical care providers who have been certified in that procedure.

“EMS provider” means an emergency medical care provider as defined in Iowa Code section 147A.1.

“Health care provider” means a person, including an emergency medical care provider, who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

“Hospital” means any hospital licensed under the provisions of Iowa Code section 135B.1.

“Life-sustaining procedure” means any medical procedure, treatment, or intervention, including resuscitation, which utilizes mechanical or artificial means to sustain, restore or supplant a spontaneous vital function, and when applied to a patient in a terminal condition, would serve only to prolong the dying process. “Life-sustaining procedure” does not include the provision of nutrition or hydration except when required to be provided parenterally or through intubation or the administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

“Medical direction” means direction, advice, or orders provided by a medical director or supervising physician.

“Medical director” means any physician licensed under Iowa Code chapter 148 who is 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.

“Online medical direction” means immediate medical direction provided directly to service program emergency medical care providers, in accordance with written parameters and protocols, by the medical director or supervising physician, either on scene or by any telecommunications system.

“Out-of-hospital do-not-resuscitate identifier” or *“OOH DNR identifier”* means a durable yet easily removable unique identification approved by the department and worn by a patient who has an out-of-hospital do-not-resuscitate order.

“Out-of-hospital do-not-resuscitate order” or *“OOH DNR order”* means a written order on a form approved by the department, signed by an attending physician, executed in accordance with the requirements of Iowa Code section 144A.7A and issued consistent with Iowa Code section 144A.2, that directs the withholding or withdrawal of resuscitation when an adult patient in a terminal condition is outside the hospital.

“Out-of-hospital do-not-resuscitate protocol” or *“OOH DNR protocol”* means the statewide protocol approved by the department and intended to avoid unwarranted resuscitation by emergency

medical care providers when a valid out-of-hospital do-not-resuscitate order or identifier is encountered.

“Patient” means any individual who is sick, injured, or otherwise incapacitated.

“Physician” means any individual licensed under Iowa Code chapter 148.

“Physician associate” or *“PA”* means an individual licensed pursuant to Iowa Code chapter 148C.

“Qualified patient” means any patient who is an adult as defined in Iowa Code section 144A.2.

“Registered nurse” or *“RN”* means an individual licensed pursuant to Iowa Code chapter 152.

“Resuscitation” means any medical intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a spontaneous vital function, including but not limited to chest compression, defibrillation, intubation, and emergency drugs intended to alter cardiac function or otherwise to sustain life.

“Service program” or *“service”* means any medical care ambulance service or nontransport service that has received authorization by the department.

“Supervising physician” means any physician licensed under Iowa Code chapter 148.

“Terminal condition” means an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery.

[ARC 9081C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—142.2(144A,147A) Responsibilities of the department.

142.2(1) *OOH DNR physician or physician associate order.* The department designates the OOH DNR order form contained in Appendix A as the uniform OOH DNR order form to be used statewide. If an attending physician or attending physician associate issues an OOH DNR order for a qualified patient, the physician or physician associate must use the form contained in Appendix A.

142.2(2) *OOH DNR personal identifier.* The department designates the identifier supplied by MedicAlert® as the uniform personal identifier to be used for mobile qualified patients statewide. Instructions for obtaining a uniform personal identifier are contained in Appendix A.

142.2(3) *OOH DNR protocol.* The department designates the OOH DNR protocol contained in Appendix B as the uniform protocol to be used by EMS providers in implementing an OOH DNR order.

142.2(4) *Appendix A and Appendix B forms.* Forms referenced in subrules 142.3(1) through 142.3(3) are available through the department’s website or by request.

[ARC 9081C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—142.3(144A,147A) EMS providers.

142.3(1) *Uniform protocol.* EMS providers shall act in accordance with the department’s OOH DNR protocol when implementing an OOH DNR order. EMS service programs shall incorporate the OOH DNR protocol as part of their service protocols and, using educational materials consistent with the curriculum developed and approved by the department, shall inform and educate EMS providers on the protocol’s requirements as well as the requirements of Iowa Code chapter 144A and these rules.

142.3(2) *Responsibility of the EMS provider.* The EMS provider responding outside a hospital as a member of a service program shall:

- a. Evaluate the patient’s status and needs through an assessment consistent with the provider’s training and certification.
- b. Determine the existence of an OOH DNR order or that the patient is wearing an OOH DNR identifier.
- c. Honor the OOH DNR order or OOH DNR identifier worn by the patient.
- d. Discontinue resuscitation if the OOH DNR order or OOH DNR identifier worn by the patient is discovered after resuscitation has begun.
- e. Follow the OOH DNR protocol.
- f. Provide comfort care to the patient at all times.

g. Contact on-line medical direction for further instructions as necessary to provide appropriate patient care.

h. If uncertainty exists regarding the validity or applicability of the OOH DNR order or identifier, the EMS provider shall provide the necessary and appropriate resuscitation.

i. Document compliance or noncompliance with the OOH DNR order and the reasons for not complying with the order, including evidence that the order was revoked or uncertainty regarding the validity or applicability of the order.

[ARC 9081C, IAB 4/2/25, effective 6/1/25]

641—142.4(144A) Guidelines for non-EMS health care providers, patients, and organizations. In order to encourage understanding and implementation of OOH DNR orders and protocols throughout Iowa and honor a qualified patient's wishes and intent regarding the provision of life-sustaining procedures in an out-of-hospital setting consistent with the requirements of Iowa Code chapter 144A, the following guidelines should be considered.

142.4(1) *Attending physicians or attending physician associates who issue OOH DNR orders.* The attending physician or attending physician associate should ensure that the following are accomplished:

- a. Establish that the patient is qualified because the patient:
 - (1) Is an adult; and
 - (2) Has a terminal condition.
- b. Explain to the patient or the individual legally authorized to act on the patient's behalf the implications of an OOH DNR order.
- c. If the qualified patient or individual legally authorized to act on the patient's behalf decides that the patient should not be resuscitated, the attending physician or attending physician associate may issue the OOH DNR order on the prescribed uniform order form. The order will direct health care providers to withhold or withdraw resuscitation.
- d. Explain to the qualified patient or the individual legally authorized to act on the patient's behalf how the OOH DNR order is revoked.
- e. Include a copy of the order in the qualified patient's medical record.
- f. Provide a copy of the order to the qualified patient or the individual legally authorized to act on the patient's behalf.

142.4(2) *Qualified patients or legally authorized persons.* A qualified patient or a person legally authorized to act on a qualified patient's behalf should:

- a. Make an informed decision concerning resuscitation in the face of a terminal condition.
- b. Ensure that the qualified patient's family members are aware of this decision and inform them of the location of the OOH DNR order and the purpose of an OOH DNR identifier.
- c. Understand the process for revocation as described in rule 641—142.5(144A).

142.4(3) *Non-EMS health care providers.* A non-EMS health care provider contemplating resuscitation for a patient should:

- a. Evaluate the patient's status and needs through an assessment consistent with the provider's training, certification and licensure.
- b. Determine that the presenting condition is within the scope of the patient's terminal condition and is not the result of a motor vehicle collision, fire, mass casualty or other cause of a sudden accident or injury.
- c. Determine the existence of an OOH DNR order or that the patient is wearing an OOH DNR identifier.
- d. Honor the OOH DNR order or OOH DNR identifier worn by the patient.
- e. Discontinue resuscitation if the OOH DNR order or OOH DNR identifier worn by the patient is discovered after resuscitation has begun.
- f. Provide comfort care to the patient at all times.

g. If uncertainty exists regarding the validity or applicability of the OOH DNR order or identifier, the health care provider shall provide the necessary and appropriate resuscitation.

h. Document compliance or noncompliance with the OOH DNR order and the reasons for not complying with the order, including evidence that the order was revoked or uncertainty regarding the validity or applicability of the order or OOH DNR identifier.

142.4(4) Hospitals. A hospital:

a. Is not precluded from honoring an OOH DNR order entered in accordance with this chapter and in compliance with established hospital policies and protocols.

b. Should, to avail itself of the immunities provided within Iowa Code chapter 142, establish such policies and protocols to address an OOH DNR order or identifier encountered on a person who presents to the emergency department or in any other area within the facility if the person presents as a patient or visitor.

c. Should integrate policies and procedures with the OOH DNR protocol for hospital-based ambulance service programs, if present.

142.4(5) Other health care organizations. A nursing home, home health care agency, hospice, or other health care organization should establish policies and protocols consistent with these rules to address admitted patients who have OOH DNR orders.

[ARC 9081C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—142.5(144A) Revocation of the out-of-hospital do-not-resuscitate order. An OOH DNR order is deemed revoked at any time that a patient, or an individual authorized to act on the patient's behalf as designated on the OOH DNR order, is able to communicate in any manner the intent that the order be revoked, without regard to the mental or physical condition of the patient. A revocation is only effective as to the health care provider upon communication to that provider by the patient, an individual authorized to act on the patient's behalf as designated in the OOH DNR order, or by another person to whom the revocation is communicated by the patient.

[ARC 9081C, IAB 4/2/25, effective 6/1/25]

641—142.6(144A) Personal wishes of family members or other individuals who are not authorized to act on the patient's behalf. The personal wishes of family members or other individuals who are not authorized in the order to act on the patient's behalf cannot supersede a valid OOH DNR order.

[ARC 9081C, IAB 4/2/25, effective 6/1/25]

641—142.7(144A) Transfer of patients.

142.7(1) An attending physician or attending physician associate who is unwilling to comply with an OOH DNR order or who is unwilling to comply with the provisions of Iowa Code section 144A.7A shall take all reasonable steps to effect the transfer of the patient to another physician or physician associate.

142.7(2) If the policies of a hospital, nursing home, home health care agency, hospice or other health care organization preclude compliance with the OOH DNR order of a qualified patient, the provider shall take all reasonable steps to effect the transfer of the patient to an organization in which the provisions of Iowa Code section 144A.7A can be carried out.

[ARC 9081C, IAB 4/2/25, effective 6/1/25; Editorial change: IAC Supplement 6/10/26]

641—142.8(144A) Application to existing orders.

142.8(1) An OOH DNR order or similar order executed prior to September 10, 2003, is valid and shall be honored in accordance with the then-applicable provisions of the law.

142.8(2) Health care providers may honor an OOH DNR order or identifier from another state if it can be validated and applied in a manner consistent with the OOH DNR order or identifier prescribed in these rules. In cases where there is uncertainty, clarification should be sought through on-line medical direction or resuscitation efforts should be initiated.

[ARC 9081C, IAB 4/2/25, effective 6/1/25]

These rules are intended to implement Iowa Code sections 144A.7A and 147A.4.

APPENDIX A

**Iowa Department of Health and Human Services
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER
(Please type or print)**

Date of Order: ____/____/____

Patient Information:

Name: (Last)____(First)____(Middle)____

Address:____(City)____(Zip)____

Date of Birth: ____/____/____ Sex (Circle): M or F

Name of Hospice or Care Facility (if applicable): _____

Attending Physician or Physician Associate Order

As the attending physician or attending physician associate for the above-named patient, I certify that this individual is over 18 years of age and has a terminal diagnosis. After consultation with this patient (or the patient's legal representative), I hereby direct any and all health care providers, including qualified emergency medical services (EMS) personnel, to withhold or withdraw the following life-sustaining procedures in accordance with Iowa law (Iowa Code chapter 142A):

- Cardiopulmonary Resuscitation/Cardiac Compression (Chest Compressions).
- Endotracheal Intubation/Artificial or Mechanical Ventilation (Advance Airway Management).
- Defibrillation and Related Procedures.
- Use of Resuscitation Drugs.

This directive does NOT apply to other medical interventions for comfort care.

Signature of Attending Physician (MD, DO) or
Attending Physician Associate

_____/_____/_____
Date

**Printed Name of Attending Physician or Attending
Physician Associate**

(____)____-_____
**Physician's or Physician Associate's
Telephone (Emergency)**

To the extent that it is possible, a person designated by the patient may revoke this order on the patient's behalf. If the patient wishes to authorize any other person(s) to revoke this order, the patient MUST list those persons' names below:

Name: _____

Name: _____

Name: _____

Name: _____

Patients, please note: Directions for obtaining a uniform identifier are listed on the back of this form. The uniform identifier is the key way the health care provider and/or EMS personnel can quickly recognize that you have an Out-of-Hospital Do-Not-Resuscitate order. If you are not wearing an identifier, the health care provider and/or EMS personnel may not realize that you do not want to be resuscitated.

Physicians or physician associates, please note: Information regarding the completion of an Out-of-Hospital Do-Not-Resuscitate order is on the back of this form.

APPENDIX A

Directions for obtaining a uniform identifier:

The uniform identifier may be obtained through MedicAlert®¹, which requires:

1. A completed MedicAlert® application, which is available in physician or physician associate offices or through MedicAlert® by phoning (800)432-5378 or the website www.medicalert.org, and fee.
2. A copy of this completed OOH DNR order, which must accompany the MedicAlert® application or be sent to MedicAlert® prior to the identifier's being mailed.

¹*MedicAlert® is a nonprofit 501C membership organization.*

Suggested guidelines for physicians or physician associates:

1. Please review the Iowa Out-of-Hospital Do-Not-Resuscitate order and related protocol with the patient/patient's legal representative(s). The following points may be helpful:
 - Patient/patient's legal representative(s) listed on this order must understand the significance of this order, that in the event the patient's heart or breathing stops or malfunctions, the anticipated result of this order is death.
 - Patient/patient's legal representative(s) listed on this order may revoke this directive at any time. However, the desire to revoke must be communicated to the EMS or other health care professionals at the scene.
 - It is important to emphasize that this order does not apply to medical interventions to make the patient more comfortable.
 - The importance of wearing the uniform identifier for those qualified patients who would benefit from the mobility this offers should be stressed. It is also helpful to walk patients through the process they must follow to acquire the identifier.
2. Provide a copy of this order to the patient/patient's legal representative(s) listed on this order and place the original in the patient's medical records.

The OOH DNR Order form is available through the department's website.

[ARC 7550B, IAB 2/11/09, effective 3/18/09; ARC 9617C, IAB 10/15/25, effective 12/1/25; Editorial change: IAC Supplement 6/10/26]

APPENDIX B

EMS OUT-OF-HOSPITAL DO-NOT-RESUSCITATE PROTOCOL

Purpose: This protocol is intended to avoid unwarranted resuscitation by emergency care providers in the out-of-hospital setting for a *qualified patient*.¹ There must be a valid Out-of-Hospital Do-Not-Resuscitate (OOH DNR) order signed by the qualified patient's attending physician or physician associate or the presence of the OOH DNR identifier indicating the existence of a valid OOH DNR order.

No resuscitation: Means withholding any medical intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a spontaneous vital function, including but not limited to:

1. Chest compressions,
2. Defibrillation,
3. Esophageal/tracheal/double-lumen airway; endotracheal intubation, or
4. Emergency drugs to alter cardiac or respiratory function or otherwise sustain life.

Patient criteria: The following patients are recognized as qualified patients to receive no resuscitation:

1. The presence of the uniform OOH DNR order or uniform OOH DNR identifier, or
2. The presence of the attending physician or attending physician associate to provide direct verbal orders for care of the patient.

The presence of a signed physician or physician associate order on a form other than the uniform OOH DNR order form approved by the department may be honored if approved by the service program EMS medical director. However, the immunities provided by law apply only in the presence of the uniform OOH DNR order or uniform OOH DNR identifier. When the uniform OOH DNR order or uniform OOH DNR identifier is not present, contact must be made with on-line medical control and on-line medical control must concur that no resuscitation is appropriate.

Revocation: An OOH DNR order is deemed revoked at any time that a patient, or an individual authorized to act on the patient's behalf as listed on the OOH DNR order, is able to communicate in any manner the intent that the order be revoked. The personal wishes of family members or other individuals who are not authorized in the order to act on the patient's behalf shall not supersede a valid OOH DNR order.

Comfort Care (♥): When a patient has met the criteria for no resuscitation under the foregoing information, the emergency care provider should continue to provide that care which is intended to make the patient comfortable (a.k.a. ♥Comfort Care). Whether other types of care are indicated will depend upon individual circumstances for which medical control may be contacted by or through the responding ambulance service personnel.

♥Comfort Care may include but is not limited to:

1. Pain medication.
2. Fluid therapy.
3. Respiratory assistance (oxygen and suctioning).

¹*Qualified patient* means an adult patient determined by an attending physician or attending physician associate to be in a terminal condition for which the attending physician or attending physician associate has issued an Out-of-Hospital DNR order in accordance with the law. (Rule 641—142.1(144A), definitions)

[Editorial change: IAC Supplement 6/10/26]

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 150
IOWA REGIONALIZED SYSTEM OF PERINATAL HEALTH CARE

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/1/30

641—150.1(135) Participation and designation. Hospitals within the state must determine whether to participate in Iowa's regionalized system of perinatal health care and will select the hospital's level of participation in the regionalized system. A hospital having determined to participate in the regionalized system must comply with the rules appropriate to the levels of participation for maternal care and neonatal care selected by the hospital. Maternal levels of designation and neonatal levels of designation are evaluated separately, and a hospital may have a level of designation for maternal care that is different from the level of designation for neonatal care; however, a pregnant woman should be cared for at the hospital that best meets both her and her newborn infant's needs.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.2(135) Definitions.

"Categorization" means a preliminary determination by the department that a hospital is capable of providing maternal care and neonatal care at Level I, Level II, Level III, or Level IV.

"Certificate of verification" means a document awarded by the department that identifies a hospital's level of maternal care and neonatal care at Level I, Level II, Level III, or Level IV and the term of verification at that level.

"Hospital" means a facility licensed under Iowa Code chapter 135B.

"Late preterm" means that a newborn infant is born between 34 0/7 and 36 6/7 weeks' gestation.

"Levels-of-care assessment tool" or *"tool"* means a tool to assess the maternal and neonatal risk-appropriate care, using the minimum information necessary to identify a hospital's maternal level of care based on criteria by the American Congress of Obstetricians and Gynecologists/Society for Maternal-Fetal Medicine and a hospital's neonatal level of care based on criteria by the American Academy of Pediatrics. The tool will be chosen by the department in consultation with the perinatal guidelines advisory committee.

"Neonate" means a newborn infant, up to 28 days of life.

"On-site verification survey" means an on-site survey conducted by the department's statewide perinatal care team based at the University of Iowa health care medical center or by a survey team of members (medical experts) contracted to assess a hospital's ability to meet the level of designation selected by the hospital.

"Perinatal" means the five months before and one month after birth.

"Perinatal center" means a medical facility capable of providing complex obstetric, fetal and neonatal care.

"Prenatal" means during pregnancy.

"Readily available" means on site or at a closely related institution by prearranged consultative agreement.

"Regionalized system of perinatal health care" means the department's program for designating regional perinatal health care services at a verified level of care, based on a hospital's functional capabilities. Levels of care designations are stratified in an increasing order of intensity and complexity for both maternal health care and neonatal health care.

"Regionalized system of perinatal health care coordinator" means the department's program manager for the regionalized system of perinatal health care.

"Respiratory distress" means tachypnea (respiratory rate of 60 or more per minute), grunting, tugging, retracting, nasal flaring, or cyanosis. Any or all of these may constitute respiratory distress in a neonate.

"Reverification" means the process of periodic review, conducted at least every three years, to certify that a hospital has maintained its designated level of care in accordance with criteria

established under these rules for hospitals that are participating in the regionalized system of perinatal health care.

“Statewide perinatal care program” means a program consisting of the regionalized system of perinatal health care coordinator, the statewide perinatal care team contracted by the department, and the regionalized system of perinatal health care as defined in these rules.

“Statewide perinatal care team” means the educational team based at the University of Iowa health care medical center and contracted by the department to support the regionalized system of perinatal health care and to provide services to decrease perinatal morbidity and mortality.

“Verification” means a process by which the department certifies a hospital’s capacity to provide perinatal care in accordance with criteria established under these rules for hospitals that are participating in the regionalized system of perinatal health care.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.3(135) Duties of statewide perinatal care team. The team will:

1. Promote evidence-based and evidence-informed care of pregnant women and newborns.
2. Provide education and consultation to regional and primary providers of perinatal care.
3. Provide chart review to assess quality of care provided and additional education required.
4. Promote change in practice when needed through sharing best practice ideas, policies and procedures.
5. Promote maternal-fetal transfer if delivery of an at-risk infant or mother is anticipated and a higher level of care is anticipated.
6. Provide on-site verification to determine a hospital’s ability to meet its level-of-care designation.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.4(135) Duties of the department. The department will:

1. Certify a hospital’s capacity to provide perinatal health care in accordance with criteria established under these rules.
2. Provide technical assistance to the hospitals that choose to participate.
3. Review the submitted levels-of-care assessment tool from all participating hospitals.
4. Conduct or coordinate the on-site verification of determined levels of care for maternal and neonatal care hospitals designated as Level I, Level II, Level III and Level IV.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.5(135) Maternal and neonatal levels of care—categorization and verification. Categorization and verification of hospitals participating in Iowa’s regionalized system of perinatal health care will be made by the department based on national recommendations from the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists.

150.5(1) Application for initial verification.

- a. An application for initial verification may be submitted when:
 - (1) A new hospital with a perinatal service is opened;
 - (2) A hospital is reopening after a previously inactive obstetrical unit; or
 - (3) A hospital requests a change to a higher-level designation in maternal care or neonatal care.
- b. A hospital requesting an initial verification may obtain application materials from the department.
- c. Upon receipt of an application from a hospital that is requesting to change to a higher level of maternal or neonatal care, the department will request and review copies of the results of the last site visit to the hospital by the statewide perinatal team or request a site visit. The results of the site visit along with the application will be shared with the statewide perinatal team and any clinical experts appointed by the department to determine if all requirements are met. The recommendations will be sent to the department, which will notify the hospital if its application is approved or denied. If the

application is denied, the applicant will be informed of the applicant's right to appeal the department's decision.

150.5(2) *Application for a hospital that has previously participated in the regionalized system of perinatal health care.*

a. If a hospital chooses to continue its participation, the hospital must select the levels for maternal care and neonatal care appropriate for the hospital's capacity to provide perinatal health care in accordance with the criteria outlined in these rules.

b. To maintain continuous participation in the regionalized system of perinatal health care, a hospital must complete the levels-of-care assessment tool and an attestation statement. These can be obtained from the department.

c. The department will set dates when each hospital's certification of verification will expire based on the statewide perinatal health care team's site visit schedule and the level of care selected.

150.5(3) *Reverification of level designation.* The levels-of-care assessment tool will be used for all reverifications. The process of reverification of a hospital participating in the regionalized system of perinatal health care will take place once every six years as follows:

a. Reverification of a Level I, Level II or Level III maternal care or neonatal care hospital will be completed through use of the levels-of-care assessment tool and an on-site reverification visit. A hospital must complete and return the levels-of-care assessment tool to the department at least 120 days before the hospital's certification is due to expire. The department will ensure that arrangements are made for the on-site reverification visit. Level II and Level III hospitals may utilize one of two on-site reverification visit options:

- (1) A review conducted by the statewide perinatal care team, or
- (2) A review by an independent out-of-state team identified by the hospital, approved by the department and paid for by the hospital.

b. Reverification of a Level IV maternal care and neonatal care hospital will be completed through the same process as that for a Level I, Level II or Level III maternal care or neonatal care hospital except that the on-site reverification team will consist of an out-of-state team identified by the hospital and approved by the department. The team will include, at a minimum, a maternal-fetal specialist, a neonatologist, an obstetrical nurse and a neonatal nurse. The Level IV hospital will pay the expense of the review team. All department staff and staff contracted by the department involved in the on-site reverification process will sign a confidentiality statement that will be kept on file at the department.

c. Reverification shall not be construed to imply any guarantee on the part of the department as to the level of perinatal health care services available at a hospital.

d. Hospital reverification of the level of care is valid for a period of six years from the effective date unless otherwise specified on the certificate of verification or unless sooner suspended or revoked.

e. As part of the reverification and renewal process, the department or a designated survey team may conduct periodic on-site reviews of the services of the maternal care and neonatal care hospitals, including chart reviews.

150.5(4) *Level designation maintenance, waiver and confidential records.*

a. A hospital that is unable to maintain its designated level of care will notify the department, in writing, within 60 days of the change in capacity to meet the designated level of care.

b. The director may grant a waiver from the requirements of rules adopted under this chapter for any hospital participating in the regionalized system of perinatal health care.

c. Proceedings, records, and reports developed pursuant to this chapter are confidential pursuant to Iowa Code section 135.11(22) and constitute peer review records under Iowa Code section 147.135, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the affected hospital, and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving verification of the participating hospital.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.6(135) Levels of maternal care. The levels of maternal care include basic obstetrical care Level I, specialty care Level II, subspecialty care Level III and regional perinatal health care Level IV. The levels reflect the overall evidence for risk-appropriate care in a hospital through the availability of appropriate personnel, physical space, equipment, technology, and organization. Each level reflects the minimal capabilities, provider type and functional criteria required.

150.6(1) Level I maternal care hospital.

a. Provider of basic obstetrical care. A Level I maternal care hospital provides care to women who are low risk and are expected to have an uncomplicated birth.

b. Capabilities. A Level I maternal care hospital has the following capabilities:

(1) To perform routine intrapartum and postpartum care that is anticipated to be uncomplicated. Care of uncomplicated pregnancies includes the ability to detect, stabilize and initiate management of unanticipated maternal, fetal or neonatal problems that occur during the antepartum, intrapartum, or postpartum period until the patient can be transferred to a facility that provides specialty maternal care.

(2) To begin an emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care.

c. Types of health care providers. A Level I maternal care hospital will have:

(1) Maternity care providers, including certified nurse-midwives, family practice physicians, or obstetrician-gynecologists, available to attend all births.

(2) Every birth attended by at least two professionals, including the primary maternal care provider and a person competent to provide neonatal resuscitation and postnatal care to stabilize the infant.

(3) Adequate numbers of registered nurses available who have completed orientation and demonstrated competence in the care of obstetric patients, including women and fetuses, consistent with Level I care criteria and who are able to stabilize and transfer high-risk women and newborns.

(4) Nursing leadership with expertise in perinatal nursing care.

(5) A provider with privileges to perform an emergency cesarean delivery, available to attend all deliveries. The provider may be a general surgeon, an obstetrician-gynecologist, or a family practice physician with certification.

(6) A provider of anesthesia services available to provide labor analgesia and surgical anesthesia.

d. Functional criteria of support services. Support services include but are not limited to access to obstetric ultrasonography, laboratory testing, and blood bank supplies at all times. A Level I maternal care hospital will:

(1) Have protocols and capabilities in place for:

1. Massive transfusion,
2. Emergency release of blood products (before full compatibility testing is complete),
3. Management of multiple component therapy.

(2) Ensure optimal care of all pregnant women by having formal transfer plans established in partnership with a higher-level receiving hospital. These plans will include:

1. Risk identification,
2. Determination of conditions necessitating consultation,
3. Referral and transfer, and
4. A reliable, accurate, and comprehensive communication system between the participating hospital and the transport team.

(3) Have education and quality improvement programs to maximize patient safety, provide such programs through collaboration with facilities with higher levels of care that receive transfers, or both.

(4) Have data collection, storage and retrieval to support quality improvement.

150.6(2) Level II maternal care hospital.

a. Provider of specialty care. In addition to meeting the criteria of a Level I maternal care hospital, a Level II maternal care hospital provides care of appropriate high-risk pregnant women, both those directly admitted to the hospital and those transferred from another hospital.

b. Capabilities. In addition to having the capabilities of a Level I maternal care hospital, a Level II maternal care hospital has the following capabilities:

(1) The infrastructure for continuous availability of adequate numbers of registered nurses who have demonstrated competence in the care of obstetric patients (women and fetuses).

(2) Orientation and demonstrated competence consistent with Level II care criteria and the capability to stabilize and transfer high-risk women and newborns who exceed Level II care criteria.

c. Types of health care providers. In addition to meeting the health care provider requirements of a Level I maternal care hospital, a Level II maternal care hospital will have:

(1) Health care providers, including certified nurse-midwives or family physicians.

(2) Nursing leaders and staff with formal training and experience in the provision of perinatal nursing care who can coordinate with respective neonatal care services.

(3) An attending obstetrician-gynecologist available at all times.

(4) A board-certified or board-eligible obstetrician-gynecologist with special interest and experience in obstetric care as the director of obstetric services.

(5) Access to a maternal-fetal medicine subspecialist for consultation, available on site, by telephone, or by telemedicine as needed.

(6) A provider of anesthesia services available at all times to provide labor analgesia and surgical anesthesia.

(7) A board-certified or board-eligible anesthesiologist with special training or experience in obstetric anesthesia, available for consultation.

(8) Medical and surgical consultants available to stabilize obstetric patients who have been directly admitted to the facility or transferred from other hospitals.

d. Functional criteria of support services. In addition to meeting the support services requirements of a Level I maternal care hospital, a Level II maternal care hospital will have:

(1) Computed tomography scan and, ideally, magnetic resonance imaging with interpretation available.

(2) Basic ultrasonographic imaging services for maternal and fetal assessment at all times, either in house or on call.

(3) Special equipment needed to accommodate the care and services needed for obese women. In addition, based on the patient's BMI and other risk factors, a consultation with an obstetrician-gynecologist or a maternal fetal medicine specialist should be considered.

(4) The ability to provide high-risk obstetrical care, but efforts should be made to transfer women whose newborns are likely to need a higher level of care than a Level II maternal care hospital can provide, or when the pregnancy has risk factors that require the consultation or care of a maternal-fetal medicine specialist.

150.6(3) Level III maternal care hospital.

a. Provider of subspecialty care. A Level III maternal care hospital provides care to women that includes all Level I and Level II services and has subspecialists available on site, by telephone, or by telemedicine to assist in providing care for more complex maternal and fetal conditions.

b. Capabilities. A Level III maternal care hospital functions as the regional perinatal health care center for some areas of Iowa if there are no Level IV maternal care hospitals available. In these areas, a Level III maternal care hospital will be responsible for the leadership; facilitation of transport and referral; educational outreach; and data collection, storage and retrieval to support quality improvement. Designation of Level III maternal care hospital should be based on the demonstrated experience and capability of the facility to provide comprehensive management of severe maternal and fetal complications.

c. Types of health care providers. In addition to meeting the health care provider requirements of a Level II maternal care hospital, a Level III maternal care hospital will have:

(1) An obstetrician-gynecologist with inpatient privileges, available on site at all times.

(2) A maternal-fetal medicine subspecialist with inpatient privileges, available at all times, either on site, by telephone, or by telemedicine.

(3) A director of the maternal-fetal medicine service who is a board-certified or board-eligible maternal-fetal medicine subspecialist.

(4) A board-certified or board-eligible obstetrician-gynecologist with special interest and experience in obstetric care directing obstetric services.

(5) A provider of anesthesia services available at all times on site.

(6) A board-certified or board-eligible anesthesiologist with special training or experience in obstetric anesthesia who is in charge of obstetric anesthesia services.

(7) A full complement of subspecialists, available for inpatient consultations, including subspecialists in:

1. Critical care,
2. General surgery,
3. Infectious disease,
4. Hematology,
5. Cardiology,
6. Nephrology,
7. Neurology, and
8. Neonatology.

(8) Nursing leaders and adequate numbers of registered nurses who have completed orientation and demonstrated competence in the care of obstetric patients (women and fetuses) consistent with Level III care criteria, including the transfer of high-risk women who exceed Level III care criteria, and who have special training and experience in the management of women with complex maternal illnesses and obstetric complications. Nursing personnel will be continuously available.

d. Functional criteria of support services. In addition to meeting the support services requirements of a Level II maternal care hospital, a Level III maternal care hospital will have:

(1) An on-site intensive care unit to accept pregnant women.

(2) Critical care providers on site to actively collaborate with maternal-fetal specialists at all times.

(3) Equipment and personnel with expertise available on site to ventilate and monitor women in the labor and delivery unit until they can be safely transferred to the intensive care unit.

(4) The ability to provide the following imaging services, with interpretation available at all times:

1. Basic interventional radiology,
2. Maternal echocardiography,
3. Computed tomography,
4. Magnetic resonance imaging, and
5. Nuclear medicine imaging.

(5) The ability to perform detailed obstetric ultrasonography and fetal assessment, including Doppler studies.

150.6(4) Level IV maternal care hospital.

a. Provider of services as a regional perinatal health care center. In addition to meeting the requirements for a Level III maternal care hospital, a Level IV maternal care hospital provides care to women with additional requirements and has considerable experience in the care of the most complex and critically ill pregnant women throughout antepartum, intrapartum, and postpartum care. The particular specialty of fetal surgery, advanced neurosurgery, transplant, and advanced cardiovascular capabilities may not all be available at an individual Level IV maternal care hospital. In some cases, specific advanced care will require care coordination to the Level IV maternal care hospital by availability of specific expertise, including but not limited to fetal surgery, advanced neurosurgery, transplant, and advanced cardiovascular capabilities. Each hospital will have a clear understanding of the categories of perinatal patients who can be managed appropriately in the local hospital and those who must be transferred.

b. Capabilities. Although Level III and Level IV maternal care hospitals may seem to overlap, a Level IV maternal care hospital is distinct from a Level III maternal care hospital in the approach to the care of pregnant women and women in the postpartum period with complex and critical illnesses. In addition to having an intensive care unit on site for obstetric patients, a Level IV maternal care hospital must have evidence of a maternal-fetal medicine care team that has the expertise to assume responsibility for pregnant women and women in the postpartum period who are in critical condition or have complex medical conditions. The maternal-fetal medicine team collaborates actively in the co-management of all obstetric patients who require critical care and intensive care unit services, including co-management of intensive care unit-admitted obstetric patients.

c. Types of health care providers. In addition to meeting the health care provider requirements of a Level III maternal care hospital, a Level IV maternal care hospital will have:

(1) A maternal-fetal medicine team member with full privileges, available at all times for on-site consultation and management.

(2) A board-certified maternal-fetal medicine subspecialist with expertise in critical care obstetrics to lead the team.

(3) A maternal-fetal medicine team with expertise in critical care at the physician level, nursing level, and ancillary services level.

(4) Institutional support for the routine involvement of a maternal-fetal medicine care team with the critical care units and specialists. A key principle of caring for critically ill pregnant and peripartum women is the hospital's recognition of the need for seamless communication between maternal-fetal medicine subspecialists and other subspecialists in the planning and facilitation of care for women with the most high-risk complications of pregnancy.

(5) A commitment to having physician and nursing leaders with expertise in maternal intensive and critical care, as well as adequate numbers of available registered nurses in a Level IV maternal care hospital who have experience in the care of women with complex medical illnesses and obstetric complications; this experience includes completed orientation and demonstrated competence in the care of obstetric patients (women and fetuses) consistent with Level IV maternal care criteria.

(6) A director of obstetric services who is a board-certified maternal-fetal medicine subspecialist or a board-certified obstetrician-gynecologist with expertise in critical care obstetrics.

(7) A provider of anesthesia services available on site at all times.

(8) A board-certified anesthesiologist with special training or experience in obstetric anesthesia who is in charge of obstetric anesthesia services.

(9) Adult medical and surgical specialty and subspecialty consultants, a minimum of those listed for a Level III maternal care hospital, available on site at all times to collaborate with the maternal-fetal medicine care team.

d. Functional criteria of support services. In addition to meeting the support services requirements of a Level III maternal care hospital, a Level IV maternal care hospital will have:

(1) The capability for on-site medical and surgical care of complex maternal conditions (e.g., congenital maternal cardiac lesions, vascular injuries, neurosurgical emergencies, and transplants) with the availability of critical (or intensive) care unit beds.

(2) Perinatal system leadership, including facilitation of maternal referral and transport, outreach education for facilities and health care providers in the region and analysis and evaluation of regional data, including perinatal complications, outcomes and quality improvement.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.7(135) Maternal-fetal transport—all levels. Maternal-fetal transport is an essential component of perinatal care. A hospital participating in the regionalized system of perinatal health care must be familiar with its own resources and capabilities in dealing with obstetrical and neonatal complications. In most instances, maternal-fetal transport is preferable to neonatal transport. Each hospital, when transporting or accepting a transport, needs a system in place to facilitate a smooth transition of care in the most expeditious manner possible. The majority of maternal-fetal transports

can be carried out by ground transportation. It is important for ambulance services to be equipped for maternal-fetal transport and have appropriately trained staff.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.8(135) Levels of neonatal care. The levels of neonatal care include basic neonatal care Level I, specialty care Level II, and subspecialty intensive care Level III and Level IV. The levels reflect the overall evidence for risk-appropriate care through the availability of appropriate functional criteria, physical facilities, medical and nursing personnel, outreach education, allied health personnel and services, infection control, newborn or neonatal safety, neonatal transport and quality improvement.

150.8(1) Level I neonatal care hospital.

a. Provider of basic neonatal care. A Level I neonatal care hospital provides a basic level of care to neonates without complications. A Level I neonatal care hospital has the following capabilities:

- (1) To provide neonatal resuscitation at every delivery.
- (2) To evaluate and provide postnatal care to stable term newborn infants.
- (3) To stabilize and provide care for infants born at 35 to 37 weeks' gestation who remain physiologically stable.
- (4) To stabilize newborn infants who are ill and those born at less than 35 weeks' gestation until transfer to a higher level of care.
- (5) To provide leadership in early risk identification before and after birth.
- (6) To seek consultation or referral for high-risk neonates.
- (7) To provide public and professional education.

b. Functions. A Level I neonatal care hospital has a family-centered philosophy. Parents have reasonable access to their newborns 24 hours a day within all functional units and are encouraged to participate in the care of their newborns. Generally, a newborn can be with its parents in the mother's room.

c. Physical facilities. A Level I neonatal care hospital will maintain a nursery for normal-term or late preterm neonates.

d. Medical personnel. At a Level I neonatal care hospital, neonatal care is under the supervision of one of the following:

- (1) A board-eligible or board-certified neonatologist,
- (2) A pediatrician,
- (3) A family medicine physician,
- (4) A board-eligible or board-certified advanced registered nurse practitioner, or
- (5) A physician associate.

e. Nursing personnel. At a Level I neonatal care hospital, a registered nurse assigned to the neonatal service has nursing orientation to and demonstrates competency in the care of a neonate.

f. Outreach education. A Level I neonatal care hospital will assume an active role in the development and coordination of wellness and preventive programs concerning neonatal and child health at the community level, including parenting, breastfeeding, and cessation of smoking.

g. Allied health personnel and services. A Level I neonatal care hospital will have available, at a minimum, the following allied health personnel and services:

- (1) Dietitian with knowledge of maternal and neonatal nutrition management,
- (2) Social worker,
- (3) Bioengineer-safety and environmental control,
- (4) Pharmacy,
- (5) Radiology,
- (6) Laboratory,
- (7) Pathology, and
- (8) Chaplain, spiritual support.

h. Infection control.

(1) Each Level I neonatal care hospital will establish written policies and procedures for assessing the health of personnel assigned to the perinatal care services and of those who have significant contact with the newborn. The policies and procedures will include restricting contact with patients when necessary and screening per department recommendations for health care providers. Routine culturing of specimens obtained from personnel is not useful, although selective culturing may be of value when a pattern of infection is suspected.

(2) No special or separate isolation facility is required for neonates born at home or in transit to the hospital. Detailed descriptions of the isolation categories and requirements will be available in each hospital's infection control manual.

i. Newborn safety. At a Level I neonatal care hospital, the protection of newborns is the responsibility of all personnel in the neonatal care hospital. Newborns will always be within the sight and supervision of hospital staff, the mother, or other family members or friends designated by the mother. Each neonatal care hospital has a policy established that addresses strategies to promote newborn safety.

150.8(2) *Level II neonatal care hospital.*

a. Provider of specialty care. In addition to meeting the requirements for care and services as a Level I neonatal care hospital, a Level II neonatal care hospital will:

- (1) Provide management of certain high-risk neonates with selected complications.
- (2) Have a board-certified or board-eligible neonatologist(s) or a board-certified or board-eligible pediatrician(s) on staff, one of whom directs the special care nursery.

b. Functions. In addition to performing the functions of a Level I neonatal care hospital, a Level II neonatal care hospital will have the capability to:

(1) At a minimum, manage neonates of greater than or equal to 32 weeks' gestation and weighing greater than or equal to 1,500 grams who have physiological immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis and, for neonates of 32 weeks' gestation and weighing less than 1,500 grams, recommend consultation with a higher-level facility by prearranged consultative agreement.

(2) Provide mechanical ventilation for a brief duration (less than 24 hours).

(3) Provide continuous positive airway pressure as needed (less than 24 hours).

(4) Stabilize infants born before 32 weeks and weighing less than 1,500 grams until transfer to a Level III or Level IV neonatal care hospital.

(5) Provide care for infants convalescing after intensive care.

c. Physical facilities. In addition to having the physical facilities of a Level I neonatal care hospital, a Level II neonatal care hospital will have:

- (1) A special care nursery (a special area designated for the care of sick neonates),
- (2) A mechanical ventilator,
- (3) A portable X-ray machine,
- (4) A laboratory with a blood gas analyzer,
- (5) Physiologic monitoring equipment, and
- (6) A pharmacy.

d. Medical personnel. In addition to having the medical personnel of a Level I neonatal care hospital, a Level II neonatal care hospital will:

(1) Be under the co-direction/supervision of a board-eligible or board-certified neonatologist or pediatrician.

(2) Have a neonatologist or pediatrician on staff. Other provider types that may be utilized include a pediatric hospitalist, a neonatal nurse practitioner or pediatric nurse practitioner or a physician associate with appropriate training.

(3) Have allied medical specialists in various disciplines on staff, including specialists in internal medicine, radiology, and pathology.

e. Nursing personnel. In addition to having the nursing personnel of a Level I neonatal care hospital, a Level II neonatal care hospital has nursing orientation to and demonstrates competency in the care of sick neonates.

f. Outreach education. A Level II neonatal care hospital has the same responsibility for outreach education as that of a Level I neonatal care hospital.

g. Allied health personnel and services. In addition to having the allied health personnel and services of a Level I neonatal care hospital, a Level II neonatal care hospital has:

- (1) Respiratory therapists,
- (2) Certified laboratory technicians/blood gas technicians, and
- (3) X-ray technologists and ultrasound technicians with neonatal/perinatal experience.

h. Infection control. A Level II neonatal care hospital has the same infection control guidelines as those for a Level I neonatal care hospital.

i. Neonatal safety. A Level II neonatal care hospital has the same requirements for newborn safety as those for a Level I neonatal care hospital.

j. Neonatal transport. In addition to having the Level I neonatal care hospital capabilities for neonatal transport, a Level II neonatal care hospital is expected to accept patient referrals when appropriate. A critical function of providers at a Level II neonatal care hospital is to communicate with the providers at a Level I neonatal care hospital in deciding whether a particular patient should be transported to the Level II neonatal care hospital. Careful assessment of the hospital's capabilities for perinatal management will be critical in these decisions. This information will need to be disseminated among the hospital staff. Providers of obstetric care need to know the critical gestational age limitations for their particular nursery. Below this gestational age, maternal-fetal transport should be utilized if delivery is anticipated and the circumstances permit.

k. Perinatal care committee.

(1) A Level II neonatal care hospital must maintain a perinatal care committee. Members of this committee will represent, at a minimum, the fields of:

1. Obstetrics,
2. Pediatrics,
3. Family practice,
4. Nursing,
5. Administration,
6. Laboratory,
7. Respiratory therapy,
8. Anesthesia, and
9. Social services.

(2) Responsibilities of the perinatal care committee include the following:

1. To develop policies for the unit, including provisions to ensure adequate patient care by qualified providers.

2. To conduct a meeting, at least semiannually, to resolve problems related to the unit.

3. To review educational activities conducted by the unit.

4. To serve as a general liaison between the various groups represented on the committee.

150.8(3) Level III neonatal care hospital.

a. Provider of subspecialty intensive care. In addition to providing the care and services of a Level II neonatal care hospital, a Level III neonatal care hospital will manage high-risk neonates, including infants born at less than 32 weeks or weighing less than 1,500 grams. High-risk neonates requiring surgical intervention or pediatric subspecialty should go to a Level IV neonatal care hospital.

b. Functions. In addition to performing the functions of a Level II neonatal care hospital, a Level III neonatal care hospital will have the capability to:

(1) Provide sustained life support.

(2) Provide comprehensive care for infants born at less than 32 weeks and weighing less than 1,500 grams and infants born at all gestations and birth weights who have critical illness.

(3) Provide an organized program for monitoring treatment and follow-up of retinopathy of prematurity.

(4) Maintain a prearranged consultative agreement with a higher-level hospital within the Level III neonatal care hospital's referral area.

(5) Transfer a surgical patient within approximately two hours from the time the referral call is made until arrival at the referral hospital.

(6) Provide follow-up care for high-risk newborns.

c. Physical facilities. In addition to having the physical facilities of a Level II neonatal care hospital, a Level III neonatal care hospital:

(1) Has a neonatal intensive care unit with continuously available personnel, including a neonatologist, neonatal nurses and respiratory therapists to provide life support for as long as necessary.

(2) Provides a full range of respiratory support that includes invasive mechanical ventilation and may include high-frequency ventilation or inhaled nitric oxide or both.

(3) Performs advanced imaging, with interpretation on an urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography.

(4) Maintains a neonatal transport team for the regional area served.

d. Medical personnel. In addition to having the medical personnel of a Level II neonatal care hospital, a Level III neonatal care hospital will:

(1) Have a medical director of the neonatal intensive care unit who is a full-time, board-eligible or board-certified neonatologist.

(2) Provide prompt and readily available access to the following, either on site or by prearranged consultative agreement. Using telemedicine technology or telephone consultation, a prearranged consultation can be performed from a distant location by:

1. Pediatric medical subspecialists,
2. A pediatric surgical specialist,
3. A pediatric anesthesiologist, and
4. A pediatric ophthalmologist.

(3) Have a neonatologist on the premises when an unstable critically ill infant is in the Level III neonatal care hospital.

e. Nursing personnel. A Level III neonatal care hospital has the same requirements for nursing personnel as those of a Level II neonatal care hospital.

f. Outreach education. Outreach education is provided to each hospital in the referral area at least once per year. This outreach education can be achieved by one or more of the following:

- (1) Sponsoring an annual conference.
- (2) Visiting a Level I neonatal care hospital and a Level II neonatal care hospital.
- (3) Providing educational programs and materials for the staff members of the Level I and Level II neonatal care hospitals.

g. Allied health personnel and services. In addition to having the allied health personnel and services of a Level II neonatal care hospital, a Level III neonatal care hospital has:

(1) X-ray technologists and ultrasound technicians with neonatal/perinatal experience, available on a 24-hour basis.

(2) Social work services with social workers assigned specifically to the neonatal units.

h. Infection control. A Level III neonatal care hospital has the same infection control guidelines as those of a Level I neonatal care hospital.

i. Neonatal safety. A Level III neonatal care hospital has the same requirements for newborn safety as those for a Level I neonatal care hospital.

j. Neonatal transport. In addition to having the Level II neonatal care hospital transport capabilities, a Level III neonatal care hospital is capable of providing neonatal transport with crews who have demonstrated competence in neonatal resuscitation and stabilization. Important decisions to be made jointly will include:

- (1) The appropriateness of transport.
- (2) The best mode of transportation.
- (3) The need for additional personnel accompanying the transport.
- (4) The appropriate medical management to initiate prior to transport.

k. *Perinatal care committee.* A Level III neonatal care hospital shall maintain a perinatal care committee that meets the same criteria as those for a Level II neonatal care hospital.

150.8(4) Level IV neonatal care hospital.

a. *Provider of subspecialty intensive care.* In addition to providing the level-of-care services of a Level III neonatal care hospital, a Level IV neonatal care hospital manages higher-risk neonates. The differentiating factor between a Level III neonatal care hospital and a Level IV neonatal care hospital is primarily one of having additional professional staff with considerable experience in the care of the most complex and critically ill infants and having the ability to provide surgical repair of complex congenital or acquired conditions.

b. *Physical facilities.* In addition to having the physical facilities of a Level III neonatal care hospital, a Level IV neonatal care hospital has more equipment, more extensive physical facilities and will serve a more complicated patient population.

c. *Medical personnel.* In addition to having the medical personnel of a Level III neonatal care hospital, a Level IV neonatal care hospital will:

(1) Have a medical director of the neonatal intensive care unit who is a full-time, board-certified neonatologist.

(2) Have anesthesia providers on staff with special training or experience in pediatric anesthesia.

(3) Maintain a full range of pediatric medical subspecialists and pediatric surgical subspecialists at the site.

(4) Have the subspecialist physicians immediately available to the Level IV neonatal care hospital.

(5) Have a neonatologist on the premises when an unstable critically ill infant is in the Level IV neonatal care hospital.

d. *Nursing personnel.* A Level IV neonatal care hospital has the same requirements for nursing personnel as those for a Level II neonatal care hospital.

e. *Outreach education.* A Level IV neonatal care hospital has the same responsibilities for outreach education as those for a Level III neonatal care hospital.

f. *Allied health personnel and services.* A Level IV neonatal care hospital has the same level of allied health personnel and services as that of a Level III neonatal care hospital.

g. *Infection control.* A Level IV neonatal care hospital has the same infection control guidelines as those for a Level I neonatal care hospital.

h. *Neonatal safety.* A Level IV neonatal care hospital has the same requirements for neonatal safety as those for a Level I neonatal care hospital.

i. *Neonatal transport.* In addition to meeting the neonatal transport requirements of a Level III neonatal care hospital, a Level IV neonatal care hospital is capable of providing ground and air transportation with crews who have demonstrated competencies in neonatal resuscitation and stabilization.

j. *Perinatal care committee.* In addition to maintaining a perinatal care committee that meets the same criteria as those for a Level II neonatal care hospital, a Level IV neonatal care hospital maintains a perinatal care committee that has additional representation by surgical specialties. The Level IV neonatal care hospital's perinatal care committee will maintain and analyze data on long-term outcomes to evaluate the effectiveness of the delivery of perinatal health care services.

[ARC 9178C, IAB 4/30/25, effective 7/1/25; Editorial change: IAC Supplement 6/10/26]

641—150.9(135) Grant or denial of certificate of verification; and offenses and penalties.

150.9(1) Upon receipt of the levels-of-care assessment tool and the on-site survey results, if required, the department will within 90 days issue its decision to grant or deny the hospital a

certificate of verification. The department may deny verification or may give a citation and warning, place on probation, suspend, or revoke existing verification if the department finds reason to believe the hospital's perinatal care program has not been or will not be operated in compliance with these rules. The denial, citation and warning, period of probation, suspension or revocation will be effected and may be appealed in accordance with the requirements of Iowa Code section 17A.12.

150.9(2) All complaints regarding the operation of a participating hospital's perinatal care program shall be reported to the department and to the department of inspections, appeals, and licensing.

150.9(3) Complaints and the investigative process will be treated as confidential to the extent they are protected by Iowa Code sections 22.7 and 135.11(27).

150.9(4) Complaint investigations may result in the department's issuance of a notice of denial, citation and warning, probation, suspension or revocation.

150.9(5) Notice of denial, citation and warning, probation, suspension or revocation will be effected in accordance with the requirements of Iowa Code section 17A.12. Notice to the hospital of denial, citation and warning, probation, suspension or revocation will be served by certified mail, return receipt requested, or by personal service.

150.9(6) Any request for a hearing concerning the denial, citation and warning, probation, suspension or revocation must be submitted by the aggrieved party in writing to the department by certified mail, return receipt requested, within 20 days of the receipt of the department's notice to take action. If the request is made within the 20-day time period, the notice to take action will be deemed to be suspended pending the hearing. Prior to or at the hearing, the department may rescind the notice upon satisfaction that the reason for the denial, citation and warning, probation, suspension or revocation has been or will be removed. If no request for a hearing is received within the 20-day time period, the department's notice of denial, citation and warning, probation, suspension or revocation will become the department's final agency action.

150.9(7) Upon receipt of a request for hearing, the request will be forwarded within five working days to the department of inspections, appeals, and licensing pursuant to the rules adopted by that agency regarding the transmission of contested cases. The information upon which the adverse action is based and any additional information, which may be provided by the aggrieved party, shall also be provided to the department of inspections, appeals, and licensing.

150.9(8) The hearing shall be conducted according to the procedural rules of the department of inspections, appeals, and licensing found in 481—Chapter 10.

150.9(9) When the administrative law judge makes a proposed decision and order, it will be served by certified mail, return receipt requested, or delivered by personal service. That proposed decision and order then becomes the department's final agency action without further proceedings ten days after it is received by the aggrieved party unless an appeal to the director is taken.

150.9(10) Any appeal to the director for review of the proposed decision and order of the administrative law judge must 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 will also be mailed to the administrative law judge. Any request for an appeal must state the reason for appeal.

150.9(11) Upon receipt of an appeal request, the administrative law judge will prepare the record of the hearing for submission to the director. The record shall include the following:

- a.* All pleadings, motions, and rules.
- b.* All evidence received or considered and all other submissions by recording or transcript.
- c.* A statement of all matters officially noticed.
- d.* All questions and offers of proof, objections and rulings on them.
- e.* All proposed findings and exceptions.
- f.* The proposed decision and order of the administrative law judge.

150.9(12) The decision and order of the director becomes the department's final agency action upon receipt by the aggrieved party and will be delivered by certified mail, return receipt requested, or by personal service.

150.9(13) 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.

150.9(14) Any petition for judicial review of a decision and order must be filed in the district court within 30 days after the decision and order becomes final. A copy of the notice of appeal will be sent to the department by certified mail, return receipt requested, or by personal service.

150.9(15) The party that appeals a final agency action to the district court must pay the cost of the preparation of a transcript of the contested case hearing for the district court.

150.9(16) Final decisions of the department relating to disciplinary proceedings may be transmitted to the department of inspections, appeals, and licensing and to the appropriate professional associations or news media.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.10(135) Prohibited acts. A hospital that imparts or conveys, or causes to be imparted or conveyed, that it is a participating hospital in Iowa's regionalized system of perinatal health care, or that uses any other term, such as a designated level of care, to indicate or imply that the hospital is a participating hospital in the regionalized system of perinatal health care without having obtained a certificate of verification from the department is subject to licensure disciplinary action by the department of inspections, appeals, and licensing, as well as to the application by the director to the district court for a writ of injunction to restrain the use of the term or terms "Level I maternal care or neonatal care hospital," "Level II maternal care or neonatal care hospital," "Level III maternal care or neonatal care hospital" and "Level IV maternal care or neonatal care hospital" in relation to the provision of perinatal health care services.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

641—150.11(135) Construction of rules. Nothing in these administrative rules shall be construed to restrict a hospital from providing any services for which it is duly authorized.

[ARC 9178C, IAB 4/30/25, effective 7/1/25]

These rules are intended to implement Iowa Code section 135.11.

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[Editorial change: IAC Supplement 6/10/26]

CHAPTER 154
MEDICAL CANNABIDIOL PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/14/29

641—154.1(124E) Definitions. For the purposes of these rules, the following definitions shall apply:

“*Acceptance criteria*” means the specified limits placed on characteristics of an item or method that are used to determine data quality.

“*Action level*” means the threshold value that provides the criterion for determining whether a sample passes or fails a test performed pursuant to these rules.

“*Advertisement*” means all representations disseminated in any manner or by any means, other than by labeling, for the purpose of inducing, or that are likely to induce, directly or indirectly, the purchase of medical cannabidiol.

“*Analyte*” means a chemical, compound, element, bacteria, yeast, fungus, or toxin to be identified or measured.

“*Analytical batch*” means a group of samples that are prepared together for the same analysis and analyzed sequentially using the same instrument calibration curve and common analytical quality control checks.

“*Analytical method*” means a technique used qualitatively or quantitatively to determine the composition of a sample or a microbial contamination of a sample.

“*Audit*” means a review by authorized personnel that includes select scope engagement or other methods of review that analyze operational or compliance issues.

“*Background investigation*” means a thorough review of an entity, an owner, investors, and employees conducted by the department of public safety, including but not limited to state and national criminal history records, credit records, and internal revenue service records.

“*Batch*” means a specifically identified quantity of dried flower and other cannabis plant matter that is uniform in strain or cultivar, harvested at the same time, and cultivated using the same pesticides and other crop inputs.

“*Biosecurity*” means a set of preventative measures designed to reduce the risk of transmission of:

1. Infectious diseases in crops;
2. Quarantined pests;
3. Invasive alien species;
4. Living modified organisms.

“*Cannabinoid*” means a chemical compound that is unique to and derived from cannabis.

“*Cannabis*” means seeds, plants, cuttings, or plant waste material from *Cannabis sativa* L. or *Cannabis indica* used in the manufacture of medical cannabidiol.

“*CBD*” means cannabidiol, Chemical Abstracts Service number 13956-29-1.

“*CBDA*” means cannabidiolic acid, Chemical Abstracts Service number 1244-58-2.

“*Certificate of analysis*” means the report prepared for the requester about the analytical testing performed and the results obtained by a laboratory.

“*Certified*” means that a laboratory demonstrates to the satisfaction of the department its ability to consistently produce valid data within the acceptance limits as specified in the department’s requirements for certification and meets the minimum requirements of this chapter and all applicable regulatory requirements.

“*Certified reference material*” means a reference material prepared by a certifying body.

“*Combusted*” means the addition of a flame to medical cannabidiol or raw flower cannabis for the purposes of burning for inhalation, or smoking cannabis.

“*Consumable hemp product*” means a hemp product that includes a substance that is metabolized or is otherwise subject to a biotransformative process when introduced into the human body.

1. A consumable hemp product may be introduced into the human body by ingestion or absorption by any device including but not limited to an electronic device.

2. A consumable hemp product may exist in a solid or liquid state.
3. A hemp product is deemed to be a consumable hemp product if it is any of the following:
 - Designed by the processor, including the manufacturer, to be introduced into the human body.
 - Advertised as an item to be introduced into the human body.
 - Distributed, exported, or imported for sale or distribution to be introduced into the human body.

“Consumable hemp product” includes but is not limited to any of the following:

1. A noncombustible form of hemp that may be digested, such as food; internally absorbed, such as chew or snuff; or absorbed through the skin, such as a topical application.
2. Hemp processed or otherwise manufactured, marketed, sold, or distributed as food, a food additive, a dietary supplement, or a drug.

“Consumable hemp product” does not include a hemp product if the intended use of the hemp product is introduced into the human body by any method of inhalation, as prohibited under Iowa Code section 204.14A.

“*Crop input*” means any substance applied to or used in the cultivation and growth of a cannabis plant. “Crop input” includes but is not limited to pesticides, fungicides, fertilizers, and other soil or medium amendments.

“*Date of expiration*” means one year from the date of issuance of the medical cannabidiol registration card by the department of transportation.

“*Date of issuance*” means the date of issuance of the medical cannabidiol registration card by the department.

“*Debilitating medical condition*” means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn’s disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
 - Severe or chronic pain.
 - Nausea or severe vomiting.
 - Cachexia or severe wasting.
8. Parkinson’s disease.
9. Chronic pain.
10. Severe, intractable autism with self-injurious or aggressive behaviors.
11. Post-traumatic stress disorder.
12. Corticobasal degeneration.
13. Ulcerative colitis.
14. Any medical condition that is recommended by the medical cannabidiol board and adopted by the board of medicine by rule pursuant to Iowa Code section 124E.5 and that is listed in 653—subrule 13.15(1).

“*Dispensary*” means an individual or entity licensed by the department to dispense medical cannabidiol to patients and primary caregivers pursuant to Iowa Code chapter 124E and these rules. “Dispensary” includes the employees and agents of the dispensary.

“*Dispensary facility*” means any secured building, space, grounds, and physical structure of a dispensary licensed by the department to dispense medical cannabidiol and where the dispensing of medical cannabidiol is authorized.

“Dispense” or *“dispensing”* means to supply medical cannabidiol to patients pursuant to Iowa Code chapter 124E and these rules.

“Disqualifying felony offense” means the same as defined in Iowa Code section 124E.2.

“Edible medical cannabidiol products” means food items containing medical cannabidiol. “Edible medical cannabidiol products” does not include pills, tinctures, oils, or other forms of medical cannabidiol that may be consumed orally or through the nasal cavity that do not contain food or food additives; provided that food or food additives used as carriers, excipients, or processing aids shall not be considered food or food additives.

“Field duplicate sample” means a sample that is taken in the identical manner and from the same batch, process lot, or lot being sampled as the primary sample. A field duplicate sample is analyzed separately from the primary sample and is used for quality control only.

“Health care practitioner” means the same as defined in Iowa Code section 124E.2.

“Inspection” means an on-site evaluation by the department; the department of public safety; or a department-approved independent consultant of facilities, records, personnel, equipment, methodology, and quality assurance practices for compliance with these rules.

“Investor” means a person making a cash investment of at least 5 percent interest in an applicant or licensed manufacturer or dispensary with the expectation of receiving financial returns.

“Laboratory” means the same as defined in Iowa Code section 124E.2.

“Limit of detection” or *“LOD”* means the lowest quantity of a substance or analyte that can be distinguished from the absence of that substance within a stated confidence limit.

“Limit of quantitation” or *“LOQ”* means the minimum concentration of an analyte in a specific matrix that can be reliably quantified while also meeting predefined goals for bias and imprecision.

“Lot” means a specific quantity of medical cannabidiol that is uniform and intended to meet specifications for identity, strength, purity, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling record.

“Lot number” means a unique numeric or alphanumeric identifier assigned to a lot by a manufacturer when medical cannabidiol is produced. The lot number shall contain the manufacturer’s number and a sequence to allow for inventory, traceability, and identification of the plant batches used in the production of a lot of medical cannabidiol.

“Manufacture” or *“manufacturing”* means the process of converting harvested cannabis plant material into medical cannabidiol.

“Manufacturer” means an individual or entity licensed by the department to produce medical cannabidiol and distribute it to dispensaries pursuant to Iowa Code chapter 124E and these rules. “Manufacturer” includes the employees and agents of the manufacturer.

“Manufacturing facility” means any secured building, space, grounds, and physical structure of a manufacturer for the cultivation, harvesting, packaging, processing, storage, and distribution of cannabis or medical cannabidiol and where access is restricted to designated employees of a manufacturer and escorted visitors.

“Matrix” means the component or substrate that contains the analyte of interest.

“Matrix spike duplicate” means a duplicate sample prepared by adding a known quantity of a target analyte to a field sample matrix or other matrix that is as closely representative of the matrix under analysis as possible.

“Matrix spike sample” means a sample prepared by adding a known quantity of the target analyte to a field sample matrix or to a matrix that is as closely representative of the matrix under analysis as possible.

“Medical assistance program” means IA Health Link, Medicaid Fee-for-Service, or hawki, as administered by the Iowa Medicaid enterprise of the department.

“Medical cannabidiol” means the same as defined in Iowa Code section 124E.2.

“Medical cannabidiol waste” means medical cannabidiol that is unused, unwanted, damaged, defective, expired, or contaminated and that is returned to a dispensary or manufacturer for disposal.

“Medical cannabis goods” means medical cannabidiol process lots, medical cannabidiol products, and cannabis plant material, including dried tissue.

“Method blank” means an analyte-free matrix to which all reagents are added in the same volumes or proportions as are used in sample preparation.

“National criminal history background check” means fingerprint processing through the department of public safety and the Federal Bureau of Investigation (FBI) and review of records on file with national organizations, courts, and law enforcement agencies to the extent allowed by law.

“Owner” means a person with a 5 percent or greater ownership interest in an applicant or licensed manufacturer or dispensary.

“Patient” means a person who is a permanent resident of the state of Iowa who suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to Iowa Code chapter 124E and these rules.

“Patient registration number” means the unique identification number issued to a patient by the department upon approval of a patient’s application by the department as described in these rules.

“Percent recovery” means the percentage of a measured concentration relative to the added (spiked) concentration in a reference material, matrix spike sample, or matrix spike duplicate.

“Plant material” means any plant of *Cannabis sativa* L. or *Cannabis indica*, or any part thereof, including flowers, leaves, trichomes, and tissue.

“Plant material waste” means plant material that is not used in the production of medical cannabidiol in a form allowable under these rules.

“Primary caregiver” means the same as defined in Iowa Code section 124E.2.

“Primary care provider” means any health care practitioner involved in the diagnosis and treatment of a patient’s debilitating medical condition.

“Primary sample” means a portion of a batch, process lot, or lot that is used for testing for identity, strength, purity, and composition.

“Process lot” means any amount of cannabinoid concentrate or extract that is uniform, produced from one or more batches, and used for testing for identity, strength, purity, and composition prior to being packaged.

“Product expiration date” means the date after which a medical cannabidiol product shall not be sold by a manufacturer or a dispensary.

“Production” or *“produce”* means:

1. Cultivating or harvesting plant material;
2. Processing or manufacturing; or
3. Packaging of medical cannabidiol.

“Proficiency test” means an evaluation of a laboratory’s performance against preestablished criteria by means of interlaboratory comparisons of test measurements.

“Qualitative analysis” means identification of an analyte in a substance or mixture.

“Quality assurance” means a set of operating principles to produce data of known accuracy and precision. “Quality assurance” encompasses employee training, equipment preventative maintenance procedures, calibration procedures, and quality control testing, among other things.

“Quality control” means a set of measures implemented within an analytical procedure to ensure that the measurement system is operating in a state of statistical control in which errors have been reduced to acceptable levels.

“Quality control samples” means samples produced and used for the purpose of ensuring quality control. Quality control samples include but are not limited to blank samples, spike samples, duplicate samples, and reference material samples.

“Reagent” means a compound or mixture added to a system to cause a chemical reaction or to test if a reaction occurs. A reagent may be used to tell whether or not a specific chemical substance is present by causing a reaction to occur with the chemical substance.

“Recall” means the return of medical cannabidiol from patients and dispensaries to a manufacturer because of the potential for serious health consequences from the use of the medical cannabidiol.

“Reference material” means a material containing a known concentration of an analyte of interest that is in solution or in a homogeneous matrix. Reference material is used to document the bias of the analytical process.

“Relative percent difference” or *“RPD”* means a comparative statistic used to calculate precision or random error. RPD is calculated using the following equation: $RPD = \frac{\text{absolute value (primary sample measurement - duplicate sample measurement)}}{[(\text{primary sample measurement} + \text{duplicate sample measurement}) / 2]} \times 100$.

“Requester” means a person who submits a request to a licensed testing laboratory for state-mandated testing of medical cannabis goods. The requester may be a licensed manufacturer or the department.

“Residual solvents and processing chemicals” means volatile organic chemicals that are used or produced in the manufacture or production of medical cannabidiol.

“Restricted access area” means a building, room, or other contiguous area on the premises where plant material is grown, cultivated, harvested, stored, packaged, or processed for sale under control of the manufacturer, and where no person under the age of 18 is permitted.

“Sample” means a representative part of or a single item from a larger whole or group.

“Sanitize” means to sterilize, disinfect, or make hygienic.

“Security alarm system” means the same as defined in rule 661—277.2(100C).

“Semiquantitative analysis” means less than quantitative precision and does not involve a full calibration. Analyte identification is based on a single-point reference or high-probability library match. The determination of amount uses the ratio of the unknown chemical analyte to that of a known analyte added to the sample before analysis. Uncertainty for semiquantitative results is higher than for quantitative results.

“Significant figures” means the number of digits used to express a measurement.

“Stability study” or *“studies”* means the process of determining the shelf-life or expiration date of a medical cannabidiol product. After storage of an unopened package of medical cannabidiol at a licensed manufacturing facility or dispensary facility, the contents shall not vary in concentrations of THC and CBD by more than an amount determined by the department and listed in the laboratory testing requirements and acceptance criteria document described in 641—Chapter 154.

“Standard operating procedure” means a written document that provides detailed instructions for the performance of all aspects of an analysis, operation, or action.

“Synthetic or semisynthetic cannabinoid” means a cannabinoid extracted from a cannabis plant, a cannabis flower, a hemp plant, or hemp plant parts with a chemical makeup that is changed after extraction to create a different cannabinoid or other chemical compound by applying a catalyst other than heat or light. “Synthetic or semisynthetic cannabinoid” includes but is not limited to any tetrahydrocannabinol created from cannabidiol.

“Tamper-evident” means that one or more one-time-use seals are affixed to the opening of a package, allowing a person to recognize whether or not the package has been opened.

“Testing laboratory record” means information relating to the testing laboratory and the analyses it performs that is prepared, owned, used, or retained by the laboratory and includes electronic files and video footage.

“THC” or *“delta-9 THC”* means tetrahydrocannabinol, Chemical Abstracts Service number 1972-08-3.

“THCA” means tetrahydrocannabinolic acid, Chemical Abstracts Service number 23978-85-0.

“Total tetrahydrocannabinol” means 87.7 percent of the amount of tetrahydrocannabinolic acid plus the amount of tetrahydrocannabinol.

“Tracking number” means the sales identification number assigned by a dispensary to a transaction at the time of the sale of a medical cannabidiol product.

“Trade name” means the name that manufacturers give to a product or range of products.

“Validation” means the confirmation by examination and objective evidence that the particular requirements for a specific intended use are fulfilled.

“Valid photo identification” means any of the following for a patient or primary caregiver: (1) a valid Iowa driver’s license, (2) a valid Iowa nonoperator’s identification card, or (3) an alternative form of valid photo identification. An individual who possesses or is eligible for a driver’s license or a nonoperator’s identification card shall present such document as valid photo identification. An individual who is ineligible to obtain a driver’s license or a nonoperator’s identification card may apply for an exemption and request submission of an alternative form of valid photo identification. An individual who applies for an exemption is subject to verification of the primary caregiver’s identity through a process established by the department to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

“Vaporization” means the heating of a medical cannabidiol concentrate or extract to a specific temperature using a device. For the purposes of these rules, vaporization does not include raw or dried cannabis flower.

“Written certification” means a document signed by a health care practitioner, with whom the patient has established a patient-provider relationship, that states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

REGISTRATION CARDS

641—154.2(124E) Health care practitioner certification—duties and prohibitions.

154.2(1) Prior to a patient’s submission of an application for a medical cannabidiol registration card pursuant to this rule, a health care practitioner shall follow all provisions of Iowa Code section 124E.3, this chapter and requests from the department for more information.

a. The written documentation required by Iowa Code section 124E.3(1)“a” shall be submitted on the application form at the department’s website.

b. Explanatory information pursuant to Iowa Code section 124E.3(1)“b” is located at the department’s website.

154.2(2) A health care practitioner may make a written request to the department to rescind a written certification the practitioner previously provided, based on reasons deemed appropriate by the health care practitioner.

154.2(3) Health care practitioner prohibitions. A health care practitioner shall not:

a. Accept, solicit, or offer any form of remuneration from or to any individual, including but not limited to a patient, a primary caregiver, or an employee, investor, or owner of a manufacturer or dispensary for the purposes of:

(1) Certifying a patient’s condition, other than accepting a fee for a patient consultation to determine if the patient should be issued a certification under Iowa Code chapter 124E.

(2) Certifying an individual as a primary caregiver, other than accepting a fee for a consultation to determine if the individual is a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol.

b. Advertise the certification of patients as one of the health care practitioner’s services.

c. Certify a qualifying debilitating medical condition for a patient who is the health care practitioner or a family or household member of the health care practitioner.

d. Be designated to act as a primary caregiver for a patient for whom the health care practitioner has certified a qualifying debilitating medical condition.

e. Receive or provide medical cannabidiol product samples.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.3(124E) Medical cannabidiol registration card—application and issuance to patient.

154.3(1) The department may issue a registration card to a patient who meets the criteria listed at Iowa Code section 124E.4(1). The application form is available on the department's website. The department shall not approve an application that does not include the information requested on the application form.

154.3(2) Upon the completion, verification, and approval of the patient's application and the receipt of the required fee, the department shall issue a registration card to the patient.

154.3(3) A registration card issued to a patient shall contain all of the following:

a. The patient's full legal name, Iowa residence address, date of birth, and sex, as shown on the patient's valid photo identification. If the patient's information has changed since the issuance of the patient's valid photo identification, the patient shall first update the patient's valid identification to reflect the patient's current information.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the patient's social security number.

d. A statement that the registration card is not valid for identification purposes.

154.3(4) Every patient 18 years of age or older must obtain a valid registration card to use medical cannabidiol in Iowa.

154.3(5) An authorization to use medical cannabidiol or cannabis for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E and is not a valid registration card for purposes of purchasing medical cannabidiol at dispensaries in Iowa.

[ARC 8124C, IAB 7/10/24, effective 8/14/24; ARC 9617C, IAB 10/15/25, effective 12/1/25]

641—154.4(124E) Medical cannabidiol registration card—reciprocity. A medical cannabidiol registration card shall hold reciprocity with other states pursuant to Iowa Code section 124E.18.

154.4(1) A patient with a valid registration card from another state or jurisdiction shall maintain the affirmative defense for possession of medical cannabidiol, provided the form of cannabis product in the patient's possession is allowable in Iowa.

154.4(2) A patient with a valid registration card under the laws of another state or jurisdiction has no affirmative defense for medical cannabidiol if the cannabis product in the patient's possession is prohibited in Iowa. Prohibited forms of medical cannabidiol include:

a. Raw cannabis flower that may be combusted or smoked;

b. Edible products with a total THC concentration greater than 0.3 percent that is not a consumable hemp product.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.5(124E) Medical cannabidiol registration card—application and issuance to primary caregiver.

154.5(1) For a patient in a primary caregiver's care, the department may issue a registration card to a primary caregiver who meets the criteria listed at Iowa Code section 124E.4(3). The application form is available on the department's website. The department shall not approve an application that does not include the information requested on the application form.

154.5(2) Upon the completion, verification, and approval of the primary caregiver's application, the department shall issue a registration card to the primary caregiver.

154.5(3) A registration card issued to a primary caregiver shall contain all of the following:

a. The primary caregiver's full legal name, current residence address, date of birth, and sex, as shown on the primary caregiver's valid photo identification. If the primary caregiver's information has changed since issuance of the primary caregiver's valid photo identification, the primary caregiver shall first update the primary caregiver's valid photo identification to reflect the primary caregiver's current information.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the primary caregiver's social security number.

d. The registration number for each patient in the primary caregiver's care. This number shall not be the primary caregiver's or patient's social security number. If the patient in the primary caregiver's care is under the age of 18, the full name of the patient's parent or legal guardian shall be printed on the primary caregiver's registration card in lieu of the patient's registration number.

e. A statement that the registration card is not valid for identification purposes.

f. A statement distinguishing the registration cardholder as a primary caregiver.

154.5(4) An authorization to use, or to act as a primary caregiver for a patient authorized to use, medical cannabidiol or cannabis for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of Iowa Code chapter 124E and is not a valid registration card for purposes of purchasing medical cannabidiol at dispensaries in Iowa.

[ARC 8124C, IAB 7/10/24, effective 8/14/24; ARC 9617C, IAB 10/15/25, effective 12/1/25]

641—154.6(124E) Denial and cancellation. The department may deny an application for a registration card, or may cancel a registration card, for any of the following reasons:

1. Information contained in the application is illegible, incomplete, falsified, misleading, deceptive, or untrue.

2. The department is unable to verify the identity of the applicant from the photo identification or other documentation presented during application.

3. The department has reasonable belief, or proof, that the patient is engaged in diversion of medical cannabidiol.

4. The applicant violates or fails to satisfy any of the provisions of Iowa Code chapter 124E or these rules.

5. A patient, the patient's legal guardian, or other person with durable power of attorney requests in writing that the department cancel the patient's registration card. The department shall notify a primary caregiver in writing when the registration card of the primary caregiver's patient has been canceled.

6. A primary caregiver requests in writing that the department cancel the primary caregiver's registration card. The department shall notify a patient in writing when the registration card of the patient's primary caregiver has been canceled.

7. The department becomes aware of the death of a patient or primary caregiver.

8. A health care practitioner requests in writing that the department rescind the written certification the practitioner provided to a patient or caregiver.

9. A patient requests in writing that the department cancel the patient's primary caregiver's registration card.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.7(124E) Appeal.

154.7(1) *Written notice of denial or cancellation.* If the department denies an application for or cancels a registration card, the department shall inform the applicant or cardholder of the denial or cancellation, state the reasons for the denial or cancellation in writing, and state the effective date of the denial or cancellation. If the department cancels a card upon request from a patient or primary caregiver, or the department becomes aware of the death of a patient or primary caregiver, the cancellation is effective immediately upon issuance of the written notice of cancellation. If the department cancels a card upon any other ground listed, the cancellation shall become effective 30 days following issuance of the written notice of cancellation.

154.7(2) *Effect of written notice of cancellation on use and possession of medical cannabidiol.* A cardholder is authorized to purchase, possess, and use medical cannabidiol up to and including the effective date of the cancellation. For purposes of the affirmative defenses in Iowa Code section

124E.12, a patient or primary caregiver shall be deemed to be in possession of a valid registration card up to and including the effective date of the cancellation.

154.7(3) *Request for appeal.* A request for appeal concerning the denial or cancellation of a registration card shall be submitted pursuant to the provisions of 441—Chapter 2506. In the event of a timely appeal, cancellation of the card shall be deemed to be suspended pending the outcome of the contested case proceeding. If the cancellation is affirmed following the contested case proceeding, the card cancellation shall become effective 30 days following issuance of the department's final agency action.

[ARC 8124C, IAB 7/10/24, effective 8/14/24; Editorial change: IAC Supplement 6/10/26]

641—154.8(124E) Duplicate card.

154.8(1) *Lost, stolen, or destroyed card.* To replace a registration card that is lost, stolen, or destroyed, a cardholder shall present to the department the cardholder's valid photo identification that was provided at the time of application.

154.8(2) *Change in card information and voluntary replacement.*

a. To replace a registration card that is damaged, the cardholder shall surrender the card to be replaced to the department and present the cardholder's valid photo identification that was provided at the time of application.

b. A patient or primary caregiver to whom a registration card is issued shall notify the department of a change in information listed on the card, within ten calendar days of the change. To replace a registration card to change the patient or primary caregiver's information, the cardholder shall surrender the card to be replaced to the department and present the patient or primary caregiver's updated valid photo identification.

c. To replace a registration card held by a primary caregiver to change, add, or remove a patient's registration number or the name of a patient's parent or legal guardian listed on the primary caregiver's card, the primary caregiver shall submit a new application to the department pursuant to rule 641—154.5(124E). A registration card issued pursuant to this paragraph shall not be considered a duplicate card.

154.8(3) *Expiration date.* A duplicate registration card shall have the same expiration date as the registration card being replaced, changed, or amended.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.9(124E) Renewal. A registration card shall be valid for one year from the date of issuance, unless canceled. Renewal of a registration card will follow the application and issuance rules of this chapter.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.10(124E) Confidentiality. The department will follow the confidentiality provisions in Iowa Code section 124E.11(1).

154.10(1) Personally identifiable information of patients and primary caregivers will be maintained as confidential and is not accessible to the public. The department will release aggregate and statistical information regarding the registration card program in a manner that prevents the identification of any patient or primary caregiver.

154.10(2) Personally identifiable information of patients and primary caregivers may be disclosed only pursuant to Iowa Code section 124E.11(1)“b” and to a patient, primary caregiver, or health care practitioner, upon written authorization of the patient or primary caregiver.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.11(124E) Fees. All fees are nonrefundable. Application fees are established in Iowa Code section 124E.4.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.12(124E) Consumption of medical cannabidiol. In accordance with Iowa Code section 124E.12, patients and caregivers are entitled to a complete and affirmative defense for unlawful possession of marijuana. Medical cannabidiol is intended to be consumed privately, and patients are subject to all applicable laws regarding public impairment and operating a vehicle, including but not limited to Iowa Code section 123.46 and chapter 321J. Medical cannabidiol products shall not be consumed in the following places:

- a.* In places open to the public, except for within a health care facility if pursuant to the standard operating procedures of the health care facility.
- b.* On the property of a school, unless pursuant to the standard operating procedure of the school.
- c.* On the property of a medical cannabidiol dispensary or manufacturer.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.13(124E) Allowable forms of medical cannabidiol.

154.13(1) *Modification of allowable forms.* Allowable forms of medical cannabidiol may be modified by approval of a recommendation by the medical cannabidiol board, subsequent approval of the board of medicine, and adoption of the recommendations by the department.

154.13(2) *Allowable forms.*

a. A manufacturer may only manufacture medical cannabidiol in the following forms:

(1) Oral forms, including but not limited to:

1. Tablet.
2. Capsule.
3. Liquid.
4. Tincture.
5. Sublingual.

(2) Topical forms, including but not limited to:

1. Gel.
2. Ointment, cream or lotion.
3. Transdermal patch.

(3) Inhaled forms, limited to:

1. Nebulizable.
2. Vaporizable.

(4) Rectal/vaginal forms, including but not limited to suppository.

b. A manufacturer shall not produce medical cannabidiol in any form that may be smoked.

c. A manufacturer shall not produce edible medical cannabidiol products.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

MANUFACTURER AND DISPENSARY LICENSING

641—154.14(124E) Notice to law enforcement. The department shall notify local law enforcement agencies and the department of public safety of the locations of manufactures and dispensaries. If the department has sufficient cause to believe that there is a threat to public safety, the department shall notify local law enforcement agencies and the department of public safety.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.15(124E) Manufacturer and dispensary licensure.

154.15(1) To be eligible for licensure, an applicant manufacturer or dispensary shall complete a background investigation pursuant to Iowa Code section 124E.19. Applicants must provide information on forms and in a manner required by the department of public safety.

154.15(2) The license shall be renewed annually unless a manufacturer or dispensary relinquishes the license, there is a change in state law prohibiting the department from renewing the license, or the license is revoked pursuant to Iowa Code chapter 124E or these rules.

154.15(3) A license to manufacture or dispense medical cannabidiol issued by the department is not assignable or transferable unless for the purpose of intra-organization restructure, subject to review and approval by the department.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.16(124E) Collection of fees in competitive licensing. Except as provided in this rule, all fees are nonrefundable, shall be retained by the department, and shall be considered repayment receipts as defined in Iowa Code section 8.2.

154.16(1) *Fees to the department for manufacturers and dispensaries.*

a. Fees for manufacturing applicants are established by Iowa Code section 124E.6(4). Fees for dispensary applicants are established by Iowa Code section 124E.8(4).

b. Licensed manufacturers and dispensaries shall pay an annual fee to the department to cover costs associated with regulating and inspecting, and for other expenses necessary for the administration of the medical cannabidiol program. The department shall assess the fee with the notice of approval of license, payable to the department no later than December 1. Annual fees assessed by the department shall not exceed \$100,000 for a manufacturing license and shall not exceed \$50,000 for a dispensary license.

154.16(2) *Fees to the department of public safety.*

a. An applicant manufacturer or dispensary shall reimburse the department of public safety the full cost of conducting background investigations related to an application for licensure. The department of public safety retains the right to bill a licensee for additional background investigations, as needed.

b. Each manufacturer or dispensary awarded a license shall, at the time of award to license, submit to the department of public safety a deposit of \$10,000 for each business owner subject to a background investigation and a national criminal history background check. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the applicant shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer or dispensary.

c. A licensed manufacturer or dispensary shall pay a deposit of \$200 per employee to the department of public safety for a background investigation and a national criminal history background check on any person being considered for hire as an employee of the manufacturer or dispensary. Background investigation costs shall be deducted from the funds deposited. If the background investigation fees exceed the funds deposited, the manufacturer or dispensary shall submit additional funds as required by the department of public safety. If the background investigation fees are less than the funds deposited, the department of public safety may refund or retain the fees as mutually agreed with the manufacturer or dispensary. The department shall retain the right to preclude a potential employee from hire based upon the results of the background investigation and national criminal history background check.

154.16(3) *Criminal background checks.*

a. A manufacturer or the owner of a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history record check.

b. An employee of a manufacturer or a dispensary shall not have been convicted of a disqualifying felony offense and shall be subject to a background investigation conducted by the department of public safety, including but not limited to a national criminal history background check.

c. An applicant or licensed manufacturer or dispensary shall respond within 30 days to a request from the department or the department of public safety for more information to complete a background investigation and national criminal history background check on an owner, investor, or employee.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.17(124E) Licensure renewal.

154.17(1) A licensed manufacturer or dispensary shall apply to renew its license with the department at least six months before the license expires. The application shall be submitted on a form on the department's website.

154.17(2) The department shall notify a manufacturer or dispensary of the decision to approve or deny the manufacturer or dispensary's license by August 1 of the year in which the renewal application is submitted.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.18(124E) Suspension or revocation of a manufacturing or dispensary license.

154.18(1) The department may suspend or revoke a manufacturer or dispensary license upon any of the following grounds:

- a.* Submission of false, inaccurate, misleading, or fraudulent information to the department in the application or inspection processes.
- b.* Failure to submit required reports and documents.
- c.* Violation of Iowa Code chapter 124E or these rules, or violation of state or local law related to operation of the licensee.
- d.* Conduct or practices detrimental to the safety, health, or welfare of a patient, primary caregiver, or the public.
- e.* Criminal, civil, or administration action taken against a license or registration in this or another state or country related to manufacturing or dispensing medical cannabidiol.
- f.* False, misleading, or deceptive representations to the department, another state or federal agency, or a law enforcement agency.
- g.* Discontinuance of operation for more than 30 days, unless the department approves an extension of such period for good cause shown.
- h.* Failure to maintain effective controls against diversion, theft, or loss of medical cannabidiol.
- i.* Failure to correct a deficiency within the time frame required by the department.
- j.* Failure of a manufacturer or dispensary's business owner or investors to have a satisfactory result in a background investigation or national criminal history background check as determined by the department.

154.18(2) The department shall notify the manufacturer or dispensary of the proposed action pursuant to Iowa Code sections 17A.12 and 17A.18. Notice of issuance of a suspension or revocation shall be served by restricted certified mail, return receipt requested, or by personal service.

154.18(3) A request for appeal concerning the suspension or revocation of a license shall be submitted pursuant to the provisions of 441—Chapter 2506.

[ARC 8124C, IAB 7/10/24, effective 8/14/24; Editorial change: IAC Supplement 6/10/26]

641—154.19(124E) Assessment of penalties. The department shall assess to a manufacturer a civil penalty of up to \$1,000 per violation of Iowa Code chapter 124E or these rules in addition to other applicable penalties.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.20(124E) Closure of operations.

154.20(1) A manufacturer or dispensary shall notify the department at least six months before the closure of the manufacturing facility.

154.20(2) If a manufacturer or dispensary ceases operation, the manufacturer or dispensary shall work with the department to verify the remaining inventory of the manufacturer or dispensary and ensure that any plant material, plant material waste, medical cannabidiol products, or combination thereof are destroyed at a waste facility or returned to a manufacturer.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.21(124E) Manufacturer and dispensary security requirements.

154.21(1) *Restricted access.* A manufacturer or dispensary shall limit entrance to all restricted areas by completing all of the following:

- a.* Mark restricted access areas with signs that state: “Do Not Enter—Restricted Access Areas Access Limited to Authorized Personnel Only”.
- b.* Use a controlled access system that:
 - (1) Limits access to authorized individuals;
 - (2) Maintains a log of individuals with approved access, including dates of approvals and revocations;
 - (3) Tracks times of personnel entry to and exit from the facility;
 - (4) Stores data for retrieval for a minimum of one year; and
 - (5) Limits access to authorized individuals in the event of a power failure.
- c.* If the controlled access system cannot electronically record visitors, visitors to restricted access areas sign manifests with name, date, and times of entry and exit. These manifests shall be kept and stored for a minimum of one year.
- d.* Visitors wear badges that are visible at all times and identify them as visitors.
- e.* If requested by the department, submit stored controlled access system data to the department within five business days.

154.21(2) *Perimeter intrusion detection system.*

a. Computer-controlled video surveillance system. A manufacturer or dispensary shall operate and maintain a computer-controlled, closed-circuit television surveillance system on its premises that operates 24 hours per day, seven days per week, and visually records:

- (1) All phases of medical cannabidiol production, if applicable;
- (2) All areas that might contain plant material, medical cannabidiol, or both;
- (3) All points of entry and exit;
- (4) The entrance to the video surveillance control room; and
- (5) Parking areas, which shall have appropriate lighting for the normal conditions of the area under surveillance.

b. Camera specifications. Cameras shall:

- (1) Capture clear and certain identification of any person entering or exiting a manufacturer or dispensary or its parking areas;
- (2) Produce a clear, color still photograph live or from a recording;
- (3) Have an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
- (4) Continue to operate during a power outage.

c. Video recording specifications. Video recording equipment shall:

- (1) Export still images in an industry standard image format, such as .jpg, .bmp, or .gif;
- (2) Archive exported video in a format that ensures authentication and guarantees that the recorded image has not been altered; and
- (3) Save exported video in an industry standard file format that can be played on a standard computer operating system.

d. Location. A dispensary shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

e. Retention. A manufacturer or dispensary shall ensure that recordings from all video cameras are:

- (1) Available for viewing by the department upon request;
- (2) Retained for at least 60 days; and
- (3) Maintained free of alteration or corruption.

f. Required signage. A manufacturer or dispensary shall post a sign in capital letters in a conspicuous location at every entrance to the manufacturing facility or dispensary that reads, “THESE PREMISES ARE UNDER CONSTANT VIDEO SURVEILLANCE.”

154.21(3) *Security alarm system requirements.*

a. A manufacturer or dispensary shall use a professionally monitored security alarm system that provides intrusion and fire detection of all the following:

- (1) Dispensary entrances and exits;
- (2) Facility entrances and exits;
- (3) Rooms with exterior windows;
- (4) Rooms with exterior walls;
- (5) Roof hatches;
- (6) Skylights; and
- (7) Storage rooms.

b. A manufacturer or dispensary's security alarm system and all devices shall continue to operate during a power outage.

c. A manufacturer or dispensary shall provide documentation of the annual inspection and device testing, by a qualified alarm vendor, to the department upon request.

154.21(4) *Personnel identification system.* A manufacturer or dispensary shall use a personnel identification system that controls and monitors individual employee access to restricted access areas.

a. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance and expiration;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A manufacturer or dispensary's employee shall keep the identification card visible at all times when the employee is in a manufacturing facility, a dispensary, or a vehicle transporting medical cannabidiol.

c. Upon termination or resignation of an employee, a manufacturer or dispensary shall immediately:

- (1) Revoke the employee's access to the manufacturing facility or dispensary; and
- (2) Destroy the employee's identification card, if possible.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.22(124E) Advertising and marketing.

154.22(1) *Permitted marketing and advertising activities.* A manufacturer or dispensary must include medical cannabidiol pricing and hours of operation on its website and may do the following:

a. Display the manufacturer or dispensary's business name and logo on medical cannabidiol labels, signs, website, and informational material provided to patients. The name or logo shall not include:

- (1) Images of cannabis or cannabis-use paraphernalia;
- (2) Colloquial references to cannabis;
- (3) Names of cannabis plant strains or varieties;
- (4) Unsubstantiated medical claims; or
- (5) Medical symbols that bear a reasonable resemblance to established medical associations.

b. Display signs on the manufacturing facility or dispensary; and

c. Maintain a business website that contains the following information:

- (1) The manufacturer or dispensary's name and contact information;
- (2) The medical cannabidiol forms and quantities manufactured or available in Iowa; and
- (3) Other information as approved by the department.

154.22(2) *Prohibited conduct, statements and illustration.*

a. An advertisement for medical cannabidiol shall not contain:

- (1) Colloquial references to cannabis;
- (2) Names of cannabis plant strains or varieties;
- (3) Any statement that is false or misleading;

- (4) Any statement that disparages a competitor's products;
 - (5) Any statement, design, or representation, picture or illustration that is obscene or indecent;
 - (6) Any statement, design, representation, picture or illustration that reasonably appeals to or targets children. Appealing to children means:
 1. When taken literally or as a plain language reading, there is a resemblance to food or product used by children;
 2. Contains child-appealing visuals/graphics, such as intense colors, bubble letters, or other interesting fonts or lettering;
 3. Unconventional or interesting product names;
 4. Unconventional or unexpected flavor, color, or shape of the product;
 5. Games or activities present on the package; or
 6. Presence of branded characters, spokespersons, licensed characters, cartoons, or celebrities;
 - (7) Any statement, design, representation, picture or illustration that encourages or represents the use of medical cannabidiol for a condition other than a qualifying debilitating medical condition;
 - (8) Any statement, design, representation, picture or illustration that encourages or represents the recreational use of medical cannabidiol or marijuana, tobacco or nicotine products, or alcohol;
 - (9) Any statement, design, representation, picture or illustration related to the safety or efficacy of medical cannabidiol, unless supported by substantial evidence, substantial clinical data, direct patient testimonials, or combination thereof;
 - (10) Any statement, design, representation, picture or illustration portraying anyone reasonably appearing to be under the age of 18, objects suggestive of the presence of anyone under the age of 18, or containing the use of a figure, symbol or language that is customarily associated with anyone under the age of 18, except that an advertisement may address medical cannabidiol products as they relate to minor patients;
 - (11) Any offer of a prize, award or inducement to a qualifying patient, primary caregiver, or health care practitioner related to the purchase of medical cannabidiol or a certification for the use of medical cannabidiol, except that non-product-specific price discounts are allowed;
 - (12) Any statement or assertion that medical cannabidiol products are safe because they are regulated under this chapter or have been tested by an approved laboratory;
 - (13) Any reference to a prohibited form of medical cannabidiol;
 - (14) Any statement that claims that medical cannabidiol products are endorsed or supported by any government agency; or
 - (15) Any statement that indicates or implies that the product or entity in the advertisement has been approved or endorsed by the department, the state of Iowa or any person or entity associated with the state of Iowa.
- b.* A manufacturer or dispensary shall not engage in any of the following activities:
- (1) Host, promote, refer, or otherwise advertise a third-party patient certification service;
 - (2) Engage in any advertising, marketing, or branded educational activities within 1,000 feet of a school;
 - (3) Host, promote, sponsor, or otherwise participate in a cannabis consumption lounge or other such encouragement of public consumption of cannabis or medical cannabidiol; or
 - (4) Advertise, or make reference to, non-approved forms of medical cannabidiol in any of its advertisements, including but not limited to:
 1. Referring to an approved form of medical cannabidiol as a prohibited form of medical cannabidiol.
 2. Advertising non-approved forms of medical cannabidiol. Consumable hemp products regulated under Iowa Code chapter 204 and 641—Chapter 156 are exempt from this provision.
- 154.22(3)** *Review of advertisements by the department.* Any advertisement for medical cannabidiol shall be submitted to the department, on a form or in a format prescribed by the department, at the same time as, or prior to, the dissemination of the advertisement.

a. The department may:

(1) Require a specific disclosure be made in the advertisement in a clear and conspicuous manner if the department determines that the advertisement would be false or misleading without such a disclosure; or

(2) Require changes that are necessary to protect the public health, safety and welfare; or

(3) Require statements for inclusion in the advertisement to address the specific efficacy of medical cannabidiol as it relates to specific disease states or approved debilitating medical conditions, disease symptoms, and population groups.

b. The department reserves the right to require that a licensee amend or remove a public advertisement.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.23(124E) Sales and inventory tracking system. The department shall establish and maintain a secure, electronic system that is available 24 hours per day, seven days per week to track:

1. Inventory of plant material and medical cannabidiol;
2. Transport of plant material and laboratory samples;
3. Application and use of crop inputs and other solvents and chemicals;
4. Sales of medical cannabidiol to dispensaries;
5. Sales of medical cannabidiol from dispensaries to patients and primary caregivers.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.24(124E) Financial transactions.

154.24(1) A manufacturer or dispensary shall maintain records that reflect all financial transactions and the financial condition of the business.

154.24(2) The following records shall be maintained for at least five years and made available for review upon request of the department:

a. Purchase invoices, bills of lading, sales records, copies of bills of sale, and any supporting documents, including the items or services purchased, from whom the items were purchased, and the date of purchase;

b. Bank statements and canceled checks for all business accounts;

c. Accounting and tax records; and

d. Records of all financial transactions, including contracts and agreements for services performed or services received.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.25(124E) Inspection by department or independent consultant. A manufacturer or dispensary is subject to reasonable inspection by the department, a department-approved consultant, or another agency pursuant to Iowa Code chapter 124E and these rules and as authorized by laws and regulations.

154.25(1) *Types of inspections.* Inspections may include:

a. Aspects of the business operations;

b. The manufacturing facility or the physical location of a dispensary, including any storage facility;

c. Vehicles used for transport or delivery of medical cannabidiol or plant material;

d. Financial information and inventory documentation;

e. Physical and electronic security alarm systems;

f. Health and sanitary inspection; and

g. Other inspections as determined by the department.

154.25(2) *Compliance required.* A manufacturer or dispensary shall respond to deficiencies found during inspections or inventory reconciliation as follows:

a. Deficiencies not related to inventory reconciliation.

(1) Upon written notification by the department of deficiencies that do not involve reconciliation of inventory, a manufacturer or dispensary shall have up to 30 days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two weeks to accept or require revision of the action plan.

b. Deficiencies related to inventory reconciliation.

(1) Upon notifying the department that the manufacturer or dispensary cannot reconcile the physical inventory with the inventory recorded in the secure sales and inventory tracking system, the manufacturer or dispensary shall have up to two business days to submit an action plan to the department with proposed remedies and timelines for completion of the remedies.

(2) The department shall have up to two business days to accept or require revision of the action plan.

(3) Failure to complete actions in the action plan within the timelines mutually agreed upon by the manufacturer and the department shall result in assessment of penalties or in suspension or revocation of a manufacturer or dispensary license.

(4) At the department's request and in a timely manner, a manufacturer or dispensary shall pay for and undergo an independent health and sanitary inspection in accordance with this rule.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

MANUFACTURING

641—154.26(124E) Manufacturer operations.

154.26(1) *Operating documents.*

a. A manufacturer shall maintain operating documents that accurately reflect the manufacturer's standard operating procedures. Unless otherwise noted, a manufacturer shall make the operating documents available to the department upon request, through secure means.

b. The operating documents of a manufacturer shall include all of the following:

(1) Procedures for the oversight of the manufacturer, including descriptions of operational and management practices regarding:

1. The forms and quantities of medical cannabidiol products that are produced at the manufacturing facility;

2. The methods of planting, harvesting, drying, and storing cannabis. A manufacturer may make operating documents for these procedures available on site only;

3. The estimated types and amounts of all crop inputs used in the production of medical cannabidiol;

4. The disposal methods for all waste materials;

5. Employee training methods for the specific phases of production. A manufacturer may make operating documents for these procedures available on site only;

6. Biosecurity measures and standard operating procedures used in the production and manufacturing of medical cannabidiol. A manufacturer may make operating documents for these procedures available on site only;

7. Strategies for identifying and reconciling discrepancies in inventory of plant material or medical cannabidiol;

8. Sampling strategy and quality testing for labeling purposes. A manufacturer may make operating documents for these procedures available on site only;

9. Medical cannabidiol packaging and labeling procedures;

10. Procedures for recall of medical cannabidiol;

11. Plans for responding to a security breach at a manufacturing facility or while medical cannabidiol is in transit to a dispensary. A manufacturer may make operating documents for these procedures available on site only;

12. A business continuity plan. A manufacturer may make this operating document available on site only;

13. Records relating to all transport activities; and
 14. Other information requested by the department.
- (2) Procedures to ensure accurate recordkeeping.
 - (3) Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas containing medical cannabidiol. A manufacturer may make operating documents for these procedures available on site only.

154.26(2) *Prohibited activities.* In addition to following all provisions of Iowa Code section 124E.7, a manufacturer shall not:

- a. Produce or manufacture medical cannabidiol in any location except in those areas approved by the department;
- b. Sell, deliver, transport, or distribute medical cannabidiol from any location except its manufacturing facility or a dispensary facility;
- c. Produce or manufacture medical cannabidiol in Iowa for sales or distribution outside of Iowa;
- d. Sell or distribute medical cannabidiol to any person or business other than a dispensary or manufacturer licensed by the department under Iowa Code chapter 124E;
- e. Refuse to sell, deliver, transport, or distribute medical cannabidiol in any form or quantity produced by the manufacturer to a dispensary, unless deemed appropriate in the manufacturer's reasonable business judgment and approved by the department in writing;
- f. Transport or deliver medical cannabidiol to any location except as allowed in subrule 154.22(1);
- g. Introduce synthetic or semisynthetic cannabinoids derived from hemp into medical cannabidiol products;
- h. Produce synthetic or semisynthetic cannabinoids within the licensed manufacturing facility.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.27(124E) Recordkeeping requirements.

154.27(1) *Manufacturer sales and distribution.* A manufacturer shall maintain complete and accurate electronic sales transaction records in the department's secure sales and inventory tracking system, including:

- a. The date of each sale or distribution;
- b. The item number, product name and description, and quantity of medical cannabidiol sold or otherwise distributed; and
- c. The sale price.

154.27(2) *Manufacturer operations and inventory reporting other records.*

a. A manufacturer or dispensary shall maintain the following for at least five years, unless otherwise noted, and provide to the department upon request:

- (1) All personnel records;
- (2) Records of any theft, loss, or other unaccountability of any medical cannabidiol or plant material;
- (3) Transportation manifests and incident reports; and
- (4) Records of all samples sent to a testing laboratory and the quality assurance test results.

b. A manufacturer or dispensary shall maintain for at least one year and provide to the department upon request its controlled access system data and visitor manifests.

154.27(3) *Manufacturer entry into the secure sales and tracking system.*

a. A manufacturer or dispensary shall use the secure sales and inventory tracking system to maintain the following:

- (1) Batch and harvest records;
- (2) Crop input and additive records;
- (3) Extraction and production records;
- (4) Transportation records;
- (5) Inventory records;

- (6) Solvent and processing chemical records; and
- (7) Other records as determined by the department.
- b. Unless otherwise provided in these rules, a manufacturer shall adhere to the following schedule for entering data into the secure sales and inventory tracking system. A manufacturer shall enter data in real time for data related to:
 - (1) Transport of medical cannabidiol, plant material, and laboratory samples;
 - (2) Sales of medical cannabidiol to dispensaries;
 - (3) The creation of process lots containing a unique identifier; and
 - (4) The creation of package lots containing a unique identifier.
- c. A manufacturer shall enter inventory reports on key inventory events into the secure sales and inventory tracking system within five business days in which the event occurred. These inventory reports include but are not limited to:
 - (1) Batch reports;
 - (2) Crop input and additive reports;
 - (3) Harvest reports;
 - (4) Extraction reports;
 - (5) Solvent and processing chemical reports;
 - (6) Package lot reports;
 - (7) Certificates of analysis from a laboratory;
 - (8) Other records as determined by the department.
- d. State of Iowa manufacturer API guide. The department shall maintain a document describing the IT requirements and acceptance criteria for reporting information to the secure sales and inventory tracking system. The department shall provide manufacturers no less than 14 days in which to comment on proposed revisions to the document, and the department shall provide no less than 30 days' notice before a revision takes effect. The document shall include:
 - (1) The schedule and means of data reporting;
 - (2) Integration requirements for third-party vendors; and
 - (3) Be available on the department's website (hhs.iowa.gov).

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.28(124E) Recall of medical cannabidiol products. Medical cannabidiol products may be recalled in the following ways:

154.28(1) Voluntarily by a licensed manufacturer.

154.28(2) By the department. If the department determines, based on an evaluation, that there is a reasonable probability that use of, or exposure to, a violative medical cannabidiol product will cause a serious adverse health consequence or death, the department may require a manufacturer to recall such violative medical cannabidiol products from dispensaries. An evaluation of the health hazard presented by medical cannabidiol being considered for recall shall be conducted by an ad hoc committee of scientists appointed by the department and shall consider, but need not be limited to, each of the following factors:

- a. Whether any disease or injuries have already occurred from the product.
- b. Whether any existing conditions could contribute to a clinical situation that could expose humans to a health hazard. Any conclusion shall be supported as completely as possible by scientific documentation, statements, or both that the conclusion is the opinion of the individual(s) making the health hazard determination.
- c. A holistic assessment of the hazard and its present and future potential consequences.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.29(124E) Quality assurance and control.

154.29(1) *Quality control program.* A manufacturer shall develop and implement a written quality assurance program that assesses the chemical and microbiological composition of medical cannabidiol. Assessment includes a profile of the active ingredients, including stability studies, and

the presence of inactive ingredients and contaminants. A manufacturer shall use these testing results to determine appropriate storage conditions and product expiration dates.

154.29(2) *Sampling protocols.* A manufacturer shall develop and follow written procedures for sampling medical cannabidiol that require the manufacturer to:

- a.* Conduct sample collection in a manner that provides analytically sound and representative samples;
- b.* Document every sampling event and provide this documentation to the department upon request;
- c.* Describe all sampling and testing plans in written procedures that include the sampling method and the number of units per lot to be tested;
- d.* Ensure that random samples from each lot are:
 - (1) Taken in an amount necessary to conduct the applicable test;
 - (2) Labeled with the lot number; and
 - (3) Submitted for testing;
- e.* Retain the results from the random samples for at least five years; and
- f.* Notify the department at least two business days prior to sample collection and allow the department or its designees to be present to observe the sampling procedures when the samples are to be sent to a laboratory for testing.

154.29(3) *Sampling and testing.* A manufacturer shall:

- a.* Work with the department and laboratory personnel to develop acceptance criteria for contaminants, including but not limited to cannabinoid content, metals, microbiological impurities, solvents, or other contaminants that the manufacturer uses in cultivating and producing medical cannabidiol;
- b.* Conduct sampling and testing of plant material and medical cannabidiol lots using acceptance criteria that are protective of patient health. Sampling method results shall be approved by the department and laboratory personnel and shall ensure that lots of medical cannabidiol are homogenous and representative of the process or package lot;
- c.* Reject and destroy medical cannabidiol from a lot that fails to meet established standards, and any other relevant quality control criteria, when remixing and retesting are not warranted;
- d.* Develop and follow a written procedure for responding to results failing to meet established standards, and any other relevant quality control criteria, including:
 - (1) Criteria for when remixing and retesting are warranted;
 - (2) Instructions for destroying contaminated or substandard medical cannabidiol when remixing and retesting are not warranted; and
 - (3) Instructions for determining the source of contamination;
- e.* Retain documentation of test results, assessment, and destruction of medical cannabidiol for at least five years.

154.29(4) *Stability testing.*

- a.* The quality assurance program shall include procedures for performing stability testing of each product type produced to determine product expiration dates. The procedures shall describe:
 - (1) Sample size and test intervals based on departmental guidance pursuant to subrule 154.47(1);
 - (2) Storage conditions for samples retained for testing; and
 - (3) Reliable and specific test methods.
- b.* Stability studies shall include:
 - (1) Medical cannabidiol testing at appropriate intervals; and
 - (2) Medical cannabidiol testing in the same container-closure system in which the medical cannabidiol is marketed and dispensed.
- c.* If product-expiration-date studies have not been completed, a manufacturer shall assign a tentative product expiration date, not to exceed one year, based on any available stability information.

d. If a manufacturer determines a product expiration date beyond one year, a manufacturer shall submit justification to the department, and receive approval, prior to labeling a product with an expiration date beyond one year.

154.29(5) Reserve samples.

a. A manufacturer shall retain a uniquely labeled reserve sample that represents each lot of medical cannabidiol and store the reserve sample under conditions consistent with product labeling. The reserve sample shall be stored in the same immediate container-closure system in which the medical cannabidiol is marketed or in one that has similar characteristics. The reserve sample shall consist of at least twice the quantity necessary to perform all the required tests.

b. A manufacturer shall retain the reserve for at least one year from the date of manufacture.

c. After one year from the date of manufacture, reserve samples shall be destroyed.

154.29(6) Retesting. If the department deems that public health may be at risk, the department may require the manufacturer to retest any sample of medical cannabidiol.

154.29(7) Disposal of substandard product. A manufacturer shall dispose of all medical cannabidiol when samples fail to meet established standards, and other relevant quality control criteria.

154.29(8) Recall procedures. Each manufacturer shall establish a procedure for recalling product from the market that has a reasonable probability of causing an unexpected or harmful response in a patient population, despite appropriate use, that outweighs the potential benefit of the medical cannabidiol. This procedure shall include:

a. Factors that make a recall necessary;

b. Manufacturer's personnel who are responsible for overseeing the recall; and

c. How to notify affected parties of a recall.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.30(124E) Packaging and labeling.

154.30(1) Trade names. A manufacturer's medical cannabidiol trade names shall comply with the following:

a. Names shall be limited to those that clearly reflect the form's medical cannabidiol nature;

b. Any name that is identical to, or similar to, the name of an existing nonmedical cannabidiol product is prohibited;

c. Any name that is identical to, or similar to, the name of an unlawful product or substance is prohibited; and

d. Any name that contains language that suggests using medical cannabidiol for recreational purposes or for a condition other than a qualifying debilitating medical condition is prohibited.

154.30(2) Medical cannabidiol packaging.

a. Requirements of medical cannabidiol package containers. The manufacturer shall use medical containers that are:

(1) Of sufficient size to accommodate a separate dispensary label containing the information described in paragraph 154.30(2) "c";

(2) Designed to maximize the shelf life of the contained medical cannabidiol;

(3) Tamper-evident; and

(4) Child-resistant.

b. Medical cannabidiol package prohibitions. The packaging for medical cannabidiol shall not:

(1) Bear a reasonable resemblance to commonly available nonmedical commercial products;

(2) Depict images other than the manufacturer's business name or logo on the packaging;

(3) Reasonably appeal to children. More information is provided in rule 641—154.22(2); or

(4) Reasonably appeal to recreational or adult use.

c. Requirements of medical cannabidiol packaging. A manufacturer shall ensure that all medical cannabidiol packaging includes the following information:

(1) The name of the manufacturer, and trade name if applicable;

- (2) A label claim concentration for cannabinoid content including:
 1. Tetrahydrocannabinol;
 2. Tetrahydrocannabinolic acid. Concentrations of tetrahydrocannabinolic acid may be omitted if the manufacturer uses decarboxylation or other means to substantially remove the acids from the product prior to testing;
 3. Cannabidiol; and
 4. Cannabidiolic acid. Concentrations of cannabinolic acid may be omitted if the manufacturer uses decarboxylation or other means to substantially remove the acids from the product prior to testing;

- (3) The number of servings per package (excluding products intended for inhalation);
- (4) The directions for use of the product, including recommended and maximum amount by age and weight, if applicable;

- (5) All ingredients of the product shown with common or usual names, including but not limited to any additives, terpenes or artificial flavors, diluents and carriers, and preservatives, listed in descending order by predominance of weight. Any third-party hemp-derived cannabinoids in medical cannabidiol products shall be specifically indicated on the ingredients list, separately from medical cannabidiol produced within the manufacturer's facility;

- (6) Instructions for storage, including light and temperature requirements, if any; and

- (7) The universal warning symbol provided by the department.

d. The following information shall be included with medical cannabidiol packaging, or contained within a package insert:

- (1) A notice with the statement, including capitalization: "This product has not been analyzed or approved by the United States Food and Drug Administration. There is limited information on the side effects of using this product, and there may be associated health risks and medication interactions. This product is not recommended for use by pregnant or breastfeeding women. KEEP THIS PRODUCT OUT OF REACH OF CHILDREN.";

- (2) A notice with the statement: "This medical cannabidiol is for therapeutic use only. Use of this product by a person other than the patient listed on the label is unlawful and may result in the cancellation of the patient's medical cannabidiol registration card. Return unused medical cannabidiol to a dispensary for disposal.";

A package may contain multiple labels if the information required by this rule is not obstructed.

154.30(3) Medical cannabidiol labeling.

a. After receiving a passing certification of analysis for a package lot from a laboratory, and prior to distribution to dispensaries, a manufacturer shall affix a label to each individual package of medical cannabidiol that contains the following information:

- (1) A unique lot number;

- (2) The date of manufacture;

- (3) Product expiration date. This date shall be one year from the date of manufacture unless a manufacturer has conducted stability studies and received approval from the department for an extended expiration date.

b. Cannabinoid content for:

- (1) Tetrahydrocannabinol;

- (2) Tetrahydrocannabinolic acid. Concentrations of tetrahydrocannabinolic acid may be omitted if the manufacturer uses chemical decarboxylation or other means to substantially remove the acids from the product prior to testing;

- (3) Cannabidiol; and

- (4) Cannabidiolic acid.

641—154.31(124E) Transportation of medical cannabidiol and plant material.

154.31(1) *Transport of medical cannabidiol or plant material.* A manufacturer is authorized to transport medical cannabidiol or plant material to and from:

- a. Dispensaries;
- b. A laboratory for testing;
- c. A waste facility for disposal;
- d. A manufacturer licensed by the department under Iowa Code chapter 124E;
- e. Other sites only with departmental approval.

154.31(2) *Chain-of-custody tracking system.*

a. A manufacturer shall use the secure sales and inventory tracking system, if available, or a department-approved manifest system to track shipping of medical cannabidiol. The system shall include a chain of custody that records:

- (1) The name and address of the destination;
- (2) The unique ID of each individual process lot or package lot that is part of the shipment, and the total number of individual packages;
- (3) The date and time the medical cannabidiol shipment is placed into the transport vehicle;
- (4) The date and time the shipment is accepted at the delivery destination;
- (5) The person's identity; and
- (6) Any handling or storage instructions.

b. Before transporting medical cannabidiol, a manufacturer shall:

- (1) Record in the secure sales and inventory tracking system or on the manifest information the material to be transported; and
- (2) Notify the dispensary, laboratory, manufacturer, or waste facility, as applicable, of the expected arrival time and transmit a copy of the manifest to the dispensary, laboratory, manufacturer, or waste facility, if applicable.

c. Each transport shall be approved electronically or in writing by:

- (1) An authorized manufacturer employee when the transport vehicle is departing the manufacturing facility; and
- (2) An authorized employee of the receiving dispensary, laboratory, manufacturer, or waste facility.

d. An authorized employee at the dispensary, laboratory, manufacturer, or waste facility receiving medical cannabidiol shall:

- (1) Verify and document the type and quantity of the transported medical cannabidiol against the information in the secure sales and inventory tracking system or written manifest;
- (2) Approve the transport electronically or return a signed copy of the manifest to the manufacturing facility; and
- (3) Record the medical cannabidiol that is received as inventory in the secure sales and inventory tracking system, if available. If a manifest system is being used, the dispensary, laboratory, manufacturer, or waste facility shall also maintain a signed copy of the manifest and shall maintain records of the inventory received consistent with these rules.

e. A manufacturer shall maintain all manifests for at least five years and make them available upon request of the department.

154.31(3) *Vehicle requirements for transport.*

a. A manufacturer shall ensure that all medical cannabidiol transported on public roadways is:

- (1) Packaged in tamper-evident, bulk containers;
- (2) Transported so it is not visible or recognizable from outside the vehicle; and
- (3) Transported in a vehicle that does not bear any markings to indicate that the vehicle contains medical cannabidiol or bears the name or logo of the manufacturer.

b. When the motor vehicle contains medical cannabidiol, manufacturer employees who are transporting the medical cannabidiol on public roadways shall:

- (1) Travel directly to a dispensary or other department-approved locations; and

- (2) Document refueling and all other stops in transit, including:
 1. The reason for the stop;
 2. The duration of the stop; and
 3. The location of the stop.
- c. If the vehicle must be stopped due to an emergency situation, the employee shall notify 911 and complete an incident report on a form approved by the department.
- d. Under no nonemergency circumstance shall any person other than a designated manufacturer employee have actual physical control of the motor vehicle that is transporting the medical cannabidiol.
- e. An employee in a transport motor vehicle shall have telephone access with the manufacturer's personnel.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.32(124E) Disposal of medical cannabidiol and plant material.

154.32(1) *Return of medical cannabidiol from dispensaries and laboratory.* A manufacturer may collect at no charge medical cannabidiol waste from dispensaries. A manufacturer that chooses to collect medical cannabidiol waste may use it for research and development or retained samples, but the manufacturer shall not introduce medical cannabidiol returned from a laboratory into lots of products intended for sale. Notwithstanding this provision, a manufacturer shall:

- a. Dispose of medical cannabidiol waste; and
- b. Maintain a written record of disposal.

154.32(2) *Medical cannabidiol and plant material waste.* A manufacturer shall store, secure, manage, and record medical cannabidiol waste and plant material waste in accordance with all applicable federal, state, and local regulations.

- a. The manufacturer shall dispose of medical cannabidiol waste and plant material waste at an approved facility.
- b. Before transport of plant material waste, the manufacturer shall render the plant material waste unusable and unrecognizable.
- c. A manufacturer shall dispose of all liquid and chemical product waste generated in the process of cultivating, manufacturing, and distributing medical cannabidiol in accordance with applications regulations.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.33(124E) Production requirements.

154.33(1) *Cultivation and processing.*

a. All phases of production shall take place in designated, restricted access areas in accordance with rule 641—154.21(124E).

- b. The production process shall be designed to limit contamination.
- c. Each production area shall allow for access, observation, and inventory of each plant group.

154.33(2) *Crop inputs and plant batches.*

a. The manufacturer shall use the secure sales and inventory tracking system to maintain an electronic record of all crop inputs. The record shall include the following:

- (1) The date of input application;
- (2) The name of the employee applying the crop input;
- (3) The crop input that was applied;
- (4) The plants that received the application; and
- (5) A copy of or electronic link to the safety data sheet for the crop input applied.

b. At the time of harvesting, all plants shall be tracked in a batch process with a unique batch number that shall remain with the batch through final processing into medical cannabidiol.

c. Each batch or part of a batch of cannabis plants that contributes to a lot of medical cannabidiol shall be recorded in the secure sales and inventory tracking system or other manifest system.

154.33(3) *Production of medical cannabidiol.*

- a. A manufacturer shall obtain approval from the department for use of any hydrocarbon-based extraction process.
- b. Medical cannabidiol shall be prepared, handled, and stored in compliance with the sanitation requirements in this rule.
- c. A manufacturer shall produce shelf-stable, nonperishable forms of medical cannabidiol.
- d. A manufacturer shall ensure that the cannabinoid content of the medical cannabidiol it produces is homogenous.
- e. Each lot of medical cannabidiol shall be assigned a unique lot number and recorded in the secure sales and inventory tracking system or other manifest system.

154.33(4) *General sanitation requirements.* A manufacturer shall take all reasonable measures and precautions to ensure that:

- a. Any employee who has a communicable disease does not perform any tasks that might contaminate plant material or medical cannabidiol;
- b. Hand-washing facilities are:
 - (1) Convenient and furnished with running water at a suitable temperature;
 - (2) Located in all production areas; and
 - (3) Equipped with effective hand-cleaning and -sanitizing preparations and sanitary towel service or electronic drying devices;
- c. All employees working in direct contact with plant material and medical cannabidiol use hygienic practices while on duty, including:
 - (1) Maintaining personal cleanliness; and
 - (2) Washing hands thoroughly in a hand-washing area before starting work and at any other time when the hands may have become soiled or contaminated;
- d. Litter and waste are routinely removed and the operating systems for waste disposal are routinely inspected;
- e. Floors, walls, and ceilings are constructed with a surface that can be easily cleaned and maintained in good repair to inhibit microbial growth;
- f. Lighting is adequate in all areas where plant material and medical cannabidiol are processed, stored, or sold;
- g. Screening or other protection against the entry of pests is provided, including that rubbish is disposed of to minimize the development of odor and the potential for the waste becoming an attractant, harborage, or breeding place for pests;
- h. Any buildings, fixtures, and other facilities are maintained in a sanitary condition;
- i. Toxic cleaning compounds, sanitizing agents, and other potentially harmful chemicals are identified and stored in a separate location away from plant material and medical cannabidiol and in accordance with applicable local, state, or federal law;
- j. All contact surfaces, utensils, and equipment used in the production of plant material and medical cannabidiol are maintained in a clean and sanitary condition;
- k. The manufacturing facility water supply is sufficient for necessary operations;
- l. Employees have accessible toilet facilities that are sanitary and in good repair; and
- m. Plant material and medical cannabidiol that could support the rapid growth of undesirable microorganisms are isolated to prevent the growth of those microorganisms.

154.33(5) *Storage.*

- a. A manufacturer shall store plant material and medical cannabidiol during production, transport, and testing, ensuring that:
 - (1) Plant material and medical cannabidiol are returned to a secure location immediately after completion; and
 - (2) The tanks, vessels, bins, or bulk containers containing plant material or medical cannabidiol are locked inside a secure area.

b. A manufacturer shall store all plant material and medical cannabidiol during production, transport, and testing, and all saleable medical cannabidiol:

- (1) In areas that are maintained in a clean, orderly, and well-ventilated condition; and
- (2) In storage areas that are free from infestation by insects, rodents, birds, and other pests of any kind.

c. To prevent degradation, at all times, a manufacturer shall store all plant material and medical cannabidiol under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

d. A manufacturer shall maintain a separate secure storage area for medical cannabidiol that is returned from a dispensary.

154.33(6) Scales. All scales used to weigh usable plant material for purposes of these rules shall be certified in accordance with ISO/IEC 17025 dated 2017, which is incorporated herein by reference. [ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.34(124E) Supply and inventory.

154.34(1) Reliable and ongoing supply. A manufacturer shall provide a reliable and ongoing supply of medical cannabidiol to medical cannabidiol dispensaries.

154.34(2) Inventory controls and procedures. A manufacturer shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.34(3) Inventory tracking required. A manufacturer shall use the secure sales and inventory tracking system to track medical cannabidiol production from seed or plant cutting through distribution of medical cannabidiol to a dispensary.

154.34(4) Reconciliation. No less often than every two calendar weeks, a manufacturer shall reconcile its physical inventory with the inventory recorded in the secure sales and inventory tracking system.

a. Reconciliation shall include:

- (1) Plant material at the manufacturing facility and in transit; and
- (2) Medical cannabidiol at the manufacturing facility.

b. Discrepancies between the physical inventory of the manufacturer and the inventory recorded in the secure sales and inventory system shall be handled as follows:

(1) A manufacturer shall report suspected diversion of medical cannabidiol to the department within 72 hours of discovery.

(2) A manufacturer shall have up to 72 hours to reconcile discrepancies in the manufacturer's physical inventory with the inventory recorded in the secure sales and inventory tracking.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

DISPENSING

641—154.35(124E) Duties of the department.

154.35(1) Inspection of dispensaries. The department or its agents shall conduct regular inspections of dispensaries and their facilities.

154.35(2) Establishment and maintenance of a secure sales and inventory tracking system. The department shall establish and maintain a secure, electronic system that is available 24 hours per day, seven days per week to track:

- a.* Inventory of medical cannabidiol and waste material;
- b.* Sales of medical cannabidiol from dispensaries to patients and primary caregivers;
- c.* Total tetrahydrocannabinol purchased in the last 90 days by a patient and the patient's primary caregiver.

154.35(3) Recall of medical cannabidiol products. If the department determines, based on an evaluation of the health hazard presented, that there is a reasonable probability that use of, or exposure to, a violative medical cannabidiol product will cause a serious adverse health consequence or death,

the department may require a dispensary to recall such violative medical cannabidiol products from the dispensary facility and from patients. An evaluation of the health hazard presented by medical cannabidiol being considered for recall shall be conducted by an ad hoc committee of scientists appointed by the director of the department and shall consider, but need not be limited to, each of the following factors:

a. Whether any disease or injuries have already occurred from the product.

b. Whether any existing conditions could contribute to a clinical situation that could expose humans to a health hazard. Any conclusion shall be supported as completely as possible by scientific documentation, statements, or both that the conclusion is the opinion of the individual(s) making the health hazard determination.

c. A holistic assessment of the hazard and its present and future potential consequences.

154.35(4) *Permissible disclosure.* The department may disclose patient-specific dispensing data to the certifying provider upon written request by the patient, caregiver, or certifying provider.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.36(124E) Dispensary operations.

154.36(1) *Operating documents.*

a. A dispensary shall maintain operating documents that accurately reflect the dispensary's standard operating procedures. Unless otherwise noted, a dispensary shall make the operating documents available to the department upon request, through secure means.

b. The operating documents of a dispensary shall include all of the following:

(1) Procedures for the oversight of the dispensary, including descriptions of operational and management practices regarding:

1. The forms and quantities of medical cannabidiol products that will be stored and dispensed at the dispensary;

2. The estimated forms and quantities of medical cannabidiol waste to be generated or collected;

3. The disposal methods for all waste materials;

4. Employee training methods for the dispensary employees;

5. Strategies for identifying and reconciling discrepancies in inventory of medical cannabidiol;

6. Procedures to ensure the dispensary does not dispense more than a patient's certified limit of total tetrahydrocannabinol to a patient and the patient's primary caregiver(s) in a 90-day period;

7. Medical cannabidiol labeling procedures;

8. Procedures for recall of medical cannabidiol;

9. Plans for responding to a security breach at the dispensary facility;

10. A business continuity plan; and

11. Other information requested by the department.

(2) Procedures to ensure accurate recordkeeping.

(3) Procedures for the implementation of appropriate security measures to deter and prevent the theft of medical cannabidiol and unauthorized entrance into areas of the dispensary facility containing medical cannabidiol.

154.36(2) *Prohibited activities.* In addition to following all provisions of Iowa Code section 124E.7, a dispensary shall not:

a. Dispense medical cannabidiol in any location except in those areas approved by the department;

b. Sell, receive, transport, or distribute medical cannabidiol from any location except its dispensary;

c. Sell, receive, or distribute medical cannabidiol from any entity other than a manufacturer licensed by the department;

d. Sell or distribute medical cannabidiol to any person other than an approved patient or primary caregiver;

(1) Transport or deliver medical cannabidiol to any location, unless approved by the department;

- (2) Sell medical cannabidiol that is not packaged and labeled in accordance with rules;
- (3) Repackage medical cannabidiol or remove the manufacturer's label.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.37(124E) Recordkeeping requirements.

154.37(1) *Dispensary sales.* Within one business day of sale, a dispensary shall record complete and accurate electronic sales transaction records in the secure sales and inventory tracking system, including:

- a. The name of the patient and, if purchase is made by the primary caregiver, the name of the primary caregiver;
- b. The date and time of each sale;
- c. The item number, product name and description, and quantity of medical cannabidiol sold;
- d. The sale price;
- e. Other information required by the department.

154.37(2) Reserved.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.38(124E) Storage.

154.38(1) *Storage of saleable medical cannabidiol.*

a. A dispensary shall store medical cannabidiol to prevent diversion, theft, or loss, including ensuring that:

- (1) Medical cannabidiol is kept in a secure and monitored location within the dispensary; and
 - (2) Cabinets or storage containers inside the secure and monitored area are locked at the end of a business day.
- b. A dispensary shall store all medical cannabidiol:
- (1) In areas that are maintained in a clean, orderly, and well-ventilated condition;
 - (2) In areas that are free from infestation by insects, rodents, birds, and other pests of any kind;
 - (3) According to the manufacturer's requirements regarding temperature, light exposure, or other environmental conditions;
 - (4) Under conditions that will protect the product and its container against physical, chemical, and microbial contamination and deterioration.

154.38(2) *Storage of returned medical cannabidiol.* A dispensary shall maintain a separate secure storage area for medical cannabidiol that is to be returned to a manufacturer for disposal, including medical cannabidiol that is outdated, damaged, deteriorated, mislabeled, or contaminated, or whose containers or packaging has been opened or breached, until the medical cannabidiol is collected by a manufacturer.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.39(124E) Dispensing.

154.39(1) *Access to all forms of product.* A dispensary shall provide access to all medical cannabidiol forms produced by each licensed manufacturer.

154.39(2) *Dispensing to a patient or primary caregiver.* Prior to dispensing any medical cannabidiol to a patient, a dispensary shall do all of the following:

- a. Verify the patient or primary caregiver's identity using acceptable photo identification and that the patient or primary caregiver is over 18 years of age. Acceptable photo identification includes:
 - (1) A valid Iowa driver's license;
 - (2) A valid Iowa nonoperator's identification card;
 - (3) A U.S. passport;
 - (4) A U.S. military ID or veteran ID; or
 - (5) A tribal ID card/document;
- b. Verify that the patient or primary caregiver, if applicable, is registered and listed in the secure sales and inventory tracking system and has a valid medical registration card;

c. Check the secure sales and inventory tracking system for the patient's total tetrahydrocannabinol 90-day purchase limit and the amount of total tetrahydrocannabinol that the patient and the patient's primary caregiver(s) have purchased on behalf of the patient in the past 90 days to ensure that the amount of total tetrahydrocannabinol sold by the dispensary to the patient does not exceed the patient's purchase limit;

d. Assign a tracking number to any medical cannabidiol that is to be dispensed to the patient or primary caregiver; or

e. Issue a label that contains the following information, which may be printed on a secondary label or package insert:

- (1) The medical cannabidiol tracking number;
- (2) The patient registration number;
- (3) The date and time the medical cannabidiol is dispensed;
- (4) The name and address of the dispensary; and
- (5) Any specific instructions for use based upon manufacturer guidelines or department rules.

Text shall not include any false, misleading, or unsubstantiated statements regarding health or physical benefits to the patient.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.40(124E) Transportation of medical cannabidiol. A dispensary is not authorized to transport medical cannabidiol, unless approved by the department. Any approved transport shall be logged in the secure sales and inventory tracking system.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.41(124E) Disposal of medical cannabidiol.

154.41(1) *Identification of excess, expired, or damaged medical cannabidiol.* Dispensaries shall identify unused, excess, expired, or damaged medical cannabidiol.

154.41(2) *Return of medical cannabidiol from a patient or primary caregiver to a dispensary.*

a. A dispensary shall accept at no charge medical cannabidiol waste from any patient or primary caregiver. A dispensary may provide all medical cannabidiol waste to the manufacturer for disposal.

b. The dispensary shall enter the following information into the secure sales and inventory tracking system for medical cannabidiol returned from a patient or primary caregiver being returned to the manufacturer:

- (1) The tracking number assigned at the time of the dispensing, if available, or the name of the patient, if the tracking number is unavailable;
- (2) The date the medical cannabidiol was returned;
- (3) The quantity of medical cannabidiol returned; and
- (4) The type and lot number of medical cannabidiol returned.

c. A dispensary shall store medical cannabidiol returned from patients and primary caregivers.

154.41(3) *Unused, excess, expired, damaged, or returned medical cannabidiol.* Unused, excess, expired, damaged, or returned medical cannabidiol shall be stored as described in subrule 154.38(2).

154.41(4) *Return of medical cannabidiol to a manufacturer.* A dispensary shall record information on all medical cannabidiol collected by the manufacturer in the secure sales and inventory tracking system. Information shall include:

- a. The date the medical cannabidiol was collected by the manufacturer;
- b. The quantity of medical cannabidiol collected; and
- c. The type and lot number of medical cannabidiol collected.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.42(124E) Inventory.

154.42(1) *Inventory controls and procedures.* A dispensary shall establish inventory controls and procedures for conducting inventory reviews to prevent and detect any diversion, theft, or loss in a timely manner.

154.42(2) *Real-time inventory required.* A dispensary shall use the secure sales and inventory tracking system to maintain a real-time record of the dispensary's inventory of medical cannabidiol to include:

- a. The quantity and form of saleable medical cannabidiol maintained at the dispensary on a daily basis;
- b. The amount of damaged, expired, or returned medical cannabidiol being held at the dispensary for return to a manufacturer; and
- c. Other information deemed necessary and requested by the department.

154.42(3) *Reconciliation.* At least once per calendar week, a dispensary shall reconcile all medical cannabidiol with the inventory recorded in the secure sales and inventory tracking system. Discrepancies shall be handled as follows:

- a. A dispensary shall report suspected diversion of medical cannabidiol to the department and law enforcement within 24 hours of discovery.
- b. A dispensary shall have up to 24 hours to reconcile the dispensary's physical inventory with the inventory recorded in the secure sales and inventory tracking system. If the dispensary cannot reconcile the dispensary's physical inventory with the secure sales and inventory tracking system's inventory within 24 hours but diversion of product is not suspected, the dispensary shall immediately contact the department to report the discrepancy and to initiate a compliance action.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.43(124E) *Quality assurance and control.* A dispensary shall cooperate with manufacturers and the department on quality assurance and control procedures, including participating in stability-testing studies, developing sampling strategies, and returning medical cannabidiol that has been recalled.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

MEDICAL CANNABIDIOL BOARD

641—154.44(124E) *Purpose and duties of board.* The purpose of the board is to administer the provisions of Iowa Code section 124E.5.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.45(124E) *Organization of board and proceedings.*

154.45(1) *Membership.* The board shall be composed of members as set forth in Iowa Code section 124E.5. The appointments, unless provided otherwise by law, shall be for three-year staggered terms that shall expire on June 30. Board members shall be knowledgeable about the use of medical cannabidiol. The medical practitioners appointed to the board shall be licensed in Iowa and be nationally board-certified in their area of specialty.

154.45(2) *Vacancies.* Vacancies shall be filled in the same manner in which the original appointments were made for the balance of the unexpired term.

154.45(3) *Absences.* Three consecutive unexcused absences shall be grounds for the governor to consider dismissal of a board member and to appoint another. Department staff is charged with providing notification of absences to the governor's office.

154.45(4) *Board meetings.*

- a. Board meetings shall be conducted in accordance with the open meetings requirements of Iowa Code chapter 21.
- b. The department's bureau of cannabis regulation shall schedule the time, date and location of meetings.
- c. A majority of the members shall constitute a quorum for conducting business of the board.
- d. An affirmative vote of a majority of the board members present at a meeting is required for a motion to pass.

154.45(5) *Facilities and staffing.* The department shall furnish the board with the necessary facilities and employees to perform the duties required by this chapter but shall be reimbursed for all costs incurred by fee revenue generated from licensing activities and registration card applications.

154.45(6) *Subcommittees.* The board may designate one or more subcommittees to perform such duties as may be deemed necessary.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.46(124E) Petitions for the addition or removal of medical conditions, medical treatments or debilitating diseases. Pursuant to Iowa Code section 124E.5(3) “a,” the board shall accept and review petitions to modify the list of debilitating medical conditions for the medical use of cannabidiol. The petition shall be in accordance with 7—Chapter 2502, except that the caption should read “Petition for Addition or Removal.”

154.46(1) *Inquiries.* Inquiries concerning the status of a petition may be made to the bureau of cannabis regulation at the department’s address.

154.46(2) *Additional information.* The board may request that the petitioner submit additional information concerning the petition. The board may also solicit comments from any person on the substance of the petition. Comments on the substance of the petition may be submitted to the board by any person.

154.46(3) *Presentation to the board.* The board may request or allow the petitioner to make an oral presentation of the contents of a petition at a board meeting following submission of the petition.

154.46(4) *Board response.* The board shall notify the petitioner in writing of the decision within six months after the filing, unless the petitioner agrees to a time extension. If the petition is granted, the board will recommend addition or removal of the medical condition, medical treatment or debilitating disease to the board of medicine. If the petition is denied, the board will provide the rationale for the denial. Notification occurs when the board mails the writing to the petitioner.

154.46(5) *Denials.* Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject that seeks to eliminate the grounds for the agency’s rejection of the petition.

[ARC 8124C, IAB 7/10/24, effective 8/14/24; Editorial change: IAC Supplement 6/10/26]

LABORATORY TESTING

641—154.47(124E) Requirements of the department.

154.47(1) *Laboratory testing requirements and acceptance criteria.* The department shall work with manufacturers and laboratories to create and maintain a document describing required sampling methodology, acceptance criteria, stability-testing procedures, and other guidance for manufacturers and laboratories on testing procedures. The department shall provide manufacturers and laboratories no less than 14 days in which to comment on proposed revisions to the document, and the department shall provide no less than 30 days’ notice before a revision takes effect. The document shall:

- a.* Describe the minimum number of sample units and reserve samples required for testing by the laboratory;
- b.* Describe an option for manufacturers to reduce the amount of testing conducted by allowing compositing of sample units or other techniques that reduce the number of tests required without compromising the safety of the products once a manufacturer has satisfactorily completed a control study for a specific extraction or production process;
- c.* Describe the minimum requirements for sample size and testing intervals for stability testing; and
- d.* Be available on the department’s website (hhs.iowa.gov).

154.47(2) *Review and approval of manufacturer sampling protocols.* The department shall have two weeks to review and approve or request revisions to a manufacturer’s sampling protocols.

154.47(3) *Review and approval of manufacturer stability-testing procedures.* The department shall have two weeks to review and approve or request revisions to a manufacturer's stability-testing procedures.

154.47(4) *Establish a laboratory review committee.* The department shall establish a laboratory review committee to assist with the review of applications by laboratories and the establishment of accepted laboratory testing standards and practices.

154.47(5) *Review of laboratory applications.* The department shall establish a process to review applications from prospective medical cannabidiol testing laboratories. Prospective laboratories shall apply on a form created by the department. The department will determine whether the laboratory meets the criteria for an independent medical cannabidiol testing facility as set forth in the definition of "laboratory" in Iowa Code section 124E.2 in addition to determining whether the laboratory meets laboratory requirements pursuant to these rules.

154.47(6) *Regulation of independent laboratories.* The department shall determine on an annual basis whether any approved independent laboratory continues to meet the application criteria of this rule. The department shall establish a process for the annual review of approved independent laboratories. An independent laboratory is subject to reasonable inspection by the department, a department-approved consultant, or another agency pursuant to Iowa Code chapter 124E and these rules and as authorized by laws and regulations.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.48(124E) Requirements of a laboratory.

154.48(1) *Minimum testing requirements.* A laboratory shall establish and implement test methods and corresponding standard operating procedures for the analyses of cannabinoids, residual solvents and processing chemicals, pesticides, microbiological impurities, and metals and other analyses as requested by the department.

154.48(2) *Level of quantitation.* A laboratory shall be able to demonstrate that its level of quantitation (LOQ) is below any action level established by the department.

154.48(3) *Inventory tracking.* A laboratory shall record the following:

- a. The receipt of medical cannabidiol from a manufacturer for testing.
- b. The return of medical cannabidiol or waste to a manufacturer.

154.48(4) *Hazardous waste disposal.* A laboratory shall do the following when dealing with hazardous waste:

- a. Discard hazardous waste, including hazardous waste containing medical cannabis goods, in accordance with federal and state hazardous waste laws.
- b. Document the waste disposal procedures followed for each sample.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.49(124E) Requirements of a manufacturer.

154.49(1) *Assuming costs.* A manufacturer shall assume the costs for all laboratory testing pertaining to verification studies on new products, the cost of standard testing protocols as outlined in a Laboratory Acceptance and Criteria Document and other tests as requested by the department. A manufacturer shall provide any necessary reference materials to the laboratory at no cost.

154.49(2) *Obtaining approval for sampling protocols.* A manufacturer shall obtain approval from the department for the manufacturer's sampling protocols prior to submitting samples for laboratory testing related to content and contamination.

154.49(3) *Obtaining approval for stability-testing procedures.* A manufacturer shall obtain approval from the department for the manufacturer's stability-testing procedures prior to submitting samples for laboratory testing related to stability testing and product-expiration-date studies.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.50(124E) Content testing.

154.50(1) *Cannabinoids.*

a. For each unique lot of medical cannabidiol, and if asked to do so by a requester for other medical cannabis goods, a laboratory shall, at minimum, test for and report measurements for the following cannabinoid analytes:

- (1) THC;
- (2) THCA;
- (3) CBD; and
- (4) CBDA.

b. A laboratory shall report that the primary sample passed or failed THC and CBD potency testing according to guidance in the Laboratory Acceptance and Criteria Document described in subrule 154.47(1).

c. For each cannabinoid analyte test, a laboratory shall issue a certificate of analysis that contains the following:

(1) Concentrations of cannabinoid analytes in mg/ml for liquids and mg/g for solids, or other measures approved by the department.

(2) Whether the primary sample passed or failed the test in accordance with paragraph 154.50(1) “b.”

d. The laboratory may test for and provide test results for additional cannabinoid analytes if asked to do so by a requester.

154.50(2) Contaminants testing.

a. For each unique lot of medical cannabidiol, unless otherwise referenced in the laboratory testing requirements and acceptance criteria document described in subrule 154.47(1), a laboratory shall conduct contaminants testing for the following analytes:

- (1) Residual solvents and processing chemicals.
- (2) Pesticides.
- (3) Microbiological impurities.
- (4) Heavy metals.

b. The laboratory may test and provide test results for additional contaminants if asked to do so by a requestor.

c. The department shall provide a list of contaminants for which primary samples are to be tested with corresponding action levels on the department’s website (hhs.iowa.gov).

d. For each contaminant for which a laboratory tests, the laboratory shall report that the primary sample passed the testing if the concentration of contaminant is at or below the action level approved by the department.

e. For each contaminant for which a laboratory tests, the laboratory shall report that the primary sample failed the testing if the concentration of contaminants is above the action level approved by the department.

f. If a laboratory is using gas chromatography-mass spectrometry instrumentation to analyze primary samples for contaminants and the laboratory determines that a primary sample contains contaminants or chemical analytes that are not included in the department-approved list of required tests, the laboratory shall attempt to achieve tentative identification and semiquantitative results of the contaminant analytes.

g. The laboratory may test for and provide test results for additional contaminants or processing chemicals if asked to do so by a requester.

h. For each primary sample tested, a laboratory shall issue a certificate of analysis that contains the following:

- (1) The name and concentration of each contaminant for which the primary sample was tested.

1. The concentrations shall be listed in parts per million (ppm) or other units as determined by the department.

2. The laboratory shall report a result of “detected but not quantified” for any contaminant that falls below the LOQ, has a signal-to-noise ratio of greater than 3:1, and meets identification criteria.

(2) Whether the primary sample passed or failed the test in accordance with paragraphs 154.50(2) “c” and “d.”

(3) The names and amounts of any additional contaminants identified by the laboratory.

i. If the primary sample fails testing for residual solvents and processing chemicals, the lot fails laboratory testing.

j. When a laboratory identifies additional contaminants in a primary sample, the laboratory shall:

(1) Notify the department of the additional contaminants and the amounts detected, if applicable.

(2) Refrain from issuing a final certificate of analysis until given approval to do so by the department.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.51(124E) Reporting requirements.

154.51(1) *Reporting test results.* The laboratory shall generate a certificate of analysis for each primary sample that it tests and make the certificate of analysis available to the manufacturer and the department.

154.51(2) *Tentatively identified analytes.* A laboratory shall report on the certificate of analysis any tentatively identified analytes detected during the analysis of the primary sample. When a laboratory identifies additional analytes in a primary sample, the laboratory shall:

a. Notify the department of the additional analytes detected.

b. Refrain from issuing a final certificate of analysis until given approval to do so by the department.

154.51(3) *Additional reporting requirements.* In addition to the requirements described in rule 641—154.50(124E), the certificate of analysis shall contain, at a minimum, the following information:

a. All requirements of ISO/IEC 17025 dated 2017;

b. Date of primary sample collection;

c. Date the primary sample was received by the laboratory;

d. Date of each analysis;

e. The LOQ and action level for each analyte, as applicable;

f. Whether the primary sample and lot passed or failed laboratory testing; and

g. A signature by the laboratory quality officer or delegate and the date the certificate of analysis was validated as being accurate by the laboratory quality officer or delegate.

154.51(4) *Measurements.*

a. Any test result that is not covered under the laboratory’s ISO/IEC 17025 scope of accreditation shall be clearly identified on the certificate of analysis.

b. Measurements below a method’s limit of detection shall be reported as “<” (less than) or “not detected” and reference the reportable limit. The reporting of zero concentration is not permitted.

c. Measurements greater than or equal to LOD but less than LOQ shall be reported as “detected but not quantified.”

d. The number of significant figures reported shall reflect the precision of the analysis.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.52(124E) Recordkeeping requirements.

154.52(1) *Data package.* A laboratory shall create a data package for each analytical batch of primary samples that the laboratory analyzes. The data package shall contain at minimum the following information:

a. The name and address of the laboratory that performed the analytical procedures;

b. The names, functions, and signatures (electronic or handwritten) of the laboratory personnel who performed the primary sample preparation, analyzed the primary samples, and reviewed and approved the data;

c. All primary sample and analytical batch quality control sample results;

d. Raw data for each primary sample analyzed;

- e.* Instrument raw data, if any was produced;
- f.* Instrument test method with parameters;
- g.* Instrument tune report, if one was created;
- h.* All instrument standard calibration data;
- i.* Test-method worksheets or forms used for primary sample identification, characterization, and calculations, including chromatograms, sample-preparation worksheets, and final datasheets;
- j.* The quality control report with worksheets, forms, or copies of laboratory notebook pages containing pertinent information related to the identification and traceability of all reagents, reference materials, and standards used for analysis;
- k.* The analytical batch sample sequence;
- l.* The field sample log; and
- m.* The chain-of-custody form.

154.52(2) *Review of data package.* After the laboratory has compiled a data package, an individual at the laboratory who was not previously involved in the creation of the data package shall:

- a.* Assess the analytical results for technical correctness and completeness;
- b.* Verify that the results of each analysis carried out by the laboratory are reported accurately, clearly, unambiguously, and objectively;
- c.* Verify that the measurements can be traced back; and
- d.* Approve the measurement results by signing and dating the data package prior to release of the certificate of analysis by the laboratory.

154.52(3) *Data package record retention.* The entire data package shall be stored by a laboratory for a minimum of five years and shall be made available upon request by the department or the requester of the laboratory testing.

154.52(4) *Other records.* A laboratory shall maintain all documents, forms, records, and standard operating procedures associated with the testing of medical cannabidiol.

- a.* A laboratory shall maintain analytical testing laboratory records in such a manner that the analyst, the date the analysis was performed, the approver of the certificate of analysis, the reviewer and approver of the data package, the test method, and the materials that were used can be determined by the department.
- b.* Records shall be stored in such a way that the data may be readily retrieved when requested by the department.
- c.* All testing laboratory records shall be kept for a minimum of five years, unless otherwise noted in these rules.
- d.* The department shall be allowed access to all electronic data, including standards records, calibration records, extraction logs, and laboratory notebooks.
- e.* A laboratory shall keep and make available to the department the following records related to the testing of medical cannabidiol:

(1) Personnel qualification, training, and competency documentation, including but not limited to résumés, training records, continuing education records, analytical proficiency testing records, and demonstration of competency records for laboratory work. These records shall be kept current.

(2) Method verification and validation records, including method modification records, method detection limit and quantitation limit determination records, ongoing verification records such as proficiency test records and reference material analysis records.

(3) Quality control and quality assurance records, including the laboratory's quality assurance manual and control charts with control limits.

(4) Chain-of-custody records, including chain-of-custody forms, field sample logs, sample-receipt records, sample-description records, sample-rejection records, laboratory information management system records, sample-storage records, sample-retention records, and disposal records.

(5) Purchasing and supply records, equipment-services records, and other equipment records, including purchase requisition records, packing slips, supplier records, and certificates of analysis.

(6) Laboratory equipment installation records, maintenance records, and calibration records. These records shall include the date and name of the person performing the installation of, calibration of, or maintenance on the equipment, with a description of the work performed, maintenance logs, pipette calibration records, balance calibration records, working and reference mass calibration records, and daily verification-of-calibration records.

(7) Customer service records, including customer contracts, customer requests, certificates of analysis, customer transactions, customer feedback, records related to the handling of complaints and nonconformities, and corrective action pertaining to complaints.

(8) Nonconforming work and corrective action records, including corrective action, nonconformance, nonconformities resolved by correction, customer notification of nonconformities, internal investigations, implementation of corrective action, and resumption-of-work records.

(9) Internal-audit and external-audit records, including audit checklists, standard operating procedures, and audit observation and findings reports. These records shall include the date and name of the person performing the audit.

(10) Management review records, including technical data review reports and final management-review reports. These records shall include the review date and the name of the reviewer.

(11) Laboratory data reports, data review, and data approval records, including instrument and equipment identification records, records with unique sample identifiers, analysts' laboratory notebooks and logbooks, traceability records, test-method worksheets and forms, instrumentation-calibration data, and test-method raw data. These records shall include the analysis date and the name of the analyst.

(12) Proficiency testing records, including the proficiency test schedule, proficiency tests, data-review records, data-reporting records, nonconforming work and corrective actions, and quality control and quality assurance records related to proficiency testing.

(13) Electronic data, backed up data, records regarding the protection of data, including unprocessed instrument output data files and processed quantitation output files, electronic data protocols and records, and authorized personnel records.

(14) Security data, including laboratory-security records and laboratory-access records, surveillance-equipment records, and security-equipment records. These records shall be stored for at least one year.

(15) Traceability, raw data, standards records, calibration records, extraction logs, reference materials records, analysts' laboratory notebooks and logbooks, supplier records, and certificates of analysis, and all other data-related records.

(16) Laboratory contamination and cleaning records, including autoclave records, acid-wash logs and records, and general laboratory-safety and chemical-hygiene protocols.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.53(124E) Quality control. The laboratory shall have quality control protocols that include the following elements:

154.53(1) *Quality control samples required.*

a. The laboratory shall run quality control samples with every analytical batch of samples for chemical and microbiological analysis.

b. For microbiological analysis, the laboratory shall develop procedures for quality control requirements for each analytical batch of samples.

c. The laboratory shall analyze the quality control samples in exactly the same manner as the test samples to validate the laboratory testing results.

154.53(2) *Types of quality control samples.* At a minimum, a laboratory shall have the following quality control samples as part of every analytical batch tested for chemical analytes:

a. Negative control (method blank). A laboratory shall prepare and run at least one method blank sample with an analytical batch of samples along with and under the same conditions, including

all sample preparation steps, as the other samples in the analytical batch, to demonstrate that the analytical process did not introduce contamination.

b. Positive control (laboratory control sample). A laboratory shall prepare and run at least one laboratory control sample with an analytical batch of samples along with and under the same conditions, including all sample preparation steps, as the other samples in the analytical batch.

c. Matrix spike sample. A laboratory shall prepare and run one or more matrix spike samples for each analytical batch.

(1) A laboratory shall calculate the percent recovery for quantitative chemical analysis by dividing the sample result by the expected result and multiplying that by 100. All quality control measures shall be assessed and evaluated on an ongoing basis, and quality control acceptance criteria shall be used. When necessary, the department may establish acceptance criteria on the department's website (hhs.iowa.gov).

(2) If quality control acceptance criteria are not acceptable, a laboratory shall investigate the cause, correct the problem, and rerun the analytical batch of samples. If the problem persists, the laboratory shall reprepare the samples and run the analysis again, if possible.

d. Field duplicate sample. A laboratory shall prepare and run a duplicate sample as described in the laboratory testing requirements and acceptance criteria document in subrule 154.47(1). The acceptance criterion between the primary sample and the duplicate sample is less than or equal to 20 percent relative percent difference.

154.53(3) *Certified reference material for chemical analysis.* The laboratory shall use a reference material for each analytical batch in accordance with the following standards:

a. The reference material should be certified and obtained from an outside source, if possible. If a reference material is not available from an outside source, the laboratory shall make its own in-house reference material.

b. Reference material made in-house should be made from a different source of standards than the source from which the calibration standards are made.

c. The test result for the reference material shall fall within the quality control acceptance criteria. If it does not, the laboratory shall document and correct the problem and run the analytical batch again.

154.53(4) *Calibration standards.* The laboratory shall prepare calibration standards by serially diluting a standard solution to produce working standards used for calibration of an instrument and quantitation of analyses in samples.

154.53(5) *Quality control-sample report.* A laboratory shall generate a quality control-sample report that includes quality control parameters and measurements, analysis date, and type of matrix.

154.53(6) *Limit-of-detection and limit-of-quantitation calculations.* For chemical method analysis, a laboratory shall calculate the limit of detection and limit of quantitation using generally accepted methodology.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

641—154.54(124E) Security requirements.

154.54(1) *Security policy requirement.* A laboratory shall maintain a security policy to prevent the loss, theft, or diversion of medical cannabidiol samples. The security policy shall apply to all staff and visitors at a laboratory facility.

154.54(2) *Restricted access.* A laboratory shall limit entrance to all restricted areas by completing all of the following:

a. The controlled access system shall do all of the following:

(1) Limit access to authorized individuals;

(2) Maintain a log of individuals with approved access, including dates of approvals and revocations;

(3) Track when personnel enter and exit the laboratory;

(4) Track times of personnel movement between restricted access areas;

- (5) Store data for retrieval for a minimum of one year; and
- (6) Remain operable in the event of a power failure.

b. A laboratory shall promptly, but no later than five business days after receipt of request, submit stored controlled access system data to the department.

154.54(3) *Personnel identification system.* A laboratory shall use a personnel identification system that controls and monitors individual employee access to restricted access areas within the laboratory facility.

a. An employee identification card shall contain:

- (1) The name of the employee;
- (2) The date of issuance and expiration;
- (3) An alphanumeric identification number that is unique to the employee; and
- (4) A photographic image of the employee.

b. A laboratory employee shall keep the identification card visible at all times when the employee is in the laboratory.

c. Upon termination or resignation of an employee, a laboratory shall immediately:

- (1) Revoke the employee's access to the laboratory; and
- (2) Obtain and destroy the employee's identification card, if possible.

154.54(4) *Video monitoring and surveillance.* A laboratory shall operate and maintain in good working order a video surveillance system for its premises that operates 24 hours per day, seven days a week, and visually records all areas where medical cannabis goods are stored or tested.

a. *Camera specifications.* Cameras shall:

- (1) Capture clear and certain identification of any person entering or exiting a restricted access area containing medical cannabis goods;
- (2) Produce a clear, color still photograph live or from a recording;
- (3) Have an embedded date-and-time stamp that is synchronized to the recording and does not obscure the picture; and
- (4) Continue to operate during a power outage.

b. *Video recording specifications.* Video recording equipment shall:

- (1) Export still images in an industry standard image format, such as .jpg, .bmp, or .gif.
- (2) Archive in a format that ensures authentication and guarantees that the recorded image has not been altered.
- (3) Save exported video in an industry standard file format that can be played on a standard computer operating system.
- (4) All recordings shall be erased or destroyed at the end of the retention period and prior to disposal of any storage medium.

c. *Additional requirements.* A laboratory shall maintain all security system equipment and recordings in a secure location to prevent theft, loss, destruction, corruption, and alterations.

d. *Retention.* A laboratory shall ensure that 24-hour recordings from all video cameras are:

- (1) Available for viewing by the department upon request;
- (2) Retained for a minimum of 60 days;
- (3) Maintained free of alteration or corruption; and
- (4) Retained longer, as needed, if a laboratory is given actual notice of a pending criminal, civil, or administrative investigation, or other legal proceeding for which the recording may contain relevant information.

154.54(5) *Chain-of-custody policy and procedures.* A laboratory shall maintain a current chain-of-custody policy and procedures. The policy should ensure that:

a. Chain of custody is maintained for samples that may have probable forensic evidentiary value; and

b. Annual training is available for individuals who will be involved with testing medical cannabis goods.

154.54(6) *Information technology systems security.* A laboratory shall maintain information technology systems protection by employing comprehensive security controls that include security firewall protection, antivirus protection, network and desktop password protection, and security patch management procedures.

[ARC 8124C, IAB 7/10/24, effective 8/14/24]

These rules are intended to implement Iowa Code chapter 124E.

[Filed ARC 1640C (Notice ARC 1571C, IAB 8/6/14), IAB 10/1/14, effective 1/30/15]

[Filed Emergency ARC 3150C, IAB 7/5/17, effective 6/13/17]

[Filed ARC 3606C (Notice ARC 3420C, IAB 10/25/17), IAB 1/31/18, effective 3/7/18]

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[Filed ARC 5200C (Notice ARC 5082C, IAB 7/15/20), IAB 10/7/20, effective 11/11/20]

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[Filed ARC 8124C (Notice ARC 7360C, IAB 1/24/24), IAB 7/10/24, effective 8/14/24]

[Filed ARC 9617C (Notice ARC 9491C, IAB 8/20/25), IAB 10/15/25, effective 12/1/25]

[Editorial change: IAC Supplement 6/10/26]

¹ July 10, 2019, effective date of Items 1, 4, 7, 10, 11, 12, 13, 15, 21, 22, and 24 of **ARC 4489C** delayed until the adjournment of the 2020 session of the General Assembly by the Administrative Rules Review Committee at its meeting held July 9, 2019.

¹ The effective date of **ARC 4928C** was corrected to June 1, 2020, in the March 11, 2020, Iowa Administrative Bulletin.

CHAPTER 155
LICENSURE STANDARDS FOR SUBSTANCE USE DISORDER
AND PROBLEM GAMBLING TREATMENT PROGRAMS

[Prior to 7/27/88, see Substance Abuse, Iowa Department of[805] Ch 3]

[Prior to 3/29/06, see 643—Ch 3]

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

641—155.1(125,135) Definitions. Unless otherwise indicated, the following definitions apply to the specific terms used in these rules:

“Accredited opioid treatment program” means an opioid treatment program that is the subject of a current, valid accreditation from an accreditation body approved by the Substance Abuse and Mental Health Services Administration (SAMHSA).

“Addictive disorder” means a substance use disorder and problem gambling.

“Addictive disorder professional” means an individual who is qualified by virtue of certification or license and education, training and experience to provide program services.

“Administration” means the direct application of a prescription medication to a patient by a prescriber or the prescriber’s authorized agent.

“Admission” means the point at which an initial assessment has been completed sufficient to determine the patient’s need and eligibility for program services and the patient has agreed to begin treatment.

“Admission, continued service, and discharge criteria” means the ASAM criteria dimensions to be considered in determining the level of care appropriate for the patient.

“Applicant” means a person, facility, or legal entity that has applied for an initial license, renewal of a license, or a license under deemed status pursuant to these rules.

“Application” means the process through which an applicant requests an initial license, renewal of a license, or a license under deemed status pursuant to these rules.

“ASAM criteria” means the clinical guide for the treatment of addictive, substance use and co-occurring conditions as published by the American Society of Addiction Medicine (ASAM) and as amended to August 1, 2025.

“Assessment” means the ongoing process of evaluating a patient’s strengths, resources, preferences, limitations, problems, and needs; determining the licensed program services needed by the patient; determining the patient’s eligibility for program services; and identifying treatment plan priorities, in accordance with the ASAM criteria and accepted standards of practice.

“Care coordination” or *“case management”* means the collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services, both internal and external to the program, to meet patient needs, using communication and available resources to promote quality care and effective outcomes.

“Certification” means the process by which SAMHSA determines that an opioid treatment program is qualified to provide opioid treatment under the federal opioid treatment standards.

“Certification application” means the application filed by an opioid treatment program for purposes of obtaining certification from SAMHSA.

“Certified opioid treatment program” means an opioid treatment program that is the subject of a current, valid certification.

“Chemical substance” means alcohol, wine, spirits and beer as defined in Iowa Code chapter 123 and controlled substances as defined in Iowa Code section 124.101.

“Clinically managed” means that program services are directed by addictive disorder professionals.

“Clinically managed high-intensity residential treatment” means the ASAM criteria level of care totaling at least 50 hours of clinically managed inpatient treatment services per week.

“Clinically managed low-intensity residential treatment” means the ASAM criteria level of care totaling at least five hours of clinically managed inpatient treatment services per week.

“Clinically managed medium-intensity residential treatment” means the ASAM criteria level of care totaling at least 30 hours of clinically managed inpatient treatment services per week.

“Clinical oversight” means oversight provided by an individual who, by virtue of certification or license and education, training and experience is qualified to oversee treatment services in accordance with subrule 155.21(3).

“Comprehensive maintenance treatment” means maintenance treatment provided in conjunction with a comprehensive range of appropriate medical and rehabilitative services.

“Concerned person” means an individual who is seeking treatment services due to problems arising from a personal relationship with an individual with an addictive disorder.

“Confidentiality” means protection of patient information in compliance with state and federal law.

“Crisis stabilization” means medically monitored subacute inpatient services for individuals with urgent addictive disorder needs requiring immediate intervention, assessment, and mobilization of family, community and program resources.

“Data reporting” means the required submission of certain patient demographic and program services information to the department by a program.

“Dimension” means one of the six ASAM criteria patient biopsychosocial areas to be considered in the assessment process to identify patient needs and determine the appropriate level of care for admission and continued services.

“Discharge” means the point at which the patient ceases participation in licensed program services, marking the end of a specific encounter or episode of care. Discharge does not require termination of the relationship between the patient and the program.

“Discharge planning” means the process, begun at admission, of determining a patient’s continued need for licensed program services and of developing a plan to address ongoing patient needs following discharge.

“DSM” means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association as amended to August 1, 2025, and all references to the DSM herein are as amended to August 1, 2025.

“Early intervention” means the ASAM criteria level of care that explores and addresses problems or risk factors that appear to be related to an addictive disorder and that helps the individual recognize potential harmful consequences.

“Enhanced program” means a licensee that provides enhanced treatment services in accordance with paragraph 155.2(2) “j” and rule 641—155.34(125,135).

“Enhanced treatment services” means licensed program services provided in accordance with paragraph 155.2(2) “j” and rule 641—155.34(125,135).

“Facility” means an institution or an installation providing care, maintenance or treatment for persons with substance use disorders licensed by the department under Iowa Code section 125.13, hospitals licensed under Iowa Code chapter 135B, or the state mental health institutes designated by Iowa Code chapter 226. “Facility” also means the physical areas such as grounds, buildings, or portions thereof under administrative control of the program.

“Governing body” means the person, group, or legal entity that has ultimate authority and responsibility for the overall operation of the program.

“Inpatient” means 24-hour licensed program services.

“Intensive outpatient treatment” means the ASAM criteria level of care totaling a minimum of nine hours of clinically managed outpatient treatment services per week for adults or a minimum of six hours of clinically managed outpatient treatment services per week for juveniles.

“Interim maintenance treatment” means withdrawal management for a period of more than 30 days but not in excess of 180 days.

“Level of care” or *“level of service”* means the different ASAM criteria service options. “Level of care” also means certain licensed program services under these rules.

“Licensed program services” means the services a licensee may be authorized to provide under these rules.

“Licensee” means a program licensed by the department pursuant to these rules.

“Licensure” means the issuance of a license by the department pursuant to these rules that validates the licensee’s compliance with these rules and authorizes the licensee to operate a program in the state of Iowa.

“Licensure weighting report” means the department’s report that is used to determine an applicant’s level of compliance with these rules and the length of time a license will be in effect.

“Maintenance” means the prolonged, scheduled administration of an opiate agonist medication such as buprenorphine or methadone by an opioid treatment program in accordance with federal and state laws, rules and regulations.

“Maintenance treatment” means the dispensing of a medication for opioid use disorder (MOUD) at stable dosage levels for a period in excess of 21 days in the treatment of an individual for opioid addiction.

“Management of care” means the ongoing application of the ASAM criteria and the coordination of care to ensure the appropriate provision of licensed program services to a patient.

“Medical and rehabilitative services” means services such as medical evaluations, counseling, and rehabilitative and other social programs (e.g., vocational and educational guidance, employment placement) that are intended to help patients in opioid treatment programs become or remain productive members of society.

“Medical director” means a physician who is licensed to practice medicine in accordance with Iowa Code chapter 148 and who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director’s direct supervision. Such delegations will not eliminate the medical director’s responsibility for all medical and behavioral health services provided by the OTP.

“Medically managed” means that the inpatient program services that involve daily medical care in a hospital setting are directed by a prescriber.

“Medically managed intensive inpatient treatment” means the ASAM criteria level of care for medically managed inpatient treatment services.

“Medically monitored” means that the program services are directed by addictive disorder professionals with medical oversight by a prescriber.

“Medically monitored intensive inpatient treatment” means the ASAM criteria level of care for medically monitored subacute inpatient treatment services.

“Medication-assisted treatment” means the medically monitored use of certain substance use disorder medications in combination with other treatment services.

“Medication unit” means an entity that is established as part of, but geographically separate from, an OTP from which appropriately licensed OTP practitioners, contractors working on behalf of the OTP, or community pharmacists may dispense or administer MOUD, collect samples for drug testing or analysis, or provide other OTP services. Medication units can be a brick-and-mortar location or mobile unit.

“Opioid addiction” means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opiate-induced problems. Opioid dependence is characterized by an individual’s repeated self-administration of opioids that usually results in opioid tolerance, withdrawal symptoms, and compulsive drug-taking. Dependency may occur with or without the physiological symptoms of tolerance and withdrawal.

“Opioid agonist treatment medication” means any opioid agonist drug that is approved by the Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 as amended to August 1, 2025) for use in the treatment of opiate addiction.

“Opioid drug” means any drug having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having such addiction-forming or addiction-sustaining liability.

“Opioid treatment program” or *“OTP”* means a substance use disorder treatment program or a substance use disorder and problem gambling treatment program licensed to provide opioid treatment services in accordance with Iowa Code section 125.21 and rules 641—155.2(125,135) and 641—155.35(125,135).

“Opioid treatment services” means medically monitored outpatient maintenance services provided in accordance with federal and state laws, rules and regulations.

“Opioid use disorder treatment” or *“OUD treatment”* means the dispensing of MOUD, along with the provision of a range of medical and behavioral health services, as clinically necessary and based on an individualized assessment and a mutually agreed-upon care plan, to an individual to alleviate the combination of adverse medical, psychological, or physical effects associated with an OUD.

“Outpatient” means non-24-hour licensed program services.

“Outpatient treatment” means the ASAM criteria level of care totaling less than nine hours of clinically managed outpatient treatment services per week for adults and less than six hours of clinically managed outpatient treatment services per week for juveniles.

“OWI evaluation” means an assessment completed solely for the purpose of compliance with the substance abuse evaluation requirements of Iowa Code chapter 321J.

“Partial/day treatment” means the ASAM criteria level of care totaling 20 or more hours of clinically managed outpatient treatment services per week.

“Patient” means an individual who participates in licensed program services.

“Placement” means selection of an appropriate licensed program service, based on ongoing assessment.

“Prescriber” means a licensed health care professional with the authority to prescribe medication in accordance with Iowa law.

“Prevention” means activities aimed at minimizing the use of potentially addictive substances, lowering risk in at-risk individuals, or minimizing potential adverse consequences of substance use or gambling.

“Prime programming time” means any period of the day, as determined by a program treating juveniles, when special attention or supervision is necessary.

“Problem gambling” means a gambling disorder that results in a functional impairment of sufficient impact and duration to meet diagnostic criteria specified within the DSM.

“Program” means a person, facility, institution, building, agency or legal entity that provides one or more of the services stated in subrule 155.2(2) and is required to be licensed under these rules.

“Program sponsor” means the person responsible for the operation of the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.

“Quality improvement” means the process of objectively and systematically monitoring and evaluating the quality and appropriateness of patient care and program services and operations to resolve identified problems and to make continued improvements.

“Recovery” means the process of addressing an addictive disorder and working toward personally defined health and well-being.

“Recovery supports” means the broad range of nontreatment services, such as transportation, that assists patients in their recovery efforts.

“Rehabilitation” means the restoration of an optimal state of health by medical, psychological, and social means, including peer group support.

“Residential” means clinically managed inpatient treatment services.

“Screening” means the brief review of a patient’s or potential patient’s current risk factors for an addictive disorder or medical or mental health condition to determine if they indicate a need for immediate admission or referral. Screening is not an assessment and is not sufficient to develop a treatment plan, rule out an addictive disorder, or determine that admission to treatment or referral to other services is not indicated.

“Short-term withdrawal management treatment” means withdrawal management treatment for a period not in excess of 30 days.

“Self-administration of medication” means the process whereby a properly trained and qualified staff person observes a patient take medication prescribed by a prescriber.

“Staff” means any individual who conducts an activity on behalf of a program as an employee, agent, consultant, contractor, volunteer or other status.

“Standards category” means the grouping of standards, such as clinical, administrative or programming, in the licensure weighting report.

“State authority” means the department, which regulates the treatment of opioid addiction with opioid drugs.

“Subacute” means medically monitored inpatient services for individuals who require management, supervision and treatment to reduce immediate risk of danger to self or others or severe disability or complication of an addictive disorder or an addictive disorder and a medical or mental health condition.

“Substance abuse treatment and rehabilitation facility” or *“substance abuse treatment program”* means a program required to be licensed under these rules.

“Substance use disorder” means a substance use disorder that results in a functional impairment of sufficient impact and duration to meet diagnostic criteria specified within the DSM.

“Telehealth” means the same as defined in Iowa Code section 514C.34(1).

“Time frames” means the periods of time specified throughout the standards.

“Treatment” means the broad range of planned services to identify and change patterns of behavior that are maladaptive, destructive or injurious to health or to restore appropriate levels of physical, psychological or social functioning. Such services may include assessment; care coordination; crisis stabilization; withdrawal management; early intervention; health promotion; individual, group and family counseling; management of care; and medication administration, provided by addictive disorder professionals and a mix of medical, mental health and peer professionals as appropriate to the structure of the program.

“Treatment plan” means a plan that outlines for each patient attainable short-term treatment goals that are mutually acceptable to the patient and the opioid treatment program and that specifies the services to be provided and the frequency and schedule for their provision.

“Treatment planning” means the process, based on ongoing assessment, by which a patient and qualified staff identify and rank problems, establish agreed-upon goals, and decide on the treatment services and resources to be utilized.

“Withdrawal management” means the safe management of intoxication states and withdrawal states in accordance with the ASAM criteria and accepted standards of practice.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.2(125,135) Licensing. In accordance with Iowa Code section 125.13, a person shall not maintain or conduct a substance use disorder program without having first obtained a license for the program from the department, and in accordance with Iowa Code section 135.150, a person shall not maintain or conduct a problem gambling treatment program funded by the department unless the person has obtained a license for the program from the department. The provision of treatment to a patient through any electronic means, regardless of the location of the program or facility, shall constitute the practice of treatment in the state of Iowa and shall be subject to regulation in accordance with Iowa Code chapter 125, Iowa Code section 135.150, and these rules. An applicant shall apply for one license only. The department will award one license only to an applicant or licensee.

155.2(1) *Program licenses.* The department will offer the following program licenses:

- a. A substance use disorder assessment and OWI evaluation-only program license.
- b. A substance use disorder treatment program license.
- c. A problem gambling treatment program license.
- d. A substance use disorder and problem gambling treatment program license.

155.2(2) *Licensed program services.* The license will delineate the licensed program service(s) the program is authorized to provide and will specify that each licensed program service is licensed for adults, juveniles, or adults and juveniles. Licensed program services are:

- a. Substance use disorder assessment and OWI evaluation only, provided by a substance use disorder assessment and OWI evaluation-only program;
- b. Outpatient treatment, provided by a substance use disorder treatment program, a problem gambling treatment program, or a substance use disorder and problem gambling treatment program;
- c. Intensive outpatient treatment, provided by a substance use disorder treatment program, a problem gambling treatment program, or a substance use disorder and problem gambling treatment program;
- d. Partial/day treatment, provided by a substance use disorder treatment program, a problem gambling treatment program, or a substance use disorder and problem gambling treatment program;
- e. Clinically managed low-intensity residential treatment, provided by a substance use disorder treatment program, a problem gambling treatment program, or a substance use disorder and problem gambling treatment program;
- f. Clinically managed medium-intensity residential treatment, provided by a substance use disorder treatment program, a problem gambling treatment program, or a substance use disorder and problem gambling treatment program;
- g. Clinically managed high-intensity residential treatment, provided by a substance use disorder treatment program, a problem gambling treatment program, or a substance use disorder and problem gambling treatment program;
- h. Medically monitored intensive inpatient treatment, provided by a substance use disorder treatment program or a substance use disorder and problem gambling treatment program;
- i. Medically managed intensive inpatient treatment, provided by a substance use disorder treatment program or a substance use disorder and problem gambling treatment program;
- j. Enhanced treatment services, provided by a substance use disorder treatment program or a substance use disorder and problem gambling treatment program;
- k. Opioid treatment services, provided by a substance use disorder treatment program or a substance use disorder and problem gambling treatment program.

155.2(3) *Licensing body.* The department will consider and approve or deny all license applications, suspensions and revocations.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.3(125,135) Types of licenses.

155.3(1) The department may issue an initial license for 270 days to a new applicant scoring a minimum rating of 70 percent in each standards category on the licensure weighting report. An initial license shall expire in 270 days and shall not be extended or renewed.

155.3(2) The department may issue a license subsequent to an initial license for one, two, or three years based on the applicant's rating on the licensure weighting report.

- a. An applicant achieving a rating of 95 percent or higher in each standards category may qualify for a three-year license.
- b. An applicant achieving a rating of less than 95 percent but not less than 90 percent in each standards category may qualify for a two-year license.
- c. An applicant achieving a rating of less than 90 percent but not less than 70 percent in each standards category may qualify for a one-year license.

d. A license for one, two, or three years shall expire on the date noted on the license and shall not be extended but may be renewed upon application.

155.3(3) The department may issue a license under deemed status to an applicant providing required documentation of accreditation by a recognized accreditation body. A deemed-status license will be effective for the same time frame as that of the accreditation granted by the accreditation body, up to three years.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.4(125,135) Nonassignability.

155.4(1) A license issued by the department for the operation of a program applies both to the licensee and the facility in which the program is operated. A license is not transferable.

155.4(2) A closing program is one that intends to cease providing licensed program services. The licensee shall notify the department 30 days before ceasing service provision. The licensee shall be responsible for the transition of patients to another program and for the preservation of all records. The licensee shall include in its notice to the department its plan to transition patients and locate records. When a program closes, the program's license is void on the date the program ceases providing licensed program services and the license shall be returned to the department.

155.4(3) A closed program is one that has ceased providing licensed program services. The licensee shall notify the department immediately of ceased service provision. The licensee shall be responsible for the transition of patients to another program and for the preservation of all records. The licensee shall include in its notice to the department its plan to transition patients and locate records. When a program is closed, the program's license is void on the date the program ceased providing licensed program services and the license shall be returned to the department.

155.4(4) A person, facility or legal entity acquiring a licensed, closing or closed program for the purpose of operating a program shall apply for a license.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.5(125,135) Application procedures. The department will provide license application forms on its website and at its office. An applicant shall submit application materials to the department. The department will proceed with inspection of the applicant upon receipt of a complete application. To be complete, an application must include all required materials and be responsive to all licensure standards, as described in these rules.

155.5(1) *Application information.* An applicant shall submit application materials on the forms provided and in the required format. Application materials shall include but may not be limited to:

a. The name and address of the applicant and, if the applicant is part of a larger organization, the name and address of the larger organization.

b. The name and address of the applicant's executive director and, if the applicant is part of a larger organization, the name and address of the executive director of the larger organization.

c. The names, titles, dates of employment, education, and years of current job-related experience of the applicant's staff and the table of organization. If the applicant is part of a larger organization or has multiple organizational components and physical facilities, the relationships between the larger organization, organizational components and physical facilities must be shown on the table of organization, with the applicant and applicant's staff positions clearly delineated.

d. The names and addresses of members of the applicant's governing body, sponsors, and advisory boards and the current articles of incorporation and bylaws.

e. The names and addresses of individuals, facilities, organizations, and legal entities with which the applicant has a contractual or affiliation agreement pertaining to licensed program services.

f. A description of the licensed program services to be provided by the applicant and a calendar showing program services each week.

g. For each physical facility, copies of reports substantiating compliance with federal, state and local laws, rules and regulations, to include appropriate department of inspections, appeals, and

licensing rules; state fire marshal rules and fire ordinances; and local health, fire, occupancy, and safety regulations.

h. Information required for programs admitting juveniles as described under Iowa Code section 125.14A.

i. Fiscal management information, to include a recent audit or opinion of auditor and program board minutes to reflect approval of the program's budget and insurance.

j. Insurance coverage related to professional and general liability; building, if the applicant has a physical location; and workers' compensation and fidelity bond, if the applicant has employees.

k. The address of each physical facility, if applicable.

l. The written policies and procedures manual that covers all the requirements of these rules.

155.5(2) *Application time frame.* An applicant seeking to be licensed subsequent to a 270-day initial license or a licensee seeking to renew a one-, two-, or three-year license or to significantly change a currently licensed program shall submit an application at least 90 days before expiration of the current license or before the program change.

155.5(3) *License under deemed status.* An organization seeking to be licensed under deemed status shall submit an application.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.6(125,135) Technical assistance. The department may provide technical assistance to an applicant or licensee.

155.6(1) An applicant may request technical assistance regarding these rules and the licensure process.

155.6(2) A licensee may request technical assistance regarding these rules and the licensure process or to bring areas of noncompliance with these rules into compliance.

155.6(3) The department may require a licensee to receive technical assistance to bring areas of noncompliance with these rules into compliance.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.7(125,135) Inspection of applicants.

155.7(1) *Inspection of applicants.* The department will inspect each applicant. Inspection will include review of the complete application and may include but may not be limited to review of patient records, review of applicant data reporting, and interviews with staff and patients. Inspection will include on-site inspection unless specifically waived as allowed under these rules. The department will send the applicant a report of inspection findings within 30 business days of the inspection.

155.7(2) *On-site inspection.* The department will schedule an on-site inspection of an applicant within 60 business days of receipt of the applicant's complete application.

a. The department may waive on-site inspection of an applicant that is:

(1) A licensee applying to renew a license when the applicant's licensed program services are limited to substance use disorder assessment and OWI evaluation services only, outpatient treatment, or intensive outpatient treatment.

(2) An applicant applying for a license under deemed status.

b. The department is not required to provide advance notice of the on-site inspection to the applicant.

c. The on-site inspection team will consist of designated employees or agents of the department.

d. The on-site inspection team will inspect the applicant to verify application information and determine compliance with all laws, rules and regulations.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.8(125,135) License—approval. The department will issue a license upon approval of an application. The license will be effective upon approval.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.9(125,135) Written corrective action plan.

155.9(1) A program approved for a license shall submit a written corrective action plan to the department within 30 days following approval to bring any area of noncompliance with these rules into compliance.

155.9(2) The written corrective action plan shall include but may not be limited to:

- a. Any area of noncompliance specified in the inspection findings report;
- b. The corrective measures to be taken by the program for each area of noncompliance; and
- c. The completion date for each corrective measure.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.10(125,135) Grounds for denial of license. The department may deny an application for a license for any of the following reasons:

155.10(1) The application is not complete, is not timely or otherwise does not meet the requirements of these rules.

155.10(2) The applicant fails to achieve the minimum licensure weighting report rating required for a 270-day initial license or a one-, two- or three-year license.

155.10(3) Lack of patients or patient records for review.

155.10(4) Violation of any of the following grounds for discipline:

- a. Submission of fraudulent or misleading information.
- b. Violation by a program or staff of any statute or rule pertaining to programs, including violation of any provision of these rules, or failure to adhere to program policies and procedures adopted pursuant to these rules.
- c. Failure to comply with licensure, inspection, health, fire, occupancy, safety, sanitation, zoning, or building codes or regulations required by federal, state or local law.
- d. Sanction, modification, termination, withdrawal, refused renewal, suspension, or revocation of accreditation by an accreditation body.
- e. Sanction, modification, termination, withdrawal, refused renewal, suspension, revocation, or refused issuance of a federal registration to distribute or dispense controlled substances.
- f. Commission of or permitting, aiding or abetting commission of an unlawful act.
- g. Conviction of a member of the governing body, a director, administrator, chief executive officer, or other managing staff person of a felony or misdemeanor related to the management, operation or integrity of the program.
- h. Use of untruthful or improbable statements in advertising.
- i. Conduct or practices determined to be detrimental to the general health, safety, or welfare of a patient, potential patient, concerned person, visitor, staff or member of the public.
- j. Violation of a patient's confidentiality or willful, substantial, or repeated violation of a patient's rights.
- k. Defrauding a patient, potential patient, concerned person, visitor, staff or third-party payor.
- l. Inappropriate conduct by staff, including sexual or other harassment or exploitation of a patient, potential patient, concerned person, visitor or staff.
- m. Utilization of treatment techniques that endanger the health, safety, or welfare of a patient, potential patient, concerned person, visitor, staff or member of the public.
- n. Discrimination or retaliation against a patient, potential patient, concerned person, visitor, staff, or member of the public who has submitted a complaint or information to the department.
- o. Failure to allow an employee or agent of the department access to the program or facility for the purpose of inspection, investigation, or other activity necessary to the performance of the department's duties.
- p. Failure to submit an acceptable written corrective action plan or failure to comply with a corrective action plan issued pursuant to rule 641—155.9(125,135) or 641—155.16(125,135).
- q. Violation of an order of the department or violating the terms or conditions of a consent agreement or informal settlement between a program and the department.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.11(125,135) Denial, suspension or revocation of a license. The department may deny an application for a license. The department may suspend or revoke a license for any of the grounds for discipline pursuant to subrule 155.10(4).

155.11(1) *Initial notice from the department.* When the department determines to deny, suspend or revoke a one-, two-, or three-year license or a license under deemed status, the department will notify the applicant or licensee by certified mail, return receipt requested, in accordance with 441—Chapter 16. Such notice will provide the applicant or licensee the opportunity to submit a written corrective action plan or written objections to the department.

155.11(2) *Submission of corrective action plan or objections.* An applicant notified of denial of a one-, two-, or three-year license or a license under deemed status or a licensee notified of suspension or revocation of a license may submit a written corrective action plan or written objections to the department within 20 days after receipt of the notice.

a. Written corrective action plan. The written corrective action plan must meet the requirements of paragraphs 155.9(1)“a” through “c.” If the applicant or licensee submits a written corrective action plan, the applicant or licensee shall have 90 days from the date of submission within which to show compliance with the plan. The applicant or licensee shall submit any information to the department that the department requests or that the applicant or licensee deems pertinent to show compliance with the plan. The department may inspect the licensee, including on-site inspection, to review the implemented corrective measures.

b. Objections. If the applicant or licensee submits written objections, the applicant or licensee shall submit to the department any information that the department or the applicant or licensee deems pertinent to support the applicant’s or licensee’s defense.

155.11(3) *Decision of department.* Following receipt of a written corrective action plan and expiration of the 90-day compliance period, or following receipt of written objections, or when a written corrective action plan or written objections have not been received within the 20-day time period, the department will determine whether to proceed with the denial, suspension or revocation.

155.11(4) *Notice of decision and opportunity for contested case hearing.*

a. When the department determines to deny, suspend, or revoke a license, the applicant or licensee shall be given written notice by restricted certified mail pursuant to 441—Chapter 16.

b. The applicant or licensee may request a hearing on the determination. The request must be in writing and sent to the department’s address within 30 days of the notice issued by the department. Failure to request a hearing will result in final action by the department.

155.11(5) *Summary suspension.* If the department finds that the health, safety or welfare of the public is endangered by continued operation of a program, the department may order summary suspension of a license, pursuant to Iowa Code sections 17A.18 and 125.15A, pending proceedings for revocation or other actions in accordance with Iowa Code sections 17A.18A and 125.15A and 441—Chapter 2506. These proceedings shall be promptly instituted and determined.

[ARC 9499C, IAB 8/20/25, effective 10/1/25; Editorial change: IAC Supplement 6/10/26]

641—155.12 to 155.14 Reserved.

641—155.15(125,135) Issuance of a license after denial, suspension or revocation. After denial, suspension, or revocation of a license, the former applicant or licensee shall not have a license issued within one year of the effective date of the denial, suspension or revocation. After one year, the former applicant or licensee may submit an application for a 270-day initial license. For purposes of this rule, “former applicant or licensee” includes any director, officer, administrator, chief executive officer, or other managing staff of the former applicant or licensee.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.16(125,135) Complaints and investigations.

155.16(1) *Complaints.* Any person may file a complaint with the department against any program licensed pursuant to this chapter. The complaint shall be made in writing and shall be emailed, mailed or delivered to the department. The complaint shall include the name and address of the complainant, the name of the program, and a concise statement of the allegations against the program, including the specific alleged violations of Iowa Code chapter 125 or this chapter, if known. A complaint may also be initiated by the department when an emergency exists that is deemed to endanger the health, safety or welfare of a patient, potential patient, concerned person, visitor, staff or the public, pursuant to evidence received by the department. Timely filing of complaints is required to ensure the availability of witnesses and to avoid initiation of an investigation under conditions that may have been significantly altered during the period of delay.

155.16(2) *Evaluation and investigation.* Upon receipt of a complaint, the department will make a preliminary review of the allegations contained in the complaint. The department may request that the complainant submit the complaint to the program's grievance process. Unless the department concludes that the complaint is intended solely to harass a program or lacks a reasonable basis, or is more reasonably addressed through the program's grievance process, the department will conduct an investigation of the program that is the subject of the complaint as soon as is practicable. The program that is the subject of the complaint will be given an opportunity to informally respond to the allegations contained in the complaint either in writing or through a personal interview or conference with department staff.

155.16(3) *Investigative report.* Within 30 days after completion of the investigation, the department will prepare a written investigative report and submit it to the executive director of the program and the chairperson of the governing body of the program. This report will include the nature of the complaint and shall indicate if the complaint allegations were substantiated, unsubstantiated, or undetermined; the basis for the finding; the specific statutes or rules at issue; a response from the program, if received; and a recommendation for action.

155.16(4) *Review of investigations.* The department will review the investigative report and determine appropriate action.

a. Closure. If the department determines that the allegations contained in the complaint are unsubstantiated, the department will close the case and promptly notify the complainant and the program by letter.

b. Further investigation. The department may determine that the complaint warrants further investigation and may conduct an additional investigation.

c. Written corrective action plan. If the department determines that the allegations contained in the complaint are substantiated and corrective action is warranted, the department may require the program to submit and comply with a written corrective action plan. A program shall submit a written corrective action plan to the department within 20 business days after receiving a request for such plan. The written corrective action plan shall include a plan for correcting areas of noncompliance as required by the department and a time frame within which such plan shall be implemented. The plan is subject to department approval. Requiring a written corrective action plan is not formal disciplinary action. Failure to submit or comply with a written corrective action plan may result in formal disciplinary action against the program.

d. Disciplinary action. If the department determines the allegations contained in the complaint are substantiated and disciplinary action is warranted, the department may proceed with such action in accordance with rule 641—155.11(125,135).

155.16(5) *Confidential information and public information.* Information contained in a complaint may be confidential pursuant to Iowa Code section 22.7(2), 22.7(18), or 125.37 or any other provision of state or federal law. Investigative reports, written corrective action plans, and all notices and orders issued pursuant to rule 641—155.11(125,135) shall refer to patients by number and shall not include patient identifying information. Investigative reports, written corrective action plans, and all notices and orders issued pursuant to rule 641—155.11(125,135) shall be available to the public as open records pursuant to Iowa Code chapter 22.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.17(125,135) License revision. A licensee shall submit a written request to the department to revise a license at least 30 days prior to any change of address, executive director, clinical oversight staff, facility, or licensed program service. The department will determine if the requested revision can be approved or if the change is significant enough to require the submission of an application for license renewal by the licensee.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.18(125,135) Deemed status.

155.18(1) Accreditation. The department will approve a license under deemed status for an applicant accredited by a recognized national accreditation body when it determines that the accreditation is for the same licensed program services as those addressed by these rules and when such accreditation is consistent with these rules.

a. An applicant for a license under deemed status shall submit a copy of the entire accreditation body survey or inspection report, certificate of accreditation, accreditation conditions, and corrective action requirements and plans with the applicant's application.

b. The department may review and accept an accreditation body's survey or inspection report, certificate of accreditation, and conditions or corrective action plans as meeting the requirements for inspection for those licensed program services described in these rules.

c. An applicant for a license under deemed status shall be licensed only for licensed program services that are described in these rules.

d. A program licensed under deemed status shall be licensed for the same period of time as that for which the program is accredited, up to three years.

155.18(2) National accreditation bodies. The national accreditation bodies recognized for the purposes of licensure under deemed status are:

a. The Joint Commission.

b. The Council on Accreditation of Rehabilitation Facilities (CARF).

c. The Council on Accreditation (COA).

d. The American Osteopathic Association (AOA).

155.18(3) Credentials and expectations of accreditation bodies. The accreditation credentials of an accreditation body shall specify the types of organizations, programs and services the body accredits.

155.18(4) Responsibilities of programs licensed under deemed status.

a. A program licensed under deemed status shall meet all requirements of these rules and all applicable laws and regulations.

b. A program licensed under deemed status may submit an application for licensure of licensed program services covered by these rules that are not covered by the accreditation.

155.18(5) Rights and responsibilities of department. The department retains the following responsibilities and rights for deemed status applicants and licensees:

a. The department may inspect the applicant or licensee.

b. The department will investigate complaints in accordance with these rules and recommend and require corrective action or other sanctions. Complaints, findings, and required corrective action may be reported to the accreditation body.

c. The department will review and act upon a license under deemed status when complaints have been founded, when the national accreditation body identifies noncompliance with accreditation, when accreditation expires without renewal, or when accreditation is sanctioned, modified, terminated, withdrawn, suspended or revoked.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.19(125,135) Funding. The issuance of a license shall not be construed as a commitment on the part of either the state or federal government to provide funds to such licensee.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.20(125,135) Inspection. An applicant or licensee agrees as a condition of licensure:

155.20(1) To permit properly designated representatives of the department to enter into and inspect any and all programs and facilities for which a license has been applied or issued to verify information contained in the application or to ensure compliance with all laws, rules, and regulations relating thereto, during all hours of operation of said applicant or licensee and at any other reasonable hour.

155.20(2) To permit properly designated representatives of the department to audit and collect statistical data from all records maintained by the applicant or licensee. An applicant or licensee that does not permit inspection by the department or examination of all records, including financial records, records pertaining to methods of administration, general and special dietary programs, and the disbursement of medications and methods of supply, and any other records the department deems relevant, will not be licensed.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.21(125,135) General standards for all programs. The following standards apply to all programs. For programs for which both the general standards and specific standards apply, both sets of standards shall be met.

155.21(1) Governing body. The program shall have a formally designated governing body that complies with Iowa Code chapter 504 and that is the ultimate authority for program operations.

a. The governing body shall develop and adopt written bylaws and policies that define the powers and duties of the governing body, its committees, its advisory groups, and the executive director. These bylaws and policies shall be reviewed and revised by the governing body as necessary.

b. The bylaws shall minimally specify the following:

- (1) The type of membership;
- (2) The term of appointment;
- (3) The frequency of meetings;
- (4) The attendance requirements; and
- (5) The quorum necessary to transact business.

c. The governing body shall maintain minutes of all meetings, and the minutes shall be available for review by the department and shall include but not necessarily be limited to:

- (1) Date of the meeting;
- (2) Names of members attending;
- (3) Topics discussed; and
- (4) Decisions reached and actions taken.

d. The duties of the governing body shall include but not necessarily be limited to:

- (1) Appointment of a qualified executive director, who shall have the responsibility and authority for the management of the program in accordance with the governing body's established policies;
- (2) Establishment of effective controls to ensure that quality services are provided;
- (3) Review and approval of the program's annual budget; and
- (4) Approval of all contracts.

e. The governing body shall approve policies and procedures for the effective operation of the program.

f. The governing body shall be responsible for all funds, equipment, and supplies and the facility in which the program operates, if applicable. The governing body shall be responsible for the appropriateness and adequacy of services provided by the program.

g. The governing body shall at least annually prepare a report, which shall include but not necessarily be limited to:

- (1) The name, address, occupation, and place of employment of each governing body member;
- (2) Disclosure of any family relationship a member of the governing body has with a program staff member;

(3) The names and addresses of any owners or controlling parties, whether they are individuals, partnerships, a corporation body, or a subdivision of other bodies;

(4) Disclosure of any potential conflict of interest a member of the governing body may have.

h. The governing body shall ensure that the program has malpractice, liability and workers' compensation insurance for all staff and a fidelity bond that covers all staff, if applicable.

155.21(2) *Executive director.* The executive director shall have primary responsibility for program operations. The duties of the executive director shall be clearly defined in accordance with the policies established by the governing body.

155.21(3) *Clinical oversight.* The program shall designate a treatment supervisor to oversee provision of licensed program services.

155.21(4) *Policies and procedures manual.* The program shall maintain and implement a written policies and procedures manual that documents the program's compliance with these rules. The manual shall describe the program's licensed program services and related activities, specify the policies and procedures to be followed, and govern all staff.

a. The manual shall have a table of contents.

b. Revisions to the manual shall be entered with the date and with the name and title of the staff person making the revisions.

155.21(5) *Staff development and training.* The program's policies and procedures shall establish a staff development and training plan that encompasses all staff and all licensed program services, considers the professional continuing education requirements of certified and licensed staff, and is available to all staff.

a. The program shall designate a staff person responsible for the staff development and training plan.

b. The staff person responsible for the staff development and training plan shall conduct an annual needs assessment.

c. The staff development and training plan shall describe orientation for new staff that includes an overview of the program and licensed program services, confidentiality, tuberculosis and bloodborne pathogens, including HIV/AIDS, and culturally and environmentally specific information. Orientation shall also address the specific responsibilities of each staff person and community resources specific to the staff person's responsibilities.

d. The staff development and training plan shall address training when program operations or licensed program services change.

e. The staff development and training plan may include on-site training activities. The program shall maintain minutes of on-site training that include the name and date of the training, the training topic, the name and title of the trainer, and the names of staff attending the training.

155.21(6) *Data reporting.* The program's policies and procedures shall describe how the program reports required data to the department in accordance with department requirements and processes.

155.21(7) *Fiscal management.* The program's policies and procedures shall ensure proper fiscal management, which shall include:

a. The preparation and maintenance of an annual written budget, which shall be reviewed and approved by the governing body prior to the beginning of the budget year.

b. A fiscal management system maintained in accordance with generally accepted accounting principles, including internal controls to reasonably protect program assets. This shall be verified by an annual independent fiscal audit of the program by the state auditor's office or a certified public accountant based on an agreement entered into by the governing body. A program with an annual budget of \$100,000 or less shall conduct a fiscal audit no less than every three years.

c. An insurance program that provides for the protection of the physical and financial resources of the program and provides coverage for all people, buildings, and equipment. The insurance program shall be reviewed annually by the governing body.

155.21(8) *Personnel.* The program shall have personnel policies and procedures.

a. Personnel policies and procedures shall address:

- (1) Recruitment and selection of staff;
- (2) Wage and salary administration;
- (3) Promotions;
- (4) Employee benefits;
- (5) Working hours;
- (6) Vacation and sick leave;
- (7) Lines of authority;
- (8) Rules of conduct;
- (9) Disciplinary actions and termination;
- (10) Methods for handling cases of inappropriate patient care;
- (11) Work performance appraisal;
- (12) Staff accidents and safety;
- (13) Staff grievances;
- (14) Prohibition of sexual harassment;
- (15) Implementation of the Americans with Disabilities Act as amended to August 1, 2025;
- (16) Implementation of the Drug-Free Workplace Act as amended to August 1, 2025;
- (17) Use of social media; and
- (18) Implementation of equal employment opportunity.

b. The program shall have for each position and each staff person a written job description that describes the duties of each position and staff and the qualifications required for each position.

(1) A staff person providing screening, OWI evaluation, assessment or treatment services in accordance with these rules shall be qualified as an addictive disorder professional by meeting at least one of the following conditions:

1. Be certified or licensed as a substance use disorder or problem gambling counselor by a national or state organization approved by the department.

2. Be licensed as a marital and family therapist or a mental health counselor under Iowa Code chapters 154D and 147, an independent social worker under Iowa Code chapters 154C and 147, or another independent professional authorized by the Iowa Code to diagnose and treat mental disorders as specified in the DSM.

3. Be licensed as a master social worker under Iowa Code chapters 154C and 147.

4. Be licensed as a bachelor social worker under Iowa Code chapters 154C and 147.

5. Be temporarily or provisionally certified or licensed as allowed under a certification or license acceptable to the department. Such staff person must meet all requirements of the temporary or provisional certification or license, must be supervised by a staff person meeting one of the requirements of paragraphs “1” through “4” above, and must be fully certified or licensed within two years of the date on which the person began to provide licensed program services.

6. A staff person employed on and after July 1, 2010, who is not qualified as described in any of the paragraphs “1” through “5” above shall be deemed qualified while the person is in the process of being certified or licensed under a certification or license acceptable to the department. Such staff must meet the requirements of the certification or licensure process, must be supervised by a staff person meeting one of the requirements of paragraphs “1” through “4” above, and must be fully certified or licensed within two years of the date on which the person began to provide licensed program services. The two-year time frame is continuous from the person’s date of first employment by the program, including if the person changes employment from one program to another.

7. A person employed before July 1, 2010, and continuously since that date at a program licensed pursuant to this chapter, who is not qualified as described in any of the paragraphs “1” through “5” above, shall be deemed qualified as long as such person remains employed by that program and that program remains licensed. Such staff shall maintain a minimum of 30 hours of training every two years, including a minimum of 3 hours of ethics training, and shall be supervised by a staff person meeting at least one of the conditions of paragraphs “1” through “4” above.

(2) The program shall review job descriptions annually and whenever there is a change in a position's duties or required qualifications.

(3) The program shall include job descriptions in the personnel section of the policies and procedures manual.

c. The program shall conduct a written evaluation of job performance with each staff person at least annually. The evaluation shall include the opportunity for the staff person to comment.

d. The program shall maintain a personnel record on each staff person. The record shall contain, as applicable:

- (1) Verification of training, experience, qualifications, and professional credentials;
- (2) Job performance evaluations;
- (3) Incident reports;
- (4) Disciplinary action taken; and
- (5) Documentation of review of and agreement to adhere to confidentiality laws and regulations.

This review and agreement shall occur prior to the staff person's assumption of duties.

e. The personnel policies and procedures shall ensure confidentiality of personnel records and shall specify staff authorized to have access to personnel information.

f. The program shall notify the department in writing within ten days of being informed that a staff person has been sanctioned or disciplined by a certifying or licensing body. Such notice shall include the sanction or discipline order.

155.21(9) *Child abuse, dependent adult abuse and criminal history background checks.* The program's policies and procedures shall address child abuse, dependent adult abuse and criminal history background checks.

a. The program shall prohibit mistreatment, neglect, or abuse of children and dependent adults and shall specify reporting and enforcement procedures. Alleged violations shall be reported immediately to the program's executive director and appropriate department personnel. Policies and procedures on reporting alleged violations shall be in compliance with subrule 155.21(10). A staff person found to be in violation of Iowa Code sections 232.67 through 232.70, as substantiated by a department investigation, shall be subject to the program's policies concerning termination.

b. For each staff person working with juveniles as set forth in Iowa Code section 125.14A or with dependent adults as set forth in Iowa Code chapter 235B, the personnel record shall contain:

(1) Documentation of a criminal history background check with the Iowa division of criminal investigation on all new staff applicants. The background check shall include asking whether the applicant has been convicted of a crime.

(2) A written, signed and dated statement furnished by a new staff applicant that discloses any substantiated report of child abuse, neglect or sexual abuse or dependent adult abuse.

(3) Documentation of a check prior to permanent acceptance of a person as staff, with the Iowa central registry for any substantiated reports of child abuse, neglect or sexual abuse pursuant to Iowa Code section 125.14A or substantiated reports of dependent adult abuse for all staff hired or accepted on or after July 1, 1994, pursuant to Iowa Code chapter 235B.

c. A person who has a record of a criminal conviction or founded child abuse report or founded dependent adult abuse report shall not be hired or accepted as staff unless an evaluation of the crime or founded child abuse or founded dependent adult abuse has been made by the department that concludes that the crime or founded child abuse or founded dependent adult abuse does not merit prohibition of employment. If a record of criminal conviction or founded child abuse or founded dependent adult abuse does exist, the person shall be offered the opportunity to complete and submit a Record Check Evaluation form. In its evaluation, the department will consider the nature and seriousness of the crime or founded abuse in relation to the position sought, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation and the number of crimes or founded abuses committed by the person involved.

d. A staff person providing screening, OWI evaluation, assessment or treatment in accordance with this chapter shall complete the department's core training curriculum pursuant to Iowa Code sections 232.69 and 235B.16 within six months of initial employment or self-employment and every three years thereafter.

155.21(10) Patient records. The program's policies and procedures shall describe compilation, storage and dissemination of patient records and release or disclosure of information.

a. The policies and procedures shall ensure that:

(1) The program protects the patient record against loss, tampering or unauthorized disclosure of information;

(2) The content and format of patient records are uniform;

(3) All entries in the patient record are in chronological order, signed, dated and legible. When records are maintained electronically, a staff identification code number authorizing access shall be accepted in lieu of a signature;

(4) Each entry in the patient record is made in permanent ink, by typewriter, or by computer; and

(5) Entries in the patient record use language consistent with generally accepted standards of practice and do not include abstract terms, technical jargon or slang.

b. The program shall provide adequate physical facilities for the secure storage, processing and handling of patient records.

c. Appropriate patient records shall be readily accessible to staff as specifically authorized by program policy.

d. The program shall appropriately maintain and dispose of patient records. Patient records shall be maintained for not less than seven years from the date they are officially closed.

e. Each file cabinet or storage area containing patient records shall be locked.

f. The program shall release or disclose information on individuals seeking program services or on patients in strict accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended to August 1, 2025, and state and federal confidentiality laws, rules and regulations.

(1) The confidentiality of substance use disorder patient records and information is protected by HIPAA as amended to August 1, 2025, and the regulations on confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2 as amended to August 1, 2025, which implement federal statutory provisions, 42 U.S.C. 290dd-2 applicable to alcohol abuse patient records, and 42 U.S.C. 290ee-3 both as amended to August 1, 2025, applicable to drug abuse patient records.

(2) The confidentiality of problem gambling patient records and information is protected by HIPAA as amended to August 1, 2025, Iowa Code chapter 228 and section 22.7(35).

g. A program that provides licensed program services via electronic means shall inform the patient of the limitations and risks associated with such services and shall document in the patient record that such notice has been provided.

h. Upon receipt of a properly executed written release of information or authorization to disclose signed by the patient, the program shall release patient records in a timely manner. A program shall not refuse to release patient records related to continuation of care solely because payment has not been received. A program may refuse to release patient records that are unrelated to continuation of care if payment has not been received. A program may refuse to file the reporting form required by 641—subrule 157.3(1), "Notice Iowa Code 321J—Confidential Medical Record," reporting screening, evaluation, and treatment completion, if payment has not been received for such services.

155.21(11) Assessment and admission. The program's policies and procedures shall address screening, assessment, referral and admission and documentation of such activities in the patient record.

a. The program shall conduct an assessment with each patient prior to admission unless the patient's current risk factors indicate a need for immediate admission.

(1) If the program admits a patient based on a screening or initial assessment that indicates the patient requires immediate admission, that screening or initial assessment must be updated and expanded to a full assessment when the patient's current risk factors are stabilized.

(2) The assessment shall be documented in the patient record and shall be organized in a manner that supports development of a treatment plan by the program or by any program to which the patient is referred.

b. The program shall implement a uniform assessment process that describes:

- (1) The information to be gathered;
- (2) Procedures for accepting a referral from another program, agency or organization;
- (3) Procedures for referring a patient to another program, agency or organization.

c. A substance use disorder treatment program, problem gambling treatment program, or substance use disorder and problem gambling treatment program shall update the assessment on an ongoing basis, when clinically indicated, and within the periods of time specified for each level of care in the management-of-care review process.

d. The results of each assessment shall be clearly explained to the patient, and to the patient's family when appropriate, and such explanation shall be documented in the patient record.

e. At the time of admission, a substance use disorder treatment program, problem gambling treatment program, or substance use disorder and problem gambling treatment program shall document that the patient has been informed of:

- (1) The general nature and goals of the program;
- (2) Rules governing patient conduct and infractions that can lead to disciplinary action or discharge from the program;
- (3) The hours during which services are available;
- (4) The costs to be borne by the patient;
- (5) Patient rights and responsibilities;
- (6) Confidentiality laws, rules and regulations; and
- (7) Safety and emergency procedures.

155.21(12) *Treatment plans.* The policies and procedures for substance use disorder treatment programs, problem gambling treatment programs, and substance use disorder and problem gambling treatment programs shall describe the program's uniform process for developing individualized treatment plans based on ongoing assessment and documentation of such plans in the patient record.

a. Staff shall initiate development of the treatment plan as soon after the patient's admission as is clinically feasible and within the period of time between admission and the review date specified for that level of care in the management-of-care review process.

b. The treatment plan shall minimally contain:

- (1) A summary of assessment findings;
- (2) Patient short- and long-term goals;
- (3) The type and frequency of planned treatment activities;
- (4) The staff responsible for the patient's treatment; and
- (5) Culturally and environmentally specific considerations.

c. Staff shall develop each treatment plan in partnership with the patient, with patient participation documented in the patient record. The treatment plan shall be written in a manner clearly understandable to the patient. Staff shall give the patient a copy of each treatment plan. The patient and staff shall review and revise the treatment plan when clinically indicated and in accordance with the time frames specified in the management-of-care review process.

d. Treatment plan reviews shall be based on ongoing assessment and shall specify the indicated level of care and licensed program services and any revision of treatment plan goals. The date of the review and any revision of the treatment plan shall be documented in the patient record.

155.21(13) *Progress notes.* The policies and procedures for substance use disorder treatment programs, problem gambling treatment programs, and substance use disorder and problem gambling treatment programs shall describe the program's uniform process for reviewing a patient's current status and progress in meeting treatment plan goals and documenting such review in the patient record.

- a. Progress notes shall include the date each service was provided or observation was made and the name and title of the staff person providing each service.
- b. Staff shall enter a progress note following each individual counseling session.
- c. Staff shall enter a summary progress note at least weekly for group counseling sessions.
- d. Progress notes that involve subjective interpretations of a patient's status or progress should be supplemented with a description of the behavioral observations that were the basis for the interpretation.

155.21(14) Patient record contents. The program's policies and procedures shall require that a record be maintained for each patient and shall specify the contents of the patient record.

- a. The patient record shall include:
 - (1) Any screening;
 - (2) Each assessment;
 - (3) Results of any physical examination or laboratory test;
 - (4) Admission information;
 - (5) Any report from a referring source or outside resource;
 - (6) Notes from any case conference, consultation, care coordination or case management;
 - (7) Any correspondence related to the patient, including letters, electronic communications and telephone conversations;
 - (8) Any treatment consent form;
 - (9) Any release of information or authorization to disclose;
 - (10) Notes on any service provided; and
 - (11) Any incident report.
- b. For substance use disorder treatment programs, problem gambling treatment programs, and substance use disorder and problem gambling treatment programs, the patient record shall also include:
 - (1) Treatment plans;
 - (2) Management-of-care reviews;
 - (3) Medication records, which shall allow for the monitoring of all medications administered and self-administered and detection of adverse drug reactions;
 - (4) Progress notes;
 - (5) Discharge summaries completed within 30 days of discharge, which shall be sufficiently detailed to identify the types of services the patient received, action taken to address specific problems identified, and plans for services and referrals postdischarge.
- c. For problem gambling treatment programs and substance use disorder and problem gambling treatment programs, the patient record shall also include documentation of financial counseling services that assist problem gambling patients in preparing a budget and addressing financial debt options, including restitution and bankruptcy.

155.21(15) Drug screening. The program's policies and procedures shall address collection of drug-screening specimens and utilization of drug-screening results. Such policies may state that the program does not conduct drug screening.

- a. A specimen obtained from a patient shall be collected under direct supervision and analyzed in accordance with program policies, or the program shall have a policy in place to reduce the patient's ability to alter the drug screening.
- b. Any laboratory used by the program for drug screening and analysis shall comply with federal and state requirements.
- c. A program conducting on-site drug screening shall comply with the Clinical Laboratory Improvement Act regulations as amended to August 1, 2025.
- d. The manner in which drug-screening results are utilized shall be documented in the patient record.

155.21(16) Medical and mental health services. The program's policies and procedures shall address patient medical and mental health conditions.

a. In addition to assessment of biomedical conditions and complications as described in the ASAM criteria, the program shall take a medical history and perform a physical examination and necessary laboratory tests as follows for patients admitted to the level of care specified:

(1) Medically managed intensive inpatient treatment and medically monitored intensive inpatient treatment: within 24 hours of admission.

(2) Clinically managed high-intensity residential treatment and clinically managed medium-intensity residential treatment: within seven days of admission.

(3) Clinically managed low-intensity residential treatment: within 21 days of admission.

(4) Crisis stabilization services and opioid treatment program services: within 24 hours of admission.

b. A program may accept a medical history or physical examination from a qualified source if the history or examination was completed no more than 90 days prior to the patient's current admission.

c. In addition to assessment of emotional, behavioral, and cognitive conditions and complications as described in the ASAM criteria, a program may accept a mental health history from a qualified source if the history was completed no more than three days prior to the patient's current admission.

155.21(17) *Emergency services.* The program's policies and procedures shall address the availability of emergency services for substance use disorders and medical and mental health conditions.

a. Emergency services shall be available 24 hours a day, seven days a week.

b. Emergency services may be provided by the program or by any other qualified individual, institution, facility, or other legal entity.

c. The program shall communicate the availability of emergency services by posting notice at facilities, having a recorded message on the program's telephone system, posting notice on the program's website and through program materials.

155.21(18) *Medication control.* The program's policies and procedures shall describe how medications are administered or self-administered in accordance with federal, state and local laws, rules and regulations. Such policies may state that the program does not conduct medication administration or self-administration.

a. Staff authorized to administer medications shall be qualified, and a current list of such staff shall be maintained.

b. Medication shall be administered only in accordance with the instructions of the attending prescriber. The type and amount of the medication, the time and date, and the staff person administering the medication shall be documented in the patient record.

c. Self-administration of medication shall be observed by a staff person who has been oriented to the program's policies and procedures on self-administration. Self-administration of medication shall be permitted only when the patient's medication is clearly labeled. The policies and procedures on self-administration shall include:

(1) Medications are ordered or prescribed by a prescriber.

(2) The prescriber agrees that the patient can self-administer the medication.

(3) The medication taken and how and when the medication is taken are documented in the patient record.

d. Prescription medication shall not be administered to or self-administered by a patient without a written order signed by a prescriber. All prescribed medications shall be clearly labeled indicating the patient's full name, the prescriber's name, the prescription number, the name and strength of the medication, the dosage, the directions for use, and the date of issue and the name, address and telephone number of the pharmacy or prescriber issuing the medication. Medications shall be packaged and labeled according to state and federal guidelines.

e. If a medication the patient brings to the program is not used, it shall be packaged, sealed and stored. The sealed package of medication shall be returned to the patient, family or designee at the time of discharge.

f. Accountability and control of medications.

(1) There shall be a specific routine for medication administration, indicating dose schedules and standardization of abbreviations.

(2) There shall be specific methods for control and accountability of medication products throughout the program.

(3) The staff person in charge of medications shall provide for monthly inspection of all storage units.

(4) Prescription medication containers having soiled, damaged, illegible, or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or prescriber for relabeling or disposal.

(5) Unused prescription medication prescribed for a patient who leaves a program without the patient's medication shall be destroyed by a staff person with a staff witness, and a notation shall be made in the patient record. When a patient is discharged or leaves the program, medication currently being administered shall be sent, in the original container, with the patient or with a responsible agent, as approved by a prescriber.

g. Medication storage shall be maintained in accordance with the security requirements of federal, state and local laws.

(1) All medication shall be maintained in locked storage. Controlled substances shall be maintained in a locked box within the locked cabinet.

(2) Medications requiring refrigeration shall be kept in a refrigerator and separated from food and other items.

(3) Disinfectants and medication for external use shall be stored separately from internal and injectable medications.

(4) The medication for each patient shall be stored in the original container.

(5) All poisonous or caustic medication shall be plainly labeled; stored separately from other medication in a specific well-illuminated cabinet, closet, or storeroom and made accessible only to authorized staff.

h. Prescription medication provided to a patient shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Iowa Code, from a licensed pharmacy in another state according to the laws of that state, or by a licensed prescriber.

i. Prescription medication prescribed for one patient shall not be administered to or allowed to be in the possession of another patient.

j. Any unusual patient reaction to a medication shall be documented in the patient record and reported to the prescriber immediately.

k. Dilution or reconstitution and labeling of medication shall be done only by a licensed pharmacist.

155.21(19) *Management of care and discharge planning.* The program's policies and procedures shall use the ASAM criteria for assessment, admission, continued service and discharge decisions and shall describe management-of-care processes.

a. The program shall conduct care coordination to meet each patient's needs and promote effective outcomes.

b. The program shall conduct management-of-care activities at least minimally within the time frames specified for each level of care.

(1) Medically managed intensive inpatient treatment and medically monitored intensive inpatient treatment: daily.

(2) Clinically managed high-intensity residential treatment, clinically managed medium-intensity residential treatment, partial/day treatment, and intensive outpatient treatment: within seven days of the patient's admission.

(3) Clinically managed low-intensity residential treatment and outpatient treatment: within 30 days of the patient's admission.

c. The program shall coordinate patient care with other programs for any licensed program service for which the program is not licensed and with qualified individuals and organizations for any related services the program does not provide, such as crisis stabilization, medical services, mental health services, and social services.

d. At the time of the patient's admission, the program shall initiate discharge planning that includes a determination of the patient's continued need for licensed program services and development of a plan to address ongoing patient needs postdischarge.

155.21(20) *Quality improvement.* The program's policies and procedures shall describe a written quality improvement plan that encompasses all licensed program services and related program operations.

a. The program shall designate a staff person responsible for the quality improvement plan.

b. The quality improvement plan shall describe and document monitoring, problem-solving and evaluation activities designed to systematically identify and resolve problems and make continued improvements.

(1) The quality improvement plan shall include specific goals, objectives, and methods.

(2) The quality improvement plan shall include objective criteria to measure its effectiveness.

c. The program shall document whether the quality of patient care and program operations are improved and identified problems are resolved.

d. The program shall communicate quality improvement plan activities and findings to all staff.

e. Quality improvement plan findings are used to detect trends, patterns of performance, and potential problems that affect patient care and program operations.

f. The program shall evaluate the effectiveness of the quality improvement plan at least annually and revise the plan as necessary.

155.21(21) *Facility safety and cleanliness.* The program's policies and procedures shall ensure that program physical facilities are clean, well-ventilated, heated, free from vermin, and appropriately furnished and are designed, constructed, equipped, and maintained in a manner that provides for the physical safety of patients, concerned persons, visitors and staff.

a. If required by local jurisdiction, the program shall maintain a certification of occupancy.

b. During all phases of construction or alterations of buildings, the level of life safety shall not be diminished in any occupied area. The construction shall be in compliance with all applicable federal, state, and local codes. New construction shall comply with Iowa Code chapter 104A and all applicable federal and local codes and provide for safe and convenient use by disabled individuals.

c. The program shall have specific policies and procedures for each of the following:

(1) Identification, development, implementation, maintenance and review of safety policies and procedures.

(2) Promotion and maintenance of an ongoing, facilitywide hazard surveillance program to detect and report all safety hazards.

(3) Safe and proper disposal of biohazardous waste.

(4) Stairways, halls, and aisles that shall be of substantial, nonslippery material, maintained in a good state of repair, adequately lighted and kept free from obstructions at all times. All stairways shall have handrails.

(5) Radiators, registers, and steam and hot water pipes, each of which shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

(6) For programs serving juveniles, fuse boxes that shall be under lock and key or six feet above the floor.

(7) Safe and proper handling and storage of hazardous materials.

(8) Prohibition against weapon possession; safe and proper removal of weapons.

(9) Swimming pools that shall conform to state and local health and safety rules and regulations. Adult supervision shall be provided at all times when juveniles are using the pool.

(10) Ponds, lakes, or any bodies of water located on or near the program and accessible to patients, concerned persons, visitors and staff.

(11) The written plan to be followed in the event of fire or tornado. The plan shall be conspicuously displayed at the facility.

155.21(22) *Therapeutic environment.* The program's policies and procedures shall provide for the establishment of an environment that preserves human dignity. Program facilities shall have adequate space for the program to provide licensed program services.

a. The program's policies and procedures shall include a description of how all licensed program services are accessible to people with disabilities or how the program provides accommodations for people with disabilities. All programs shall comply with the Americans with Disabilities Act as amended to August 1, 2025.

b. The waiting or reception areas shall be of adequate size and be located so as to ensure patient confidentiality.

c. Staff shall be available in waiting or reception areas to address the needs of the patients, potential patients, concerned persons, and visitors.

d. The program's policies and procedures shall include:

- (1) Possession and use of chemical substances in the facility.
- (2) Prohibition of smoking.
- (3) Prohibition of the sale or other provision of any tobacco product.
- (4) Informing patients of their legal and human rights at the time of admission.
- (5) Patient communication, opinions, or grievances, with a mechanism for redress.
- (6) Prohibition of sexual harassment.
- (7) Patient right to privacy.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.22(125,135) Inpatient and residential program facilities. Specific standards apply for programs providing clinically managed low-intensity residential treatment, clinically managed medium-intensity residential treatment, clinically managed high-intensity residential treatment, medically monitored intensive inpatient treatment, and medically managed intensive inpatient treatment. The program's policies and procedures shall address each standard.

155.22(1) *Health and fire safety inspections.* Inpatient and residential programs shall comply with applicable department of inspections, appeals, and licensing rules; state fire marshal's rules and fire ordinances; and applicable local health, fire, occupancy, and safety regulations. The program shall maintain documentation of such compliance.

a. Inpatient and residential programs shall comply with standards for food service sanitation in accordance with rules promulgated by the department of inspections, appeals, and licensing pursuant to 481—Chapter 30 and Iowa Code chapter 137F.

b. The use of door locks or closed sections shall be documented in written policies and procedures approved by the fire marshal and governing body.

155.22(2) *Emergency preparedness.* Inpatient and residential programs shall have a written emergency preparedness plan for continuation of licensed program services during an emergency or disaster.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.23(125,135) Specific standards for inpatient and residential programs. The program's policies and procedures shall address each standard.

155.23(1) *Hours of operation.* Inpatient and residential programs shall operate seven days per week, 24 hours per day.

155.23(2) *Meals.* Inpatient and residential programs shall provide a minimum of three meals per day to each patient. A program where patients are not present during mealtime shall make provisions to make available the necessary meals. Menus shall be prepared in consultation with a dietitian. If

patients are allowed to prepare meals, the program shall document conformity with all commonly accepted policies and procedures of state health rules and regulations and food hygiene.

155.23(3) *Consultation with counsel.* Patients shall have opportunity for and access to consultation with legal counsel at any reasonable time.

155.23(4) *Visitation with family and friends.*

a. Each patient shall have opportunities for continuing contact with family and friends. If such contact is clinically contraindicated, it may be restricted. Any restriction shall be approved by the treatment supervisor and the executive director. Justification for the restriction shall be documented in the patient record. Any restriction shall be reviewed within three calendar days by the treatment supervisor, who may continue or end the restriction. Continuation of a restriction shall be documented in the patient record and shall be reviewed by the treatment supervisor every three calendar days.

b. The program shall establish visiting hours, which shall be conspicuously displayed at the facility in such a manner to be visible to those entering the facility.

155.23(5) *Telephone use.*

a. Each patient shall have opportunities to conduct private telephone conversations. If such conversations are clinically contraindicated, they may be restricted. Any restriction shall be approved by the treatment supervisor and the executive director. Justification for the restriction shall be documented in the patient record. Any restriction shall be reviewed within three calendar days by the treatment supervisor, who may continue or end the restriction. Continuation of a restriction shall be documented in the patient record and shall be reviewed by the treatment supervisor every three calendar days.

b. The program shall establish telephone hours. Emergency telephone conversations may be received at the time of the call or made when necessary.

155.23(6) *Written communication.*

a. Each patient shall have opportunities to conduct private written communications. If such communications are clinically contraindicated, they may be restricted. Any restriction shall be approved by the treatment supervisor and the executive director. Justification for the restriction shall be documented in the patient record. Any restriction shall be reviewed within three calendar days by the treatment supervisor, who may continue or end the restriction. Continuation of a restriction shall be documented in the patient record and shall be reviewed by the treatment supervisor every three calendar days.

b. The program shall establish access to written communications. The program shall not intercept, read, or censor the U.S. mail.

155.23(7) *Facility.* Inpatient and residential program facilities shall be appropriate for 24-hour occupancy.

a. Patient bedrooms shall include:

- (1) A sturdily constructed bed;
- (2) A clean mattress protected with a clean mattress pad;
- (3) A designated space for personal possessions and for hanging clothing in proximity to the sleeping area; and

- (4) Curtains or window blinds on any windows.

b. Sleeping areas.

- (1) Sleeping areas shall include doors for privacy.
- (2) Sleeping areas shall include partitioning or placement of furniture to provide privacy for all patients.

- (3) The number of patients in a room shall be appropriate to the goals of the facility and to the ages, developmental levels, and clinical needs of the patients.

- (4) Patients will be allowed to keep and display personal belongings and add personal touches to the decoration of their rooms in accordance with program policy.

- (5) Staff shall respect the patient's right to privacy by knocking on the door of the patient's room before entering.

c. Clean linen, towels and washcloths shall be available minimally on a weekly basis and more often as needed.

d. Bathrooms.

(1) Bathrooms shall provide the facilities necessary for patients' personal hygiene and personal privacy, including:

1. A safe supply of hot and cold running potable water;
2. Clean towels, electric hand dryers or paper towel dispensers, toilet paper and soap;
3. Natural or mechanical ventilation capable of removing odors;
4. Tubs or showers that have slip-proof surfaces;
5. Partitions with doors that provide privacy if a bathroom has multiple toilet stools; and
6. Toilets, wash basins, and other plumbing or sanitary facilities that shall at all times be maintained in good operating condition.

(2) The ratio of bathroom facilities to inpatient and residential patients shall be one tub or shower head per 12 patients, one wash basin per 12 patients and one toilet per 8 patients.

(3) If the facility is coeducational, the program shall designate and so identify separate bathrooms for male and female patients.

e. The written plan to be followed in the event of fire or tornado shall be conspicuously displayed on each floor or in each area that patients, concerned persons, staff or visitors occupy at the facility and shall be explained to all inpatient and residential patients as a part of their orientation to the program. Fire drills shall be conducted at least monthly, and tornado drills shall be conducted monthly from April through October.

f. Written reports of annual inspections by state or local fire safety officials or private fire protection companies approved by the department shall be maintained with records of corrective action taken by the program based on recommendations articulated in such reports.

g. Every facility shall have an adequate water supply from an approved source. A municipal water system shall meet this requirement. Private water sources shall be tested annually.

h. The facility shall allow for the following:

- (1) Areas in which a patient may be alone when appropriate; and
- (2) Areas for private conversations with others.

i. Articles of grooming and personal hygiene that are appropriate to the patient's age, developmental level, and clinical state shall be readily available in a space reserved near the patient's sleeping area. If access to such articles is clinically contraindicated as approved by the treatment supervisor, a patient's personal articles may be kept under lock and key by staff. Staff shall explain to the patient the conditions under which the articles may be used. Justification for this restriction shall be documented in the patient record.

j. If patients maintain their own living quarters or perform day-to-day housekeeping activities, these responsibilities shall be clearly defined in writing and be a part of the patient orientation program. Staff assistance and equipment shall be provided as needed.

k. Patients shall be allowed to wear their own clothing in accordance with program rules. If clothing is provided by programs, it shall be suited to the climate and appropriate. A laundry room shall be accessible so patients may wash their clothing.

l. The program shall ensure that the use and location of noise-producing equipment and appliances, such as television sets, radios, computers, and CD players, do not interfere with clinical and therapeutic activities.

m. The program shall provide recreation and outdoor activities unless clinically contraindicated.

155.23(8) Religion-culture. Program policies and procedures shall include a written description of any religious orientation, religious practice, or religious restrictions. For juvenile patients, this description shall be provided to the patient, parent(s) or guardian, and placing agency at the time of admission in compliance with HIPAA as amended to August 1, 2025, and U.S. Department of Health and Human Services (DHHS), 42 CFR Part 2 as amended to August 1, 2025, regulations on the confidentiality of alcohol and drug abuse patient records. For adult patients, this information

shall be available during orientation. The patient shall have the opportunity to participate in religious activities and services in accordance with the patient's faith or that of a patient's parent(s) or guardian if the patient is a minor. The program shall, when necessary and reasonable, arrange transportation to religious activities.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.24(125,135) Specific standards for inpatient and residential programs licensed to provide services to juveniles. Inpatient and residential programs that provide services to juveniles under the age of 18 shall also comply with the following standards. The program's policies and procedures shall address each standard.

155.24(1) *Personal possessions.* A program shall allow a patient to bring personal belongings. The program may limit or supervise the use of these items. The program shall ensure that each patient has adequate, clean, well-fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being. The clothes should be appropriate to the patient's individual needs, age, and sex.

155.24(2) *Family involvement.* The program shall encourage family involvement.

155.24(3) *Money.* Money earned or received as a gift or as an allowance by a patient shall be that patient's personal property. The program shall maintain a separate accounting system for patient money and shall address the patient's use of funds.

155.24(4) *Discipline.* The program's methods for control and discipline of juveniles shall be available to all staff and to the juvenile's family. Staff shall be in control of and responsible for discipline at all times. Discipline shall not include withholding basic necessities such as food, clothing, or sleep.

a. The program shall prohibit staff or patients from utilizing corporal punishment as a method of disciplining or correcting patients. This policy shall be communicated in writing to all staff.

b. The program's written policies on behavior expectations shall be made available to the patient and the patient's parent(s) or guardian, including:

(1) The general expectations of behavior, including the program's rules and practices.

(2) The range of reasonable consequences that may be used to deal with inappropriate behavior.

155.24(5) *Number of staff.* The program shall have staff coverage seven days per week, 24 hours per day. The number and qualifications of the staff will vary depending on the needs of the patients.

a. The program shall have a 24-hour supervisory consultation on-call system. During prime programming time, there shall be at least a one-to-eight staff-to-patient ratio.

b. Comprehensive residential facilities, as defined in 441—Chapter 115, shall have at least a one-to-five staff-to-patient ratio during prime programming time. A staff person shall be in each living unit at all times when juveniles are in residence, and there shall be a minimum of three nighttime checks between the hours of 12 midnight and 6 a.m. These checks shall be logged. The program's policies and procedures shall address nighttime checks.

c. The program shall define its prime programming time.

155.24(6) *Illness, accident, death, or absence from the inpatient or residential program.* The program shall notify the patient's parent(s), guardian, and responsible agency of any serious illness, incident involving serious bodily injury, absence, or removal of the juvenile from the facility in compliance with HIPAA as amended to August 1, 2025, and DHHS, 42 CFR Part 2 as amended to August 1, 2025, regulations on the confidentiality of alcohol and drug abuse patient records. In the event of the death of a patient, the program shall immediately notify the prescriber, the patient's parent(s) or guardian, the placing agency, and the appropriate state authority.

155.24(7) *Educational services.* The program's educational program shall meet the requirements of the department of education and shall be available for each patient in accordance with abilities and needs.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.25(125,135) Specific standards for substance use assessment and OWI evaluation-only programs. Programs that provide substance use assessment and OWI evaluation-only services shall also comply with the following standards. The program's policies and procedures shall address each standard.

155.25(1) A program conducting OWI evaluations on persons convicted of operating a motor vehicle while intoxicated (OWI) pursuant to Iowa Code section 321J.2 and on persons whose driver's license or nonresident operating privileges are revoked under Iowa Code chapter 321J shall do so in accordance with 641—Chapter 157.

155.25(2) The program shall make its fees public and shall inform potential patients of the fee at the time the assessment or evaluation is scheduled.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.26 to 155.33 Reserved.

641—155.34(125,135) Specific standards for enhanced treatment services.

155.34(1) Standards. Substance use disorder and problem gambling treatment programs licensed to provide enhanced treatment services shall also comply with the following standards. The program's policies and procedures shall address each standard.

155.34(2) Personnel. The program shall meet the requirements in subrule 155.21(8). In addition:

a. The program's policies and procedures shall include job descriptions for positions that provide prevention services for substance use disorders and problem gambling, treatment for substance use disorders and problem gambling, services for medical conditions, and services for mental health conditions.

b. The program shall have staff on site who are qualified to provide prevention and early intervention services for substance use disorders and problem gambling, treatment for substance use disorders and problem gambling, services for medical conditions, and services for mental health conditions.

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

641—155.35(125,135) Specific standards for opioid treatment programs. All programs that use methadone or other medications approved by the Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355 as amended to August 1, 2025) and by the state of Iowa for use in the treatment of opioid addiction shall comply with this rule; HIPAA, as amended to August 1, 2025; and Part II, DHHS, Substance Abuse and Mental Health Services Administration, 42 CFR Part 8, Opioid Drugs in Maintenance and Detoxification Treatment of Opioid Addiction, effective February 2, 2024, and as amended to August 1, 2025.

155.35(1) Required approvals. All opioid treatment programs shall be licensed or approved by the department and shall maintain all other approvals required by the federal Drug Enforcement Administration, SAMHSA and the Iowa board of pharmacy in order to provide services.

155.35(2) Central registry system. To prevent simultaneous enrollment of a patient in more than one program, all opioid treatment programs shall participate in a central registry as established by the department.

Prior to admission of an applicant to an opioid treatment program, the program shall submit to the registry the applicant's name, birth date, and date of intended admission, and any other information required for the clearance procedure. No person shall be admitted to a program who is found by the registry to be participating in another such program. All opioid treatment programs shall report all admissions, discharges, and transfers to the registry immediately. All information reported to the registry from the programs and all information reported to the programs from the registry shall be treated as confidential in accordance with HIPAA as amended to August 1, 2025, and regulations on the confidentiality of alcohol and drug abuse patient records, DHHS, 42 CFR Part 2 as amended to August 1, 2025.

a. Definitions. For purposes of this subrule:

“*Central registry*” means the system through which the department obtains patient identifying information about individuals applying for maintenance treatment for the purpose of preventing an individual’s concurrent enrollment in more than one such program.

“*Opioid treatment program*” means a withdrawal management or maintenance treatment program that is required to report patient identifying information to the central registry and that is located in the state.

b. Restrictions on disclosure.

(1) A program may disclose patient identifying information to a central registry for the purpose of preventing the multiple enrollment of a patient only if:

1. The disclosure is made when:
 - The patient is admitted for treatment; or
 - The treatment is interrupted, resumed or terminated.
2. The disclosure is limited to:
 - Patient identifying information; and
 - Relevant dates of admission.

(2) The program shall inform the patient of the required disclosure prior to admission.

c. Use of information limited to prevention of multiple enrollments. Any information disclosed to the central registry to prevent multiple enrollments shall not be redisclosed by the registry nor shall such information be used for any other purpose than the prevention of multiple enrollments unless so authorized by court order in accordance with HIPAA as amended to August 1, 2025, and 42 CFR Part 2 as amended to August 1, 2025.

d. Permitted disclosure by the central registry to prevent a multiple enrollment. If a program petitions the central registry and an identified patient is enrolled in another program, the registry may disclose:

(1) The name, address, and telephone number of the program in which the patient is currently enrolled to the inquiring program; and

(2) The name, address, and telephone number of the inquiring program to the program in which the patient is currently enrolled. The programs may communicate as necessary to verify that no error has been made and to prevent or eliminate any multiple enrollment.

155.35(3) *Admission requirements.*

a. Prior to or at the time of a patient’s admission to an opioid treatment program, the program shall conduct a comprehensive assessment so as to determine appropriateness for admission.

b. The program shall verify, to the extent possible, the patient’s name, address, and date of birth.

c. Determination and documentation.

(1) An OTP shall maintain current procedures designed to ensure that patients are admitted to treatment by qualified personnel who have determined, using accepted medical criteria, that:

1. The person meets diagnostic criteria for a moderate to severe OUD; or
2. The individual has an active moderate to severe OUD, or OUD in remission, or is at high risk for recurrence or overdose.

(2) Such decisions must be appropriately documented in the patient's clinical record. In addition, a health care practitioner shall ensure that each patient voluntarily chooses treatment with MOUD, that all relevant facts concerning the use of MOUD are clearly and adequately explained to the patient, and that each patient provides informed consent to treatment.

(3) When physiological addiction cannot be clearly documented, the program physician or an appropriately trained staff member designated and supervised by the physician shall record in the patient’s record the criteria used to determine the patient’s current physiologic dependence and history of addiction. In the latter circumstance, the program physician shall review, date, and countersign the supervised staff member’s evaluation to demonstrate the physician’s agreement with the evaluation. The program physician shall make the final determination concerning a patient’s physiologic dependence and history of addiction.

(4) When a patient has voluntarily left an opioid treatment program in good standing and seeks readmission within two years of discharge, the program shall document the following information about the patient:

1. Prior opioid treatment of six months or more; and
2. That in the physician's medical judgment, treatment of the patient is warranted. Such documentation shall be entered in the patient's record by the program physician.

d. The program shall collect a drug screening sample for analysis. Where dependence is substantially verified through other indicators, a negative drug screen will not necessarily preclude admission to the program.

e. Prior to a patient's admission, the program shall confirm with the central registry that the patient is not currently enrolled in another opioid treatment program.

f. If a potential patient has previously been enrolled in another program, the admitting program shall request from the previous program a copy of the patient's assessment data, treatment plan, and discharge summary including the type of or reason for discharge. All programs subject to these rules shall promptly respond to such a request upon receipt of a valid release of information.

g. A person under the age of 18 is required to have had two documented attempts at short-term withdrawal management or drug-free treatment to be eligible for maintenance treatment. A one-week waiting period is required after such a short-term withdrawal management attempt, however, before an attempt is repeated. The program physician shall document in the patient's record that the patient continues to be, or is again, physiologically dependent on narcotic drugs. No person under 18 years of age may be admitted to OTP treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.

h. Program staff shall ensure that a patient is voluntarily participating in the program, and the patient shall sign a Consent to Treatment Form.

i. Pregnant patients may be admitted to opioid treatment in accordance with the following provisions:

- (1) Evidence of current physiological dependency is not needed if the program physician certifies the pregnancy and, in the physician's reasonable judgment, finds treatment to be justified. Documentation of all findings and justifications for admission shall be documented in the patient's record by the program physician prior to the administration of the initial dose of medication.

- (2) Pregnant patients shall be offered comprehensive prenatal care. If the program cannot provide prenatal services, the program shall assist the patient in obtaining such services and shall coordinate ongoing care with the collateral provider.

- (3) The program physician shall document that the patient has been informed of the possible risks to the unborn child from the use of medication and the risks of continued use of illicit substances.

- (4) Should a program have a waiting list for admission to the program, pregnant patients shall be given priority.

155.35(4) *Placement, admission and assessment.* The program shall have written criteria for considering an individual for placement and admission. In addition, the program shall maintain current procedures to ensure that patients are admitted to maintenance treatment by qualified staff who have determined by using accepted medical criteria, such as those outlined in the DSM.

a. The program shall require each patient to undergo an initial medical examination. The initial medical examination is comprised of two parts:

- (1) A screening examination to ensure that the patient meets criteria for admission and that there are no contraindications to treatment with MOUD; and

- (2) A full history and examination to determine the patient's broader health status, with lab testing as determined to be required by an appropriately licensed practitioner. A patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude the patient from access to treatment, provided such refusal does not have potential to negatively impact treatment with medications.

b. Assuming there are no contraindications, a patient may commence treatment with MOUD after the screening examination has been completed. Both the screening examination and full examination must be completed by an appropriately licensed practitioner. If the licensed practitioner is not an OTP practitioner, the screening examination must be completed no more than seven days prior to OTP admission. Where the examination is performed outside of the OTP, the written results and narrative of the examination, as well as available lab testing results, must be transmitted, consistent with applicable privacy laws, to the OTP and verified by an OTP practitioner.

c. A full in-person physical examination, including the results of serology and other tests that are considered to be clinically appropriate, must be completed within 14 calendar days following a patient's admission to the OTP. The full examination can be completed by a non-OTP practitioner if the examination is verified by a licensed OTP practitioner as being true and accurate and transmitted in accordance with applicable privacy laws.

d. Serology testing and other testing as deemed medically appropriate by the licensed OTP practitioner based on the screening or full history and examination, drawn not more than 30 days prior to admission to the OTP, may form part of the full history and examination.

e. The screening and full examination may be completed via telehealth for those patients being admitted for treatment at the OTP with either buprenorphine or methadone if a practitioner or primary care provider determines that an adequate evaluation of the patient can be accomplished via telehealth. When using telehealth, the following caveats apply:

(1) In evaluating patients for treatment with Schedule II medications (such as methadone), audiovisual telehealth platforms must be used, except when not available to the patient, in which case, it is acceptable to use audio-only devices but only when the patient is in the presence of a licensed practitioner who is registered to prescribe (including dispense) controlled medications. The OTP practitioner shall review the examination results and order treatment medications as indicated.

(2) In evaluating patients for treatment with Schedule III medications or medications not classified as a controlled medication, audiovisual or audio-only platforms may be used. The OTP practitioner shall review the examination results and order treatment medications as indicated.

f. The medical evaluation of the patient shall include but not be limited to:

- (1) A complete medical history;
- (2) An assessment of the patient's current psychological and mental status;
- (3) A physical examination, including examination for:
 1. Pulmonary, liver, or cardiac abnormalities;
 2. Infectious disease; and
 3. Dermatologic sequela of addiction;
- (4) Laboratory tests, including:
 1. Serological test for syphilis; and
 2. Urine screening for drugs;
- (5) An intradermal PPD (tuberculosis skin test) and review of tetanus immunization status; and
- (6) When indicated, an EKG, chest X-ray, pap smear, pregnancy test, sickle cell screening, complete blood count and white cell differential, multiphasic chemistry profile, routine and microscopic urinalysis, or other tests indicated by the patient's condition. A patient's refusal to undergo lab testing for co-occurring physical health conditions should not preclude the patient from access to treatment, provided such refusal does not have potential to negatively impact treatment with medications.

155.35(5) Treatment plans. Based upon the initial assessment, an individualized written treatment plan shall be developed and recorded in the patient's case record.

a. A treatment plan shall be developed and shall delineate the patient's immediate needs and the actions required to meet these needs.

b. The treatment plan shall be developed as soon after the patient's admission as is clinically feasible but no later than 30 days following the patient's admission to an outpatient opioid maintenance treatment program.

c. Treatment plans shall be developed in partnership with the patient. Comprehensive treatment plans shall be reviewed by the primary counselor and the patient as often as necessary but no less than every 90 days during the first year and semiannually each subsequent year for opioid treatment modalities. Treatment plans shall be reviewed by the program physician on an annual basis.

155.35(6) *Rehabilitative services.*

a. OTPs must provide adequate substance use disorder counseling and psychoeducation to each patient as clinically necessary and mutually agreed upon, including harm reduction education and recovery-oriented counseling. This counseling shall be provided by a program counselor, qualified by education, training, or experience to assess the psychological and sociological background of patients and engage with patients, to contribute to the appropriate care plan for the patient and to monitor and update patient progress. Patient refusal of counseling shall not preclude the patient from receiving MOUD.

b. OTPs must provide counseling on preventing exposure to, and the transmission of, human immunodeficiency virus (HIV), viral hepatitis, and sexually transmitted infections (STIs) and either directly provide services and treatments or actively link to treatment each patient admitted or readmitted to treatment who has received positive test results for these conditions from an initial or periodic medical examination.

c. OTPs must provide directly, or through referral to adequate and reasonably accessible community resources, vocational training, education, and employment services for patients who request such services or for whom these needs have been identified and mutually agreed upon as beneficial by the patient and program staff.

155.35(7) *Medication administration.*

a. The program physician shall determine the patient's initial and subsequent dose of medication and on-site dosing schedule and shall assume responsibility for the amount of the narcotic drug administered or dispensed and shall record, date, and sign in each patient's case record each change in the dosage schedule. The physician shall directly communicate orders to the pharmacy or registered or licensed personnel supervising medication administration. The program physician may communicate such orders verbally; however, orders shall be reduced to writing and countersigned within 72 hours by the program physician.

b. For each new patient enrolled in an OTP, the initial dose of methadone shall be individually determined and shall include consideration of the type(s) of opioid(s) involved in the patient's OUD, other medications or substances being taken, medical history, and severity of opioid withdrawal. The total dose for the first day should not exceed 50 milligrams unless the OTP practitioner, licensed under the appropriate state law and registered under the appropriate state and federal laws to administer or dispense MOUD, finds sufficient medical rationale, including but not limited to if the patient is transferring from another OTP on a higher dose that has been verified, and documents in the patient's record that a higher dose was clinically indicated.

(1) Medication shall be administered by a professional authorized by law.

(2) No medication shall be administered until the patient has completed admission procedures unless the patient enters the program on a weekend and the central registry cannot be contacted. If, in the clinical judgment of the program physician, a patient is experiencing an emergency situation, the admission procedures may be completed on the following workday.

c. Administration.

(1) Take-home medication shall be labeled in accordance with state and federal law and have childproof caps.

(2) A medication administration log shall be kept in the dosing area and in the patient's case record. The amount of medication administered and the signature of the staff member authorized to administer the medication shall also be included in the patient's case record. No dose shall be administered until the patient has been positively identified and the dosage amount has been compared with the currently ordered and documented dosage level.

(3) Ingestion shall be observed and verified by the staff person authorized to administer the medication.

(4) The program physician shall record, date, and sign in each patient's case record each change in the dosage schedule. Daily dosages of medications in excess of 100 milligrams shall be dispensed only with the approval of the program physician and shall be documented and justified in the patient's case record.

155.35(8) *Take-home or unsupervised medication use.*

a. Unsupervised (take-home) medication doses may be provided under the following circumstances:

(1) Any patient in comprehensive treatment may receive individualized take-home doses as ordered for days that the clinic is closed for business, including one weekend day (e.g., Sunday) and state and federal holidays, no matter the patient's length of time in treatment.

(2) OTP decisions on dispensing MOUD to patients for unsupervised use shall be determined by an appropriately licensed OTP medical practitioner or the medical director. In determining which patients may receive unsupervised medication doses, the medical director or program medical practitioner shall consider, among other pertinent factors that indicate that the therapeutic benefits of unsupervised doses outweigh the risks, the following criteria:

1. Absence of active substance use disorders, other physical or behavioral health conditions that increase the risk of patient harm as it relates to the potential for overdose, or the ability to function safely;

2. Regularity of attendance for supervised medication administration;

3. Absence of serious behavioral problems that endanger the patient, the public or others;

4. Absence of known recent diversion activity;

5. Whether take-home medication can be safely transported and stored; and

6. Any other criteria that the medical director or medical practitioner considers relevant to the patient's safety and the public's health.

(3) Such determinations and the basis for such determinations consistent with the criteria outlined shall be documented in the patient's medical record. If it is determined that a patient is safely able to manage unsupervised doses of MOUD, the dispensing restrictions set forth in this rule apply. The dispensing restrictions set forth in this rule do not apply to buprenorphine and buprenorphine products listed in this rule.

1. During the first 14 days of treatment, the take-home supply is limited to 7 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to seven days, but decisions must be based on the criteria listed in this rule. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record.

2. From 15 days of treatment, the take-home supply is limited to 14 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 14 days, but this determination must be based on the criteria listed in this rule. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record.

3. From 31 days of treatment, the take-home supply provided to a patient is not to exceed 28 days. It remains within the OTP practitioner's discretion to determine the number of take-home doses up to 28 days, but this determination must be based on the criteria listed in this subrule. The rationale underlying the decision to provide unsupervised doses of methadone must be documented in the patient's clinical record.

(4) OTPs must maintain current procedures adequate to identify the theft or diversion of take-home medications, including labeling containers with the OTP's name, address, and telephone number. Programs also must ensure that each individual take-home dose is packaged in a manner that is designed to reduce the risk of accidental ingestion, including child-proof containers. Programs must provide education to each patient on the following: safely transporting medication from the OTP to the patient's place of residence and the safe storage of take-home doses at the individual's place of

residence, including child and household safety precautions. The provision of this education should be documented in the patient's clinical record.

b. If a patient is unable to conform to the applicable mandatory schedule, a revised schedule may be permitted provided that the program receives an exception to these rules from the department and SAMHSA, when applicable. A copy of the written exception shall be placed in the patient's case record. The department will consider exceptions only in unusual circumstances. When a program is applying for less frequent pickups for patients, approval will be based on considerations in addition to distance if another program exists within 25 miles of the patient's residence.

c. Should a patient receiving take-home medication provide a drug screen that is confirmed either positive for substances or negative for the prescribed medication, the program shall ensure that, when test results are used, presumptive laboratory results are distinguished from results that are definitive.

155.35(9) *Drug testing.* Each program shall establish policies and procedures for the collection of drug-screening specimens and utilization of results.

a. The program shall ensure that an initial drug-screening test or analysis is completed for each prospective patient and that at least eight additional random tests or analyses are performed on each patient during the patient's first year in maintenance treatment and that at least quarterly random tests or analyses are performed on each patient in maintenance treatment for each subsequent year. When a sample is collected from each patient for such a test or analysis, it shall be done in a manner that minimizes opportunity for falsification. Each test or analysis shall be analyzed for opioids, methadone, amphetamines, cocaine, and barbiturates. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each test or analysis must be analyzed for any of those drugs as well. Any laboratory that performs the testing required under this rule shall be in compliance with all applicable federal proficiency testing and licensing standards and all applicable state standards.

b. The program shall ensure that test results are not used as the sole criterion to force a patient out of treatment but are used as a guide to change treatment approaches. The program shall also ensure that when test results are used, presumptive laboratory results are distinguished from results that are definitive.

155.35(10) *Diversion prevention plan.*

a. The program shall develop a diversion identification and prevention plan that:

(1) Outlines the methods by which the program shall detect possible diversion of take-home medication; and

(2) Describes the actions to be taken when diversion is identified or suspected.

b. The program shall establish and implement proactive procedures to reduce the likelihood or possibility of diversion.

155.35(11) *Interim maintenance treatment.*

a. An approved program may offer interim maintenance treatment when, due to capacity, the program cannot place the patient in a program offering comprehensive services within 14 days of the patient's application for admission.

b. An approved program may provide interim maintenance treatment only if the program also provides comprehensive maintenance treatment to which interim maintenance treatment patients may be transferred.

c. Interim maintenance treatment program approval.

(1) Before a public or nonprofit private narcotic treatment program may provide interim maintenance treatment:

1. The program must receive approval of both the U.S. Food and Drug Administration and the department; and

2. The program director must certify that the program seeking such authorization is unable to place patients in a public or private nonprofit program within a reasonable geographic area within 14

days of the patient's application for admission and that interim maintenance treatment will not reduce the capacity of the program's comprehensive maintenance treatment.

(2) Patients admitted to interim maintenance treatment shall be transferred to comprehensive maintenance treatment within 120 days of admission.

d. Minimum standards for interim maintenance treatment. The program may admit a patient who is eligible for comprehensive maintenance treatment to interim maintenance treatment if the patient cannot be placed in a public or private nonprofit comprehensive program within a reasonable geographic area and within 14 days of application for services. An initial drug screen and at least two other drug screens shall be taken from the patient during the maximum admission period of 120 days. A program shall establish and follow reasonable criteria for determining the transfer of patients to comprehensive maintenance treatment. These transfer criteria shall be in writing and available for inspection and shall include at a minimum a preference for the transfer of pregnant patients. Interim maintenance shall be conducted in accordance with all applicable federal regulations and state rules. The program shall notify the department when a patient begins interim treatment, when a patient leaves interim treatment, and when a patient transfers to comprehensive maintenance treatment. Such notifications shall be documented by the program in the patient's case record. All requirements for comprehensive maintenance treatment apply to interim maintenance treatment, with the following exceptions:

- (1) The medication is required to be administered daily under observation;
- (2) Take-home medication is not allowed;
- (3) Initial and comprehensive treatment plans are not required;
- (4) A primary counselor is not required to be assigned to the patient; and
- (5) Interim maintenance treatment cannot be provided for longer than 120 days in any 12-month period.

155.35(12) Accreditation. All opioid treatment programs shall obtain and retain accreditation by a recognized national accreditation organization. The national accreditation bodies currently recognized as meeting committee criteria are:

- a.* The Joint Commission.
- b.* The Council on Accreditation of Rehabilitation Facilities (CARF).
- c.* The Council on Accreditation (COA).
- d.* The American Osteopathic Association (AOA).

[ARC 9499C, IAB 8/20/25, effective 10/1/25]

TUBERCULOSIS (TB) SCREENING: HEALTH CARE WORKERS AND RESIDENTS

641—155.36 Reserved.

641—155.37(125,135) Definitions. For the purpose of these rules, the following definitions shall apply:

“Bacille Calmette-Guerin vaccination” or *“BCG vaccination”* means a vaccine for tuberculosis (TB). BCG is used in many countries with a high prevalence of TB to prevent childhood tuberculosis meningitis and military disease. BCG is not generally recommended for use in the United States because of the low risk of infection with *Mycobacterium tuberculosis*, the variable effectiveness of the vaccine against adult pulmonary TB, and the vaccine's potential interference with tuberculin skin test reactivity.

“Baseline TB screening” means the screening of staff and residents for latent tuberculosis infection (LTBI) and TB disease at the beginning of employment or upon admission to a facility. Baseline TB screening includes a symptom screen for all staff and residents and tuberculin skin tests (TSTs) or interferon-gamma release assay (IGRA) for *Mycobacterium tuberculosis* for those staff and residents with previous negative test results for *M. tuberculosis* infection.

“Baseline TST” or *“baseline IGRA”* means the TST or IGRA, respectively, that is administered at the beginning of employment to newly hired staff or upon admission to residents of facilities.

“*Boosting*” means a phenomenon in which a person has a negative TST (i.e., false-negative) result years after infection with *M. tuberculosis* and then a positive subsequent TST result. The positive TST result is caused by a boosted immune response of previous sensitivity rather than by a new infection (false-positive TST conversion). Two-step testing reduces the likelihood of mistaking a boosted reaction for a new infection.

“*Extrapulmonary TB*” means TB disease in any part of the body other than the lungs (e.g., kidney, spine, or lymph nodes).

“*Interferon-gamma release assay*” or “*IGRA*” means a whole-blood test that can aid in diagnosing *Mycobacterium tuberculosis* infection.

“*Laryngeal TB*” means a form of TB disease that involves the larynx and may be highly infectious.

“*Latent TB infection*” or “*LTBI*” means infection with *M. tuberculosis* without symptoms or signs of disease having manifested.

“*Mantoux method*” means a skin test performed by intradermally injecting 0.1 mL of purified protein derivative (PPD) tuberculin solution into the volar or dorsal surface of the forearm.

“*Pulmonary TB*” means TB disease that occurs in the lung parenchyma, usually producing a cough that lasts three weeks or longer. Pulmonary TB is usually infectious.

“*Purified protein derivative (PPD) tuberculin*” means a material used in diagnostic tests for detecting infection with *M. tuberculosis*.

“*Risk classification*” means the category on which the infection control team, or designated other, determines the setting’s TB risk classification is based as a result of the TB risk assessment.

“*Serial screening*” refers to TB screening performed at regular intervals following baseline TB screening. Serial TB screening, also called annual or ongoing TB testing, consists of two components: (1) assessing for current symptoms of active TB disease and (2) testing for the presence of infection with *M. tuberculosis* by administering either a TST or single IGRA.

“*Symptom screen*” means a procedure used during a clinical evaluation in which patients are asked if they have experienced any departure from normal in function, appearance, or sensation related to TB disease (e.g., cough).

“*TB patient*” means a person who had undiagnosed infectious pulmonary or laryngeal TB while in the facility during the preceding year. “TB patient” does not include persons with LTBI (treated or untreated), extrapulmonary TB disease, pulmonary, or laryngeal TB who have met criteria for noninfectiousness.

“*TB risk assessment*” means an initial and ongoing evaluation of the risk for transmission of *M. tuberculosis* in a particular health care setting.

“*TB screening*” means an administrative control measure in which evaluation for LTBI and TB disease is performed through baseline and serial screening of staff and residents of facilities.

“*TB screening plan*” means a plan that facilities develop and implement that comprises four major components: (1) baseline testing for *M. tuberculosis* infection, (2) serial testing for *M. tuberculosis* infection, (3) serial screening for signs or symptoms of TB disease, and (4) TB training and education.

“*Treatment for LTBI*” means treatment that prevents the progression of *M. tuberculosis* infection into TB disease.

“*Tuberculin skin test*” or “*TST*” means a diagnostic aid for finding *M. tuberculosis* infection. The Mantoux method is the recommended method to be used for the TST.

“*Tuberculosis*” or “*TB*” means the namesake member organism of *M. tuberculosis* complex and the most common causative infectious agent of TB disease in humans. In certain instances, the species name refers to the entire *M. tuberculosis* complex, which includes *M. bovis* and *M. africanum*, *M. microti*, *M. canetti*, *M. caprae*, and *M. pinnipedii*.

“*Tuberculosis disease*” or “*TB disease*” means a condition caused by infection with a member of the *M. tuberculosis* complex that has progressed to causing clinical (manifesting symptoms or signs) or subclinical (early stage of disease in which signs or symptoms are not present but other indications of disease activity are present) illness.

“Two-step tuberculin skin test” or “two-step TST” means the procedure used for the baseline skin testing of persons who will receive serial TSTs to reduce the likelihood of mistaking a boosted reaction for a new infection.

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641—155.38(125,135) Tuberculosis screening of staff and residents.

155.38(1) *TB risk assessment.* Annually, each facility shall conduct a TB risk assessment to evaluate the risk for transmission of *M. tuberculosis*, regardless of whether a person with suspected or confirmed TB disease is expected to be encountered in the facility. The TB risk assessment shall be utilized to determine the types of administrative, environmental, and respiratory protection controls needed and serves as an ongoing evaluation tool of the quality of TB infection control and for the identification of needed improvements in infection control measures. The risk assessment shall include:

- a. The community rate of TB,
- b. The number of persons with infectious TB encountered in the facility, and
- c. The speed with which persons with infectious TB are suspected, isolated, and evaluated to determine if persons with infectious TB exposed staff or others in the facility. TB cases include persons who had undiagnosed infectious pulmonary or laryngeal TB while in the facility during the preceding year. This does not include persons with LTBI (treated or untreated), persons with extrapulmonary TB disease, or persons with pulmonary or laryngeal TB who have met criteria for noninfectiousness.

155.38(2) *Facility risk classification.* The infection control team or designated staff in a facility is responsible for determining the type of risk classification of the facility. The facility risk classification is used to determine the frequency of TB screening. The facility risk classification may change due to an increase or decrease in the number of TB cases during the preceding year.

a. *Types of risk classifications.*

(1) “Low risk” means that a facility is one in which persons with active TB disease are not expected to be encountered and in which exposure to TB is unlikely.

(2) “Medium risk” means that a facility is one in which health care workers will or might be exposed to persons with active TB disease or to clinical specimens that might contain *M. tuberculosis*.

(3) “Potential ongoing transmission” means that a facility is one in which there is evidence of person-to-person transmission of *M. tuberculosis*. This classification is a temporary classification. If it is determined that this classification applies to a facility, the facility shall consult with the department’s TB control program.

b. *Classification criteria—low risk.*

(1) Inpatient settings with 200 or more beds. If a facility has fewer than six TB patients for the preceding year, the facility will be classified as low risk.

(2) Inpatient settings with fewer than 200 beds. If a facility has fewer than three TB patients for the preceding year, the facility will be classified as low risk.

(3) Outpatient, outreach, and home-based health care settings. If a facility has fewer than three TB patients for the preceding year, the facility will be classified as low risk.

c. *Classification criteria—medium risk.*

(1) Inpatient settings with 200 or more beds. If a facility has six or more TB patients for the preceding year, the facility will be classified as medium risk.

(2) Inpatient settings with fewer than 200 beds. If a facility has three or more TB patients for the preceding year, the facility will be classified as medium risk.

(3) Outpatient, outreach, and home-based health care settings. If a facility has three or more TB patients for the preceding year, the facility will be classified as medium risk.

d. *Classification criteria—potential ongoing transmission.* If evidence of ongoing *M. tuberculosis* transmission exists at a facility, the facility will be classified as potential ongoing transmission, regardless of the facility’s previous classification.

155.38(3) *Baseline TB screening procedures for facilities.*

a. All facility staff members shall receive baseline TB screening upon hire. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using a two-step TST or a single IGRA to test for infection with *M. tuberculosis*.

b. A staff member may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative TST (i.e., first step) or a negative IGRA. The second TST may be performed after the staff member starts working with patients.

c. A staff member with a new positive test result for *M. tuberculosis* infection (i.e., TST or IGRA) shall receive one chest radiograph result to exclude TB disease. Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. Treatment for LTBI should be considered in accordance with CDC guidelines.

d. A staff member with documentation of past positive test results (i.e., TST or IGRA) and documentation of the results of a chest radiograph indicating no active disease, dated after the date of the positive TST or IGRA test result, does not need another chest radiograph at the time of hire.

e. TB, TST or IGRA tests for *M. tuberculosis* infection do not need to be performed for staff with a documented history of TB disease, documented previously positive test result for *M. tuberculosis* infection, or documented completion of treatment for LTBI or TB disease. Documentation of a previously positive test result for *M. tuberculosis* infection can be substituted for a baseline test result if the documentation includes a recorded TST result in millimeters or IGRA result, including the concentration of cytokine measured (e.g., interferon-gamma (IFN-g)). All other staff should undergo baseline testing for *M. tuberculosis* infection to ensure that the test result on record in the setting has been performed and measured using the recommended diagnostic procedures.

f. A second TST is not needed if the staff member has a documented TST result from any time during the previous 12 months. If a newly employed staff member has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the setting.

g. Previous BCG vaccination is not a contraindication to having an IGRA, a TST or two-step skin testing administered. Health care workers with previous BCG vaccination should receive baseline and serial testing in the same manner as those without BCG vaccination. Evaluation of TST reactions in persons vaccinated with BCG should be interpreted using the same criteria for those not BCG-vaccinated. A health care worker's history of BCG vaccination should be disregarded when administering and interpreting TST results. Previous BCG vaccination does not cause a false-positive IGRA test result.

155.38(4) *Serial TB screening procedures for facilities.*

a. *Facilities classified as low risk.* After baseline testing of staff for infection with *M. tuberculosis*, additional TB screening of staff is not necessary unless an exposure to *M. tuberculosis* occurs.

b. *Facilities classified as medium risk.*

(1) After undergoing baseline testing for infection with *M. tuberculosis*, staff should receive TB screening annually (i.e., symptom screen for all staff members and testing for infection with *M. tuberculosis* for staff members with baseline negative test results).

(2) Staff members with a baseline positive or new positive test result for *M. tuberculosis* infection or documentation of previous treatment for LTBI or TB disease shall receive one chest radiograph result to exclude TB disease. Instead of participating in serial testing, staff should receive a symptom screen annually. This screen should be accomplished by educating the staff about symptoms of TB disease and instructing the staff members to report any such symptoms immediately to the occupational health unit. Treatment for LTBI should be considered in accordance with CDC guidelines.

c. Facilities classified as potential ongoing transmission. Testing for infection with *M. tuberculosis* may need to be performed every eight to ten weeks until lapses in infection control have been corrected and no additional evidence of ongoing transmission is apparent. The potential ongoing transmission classification should be used only as a temporary classification. This classification warrants immediate investigation and corrective steps. After a determination that ongoing transmission has ceased, the setting will be reclassified as medium risk for a minimum of one year.

155.38(5) *Screening of staff who transfer to other facilities.*

a. Staff transferring from a low-risk facility to another low-risk facility. After a baseline result for infection with *M. tuberculosis* is established and documented, serial testing for *M. tuberculosis* infection is not necessary for staff transferring from a low-risk facility to another low-risk facility.

b. Staff transferring from a low-risk facility to a medium-risk facility. After a baseline result for infection with *M. tuberculosis* is established and documented, annual TB screening, including a symptom screen and TST or IGRA for persons with previously negative test results, should be performed for staff transferring from a low-risk facility to a medium-risk facility.

155.38(6) *Baseline TB screening procedures for residents of residential, inpatient, and halfway house facilities.*

a. TB screening is a formal procedure to evaluate residents for LTBI and TB disease. Baseline TB screening consists of two components: (1) assessing for current symptoms of active TB disease and (2) using a two-step TST or a single IGRA to test for infection with *M. tuberculosis*.

b. All residents shall be assessed for current symptoms of active TB disease upon admission. Within 72 hours of a resident's admission, baseline TB testing for infection shall be initiated unless baseline TB testing occurred within three months prior to the resident's admission.

c. Residents with a new positive test result for *M. tuberculosis* infection (i.e., TST or IGRA) shall receive one chest radiograph result to exclude TB disease. Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician.

d. Residents with documentation of past positive test results (i.e., TST or IGRA) and documentation of the results of a chest radiograph indicating no active disease, dated after the date of the positive TST or IGRA test result, do not need another chest radiograph at the time of admission.

e. TB, TST or IGRA tests for *M. tuberculosis* infection do not need to be performed for residents with a documented history of TB disease, a documented previously positive test result for *M. tuberculosis* infection, or documented completion of treatment for LTBI or TB disease. Documentation of a previously positive test result for *M. tuberculosis* infection can be substituted for a baseline test result if the documentation includes a recorded TST result in millimeters or IGRA result, including the concentration of cytokine measured (e.g., IFN-g). All other residents should undergo baseline testing for *M. tuberculosis* infection to ensure that the test result on record in the setting has been performed and measured using the recommended diagnostic procedures.

f. A second TST is not needed if the resident has a documented TST result from any time during the previous 12 months. If a new resident has had a documented negative TST result within the previous 12 months, a single TST can be administered in the new setting. This additional TST represents the second stage of two-step testing. The second test decreases the possibility that boosting on later testing will lead to incorrect suspicion of transmission of *M. tuberculosis* in the setting.

g. After baseline TB screening is accomplished, serial TB screening of the residents is not recommended.

155.38(7) *Serial TB screening procedures for residents of residential, inpatient, and halfway house facilities.*

a. If a resident is discharged and readmitted to a facility and less than 12 months have passed since the last TB screening, residents should receive a symptom screen upon readmittance. This screen should be accomplished by educating the resident about symptoms of TB disease and instructing the resident to report any such symptoms immediately to the infection control team or designated other

staff. If symptoms or signs of TB disease are documented, then a medical evaluation to include a chest X-ray to rule out TB disease is required.

b. If a resident is discharged and readmitted to a facility and more than 12 months have passed since the last TB screening, baseline TB screening should be repeated as outlined in subrule 155.38(6).

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[Editorial change: IAC Supplement 6/10/26]

- ¹ Effective date of Ch 3 delayed by the Administrative Rules Review Committee 70 days from 8/2/78. Delay suspended by the Administrative Rules Review Committee at their meeting held on 9/11/78.
- ² Effective date of 643—3.35(125) delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 1994; on June 15, 1994, the Committee voted to delay the rule until adjournment of the 1995 General Assembly.

CHAPTER 156
CONSUMABLE HEMP PRODUCTS

[Prior to 6/14/23, see Inspections and Appeals Department[481] Ch 32]

Chapter rescission date pursuant to Iowa Code section 17A.7: 7/17/29

641—156.1(204) Definitions. For the purpose of these rules, the following terms have the meanings indicated in this chapter. The definitions set out in Iowa Code section 204.2 are incorporated verbatim herein.

“Accredited laboratory” means a laboratory accredited in accordance with the International Organization for Standardization/International Electrotechnical Commission (ISO/IEC) Standard 17025:2017 (July 17, 2024) by an International Laboratory Accreditation Cooperation (ILAC)-recognized accreditation body for the analyses performed on consumable hemp products.

“Adulterated” means the same as in 21 U.S.C. Section 342(a)(4) (as amended to July 17, 2024), except that a consumable hemp product is not deemed “adulterated” pursuant to this chapter solely because it contains a hemp product not generally recognized as safe (GRAS) by the federal Food and Drug Administration.

“Approved hemp source” means a manufacturer of a consumable hemp product that is engaged in the wholesale or retail sale of the product and that is:

1. Located in this state and manufactures the consumable hemp product in compliance with Iowa Code chapter 204 and these rules; or
2. Located in a state that has a state hemp plan approved by the United States Department of Agriculture under 7 U.S.C. Chapter 38, Subchapter VII (as amended to July 17, 2024).

“Batch” means a specific quantity of a consumable hemp product that contains a lot number; is uniform and intended to meet specifications for identity, strength, purity, and composition; and is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling record.

“Cannabidiol” or *“CBD”* means the specific chemical compound with the Chemical Abstracts Service number 13956-29-1.

“Certificate of analysis” or *“COA”* means an official document released by an accredited laboratory following an analysis of a consumable hemp product. The certificate of analysis contains all of the concentrations of cannabinoids, pesticides, residual solvents, metals, harmful pathogens, toxicants, and synthetic or semisynthetic cannabinoids, including data on levels of total delta-9 tetrahydrocannabinol content concentration and whether a sample passed or failed any limits related to these analyses.

“Certificate of free sale” means a government certification that products such as food, drugs, medicine, or cosmetics are approved for unrestricted sale in the jurisdiction in which they originate.

“Consumable hemp establishment” means an individual or entity engaged in manufacturing, processing, packing, holding, preparing, distributing, or selling a consumable hemp product in Iowa or to purchasers located in Iowa. A consumable hemp establishment does not include an individual or entity manufacturing, processing, packing, holding, preparing, distributing, or selling a consumable hemp product containing only hemp seed or hemp seed-derived food ingredients GRAS under the conditions of use by the federal Food and Drug Administration.

“Consumable hemp manufacturer” means a consumable hemp establishment engaged in manufacturing, processing, packing, holding, preparing, distributing, or selling a consumable hemp product on a wholesale basis. A consumable hemp manufacturer includes individuals and entities outside of Iowa that distribute consumable hemp products in Iowa. A consumable hemp manufacturer does not include individuals or entities exclusively engaged in the harvesting, storage, or distribution of raw hemp.

“Consumable hemp retailer” means a consumable hemp establishment selling consumable hemp product to consumers on a retail basis. A consumable hemp retailer includes an establishment selling consumable hemp products online.

“Container” means the object that holds one or more servings of a consumable hemp product.

“Delta-9 tetrahydrocannabinol” or *“THC”* means the specific chemical compound with the Chemical Abstracts Service number 1972-08-3.

“Expiration date” means the month and year as determined by the manufacturer, packer, or distributor on the basis of tests showing that the product, until that date, under the conditions of handling, storage, preparation, and use per label directions, will, when consumed, contain not less than the quantity of each ingredient as set forth on its label.

“Food” means the same as defined in Iowa Code section 137F.1. Food includes human dietary supplements and alcoholic beverages.

“Harvesting” applies to farms and farm mixed-type facilities and means activities that are traditionally performed on farms for the purpose of removing raw agricultural commodities from the place they were grown or raised and preparing them for use as food. Harvesting is limited to activities performed on raw agricultural commodities, or on processed foods created by drying/dehydrating a raw agricultural commodity without additional manufacturing/processing, on a farm. Harvesting does not include activities that transform a raw agricultural commodity into a processed food as defined in Section 201(gg) of the federal Food, Drug, and Cosmetic Act (as amended to July 17, 2024).

“Jurisdiction of origin” means the federal, state, or local regulatory jurisdiction that has the authority to conduct inspections of the facility in which a consumable hemp product was most recently subject to a manufacturing/processing activity.

“Lot number” means a specific quantity of raw hemp or processed hemp product that is uniform and intended to meet specifications for identity, strength, purity, and composition that contains the manufacturer’s, processor’s, or distributor’s number and a sequence to allow for inventory, traceability, and identification of the plant batches used in the production of consumable hemp products.

“Manufacturing/processing” means making food from one or more ingredients or synthesizing, preparing, treating, modifying or manipulating food, including food crops or ingredients. For farms and farm mixed-type facilities, manufacturing/processing does not include activities that are part of harvesting, packing, or holding.

“Misbranded” means a food that violates 21 U.S.C. Section 343 (as amended to July 17, 2024).

“QR code” means a quick response machine-readable code that can be read by a camera, consisting of an array of black and white squares used for storing information or directing or leading a user to product information regarding manufacturer data and accredited laboratory certificates of analysis.

“Raw agricultural commodity” means any food in its raw or natural state, including all fruits that are washed, colored, or otherwise treated in their unpeeled natural form prior to marketing.

“Raw hemp” means an unprocessed hemp plant, or any part of the hemp plant, in its raw or natural state. Raw hemp is a raw agricultural commodity.

“Serving” means the size or portion customarily consumed per eating occasion, expressed in a common household measure as established in table 2 of 21 CFR 101.12 (as amended to July 17, 2024). If a solid consumable hemp product is packaged in a manner that includes more than a single serving, each serving must be clearly identified and severable from the other servings in the container. If a liquid consumable hemp product is packaged in a manner that includes more than a single serving, the number of servings must be conspicuously labeled. Liquid consumable hemp products shall be packaged in a container that holds a minimum of 12 fluid ounces.

“Synthetic consumable hemp products” means products containing synthetic or semisynthetic cannabinoids. Synthetic and semisynthetic cannabinoids refer to a class of cannabinoids that are created through a chemical process and are structurally similar to naturally occurring cannabinoids or cannabinoids that may occur in very small amounts naturally. Examples of

synthetic consumable hemp products include but may not be limited to delta-8 tetrahydrocannabinol, delta-10 tetrahydrocannabinol, hexahydrocannabinol (HHC), tetrahydrocannabiphorol (THC-P), and tetrahydrocannabinol-O-acetate (THC-O).

“*Tetrahydrocannabinolic acid*” or “*THCA*” means the specific chemical compound with the Chemical Abstracts Service number 23978-85-0.

“*Total delta-9 tetrahydrocannabinol*” or “*total THC*” means 87.7 percent of the amount of tetrahydrocannabinolic acid plus the amount of delta-9 tetrahydrocannabinol.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.2(204) Registration and posting. A consumable hemp establishment shall not engage in manufacturing, processing, packing, holding, preparing, distributing, or selling a consumable hemp product in Iowa or to purchasers located in Iowa until it has submitted a consumable hemp registration that is approved by the department.

156.2(1) Consumable hemp manufactures/distributors. At least 30 days prior to manufacturing, processing, packing, holding, preparing, distributing, or selling any consumable hemp product in Iowa or to purchasers located in Iowa, a consumable hemp manufacturer shall:

- a. Complete the online registration form prescribed by the department;
- b. Remit the registration fee set by the department in accordance with Iowa Code section 204.7; and
- c. Submit a complete list of all consumable hemp products the consumable hemp manufacturer intends to manufacture, process, pack, hold, prepare, distribute, or sell, along with documentation of the jurisdiction of origin for each consumable hemp product.

156.2(2) Consumable hemp retailers. At least 30 days prior to selling any consumable hemp product in Iowa or to purchasers located in Iowa, a consumable hemp retailer shall register with the department by doing the following:

- a. Complete the online registration form prescribed by the department;
- b. Remit the registration fee set by the department in accordance with Iowa Code section 204.7; and
- c. Submit a complete list of all consumable hemp products the consumable hemp retailer intends to sell, along with documentation of the jurisdiction of origin for each consumable hemp product.

156.2(3) Combined consumable hemp manufacturers and retailers. A consumable hemp establishment engaged in activities of a consumable hemp manufacturer and a consumable hemp retailer shall register separately for each activity. A registered consumable hemp manufacturer that exclusively sells consumable hemp products it has manufactured to consumers on a retail basis is not mandated to register as a consumable hemp retailer.

156.2(4) Physical location. A consumable hemp establishment’s registration is valid for one physical location. A consumable hemp establishment that manufactures, processes, packs, holds, prepares, distributes, or sells a consumable hemp product at more than one physical location shall separately register each physical location.

156.2(5) Expiration and renewal. A consumable hemp registration, unless sooner suspended or revoked, expires one year after the registration is approved by the department. A consumable hemp registration may be renewed annually through the department’s online registration system, accompanied by the registration fee, at least 30 days prior to expiration. Consumable hemp registrations that are expired more than 60 days will be revoked without notice.

156.2(6) Transferability. A consumable hemp registration is not transferable to a new owner or new physical location.

156.2(7) Posting of registrations. A valid registration shall be posted on the premises of the consumable hemp establishment in a location that is visible to the public. An image of the valid registration must also be posted on any website or online point of sale in a location that is visible to the public prior to payment.

156.2(8) *Returned payments.* The department will attempt to redeem a payment submitted for a consumable hemp registration that is not honored by the bank on which it is drafted. The department will notify the applicant of the need to provide sufficient payment. An additional fee of \$25 shall be assessed for each dishonored payment. If the department does not receive payment, the establishment will be operating without a valid registration and is subject to penalties set forth in rule 641—156.7(204).

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.3(204) Testing requirements and documentation.

156.3(1) *Approved hemp source; certificate of analysis.* A consumable hemp product cannot be distributed or sold unless:

a. The consumable hemp product is from an approved hemp source and is accompanied by documentation that identifies the jurisdiction of origin. Documentation that identifies the jurisdiction of origin includes:

- (1) Certificate of free sale issued by the jurisdiction of origin;
- (2) Product label statements, provided the product label identifies the jurisdiction of origin; or
- (3) Other documentation that identifies the jurisdiction of origin and also identifies the following:
 1. Brand name;
 2. Product name;
 3. Serving and container size in terms of net quantity of contents; and
 4. Lot number for the batch.

b. The consumable hemp product has a certificate of analysis issued within the last year by an independent accredited laboratory that verifies and states:

(1) The consumable hemp product is from a batch that has been tested by the independent accredited laboratory consistent with generally accepted industry standards for herbal and botanical substances;

(2) The presence and concentration of cannabinoids, including delta-9 tetrahydrocannabinol, tetrahydrocannabinolic acid, cannabidiol, and any other cannabinoids for which the product is being marketed;

(3) The consumable hemp product is from a batch that contained a total delta-9 tetrahydrocannabinol concentration that did not exceed 0.3 percent on a dry weight basis as calculated pursuant to an official postdecarboxylation analysis, as provided in Iowa Code section 204.8;

(4) The consumable hemp product is from a batch that has been tested for, and does not contain more than trace amounts of, pesticides, residual solvents, metals, harmful pathogens, and toxicants; and

(5) The batch does not contain synthetic or semisynthetic cannabinoids as described in these rules.

156.3(2) *Toxicant limits.* If a testing sample is found to contain greater than trace amounts of any pesticide, residual solvent, metal, harmful pathogen, or toxicants, the product is considered adulterated and cannot enter commerce.

156.3(3) *Examination of records.* All documentation mandated by this rule shall be maintained by the consumable hemp establishment and provided to the department or other regulatory authority immediately upon request.

156.3(4) *Independent accredited laboratory.* A consumable hemp establishment cannot utilize an accredited laboratory in which it has an ownership interest unless the consumable hemp establishment holds less than a 10 percent ownership interest in the accredited laboratory if the accredited laboratory is a publicly traded company. All testing of consumable hemp products under this rule must be conducted by an independent accredited testing laboratory.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.4(204) Packaging and labeling.

156.4(1) Contents. Each consumable hemp product intended for individual retail sale is labeled such that a reasonable consumer would plainly identify the product as a consumable hemp product and contains the following information:

- a.* Lot number for the batch;
- b.* Expiration date;
- c.* Brand name;
- d.* Product name;
- e.* List of ingredients;
- f.* Name, telephone number, and email address of the product manufacturer. If the registered manufacturer uses a contracted third-party or white-label manufacturer, the name of that entity must also be included on the container or label and is not proprietary or confidential under Iowa Code section 22.7;
- g.* If specific cannabinoids are contained within or marketed for the product, the number of milligrams of each cannabinoid per serving and serving size;
- h.* A certificate of analysis that the batch contained a total THC concentration that did not exceed 0.3 percent on a dry weight basis as calculated pursuant to an official test as provided in Iowa Code section 204.8;
- i.* A declaration of the net quantity of contents indicating the number of servings and total THC per serving and per container in compliance with Iowa Code section 204.2; and
- j.* A warning label containing the following or substantially similar language, in addition to any other warning language necessitated by the specific product. This warning label may be divided into multiple sections on a label, provided that all the information is included in a prominent and conspicuous manner as compared to other words, statements, or designs on the container label:
 - (1) A statement that the product has not been evaluated or approved by the United States Food and Drug Administration (unless such approval has been secured);
 - (2) The potential for the product to cause the consumer to fail a drug test for THC;
 - (3) A statement that products containing THC may cause impairment and impact a consumer's ability to operate a vehicle;
 - (4) A statement that the product is not recommended for use by pregnant or breastfeeding women;
 - (5) A statement that product use may result in health risks and medication interactions; and
 - (6) A statement in capital letters to KEEP THIS PRODUCT OUT OF REACH OF CHILDREN.

The labeling must not contain any claim that the product may be used or is effective for the prevention, treatment, or cure of a disease or that it may be used to alter the structure or function of human or animal bodies unless the claim has been approved by the federal Food and Drug Administration.

156.4(2) Form. The labeling mandated in paragraphs 156.4(1) "*f*" and "*h*" may be in the form of:

- a.* A uniform resource locator (URL) for the manufacturer's internet website that provides or links to the information mandated by this rule; or
- b.* A QR code or other bar code that may be scanned and that leads to the information required on the label.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.5(204) Applicability of other laws and regulations.

156.5(1) A consumable hemp establishment shall comply with all relevant Iowa laws and regulations applicable to the manufacturing, processing, storage, distribution, and sale of food, including but not limited to Iowa Code chapter 137F, Iowa Code chapter 137D, and regulations promulgated under those chapters.

156.5(2) An individual or entity subject to Iowa Code chapter 123 shall not introduce any consumable hemp product into the alcoholic beverage product for which the individual or entity is subject to Iowa Code chapter 123 unless the consumable hemp product is GRAS by the federal Food and Drug Administration and is thus not deemed adulterated.

156.5(3) An individual or entity subject to Iowa Code chapter 189A shall not introduce any consumable hemp product into the meat or poultry product for which the individual or entity is subject to Iowa Code chapter 189A unless the consumable hemp product is GRAS by the federal Food and Drug Administration and is thus not deemed adulterated. A consumable hemp retailer may introduce any consumable hemp product into meat or poultry sold to consumers on a retail basis in intrastate commerce.

156.5(4) An individual or entity subject to Iowa Code chapters 190 through 192 shall not introduce any consumable hemp product into the dairy product for which the individual or entity is subject to Iowa Code chapters 190 through 192 unless the consumable hemp product is GRAS by the federal Food and Drug Administration and is thus not deemed adulterated. A consumable hemp retailer may introduce any consumable hemp products into dairy products sold to consumers on a retail basis in intrastate commerce.

156.5(5) Consumable hemp products in interstate commerce are subject to federal law. Compliance with Iowa Code chapter 204 and this chapter does not represent compliance with federal law.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.6(204) Prohibitions.

156.6(1) A consumable hemp establishment cannot manufacture, process, pack, hold, prepare, distribute, or sell consumable hemp products:

- a.* On the premises of a private residence, except a portion of a private residence that is distinctly separate from any living space, that is dedicated to the production or sale of food, and that meets all applicable state and local regulations;
- b.* On the premises of a temporary location, including but not limited to a food stand, roadside stand, temporary booth, or any other temporary structure;
- c.* Door to door;
- d.* Through vending machines; or
- e.* At private parties.

156.6(2) A consumable hemp product may be sold at a stand at a farmers market, provided:

- a.* The farmers market is listed on the Iowa department of agriculture and land stewardship's farmers market directory;
- b.* The individual selling the consumable hemp product maintains a valid consumable hemp retailer registration at any location where consumable hemp is stored;
- c.* The consumable hemp establishment registration is posted in plain sight at the farmers market stand; and
- d.* All consumable hemp products sold are listed and maintained up to date with the department.

156.6(3) A consumable hemp product label and any associated marketing materials shall not contain any claim that the product may be used or is effective for the prevention, treatment, or cure of a disease or that it may be used to alter the structure or function of human or animal bodies unless the claim has been approved by the federal Food and Drug Administration.

156.6(4) A consumable hemp retailer cannot manufacture, process, package, repackage, relabel, mix, blend, or otherwise manipulate a consumable hemp product. This subrule does not apply to a food service establishment that utilizes a consumable hemp product from an approved hemp source as a food ingredient intended for immediate consumption by the consumer, provided that the food service establishment discloses all label information mandated by rule 641—156.4(204) to the consumer through the menu, menu board, placard, table tent, or other effective means.

156.6(5) A consumable hemp product that does not conform to this chapter is considered adulterated or misbranded and cannot enter commerce.

156.6(6) A consumable hemp retailer or manufacturer shall not sell or distribute consumable hemp products to person under 21 years of age, subject to verification. Proof of age may be established by a valid driver's license, identification card issued by Iowa or another state, or other form of government-issued identification and must include the photograph and date of birth of the person.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.7(204) Violations and enforcement.

156.7(1) Any consumable hemp product introduced into commerce by an individual or entity without a consumable hemp registration approved by the department in accordance with rule 641—156.2(204) is subject to immediate embargo.

156.7(2) A consumable hemp product that is adulterated or misbranded when introduced into commerce is subject to immediate embargo.

156.7(3) A consumable hemp product that the department reasonably believes may be injurious to public health or that has entered commerce and is not in conformance with this chapter is subject to immediate embargo.

156.7(4) The embargo of a consumable hemp product is effective until such a time as the violation is remedied or the product is disposed of in a reasonable manner as determined by the department. If the violation cannot be remedied and disposal is necessary, the cost of disposal is the responsibility of the consumable hemp establishment. Disposal shall be observed by a person approved by the department. The embargo of a consumable hemp product may be appealed in accordance with rule 641—156.8(204).

156.7(5) A consumable hemp manufacturer will conduct a recall of a consumable hemp product lot that has been tested and found to be adulterated. The cost of a recall or disposal of the product is the responsibility of the consumable hemp manufacturer.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.8(204) Denial, suspension, or revocation of registration. The department may deny, suspend, or revoke a registration in any case where the department finds there has been repeated failure on the part of the consumable hemp establishment to comply with the provisions of this chapter, or for any of the following reasons:

156.8(1) Failure to register. An individual or entity that introduces a consumable hemp product into commerce without a consumable hemp registration approved by the department in accordance with rule 641—156.2(204) may be denied a consumable hemp registration for a period of up to 30 days for a first violation, up to one year for a second violation, and up to five years for a third or any subsequent violation.

156.8(2) Nonconforming consumable hemp product. A registered consumable hemp establishment that introduces a consumable hemp product into commerce that is not in conformance with Iowa Code chapter 204 or this chapter is subject to the immediate revocation of its registration.

156.8(3) Qualifying criminal offense.

a. The conviction of any individual with an ownership interest in a consumable hemp establishment constituting a felony, serious misdemeanor, or aggravated misdemeanor and resulting from an activity constituting a criminal offense in the consumable hemp establishment may result in the denial, suspension, or revocation of the registration.

b. A conviction for committing a criminal offense involving a controlled substance as described in Iowa Code section 204.7 may result in the denial, suspension, or revocation of the registration.

c. A certified copy of the final order or judgment of conviction or plea of guilty shall be conclusive evidence of the conviction of the registration holder.

d. A deferred judgment, until discharged, is considered a conviction for purposes of this rule.

156.8(4) False or misleading information. Providing false or misleading information to the department under this chapter, including by submitting a false registration, may result in the denial, suspension, or revocation of the registration.

156.8(5) Failure to comply. Failing to comply with an order issued by the department under this chapter may result in the denial, suspension, or revocation of the registration.

156.8(6) Successive violations. A third violation of any provision of this chapter in a five-year period will result in the denial, suspension, or revocation of the registration. The department will disapprove any registration of the consumable hemp establishment for a five-year period following the date of the last violation.

156.8(7) Materially false information supplied. An individual or entity that materially falsifies any information contained in a consumable hemp registration is ineligible for registration.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.9(204) Inspection and access to records. The department may enter a consumable hemp establishment at any reasonable hour to assess compliance with Iowa Code chapter 204 and these rules. The manager or person in charge of the consumable hemp establishment will afford free access to every part of the premises, including access to records related to consumable hemp products, and render all aid and assistance necessary to enable the regulatory authority to make a thorough and complete assessment.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.10(204) Public examination of records.

156.10(1) *Public information.* Generally, information collected by the department and contractors is considered public information. Records are stored in computer files and are not matched with any other data system. Information is available for public review and will be provided when requested from the department.

156.10(2) *Confidential information.*

a. The following are examples of confidential records:

- (1) Trade secrets and proprietary information including items such as formulations, processes, policies and procedures, and customer lists;
- (2) Health information related to foodborne illness complaints and outbreaks;
- (3) The name or any identifying information of a person who files a complaint with the department; and
- (4) Other state or federal agencies' records.

b. A party claiming that information submitted to the department contains trade secrets or proprietary information should clearly mark those portions of the submission as confidential/trade secret.

[ARC 8178C, IAB 8/7/24, effective 7/17/24]

641—156.11(204) Appeals. All decisions of the department may be contested by an adversely affected party in accordance with 441—Chapter 2506.

[ARC 8178C, IAB 8/7/24, effective 7/17/24; Editorial change: IAC Supplement 6/10/26]

These rules are intended to implement Iowa Code section 124.506 and Iowa Code chapter 204 as amended by 2024 Iowa Acts, House File 2605.

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CHAPTER 196
EMERGENCY MEDICAL SERVICES—MILITARY SERVICE, VETERAN RECIPROCITY,
AND SPOUSES OF ACTIVE DUTY SERVICE MEMBERS

Chapter rescission date pursuant to Iowa Code section 17A.7: 8/14/29

641—196.1(272C) Definitions.

“License” means the same as defined in Iowa Code section 272D.1.

“Licensing authority” means the same as defined in Iowa Code section 272D.1.

“Military service” means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c) (2021); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101 (2006).

“Military service applicant” means an individual requesting credit toward licensure for military education, training, or service obtained or completed in military service.

“Spouse” means a spouse of an active duty member of the military forces of the United States.

“Veteran” means the same as defined in Iowa Code section 35.1.

[ARC 8128C, IAB 7/10/24, effective 8/14/24]

641—196.2(272C,147D) Military education, training, and service credit. A military service applicant may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting a military service application form to the licensing authority. No fee is required with submission of an application for military service credit.

196.2(1) The licensing authority shall grant credit requested in the application pursuant to the emergency medical services (EMS) personnel licensure interstate compact described in Iowa Code section 147D.1.

196.2(2) The licensing authority shall inform the military service applicant in writing of the credit, if any, given toward an experience or educational qualification for licensure or explain why no credit was granted. The applicant may request reconsideration upon submission of additional documentation or information.

196.2(3) A military service applicant who is aggrieved by the licensing authority’s decision may appeal pursuant to the provisions of 441—Chapter 2506, except that no fees or costs shall be assessed against the military service applicant in connection with a contested case conducted pursuant to this subrule.

196.2(4) The licensing authority shall grant or deny the credit requested in the military service application prior to ruling on the application for licensure. The applicant shall not be required to submit any fees in connection with the licensure application unless the licensing authority grants the credit requested in the military service application. If the licensing authority does not grant the credit requested in the military service application, the applicant may withdraw the licensure application or request that the licensure application be placed in pending status for up to one year or as mutually agreed. The withdrawal of a licensure application shall not preclude subsequent applications supported by additional documentation or information.

[ARC 8128C, IAB 7/10/24, effective 8/14/24; Editorial change: IAC Supplement 6/10/26]

641—196.3(272C,147D) Veteran and active duty military spouse privilege to practice. A veteran or spouse with an unrestricted license in another EMS personnel licensure jurisdiction may practice in Iowa pursuant to the EMS personnel licensure interstate compact described in Iowa Code section 147D.1.

[ARC 8128C, IAB 7/10/24, effective 8/14/24]

These rules are intended to implement Iowa Code sections 272C.4 and 147D.1.

[Filed ARC 1749C (Notice ARC 1646C, IAB 10/1/14), IAB 12/10/14, effective 1/14/15]

[Filed ARC 5061C (Notice ARC 5000C, IAB 3/25/20), IAB 6/17/20, effective 7/22/20]

[Filed ARC 7032C (Notice ARC 6942C, IAB 3/8/23), IAB 5/31/23, effective 7/5/23]

[Filed ARC 8128C (Notice ARC 7337C, IAB 1/24/24), IAB 7/10/24, effective 8/14/24]

[Editorial change: IAC Supplement 6/10/26]

PUBLIC SAFETY DEPARTMENT[661]

Rules transferred from agency number 680 to 661 to conform with the reorganization numbering scheme in general

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Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0333D, IAB 6/10/26, effective 6/30/26]

661—2503.8(17A) Refusal to issue order.

2503.8(1)

l. The petitioner requests the agency to determine whether a statute is unconstitutional on its face.

m. The petition relates to any criminal investigation.

[ARC 0333D, IAB 6/10/26, effective 6/30/26]

[Filed Emergency ARC 0333D, IAB 6/10/26, effective 6/30/26]

SECRETARY OF STATE[721]

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CHAPTER 22
VOTING SYSTEMS AND ELECTRONIC POLL BOOKS
[Prior to 7/13/88, see Secretary of State[750] Ch 10]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

TESTING AND EXAMINATION OF VOTING EQUIPMENT

721—22.1(52) Definitions for certification of voting equipment.

“Accredited independent test authority” means a person or agency that was formally recognized by the National Association of State Election Directors as competent to design and perform qualification tests for voting system hardware and software. *“Accredited independent test authority”* also includes voting system test laboratories accredited by the Election Assistance Commission to test voting systems for compliance with federal voting system standards and guidelines, as required by the Help America Vote Act, Section 231.

“Audio ballot” means the presentation of the contents of a ballot on an electronic ballot marking device in a recorded format, played to the voter over headphones.

“Automatic tabulating equipment” means apparatuses that are utilized to ascertain the manner in which optical scan ballots have been marked by voters or by electronic ballot marking devices and to count the votes marked on the ballots.

“Ballot” means the official document that includes all of the offices or public measures to be voted upon at a single election, whether they appear on one or more paper ballots. The term includes optical scan paper ballots designed to be read by automatic tabulating equipment. In appropriate contexts, *“ballot”* also includes conventional paper ballots.

“Ballot marking device” means a pen, pencil, or similar writing tool, or an electronic device, all designed for use in marking an optical scan ballot, and so designed or fabricated that the mark it leaves may be detected and the vote so cast counted by automatic tabulating equipment.

“Certification” means formal approval of an optical scan voting system for use in Iowa pursuant to Iowa Code sections 52.5 and 52.26.

“De minimis change” means a change to a certified voting system’s hardware, software, technical data package (TDP), or data, the nature of which will not materially alter the system’s reliability, functionality, capability, or operation. Under no circumstances shall a change be considered de minimis if it has reasonable and identifiable potential to impact the system’s performance and compliance with the applicable voting standard.

“Early voting” means the process of receiving ballots from voters before election day without using absentee voting procedures. Iowa law does not authorize this process.

“Electronic ballot marking device” means a component of an optical scan voting system designed to assist voters with disabilities by displaying audio and visual ballot information to the voter, providing accessible methods for the voter to make selections, and then printing the voter’s choices on an optical scan ballot.

“Electronic poll book,” “epollbook,” “e-poll book,” or “electronic register” means hardware and software components used to verify and process voting activity and changes in voter registration and to check in voters. This definition includes e-poll books in use in the commissioner’s office. However, this definition does not apply to the I-Voters statewide voter registration database.

“Electronic transmission” means using hardware and software components to send data over distances both within and external to the polling place and to receive an accurate copy of the transmission.

“Examiners” means the board of examiners for voting systems described in Iowa Code section 52.4.

“Memory storage device” means a small, removable device containing data files of the election definition programmed for use in voting equipment for each election.

“Modification” means a change to a certified voting system’s software or firmware. Modification also means a change to a certified voting system’s hardware that has the potential to affect the reliability, functionality, capability, security or operability of a system.

“Optical scan ballot” means a printed ballot designed to be marked by a voter with a ballot marking device and to be counted by use of automatic tabulating equipment.

“Optical scan voting system” means a system employing paper ballots under which votes are cast by voters by marking paper ballots with a ballot marking device and thereafter counted by use of automatic tabulating equipment.

“Program” means the written record of the set of instructions defining the operations to be performed by a computer in examining, counting, tabulating, and printing votes.

“Qualification test” means the examination and testing of a voting system by an independent test authority using the voting system standards required by Iowa Code section 52.5 and rule 721—22.2(52) to determine whether the system complies with those standards.

“Vendor” means a person or representative of a person owning or being interested in an optical scan voting system and seeking certification of the equipment for use in elections in Iowa.

“Voting booth” means an enclosure designed to be used by a voter while marking a conventional paper ballot, optical scan ballot or ballot card.

“Voting equipment” means an optical scan voting system which is required by Iowa Code sections 52.5 and 52.26 to be approved for use by the examiners.

“Voting equipment malfunction” means a problem with the voting equipment that renders the equipment inoperable for a period of time when it has been deployed for use during an election. “Voting equipment malfunction” does not include interruptions of equipment operations due to routine error messages as referred to in subrule 22.261(5), 22.262(6) or 22.266(5).

“Voting system” means the total combination of mechanical, electromechanical or electronic equipment (including the software, firmware and documentation required to program, control and support the equipment that is used to define ballots, to cast and count votes, to report or display election results and to maintain and produce any audit trail information). “Voting system” also includes the practices and associated documentation used to identify system components and versions of such components, to test the system during its development and maintenance, to maintain records of system errors and defects, to determine specific system changes to be made to a system after the initial qualification of the system and to make available any materials to the voter such as notices, instructions, forms or paper ballots. (See Section 301(b) of HAVA.)

[ARC 8244B, IAB 10/21/09, effective 10/2/09; ARC 9468B, IAB 4/20/11, effective 5/25/11; ARC 0801C, IAB 6/26/13, effective 7/31/13; ARC 3468C, IAB 11/22/17, effective 12/31/17]

721—22.2(52) Voting system standards. All electronic voting systems approved for use by the board of examiners after April 9, 2003, shall meet Voting Systems Performance and Test Standards, as adopted by the Federal Election Commission April 30, 2002, or the 2005 Voluntary Voting Systems Guidelines, as adopted by the U.S. Election Assistance Commission in December 2005. The report of an accredited independent test authority certifying that the system is in compliance with these standards shall be submitted with the application for examination.

This rule is intended to implement Iowa Code section 52.5.

[ARC 9468B, IAB 4/20/11, effective 5/25/11; ARC 9762B, IAB 10/5/11, effective 9/8/11]

721—22.3(52) Examiners. The examiners annually shall elect a chairperson. All three examiners must be present for any formal action. Approval by two of the three examiners is required to approve any action to be taken by the examiners.

22.3(1) Notice of the time and place of any meeting by the board of examiners must be published pursuant to Iowa Code section 21.4.

22.3(2) Meetings of the examiners are open to the public, except that closed meetings may be held as permitted by Iowa Code section 21.5.

22.3(3) Correspondence and materials required to be filed with the board of examiners shall be addressed to the examiners in care of the Elections Division, Office of the Secretary of State, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319.

721—22.4(52) Fees and expenses paid to the examiners.

22.4(1) The examiners shall be reimbursed for travel to and from the meeting place at the rate specified in Iowa Code section 70A.9. The examiners shall also be reimbursed for actual expenses for meals and lodging, if necessary.

a. If the meeting was called for the purpose of examining, reexamining, testing, or discussing the certification of voting equipment offered by a vendor, the examiners' expenses shall be paid by the vendor within seven days following the completion of the examination and testing of the voting equipment.

b. If the meeting was called for the purpose of advising the secretary of state regarding administrative rules for the examiners, or to hear complaints or requests for decertification of voting equipment, or any other business of interest to the examiners, the expenses shall be paid by the secretary of state.

22.4(2) The vendor shall pay the examiners the amount of compensation specified in Iowa Code section 52.6 at the beginning of each meeting for which compensation is required to be provided to the examiners. The fee shall be paid as follows:

a. For each meeting or series of meetings held for the purpose of certifying an optical scan voting system or component thereof.

b. For each meeting or series of meetings for reconsideration of an optical scan voting system or component thereof after denial of certification.

This rule is intended to implement Iowa Code sections 17A.19, 49.25(3), 52.5, 52.6, and 52.26.

[ARC 8244B, IAB 10/21/09, effective 10/2/09]

721—22.5(52) Examination of voting equipment—application. Any vendor who wishes to apply for certification of voting equipment for use in the state of Iowa shall apply to the secretary of state for an appointment with the examiners. The application shall include five copies of each of the following:

22.5(1) History of the equipment to be examined. This history shall include a complete description of the equipment to be examined, descriptions of any previous models of the equipment, the date the system to be examined went into production, and a complete list of jurisdictions which have used the equipment. The user list shall include jurisdictions which used the equipment experimentally without purchasing it, jurisdictions which purchased earlier versions of the equipment to be examined, and jurisdictions which purchased the current version of the equipment to be examined.

22.5(2) Copies of all manuals developed for use with the system including, but not limited to, technical manuals for repair and maintenance of the equipment, operations manuals for election officials, printer's manuals for ballot production, and any other written documents prepared by the vendor that describe the operation, use, and maintenance of the machine.

22.5(3) Report of an accredited independent test authority certifying that the system is in compliance with the voting systems standards required by rule 721—22.2(52). Copies of these reports are confidential records as defined by Iowa Code section 22.7 and Iowa Code chapter 550. Independent test authority reports shall be available to the secretary of state, deputy secretary of state, director of elections, members of the board of examiners, and any other person designated by the secretary of state to have a bona fide need to review the report. No other person shall have access to the reports, and no copies shall be made. All independent test authority reports shall be marked "CONFIDENTIAL" and shall also be accompanied by a list of those persons who are authorized to examine the report. The reports shall be kept in a locked cabinet.

22.5(4) Copies of the reports of any test authority who has examined the equipment in conjunction with certification requirements of other states.

22.5(5) Reports of the certifying authorities of any other states that have examined the equipment, whether or not the equipment was approved for use.

22.5(6) Brochures, photographs and advertising material used to encourage sales of the equipment.

22.5(7) Manuals for the use and maintenance of any components of the equipment that are not manufactured by the vendor.

22.5(8) Rescinded IAB 4/20/11, effective 5/25/11.

22.5(9) Reserved.

22.5(10) The form prescribed by the state commissioner of elections to request examination and testing of voting systems.

[ARC 8244B, IAB 10/21/09, effective 10/2/09; ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.6(52) Review of application by examiners. Upon receipt of the application, the secretary of state shall immediately forward copies of the application to each of the examiners. The examiners shall review the application and within seven days a date shall be set for the examiners to meet and examine the equipment. If additional information is needed by the examiners, they may delay setting a date for the examination pending the submission of the requested materials.

721—22.7(52) Consultant. If the examiners determine that a consultant is necessary to determine whether a system meets the requirements of Iowa law or whether a change to a voting system is de minimis or a modification, the examiners shall notify the vendor of the decision. The vendor may suggest the names of reliable independent test authorities to the examiners and may decline to submit the equipment to the examination of an individual for good reason.

A consultant may be employed if no other state has certified the equipment for use. The examiners may require a consultant if the equipment has been modified following certification by other states, or if the examiners believe it to be necessary.

If a test authority has been determined to be necessary by the examiners and a suitable consultant cannot be agreed upon by the examiners and the vendor, the equipment shall not be approved for use.

[ARC 8244B, IAB 10/21/09, effective 10/2/09]

721—22.8(52) Contact other users. The examiners shall contact a representative sample of the users of the equipment to determine the nature of the experience of other users.

721—22.9(52) Testing the equipment. The vendor shall provide to the examiners one, or more, if deemed necessary by the examiners, production models of the equipment submitted for certification. The equipment shall be prepared by the examiners with the aid of the vendor to be tested at two sample elections: a sample partisan primary election, and a sample general election.

22.9(1) Test county for absentee voting. Voting equipment which is designed to be used for tabulation of absentee ballots shall be tested using a model county consisting of 155 precincts, with 180,000 registered voters. The county shall include one U.S. congressional district, five state senate districts, 11 state house of representatives districts, and 30 townships. Each township shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(2) Test county for absentee systems. Voting equipment which is designed to be used for tabulation of absentee ballots only shall be tested using a model county consisting of 155 precincts, with 180,000 registered voters. The county shall include one U.S. Congressional District, five state senate districts, 11 state house of representatives districts, and 30 townships. Each township shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(3) Test precinct for precinct count systems. The test precinct shall include both rural voters (who are eligible to vote for township officers) and city voters (who are not eligible to vote for township officers).

22.9(4) All requirements for preparation and printing of test ballots shall be met in the preparation of ballots for the test elections including, but not limited to, rotation of candidates' names and the provision of space for write-in votes.

22.9(5) Test ballots provided by vendor. The vendor shall provide the ballots to be used in the testing of the equipment. A total of at least 2000 ballots shall be printed for each of the two test elections. One thousand ballots for each test election shall be marked and manually tabulated by the vendor to use as a test of the ability to tabulate results accurately. The balance of the ballots shall be delivered to the examiners before the date set for the examination. The examiners shall mark and manually tabulate an additional set of at least 300 test ballots.

22.9(6) Accessibility testing by other interested parties. Any party interested in the accessibility of voting equipment that is being considered for state certification may request to be included on notices of meetings of the board of examiners. Requests shall be sent to the examiners, in care of the Elections Division, Office of the Secretary of State, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319. Any parties present at the meeting may complete accessibility testing on the equipment and submit a report on the accessibility of the voting system to the examiners within 30 days of the date of the examination and test. The report may be made in written or oral form. If an interested party would like to make an oral report, the examiners may hear the report either in person or by conference call organized by the elections division, whichever the examiners prefer.

[ARC 0736C, IAB 5/15/13, effective 6/19/13]

721—22.10(52) Test primary election for three political parties.

22.10(1) *Closed primary election.* Voters may only cast votes for the candidates of one of the parties.

22.10(2) *Offices.* The following offices shall each have two candidates for each party. Candidate names shall be rotated as required by Iowa Code section 43.28.

- a. U.S. Senator
- b. U.S. Representative
- c. Governor
- d. Secretary of State
- e. Auditor of State
- f. Treasurer of State
- g. Secretary of Agriculture
- h. Attorney General
- i. State Senator
- j. State Representative
- k. County Supervisor (vote for no more than three of six candidates)
- l. County Treasurer
- m. County Recorder
- n. County Attorney
- o. and p. Rescinded IAB 8/1/07, effective 7/13/07.

22.10(3) *Write-in votes.* Spaces for write-in votes shall be provided for each office on the ballot. The number of spaces shall equal the number of persons to be elected to the office.

721—22.11(52) Test general election. The ballots for the test general election shall include the following:

22.11(1) *Offices.* In the test general election all of the above offices shall be included with the addition of candidates for lieutenant governor to be voted for jointly with each candidate for governor. Each political party and nonparty political organization shall have one candidate for each office that appeared on the primary ballot, except county supervisor, which shall have three candidates for each party and nonparty political organization. Names of candidates for county supervisor shall be rotated as required by Iowa Code section 49.31, subsection 2.

The following nonpartisan offices shall also be included on the ballot with the heading “Nominated by Petition”:

- a. Township Trustee
- b. Township Clerk
- c. County Public Hospital Trustee
- d. Soil and Water Conservation District Commissioners
- e. Agricultural Extension Council

22.11(2) Judicial ballot. Portions of the judicial ballot may be printed separately if necessary.

- a. Supreme Court (five justices)
- b. Appeals (four judges)
- c. District Court (six judges)
- d. District Associate Judges (three judges)

22.11(3) Public measures.

- a. Constitutional Amendments (two)
- b. Local public measures (three)

22.11(4) Rescinded IAB 11/8/17, effective 12/31/17.

22.11(5) Write-in votes. Spaces for write-in votes shall be provided for each office on the ballot. The number of spaces shall equal the number of persons to be elected to the office. This does not include judges standing for retention.

[ARC 3447C, IAB 11/8/17, effective 12/31/17]

721—22.12(52) Report of findings. Within 60 days of examining a voting system pursuant to this chapter, the examiners shall complete a report showing their findings. The report shall include a checklist containing all statutory requirements for voting systems and shall indicate whether each requirement applies to the voting system being examined and whether the voting system is compliant or not compliant. The checklist must indicate that all applicable items are compliant with statutory requirements in order for the examiners to find that the voting system may be approved for use.

22.12(1) Accessibility reports. If interested parties are present at the examination and test and participate in accessibility testing of the equipment, the examiners shall wait a minimum of 30 days from the date of the examination and test before completing the report required by this rule so that the examiners have sufficient time to receive and review any accessibility reports submitted by interested parties pursuant to subrule 22.9(6).

22.12(2) Approval prior to use. If the report states that the voting system has been approved for use, the voting system may be adopted for use at elections.

22.12(3) Report filed with the secretary of state. The report shall be filed with the secretary of state. The secretary of state shall retain the vendor’s application and other documents submitted pertaining to the certification as long as the voting system remains certified.

[ARC 0736C, IAB 5/15/13, effective 6/19/13]

721—22.13(52) Notification. The examiners shall promptly notify the vendor of their decision and shall provide the vendor with a copy of their report.

721—22.14(52) Denial of certification. If the examiners find that the equipment does not meet the requirements prescribed by the Code of Iowa and the Iowa Administrative Code, the examiners shall deny certification to the equipment. The report of the board shall specify the reasons for the denial, as well as all areas in which the equipment complied with the requirements of the law. Certification may be denied for any of the following reasons:

22.14(1) The absence of any feature required by Iowa Code section 52.5 or 52.26.

22.14(2) Failure to pay the examiners’ fees and expenses, or the fees of any consultant mutually agreed upon by the examiners and the vendor.

22.14(3) Failure to provide the examiners with a complete application as required by rule 721—22.5(52).

22.14(4) Failure of the equipment to produce accurate results in one or both of the test elections. The test groups of ballots shall be tabulated manually to determine the expected outcome of each test election. If the equipment fails to reproduce exactly the results of the manual tabulation, the system shall not be approved for use, unless it can be demonstrated that the manual tabulation was in error and the machine tabulation was accurate.

[ARC 9468B, IAB 4/20/11, effective 5/25/11]

721—22.15(52) Application for reconsideration. Following denial of certification a vendor may make the necessary modifications to the system and apply for reconsideration. Aspects of the equipment which were approved in the initial application do not need to be reexamined unless the examiners find that the modifications may have affected the ability of the equipment to comply in other areas. If certification was denied for the reasons cited in 22.14(1) or 22.14(4), both test elections must be completed satisfactorily, or approval shall not be granted.

721—22.16(52) Appeal. If the vendor believes the denial of certification is in error, the vendor must file written exceptions with the examiners within 30 days after issuance of the report. The examiners will issue a response to the exceptions within 30 days after filing of the exceptions. A vendor who is aggrieved or adversely affected by a denial after a ruling on exceptions may seek judicial review pursuant to Iowa Code section 17A.19.

721—22.17(52) Changes to certified voting systems. The procedures in this rule shall be followed anytime a change is made to a certified voting system, including a change in tabulation software, firmware, or hardware.

22.17(1) Notification of change. The vendor shall notify the examiners of any changes in a certified voting system. The vendor shall provide the examiners with the following information at the time the vendor provides notice of the change(s):

- a. A description of the changes made.
- b. Reports of test results conducted by an accredited independent test authority, and any reports of test results conducted by or for other states following the changes to the voting system.
- c. Copies of manuals, instructions, advertisements and other documents submitted with the voting system's original application for certification that have been updated since the original application was submitted.
- d. An assessment from an accredited independent test authority of the change as either a de minimis change or a modification to the voting system.

22.17(2) Commencing review proceedings. Within seven days of receiving a voting system change notice from a vendor, the examiners shall commence review proceedings to independently determine whether the change submitted by the vendor is a de minimis change or a modification to the voting system. In making this independent determination, the examiners may use any means available, including hiring a consultant pursuant to rule 721—22.7(52).

22.17(3) De minimis changes. If the examiners determine a change to a voting system is de minimis, the examiners may approve the changes by motion and certify the changed voting system for use in the state.

22.17(4) Modifications to voting systems. If the examiners determine a change to a voting system is a modification to the voting system, the examiners shall require the vendor to submit a new application for certification and testing of the voting system pursuant to rules 721—22.5(52) to 721—22.11(52).

[ARC 8244B, IAB 10/21/09, effective 10/2/09]

721—22.18(52) Rescinding certification.

22.18(1) Grounds for rescinding certification. Certification may be rescinded if it is found that:

- a. The equipment does not produce accurate results and reports as required for an election.

b. Modifications have been made in a certified voting system that have not been approved by the examiners.

c. Equipment which has been certified for use has not been adopted by any county in Iowa, or is no longer used by any county in Iowa, and is no longer available for purchase from the manufacturer. The examiners may rescind certification of such voting equipment without a complaint or contested case proceedings.

d. Equipment that has been certified for use no longer complies with the requirements of Iowa law.

e. Any other grounds that may materially affect delivery or performance of the equipment.

22.18(2) *Procedure for rescinding certification.* Complaints regarding voting equipment certified for use in Iowa shall be filed with the secretary of state. The examiners shall review all complaints and may initiate a contested case to rescind certification on any ground listed above. The contested case may be conducted before the examiners or before an administrative law judge. A contested case for rescinding certification shall be conducted, to the extent applicable, in accordance with the procedural rules specified in 481—Chapter 10, Iowa Administrative Code.

22.18(3) *Suspension of certification.* If the administrative law judge hearing the contested case, or the examiners, as the case may be, find that the voting equipment can be modified to correct the deficiency, certification may be suspended until the deficiency is corrected. If it is found that the deficiency is limited to a specific flaw not present in all models of the equipment, the suspension may be limited to the deficient models. While certification is suspended, the equipment may not be used for any election.

After the required modifications have been made the vendor may apply for reexamination of the equipment following the procedure described in rule 721—22.17(52).

22.18(4) *Further use prohibited.* If certification of voting equipment is rescinded without qualification, no further use shall be permitted by any county.

[ARC 8244B, IAB 10/21/09, effective 10/2/09]

These rules are intended to implement Iowa Code sections 17A.12, 21.4, 21.5, 52.4, 52.5, 52.6, 52.7, 52.26, and 70A.9.

721—22.19(52) Examination of voting booths—application. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.20(52) Review of application by examiners. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.21(52) Contact other users. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.22(52) Criteria for approval. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.23(52) Report. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.24(52) Notification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.25(52) Denial of certification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.26(52) Application for reconsideration. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.27(52) Appeal. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.28(52) Reexamination following changes in voting booth. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.29(52) Rescinding certification. Rescinded IAB 10/21/09, effective 10/2/09.

721—22.30(50,52) Electronic transmission of election results.

22.30(1) *Certification of equipment.* On or after December 17, 2003, new components for transmission of election results by any electronic means may be used in elections in Iowa only if the components are approved by the board of examiners for use with a certified voting system. Existing systems containing electronic transmission components in use before December 17, 2003, may continue to be used until January 1, 2006, when the Help America Vote Act voting system requirements become effective.

The examiners shall review the qualification test report submitted with the application for examination and testing of the voting system. If the test report for the voting system under examination shows that the electronic transmission components have met the voting system standards and the examiners concur, the electronic transmission components may be used in conjunction with the voting system. If the qualification test report or the examiners conclude that the electronic transmission components do not meet the voting system standards, or if this feature is not mentioned in the report, purchasers of the voting system may not transmit election results electronically.

22.30(2) *Procedures on election day.* The election results may be transmitted electronically from voting equipment to the county commissioner of elections' office only after the precinct election officials have produced a written report of the election results as required by Iowa Code section 50.11. All election officials of the precinct shall sign the printed report of the election results. The signed copy shall be the official tabulation from that precinct.

22.30(3) *Procedures after election day.* Before the canvass by the board of supervisors, the county commissioner of elections shall compare the signed, printed report from each precinct with the results transmitted electronically from the precinct on election night. The commissioner shall report any discrepancies between the two sets of election results to the board of supervisors. The signed, printed results produced pursuant to Iowa Code section 50.11 shall be considered the correct results.

This rule is intended to implement Iowa Code sections 50.11 and 52.41.

721—22.31(52) Acceptance testing. When the commissioner receives voting equipment from a vendor, the commissioner shall carefully examine and test the equipment to:

22.31(1) Verify that the system delivered is certified for use in Iowa. The commissioner shall compare the voting system version numbers with the list of certified voting equipment provided by the state commissioner;

22.31(2) Verify that everything in the contract has been delivered by:

- a.* Comparing a copy of the purchase contract with the items received;
- b.* Making certain that all components, such as power cords, casters, and keys, are included;
- c.* Reviewing instruction and maintenance manuals to be sure that the correct version of each manual was provided; and

22.31(3) Verify that everything delivered actually works. The commissioner shall run a simulated election to confirm that each part of the system and the system as a whole function properly.

721—22.32(52) Optical scan voting system purchase program. Rescinded IAB 4/20/11, effective 5/25/11.

721—22.33 to 22.38 Reserved.

721—22.39(52) Public testing for direct recording electronic voting machines. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.40(52) Public testing of lever voting machines. Rescinded IAB 8/1/07, effective 7/13/07.

721—22.41(52) Public testing of optical scan systems. All automatic tabulating equipment (including equipment used to tabulate absentee ballots) shall be tested before use at any election,

as required by Iowa Code section 52.35. The process and results of the test shall be documented and available for inspection.

22.41(1) Each automatic tabulating device (including equipment that will be used for counting absentee ballots) shall be tested to determine the following:

- a.* The device and its programs will accurately tabulate votes for each candidate and question on the ballot.
- b.* Votes cast for more candidates for any office than the number to be elected will result in the rejection of all votes cast for that office on that ballot. Votes properly cast for other offices on the same ballot shall be counted.
- c.* The tabulating equipment records all votes cast and no others. A written tally of the test votes shall be prepared before the test. The results of the test voting shall be recorded. The results of the machine tabulation shall be printed and compared with the test plan.
- d.* The voter may cast as many write-in votes for each office on the ballot as there are positions to be filled, and the write-in votes are tallied correctly.
- e.* For primary elections, the tabulating equipment accurately records votes cast for all political parties.

22.41(2) Conducting the test.

- a.* The commissioner shall follow the process described in rule 721—22.42(52) for preparing test decks.
- b.* If, during the test, there are differences between the test plan and the results produced by the optical scan device, the cause of the discrepancy shall be determined. If the cause of the discrepancy cannot be determined and corrected, the faulty program or equipment shall not be used in the election.
- c.* The test decks, the preparer's tally, and the printed results of the test shall be kept with the records of the election and preserved as required by Iowa Code section 50.19.

[ARC 3447C, IAB 11/8/17, effective 12/31/17]

721—22.42(52) Preparing test decks. The commissioner shall prepare test decks from all ballots printed for use in the election, including those for use at the polling places and for absentee balloting. Each of the following test decks shall be prepared for every precinct and ballot style in the election. Commissioners may use additional test methods to supplement the process described in this rule.

22.42(1) *Requirements for all test decks prepared by the commissioner and used in public testing.* The commissioner shall:

- a.* Replace ballots spoiled during the marking process instead of attempting to correct errors.
- b.* Fill in each oval completely using the recommended pen, pencil or voter assist terminal.
- c.* Mark each ballot "Test Ballot."
- d.* Mark at least one valid vote for each candidate and question on the ballot using the OVI unit (if applicable). The ballots marked by the OVI unit may be used as part of the systematic test deck (if applicable).
- e.* Mark at least one valid vote for each candidate and question on the ballot using the ImageCast Evolution or ImageCast Precinct with audio and printer (if applicable). The ballots marked by one of these units may be used as part of the systematic test deck (if applicable).

22.42(2) *Required test method.* The commissioner shall:

- a.* Prepare a test plan showing the planned number of votes, including undervotes and overvotes for each oval on the ballot. Follow the instructions in subrules 22.42(3) through 22.42(5) in preparing the test decks.
- b.* Mark the test ballots according to the test plan.
- c.* Print a zero totals report from the optical scan tabulator before inserting any ballots.
- d.* Insert the ballots into the optical scan tabulator and print a report showing the number of votes recorded for all offices, questions and judges, including undervotes and overvotes.
- e.* Compare the printed report with the test plan to ensure that the correct number of votes was counted for each oval.

f. If the commissioner finds errors, the commissioner shall identify and correct them. The commissioner shall repeat the testing process until the printed results from the tabulator match the test plan. If the commissioner cannot produce an errorless test, the equipment shall not be used in the election.

22.42(3) *Systematic test deck.* The commissioner shall determine a unique number of votes for each candidate in each office, such as one vote for each write-in oval for the office, two votes for the first candidate listed (or “NO” votes on public measures and judges), three votes for the second candidate, etc. It is not necessary to have a different number of votes for each write-in oval for offices for which the voter may select more than one candidate. However, the write-in oval shall have a different number of votes marked than any candidate for the office. The commissioner shall:

- a.* For offices without candidates, mark all of the write-in ovals for that office.
- b.* For offices in which the voter may vote for more than one candidate, vote for the maximum allowed on at least one ballot.
- c.* On a ballot that contains at least one valid vote, overvote one other office or question.

22.42(4) *System-specific testing requirements.* Separate tests are prescribed for each certified voting system.

a. Election Systems & Software, Unisyn OpenElect and Dominion Democracy Suite—overvote and blank ballot test. For an overvote and blank ballot test, the commissioner shall:

(1) Overvote all offices and questions (including judges) on one ballot, by marking one more vote than permitted. Do not mark the write-in ovals for any offices for which there are no candidates’ names on the ballot.

(2) When the overvoted ballots are rejected by the optical scan tabulator, override the rejection and include the ballot in the tally. Add to the manual tally the number of overvotes in this test. The tally for this part of the test deck will show no votes for any candidate.

(3) Insert a blank ballot. When the blank ballot is rejected by the optical scan tabulator, override the rejection and include the ballot in the tally. This is a very important test of the accuracy of ballot printing. Printing errors sometimes put readable marks in the voting target area.

(4) Orientation test. Mark the maximum number of choices for each office and question on one ballot.

Scan this ballot in each of the four possible orientations:

- Face up, head first.
- Face down, head first.
- Face up, feet first.
- Face down, feet first.

b. Premier Election Solutions.

(1) Blank and fully voted test. The commissioner shall use two ballots for this test.

1. Leave one ballot completely blank.

2. On the second ballot, mark every oval on both sides of the ballot.

3. Select “Test Blank Ballots” and insert the blank ballot in all four orientations:

- Face up, head first.
- Face down, head first.
- Face up, feet first.
- Face down, feet first.

4. Select “Test Fully Voted Ballots” and insert the second ballot in each of the four orientations listed in numbered paragraph “3” above.

5. Reinsert the blank ballot and the fully voted ballot and override the rejection feature.

(2) Overvote. Overvote all offices and questions (including judges) on one ballot, by marking one more vote than permitted. Do not mark the write-in ovals for any offices for which there are no candidates’ names on the ballot.

721—22.43(52) Conducting the public test.

22.43(1) The equipment shall be inspected to determine whether it has been prepared properly for the election at which it will be used. The following information shall be verified:

a. The correct program cartridge or memory card is in place for the election and the precinct or precincts in which it will be used.

b. All counters are set at zero before the test is begun.

22.43(2) The commissioner shall conclude the test not later than 12 hours before the polls open on election day. Following the test, the tabulating equipment shall be inspected to determine that:

a. All counters have been returned to zero.

b. All required locks or seals are in place.

c. The automatic tabulating equipment is ready for operation at the election.

The results tape from each scanner produced during the public test shall be signed by the person conducting the test and by any observers present at the test. The signers shall write their signatures at the end of the tape where it will be detached from the machine. The tape shall be torn or cut across the signatures, so that a portion of the signature is on the tape remaining on the tabulating device. The test results tape, including a part of the tester's signature, shall be retained with the appropriate test deck for the period of time required by Iowa Code section 50.19.

22.43(3) Test deck submitted by observers. Any person who is present at the public test may mark ballots to be used to test the voting equipment. The following conditions apply:

a. Not more than ten ballots may be submitted by any person.

b. Only official ballots provided by the commissioner at the test shall be used.

c. The observer submitting the test shall provide a written tally of the test deck.

d. The results of the machine tabulation shall be printed and compared with the observer's tally. If there are differences, the cause of the discrepancy shall be determined. If the cause of the discrepancy cannot be determined and corrected, the program or equipment shall not be used at the election.

e. The test decks, the tally, and the printed results of the test shall be kept with the records of the election and preserved as required by Iowa Code section 50.19.

Rules 721—22.41(52) through 721—22.43(52) are intended to implement Iowa Code section 52.35.

721—22.44 to 22.49 Reserved.

721—22.50(52) Voting system security. Each county shall have a written security policy. The policy shall include detailed plans to protect the election equipment and data from unauthorized access. The policy shall describe the methods to be used to preserve the integrity of the election and to document the election process.

22.50(1) *Staff access.* The security policy shall describe who shall have access to the voting equipment, including the computers used in the commissioner's office to prepare ballots and voting equipment programs or to compile election results.

22.50(2) *Computers.* For security purposes, computers used in the commissioner's office to prepare ballots and voting equipment programs or to compile election results shall not be used for any other function and shall not be linked to any computer network or to the internet unless the commissioner has on file in the office of the state commissioner a current Election Computer Risk Acceptance Form indicating acceptance of this security risk. The Election Computer Risk Acceptance Form, once submitted, is current until the end of the next even-numbered calendar year.

a. If the election computers are linked to a network or to the internet, the commissioner shall use a firewall to filter network traffic. Data transmissions over the internet shall be encrypted and password-protected. Information posted to a website shall not be considered transmission of data over the internet.

b. Access to the computer(s) used to prepare ballots and voting equipment programs or to compile election results shall be limited to persons specified by the commissioner in the written security policy. The level of access granted to each person identified in the policy shall be specified.

(1) Uniqueness. The usernames and passwords for each user authorized in the security policy shall be unique. The creation of generic or shared usernames is specifically prohibited. Each user shall have exactly one username and password, except where job requirements necessitate the creation of multiple usernames to access different business functions.

(2) Authority. Each user shall be granted only the level of access specifically required by the user's job. Use of "Administrator," "Super User," "Security Administrator," or "SA" levels of authority shall be severely restricted.

(3) Generic usernames. Staff members with generic usernames are not allowed to sign on to voting systems.

(4) Password standards.

Account Policy	Recommended Setting
Maximum Password Age	90 days
Minimum Password Age	2 days
Minimum Password Length	8 characters
Enforced Password History	6 passwords (last 6 cannot be used)
Account Lockout (number of unsuccessful log-on attempts)	3 bad attempts
Account Lockout Duration	6 hours
Reset Account Lockout Counter After	6 hours

c. Hardened operating system. For security purposes, users of Election Systems & Software, Unity 3.4.0.1, Election Systems & Software EVS 5.3.0.0, Democracy Suite 4.6 and Democracy Suite 4.14B shall harden the operating system on the computer on which the election management system is housed according to the specifications of the vendor and the recommendations of the county information technology department (if any).

22.50(3) *Evacuation.* If it is necessary to evacuate the election office, a satellite absentee voting station or a polling place, the precinct election staff or the election officials shall immediately attempt to notify the commissioner and take the following actions:

a. Keep people safe.

b. If possible, gather and secure voted ballots, election equipment and critical election documents.

[ARC 0801C, IAB 6/26/13, effective 7/31/13; ARC 1746C, IAB 12/10/14, effective 1/14/15; ARC 2074C, IAB 8/5/15, effective 9/9/15]

721—22.51(52) Memory storage devices. For all voting equipment, the following security measures for memory storage devices are required:

22.51(1) *Serial number.* Each memory storage device shall have a serial number printed on a readily visible label. The label shall include the name of the county.

22.51(2) *Inventory.* Memory storage devices owned by the county and retained in the custody of the county commissioner shall be maintained under perpetual inventory, with a record of inventory activity. The commissioner shall maintain a similar record of relevant actions if the memory storage devices are acquired from a vendor for each election. The record of inventory activity shall reflect:

a. The date each memory storage device was acquired;

b. Each use of each memory storage device in an election;

c. Each maintenance activity to a memory storage device, such as changing the battery;

d. Any problems or errors detected while using the memory storage device during its life;

e. Records of the disposal of any memory storage devices at the end of their useful life or upon return to the vendor for maintenance or warranty claims.

22.51(3) *Custody.*

a. In counties where the commissioner has the necessary software and equipment to program the memory storage devices locally, the commissioner shall maintain a memory storage device log for each election as required in subrule 22.51(4) during the period when the memory storage devices are removed from storage, prepared for an election, and until they are sealed into a voting device. Only county employees and precinct election officials, as applicable, authorized by the county's security policy shall be permitted to handle the memory storage devices. No one individual should be alone with the unsecured memory storage devices at any time. If a person who is not authorized by the security policy to have access to the memory storage devices transports them to another location, such as a warehouse, the memory storage devices shall be enclosed in a transport container with a tamper-evident seal.

b. In counties where the commissioner purchases programming services from a vendor, the memory storage devices shall be shipped to and from the vendor by a shipping service that employs tracking numbers. The memory storage devices shall be enclosed in a package sealed with a numbered, tamper-evident seal. Programmed memory storage devices shall be shipped in a package sealed with a numbered, tamper-evident seal from the vendor to the commissioner. If the seal is not intact upon arrival, the commissioner shall immediately contact the vendor for replacement storage devices. Only county employees authorized by the county's security policy (and precinct election officials, as applicable) shall be permitted to handle the memory storage devices. No one individual should be alone with the unsecured memory storage devices at any time.

22.51(4) Memory storage device log. For each election, the commissioner shall create a log to record the serial numbers of each memory storage device, the voting equipment into which the memory storage device was installed, the serial number of the seal, the ballot style and the precinct to which the equipment is assigned. The log shall be in substantially the same form as Form A or Form B, as applicable:

Form A

State of Iowa

Election Log: Memory Storage Devices for _____ County

Use this form in counties where the memory storage devices are programmed locally.

Memory storage device chain of custody record for: _____ Election to be held ____ / ____ /20____

[illegible]

Memory Storage Device Shipping Record for _____ County

Shipped for programming:

Record each storage device number before packing to ship, and check out each storage device number on the chain of custody record. Enclose a photocopy of the Memory Storage Device Record with the storage devices.

Shipped by: _____ Date: ____/____/____ Time: ____:____ a.m./p.m.
 Print name Signature

Shipped to: _____ Shipped via: _____
 _____ Tracking number: _____

Instructions to vendor:

Check in each storage device number on the enclosed chain of custody record when unpacking storage devices.

By: _____ Date: ____/____/____ Time: ____:____ a.m./p.m.
 Print name Signature

- If memory storage devices are removed from this inventory for any reason, make a notation of which storage device(s) on the Memory Storage Device Record.
- Replacement storage device(s) if issued should be added to the bottom of the Memory Storage Device Record as a new storage device. A serial number will be assigned later by the receiving county.

Shipped via: _____ Date: _____ Tracking number: _____

Received by County Election Department on Date: ____/____/____

Was the package sealed? _____ Was the seal intact? _____ Notes: _____

Keep the memory storage devices in secure storage after they are received and until they are installed in the voting equipment.

22.51(5) Preparation and installation. When memory storage devices are installed, they shall be sealed immediately into the machine using a numbered, tamper-evident seal. Appropriate log entries shall be completed.

22.51(6) Replacing seals or memory storage devices. If a seal is accidentally broken or a memory storage device is replaced for any reason, the issuance of a new seal and the entry into the log shall be witnessed by more than one person. The facts of the incident and the names of the individuals who detected and resolved it shall be recorded.

22.51(7) Opening the polls. Immediately before the polls open on election day, the precinct election officials shall turn on the voting equipment and print the report showing that all counters are set at zero.

22.51(8) Verification log. The commissioner shall provide to each precinct a precinct verification log with the ballot record and receipt. The verification log shall provide places for precinct election officials to record or check the following information before the polls open and again before leaving the polling place at the end of the day:

- a. Seal numbers from the voting equipment; and
- b. Condition of seals on ballot containers.

22.51(9) Election day.

a. Before the polls are opened, the precinct election officials shall verify the required information in the verification log and sign the log.

b. After the polls are closed, the precinct election officials shall verify the required information in the verification log and sign the log before leaving the polling place.

c. If the precinct election officials remove the memory storage devices from the voting equipment, the officials shall first print the results report from the voting equipment.

22.51(10) *Return of memory storage devices.* If the precinct election officials remove the memory storage devices from the voting equipment on election night, they shall return to the commissioner the memory storage devices and the seals used to secure them in a sealed envelope or other container. All officials of the precinct shall witness the statement on the envelope or other container. The label on the envelope or other container shall be in substantially the following form:

Memory Storage Devices

Election Date: _____

Precinct: _____

This envelope contains Memory Storage Devices and memory storage device access seals from this precinct.

Machine Number	Memory Storage Device #	Memory Storage Device Seal #

[Signatures of all precinct election officials shall be included on the label.]

22.51(11) *Storage.* If the memory storage devices are returned inside the voting equipment to the commissioner, the machine serial numbers and the seal numbers shall be verified against the verification log described in subrule 22.51(8). When the memory storage devices are removed, their serial numbers shall also be verified against the verification log returned by the precinct's election officials. The memory storage device audit log shall be retained for the time period required by Iowa Code section 50.19.

22.51(12) *Results verified.* Before the conclusion of the canvass of votes, the individual results reports from the precincts, as signed by the precinct election officials at the polls on election night, shall be compared to the election results compiled for the canvass (either manually or electronically) to verify that transmitted and accumulated totals match the results witnessed by the election officials. Any discrepancies in these totals shall be reconciled before the supervisors conclude the canvass.

22.51(13) *Retention of programmed memory storage devices.* The election information on all memory storage devices used for an election shall be retained on the memory storage devices until after the time to file requests for recounts and election contests has passed. If a contest is pending, the memory storage devices shall be retained until the contest is resolved. Before the memory storage devices are permanently erased, the commissioner shall print the memory storage device audit log from each storage device.

22.51(14) *Retention of program information.* The commissioner shall retain all instructions and other written records of the process for programming the memory storage devices and the memory storage device audit logs for the period required by Iowa Code section 50.19. The contents of memory storage devices and other electronic records of the election process shall be collected and retained in an electronic or other medium and stored with the other election records for the time period required by Iowa Code section 50.19.

[ARC 0801C, IAB 6/26/13, effective 7/31/13]

721—22.52(52) Voting equipment malfunction at the polls. The precinct election officials shall immediately cease using any malfunctioning voting equipment and report the problem to the commissioner. Only a person who is authorized in writing by the commissioner to do so shall be permitted to attempt to repair malfunctioning voting equipment. The person shall show identification

to the precinct election official. The commissioner shall keep a written record of all known malfunctions and their resolution. The precinct election officials shall return the voting equipment to service only if the malfunction is corrected.

22.52(1) Routine resolution. Some problems may be easily resolved by following simple instructions. If the commissioner and the precinct election officials are able to resolve a problem without replacing the equipment, the officials shall document the problem, the time it occurred, how it was resolved, and by whom.

22.52(2) Repair or replacement. Repairs to voting equipment at the polls on election day shall be limited. If the problem cannot be easily resolved, a person who is authorized to do so by the commissioner shall replace the equipment as soon as possible. Two election officials, one from each political party, shall witness repair or replacement of any voting equipment, including memory cards. The authorized person making the repair or replacement and the two election officials shall sign a report of the incident.

721—22.53 to 22.99 Reserved.

OPTICAL SCAN VOTING SYSTEMS

721—22.100(52) Optical scan ballots, automatic tabulating equipment, and absentee voting. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.101(52) Definitions. The definitions established by this rule shall apply whenever the terms defined appear in relation to an optical scan system used with the type of ballot defined in this rule.

“Ballot” means the official document that includes all of the offices or public measures to be voted upon at a single election, whether they appear on one or more optical scan ballots.

“Optical scan voting system” means a system employing optical scan ballots under which votes are cast by voters by marking the optical scan ballots with a ballot marking device and thereafter counted by use of automatic tabulating equipment.

“Overvote” means to vote for more than the permitted number of choices for any office or question on a ballot.

“Secrecy envelope” means a reusable envelope of sufficient construction that when the optical scan ballot is inserted in it all portions indicating voting marks are hidden from view.

“Tabulating device” means the portable apparatus which examines and counts the votes recorded on the optical scan ballot and produces a paper printout of the results of the voting.

“Ticket” means each list of candidates nominated by a political party or group of petitioners.

“Undervote” means to vote for fewer than the permitted number of choices for any office or question on a ballot.

“Voting system” means the total combination of mechanical, electromechanical or electronic equipment (including the software, firmware and documentation required to program, control and support the equipment that is used to define ballots, to cast and count votes, to report or display election results and to maintain and produce any audit trail information). “Voting system” also includes the practices and associated documentation used to identify system components and versions of such components, to test the system during its development and maintenance, to maintain records of system errors and defects, to determine specific system changes to be made to a system after the initial qualification of the system and to make available any materials to the voter such as notices, instructions, forms or paper ballots. (See Section 301(b) of HAVA.)

“Voting target” means the space on an optical scan ballot which the voter marks to cast a vote for a candidate, judge or question. This target shall be printed according to the requirements of the voting system to be used to read the ballots.

721—22.102(52) Optical scan ballots. The optical scan ballots shall be printed pursuant to Iowa Code chapters 43 and 49 and by any relevant provisions of any statutes which specify the form of

ballots for special elections, so far as possible within the constraints of the physical characteristics of the system.

22.102(1) The optical scan ballots may be printed on both sides of a sheet of paper. If both sides are used, the words “Turn the ballot over” shall be clearly printed on the front and the back of the optical scan ballot, at the bottom.

22.102(2) Printed at the top of the front side of the optical scan ballot shall be the name and date of the election; the words “Official Ballot”; a designation of the ballot style or precinct, if any; and a facsimile of the commissioner’s signature.

22.102(3) The voting target shall be printed opposite each candidate’s name and write-in line on the optical scan ballot, and opposite the “yes” and “no” for each public measure and judge. The voting target shall be printed on the left side of the name or “yes” and “no”. The voting target shall be an oval unless the voting system requires a target with a different shape.

22.102(4) For partisan primary elections, the names of candidates representing each political party shall be printed on separate optical scan ballots. The ballots shall be uniform in quality, texture and size. The name of the political party shall be printed in at least 24-point type ($\frac{1}{4}$ " high) at the top of the ballot.

22.102(5) There shall be printed on the ballot a line to accommodate the initials of the precinct election official who endorses the ballot as provided in Iowa Code sections 43.36 and 49.82.

22.102(6) It is not necessary for public measures to be printed on colored paper.

22.102(7) Ballots shall be coded as necessary to allow the tabulation program to identify the appropriate ballots for the precinct. Ballots shall be coded so the tabulating device can identify by precinct the votes cast for each office and question on the ballot by precinct. The votes from the absentee and special voters precinct shall be reported as a single precinct except in general elections pursuant to Iowa Code section 53.20 as amended by 2008 Iowa Acts, House File 2367. Identical ballots shall not be coded to identify groups of voters within a precinct.

22.102(8) No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot. If the full text of a public measure will not fit on a single column of the ballot, the commissioner shall prepare a summary for the ballot and post the full text in the voting booth as required by Iowa Code section 52.25.

22.102(9) Ballots shall be stored in a locked room or storage area. Access to the storage area shall be restricted to those persons identified in the election security plan. Throughout the election process, the commissioner shall keep accurate records of the number of each type of ballot or ballot style printed for the election. This record shall include the number of ballots:

- a. Ordered from the printer.
- b. Printed and delivered by the printer to the commissioner. The commissioner may store sealed, unopened packages of ballots without verifying the number of ballots in the package.
- c. Used for testing as required by Iowa Code sections 52.9 and 52.35 and rule 721—22.41(52).
- d. Held in reserve for emergencies as required by Iowa Code section 49.66.
- e. Delivered to and returned from the polling places as required by Iowa Code sections 49.65 and 50.10.
- f. Used for absentee voting, including any spoiled ballots.
- g. Issued as sample ballots to the public as permitted by Iowa Code section 43.30.
- h. Photocopied ballots used pursuant to Iowa Code section 49.67.
- i. Printed by the commissioner using any voting system program, such as Election Systems & Software’s Ballot on Demand program.

721—22.103 to 22.199 Reserved.

PRECINCT COUNT SYSTEMS

721—22.200(52) Security.

22.200(1) At least one tabulating device shall be provided at each precinct polling place for an election. If the tabulating device is delivered to the polling place before election day, it shall be secured against tampering or kept in a locked room.

22.200(2) The maintenance key or keys used to gain access to the internal parts of the tabulating device shall be kept in a secure place and in a secure manner, in the custody of the commissioner. On election day, the key used to obtain the paper printout shall be kept by the chairperson of the precinct election officials in a secure manner. Small electronic devices, such as memory cards, cartridges or other data storage devices used to activate tabulation equipment or to store election information, shall be in the custody of the precinct chairperson when the devices are not installed on the voting equipment.

22.200(3) If a password is needed for precinct election officials to have routine access to the tabulating device during election day, the password shall be changed for every election. The commissioner shall restrict access to the password in the written security policy.

721—22.201(52) Programming and testing the tabulating devices for precinct count systems.

22.201(1) All programming of tabulating devices shall be performed under the supervision of the commissioner. The devices shall be programmed to ensure that all votes will be counted in accordance with the laws of Iowa. Tabulating devices shall be programmed to return to the voter any ballots:

- a. That are not coded to be used in the precinct.
- b. That are read as blank.
- c. That have one or more overvoted offices or public measures.

22.201(2) Digital ballot images that are saved as the voted ballots are scanned and the portions of those images that are printed on the results tapes may be used for the purpose of tallying write-in votes cast in the election. Digital ballot images that are saved as the voted ballots are scanned shall not be transferred to the election computer used as part of the voting system as defined by rule 721—22.1(52). Digital ballot images shall be treated as voted ballots under Iowa Code section 50.12 in terms of preservation, access, retention, and destruction, except the images shall not be accessed in the event of an official recount as required by Iowa Code section 50.48(4) “a” or election contest unless the actual physical ballots are unavailable.

[ARC 1548C, IAB 7/23/14, effective 8/27/14]

721—22.202(50) Unique race and candidate ID numbers for election night results reporting. All tabulating devices programmed for primary and general elections and for special elections conducted pursuant to Iowa Code section 69.14 shall be programmed using the unique race and candidate ID numbers assigned by the state commissioner. The unique race and candidate ID numbers will be provided to the county commissioners with the candidate certification prepared by the state commissioner.

This rule is intended to implement Iowa Code chapter 50.

[ARC 9989B, IAB 2/8/12, effective 1/17/12]

721—22.203(50) Reporting election night results electronically. For all primary and general elections, the county commissioner shall provide the state commissioner with an electronic results file generated from the county’s vote tabulation software system, if any. For special elections conducted pursuant to Iowa Code section 69.14, the county commissioner shall provide election night results in the manner requested by the state commissioner.

This rule is intended to implement Iowa Code chapter 50.

[ARC 9989B, IAB 2/8/12, effective 1/17/12]

721—22.204 to 22.220 Reserved.

721—22.221(52) Sample ballots and instructions to voters. Sample special paper ballots and printed instructions for casting votes on special paper ballots shall be prominently displayed in each polling place. Instructions shall also be displayed inside each voting booth. Each special paper ballot shall also include an example of the method of marking the ballot recommended by the manufacturer of the tabulating device. Further instructions shall be provided to any voter who requests assistance in accordance with Iowa Code section 49.90.

721—22.222 to 22.230 Reserved.

721—22.231(52) Emergency ballot box or bin. Each precinct shall be furnished with an emergency ballot box or bin that is suitably equipped with a lock and key or numbered, tamperproof seal. In the event of power failure or malfunction of the tabulating device, voted ballots shall be deposited in the locked or sealed emergency ballot box or bin. A precinct election official shall put the ballot into the emergency ballot box or bin for the voter. The voted ballots so deposited may be removed from the locked emergency ballot box or bin and tabulated before the polls close whenever a properly functioning tabulating device becomes available, or the voted ballots so deposited may be removed and counted electronically or manually immediately after the polls are closed. If the ballots are counted manually, the precinct election officials shall follow the requirements of 721—Chapter 26.

721—22.232(52) Manner of voting. After the precinct election official has endorsed a ballot, the official shall instruct the voter to use only the marker provided. The ballot shall be inserted in a secrecy folder and given to the person who is entitled to receive the ballot in accordance with the provisions of Iowa Code section 49.77.

22.232(1) The precinct officials shall provide each voter with a secrecy folder. The commissioner may print basic ballot marking instructions on the secrecy folder. It is not necessary to print information on secrecy folders that will limit the usefulness of the secrecy folder to one or more elections or election types. Upon receipt of the ballot in the secrecy folder, the voter shall retire alone to a voting booth and without delay mark the ballot.

22.232(2) The voter shall vote upon the ballot by marking the appropriate voting target with an appropriate pen or pencil in the manner described in the instructions printed on the ballot.

When a write-in vote has been cast, the ballot must also be marked in the corresponding voting target in order to be counted.

22.232(3) After marking the ballot, the voter shall replace it in the secrecy folder and leave the voting booth at once.

22.232(4) The voter shall at once deposit the ballot, still enclosed in the secrecy folder, in the tabulating device so that the ballot is automatically removed from the secrecy folder, the votes tabulated, and the ballot deposited in the ballot box.

22.232(5) If the tabulating device is equipped with a mechanism that will not permit more than one ballot to be inserted at one time, the voter may insert the ballot into the tabulating device. If the tabulating device cannot detect and reject multiple ballots, the voter shall be required to hand the ballot in the secrecy folder to the precinct election official without revealing any of the marks on the ballot. The precinct election official shall at once deposit the ballot in the manner described in subrule 22.232(4).

22.232(6) If the tabulating device returns a ballot, the precinct official attending the device shall ask the voter to wait. Without examining the ballot, the official shall enclose the returned ballot in a secrecy folder. If necessary, the official shall read to the voter the information provided by the device about the reason the ballot was returned. The official shall offer the voter the opportunity to correct the ballot. The precinct official shall mark the returned ballot “spoiled” and shall also tear or mark the ballot so that the tabulating device cannot count it. The voter may use the spoiled ballot as a guide

for marking the corrected ballot. After the voter has marked the corrected ballot, the precinct officials shall collect the spoiled ballot and keep it with other spoiled ballots.

22.232(7) If the voter who cast the returned ballot is not available, or declines to correct the ballot, the precinct official shall not mark the ballot “spoiled.” Either the voter or the official shall reset the tabulating device to accept the ballot. The voter, or the official if the voter has gone, shall insert the ballot into the precinct counter without further examination.

721—22.233 to 22.239 Reserved.

721—22.240(52) Results. After the polls are closed and the tabulating device has processed all of the ballots, including any ballots from the emergency ballot box or bin, the precinct election officials shall:

22.240(1) Unlock the tabulating device and obtain a paper printout showing the votes cast for each candidate and public measure.

22.240(2) Fasten the paper printout to the official tally sheet.

22.240(3) Unlock or remove the seal on the ballot box or bin containing ballots with write-in votes and open it. The precinct officials shall remove the ballots and manually count the write-in votes as required by 721—Chapter 26. The officials shall record the write-in votes in the tally list. A single tally list is sufficient for use when tabulating write-in votes.

22.240(4) Seal all ballots in a transfer case to be returned to the commissioner in accordance with Iowa Code section 50.12.

22.240(5) It is not necessary for the precinct officials to separate primary election ballots by political party.

721—22.241(52) Electronic transmission of election results. If the equipment includes a modem for the electronic transmission of election results, the precinct officials may transmit the results after a printed copy has been made. If the voting system includes a data card, cartridge or other small device that contains an electronic copy of the election results, the precinct chairperson shall secure the device and ensure its safe delivery to the commissioner.

721—22.242 to 22.249 Reserved.

721—22.250(52) Absentee voting instructions. Printed instructions shall be included with the ballot or ballots given to or mailed to each absentee voter. Written instructions to the voter shall be sent with every absentee ballot. For federal elections, the commissioner shall use only the instructions provided by the state commissioner.

721—22.251(52) Absentee voting instructions. Rescinded IAB 11/23/05, effective 12/28/05.

721—22.252 to 22.259 Reserved.

721—22.260(52) Specific precinct count systems. Additional rules are provided for each voting system approved for use in Iowa. The requirements in rules 721—22.261(52) through 721—22.265(52) apply only to the voting systems indicated and are in addition to the general provisions set forth in rules 721—22.200(52) through 721—22.250(52).

[ARC 0238C, IAB 8/8/12, effective 7/11/12]

721—22.261(52) Election Systems & Software Voting Systems—preparation and use in elections.

22.261(1) Security. The commissioner shall have a written security plan for the voting system. Access to equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at the polling places on election day shall be changed for each election.

b. The control key for the precinct automatic tabulators shall be in the possession of the precinct chairperson on election day.

22.261(2) *Precinct automatic tabulator configuration choices.* The following settings are mandatory for all elections.

a. Ballot control. In an official election, the commissioner shall not program the precinct automatic tabulators for unconditional acceptance of all ballots, shall not divert blank ballots to the write-in bin, and shall always accept undervoted ballots. The system shall be programmed to query the voter in each of the following situations:

- (1) Overvoted ballot.
- (2) Blank ballot.
- (3) Unreadable ballot.

b. Unit control. The commissioner shall not select automatic transmission of election results by modem. The precinct officials must print the official results at the polling place before transmitting them.

c. Reports. The following are required reports:

- (1) Opening the polls. Print the Zero Certification report.
- (2) Closing the polls. Print the poll report before transmitting the election results by modem.

The poll report is the official record of the votes cast in the precinct on election day. The following certification text shall appear at the end of the poll report:

We, the undersigned precinct election officials of this precinct, hereby attest that this tape shows the results of all ballots cast and counted by the Optical Scan tabulation device at this election.

[print lines for each of the officials to sign]

Precinct Election Officials Date: _____ Time: _____

d. Reopen polls. The commissioner shall enable the option to reopen the polls, but protect it against unauthorized use. If it is necessary to reopen the polls, the chairperson of the precinct board shall contact the commissioner for the password.

e. Ballot images. Rescinded IAB 7/23/14, effective 8/27/14.

22.261(3) *Central count automatic tabulator configuration choices.* The following settings are mandatory for all elections in which the M650 or DS850 is used.

a. Ballot control. In an official election, the commissioner shall program the central count automatic tabulator to accept overvoted ballots and undervoted ballots. The commissioner shall program the central count automatic tabulator to sort blank ballots and unreadable ballots as required by Iowa Code section 52.37. Ballots with write-in votes may be sorted for further review by the absentee and special voters precinct board at the commissioner's discretion.

b. Reports. The following are required reports:

- (1) Opening the polls. Before ballots are tabulated in the central count automatic tabulator, a Zero Certification report shall be printed.
- (2) Closing the polls. After all ballots are tabulated by the central count automatic tabulator, a poll report shall be printed. The poll report is the official record of ballots tabulated in the absentee precinct. The following certification text shall appear at the end of the poll report:

We, the undersigned precinct election officials of this precinct, hereby attest that this tape shows the results of all ballots cast and counted by the Optical Scan tabulation device at this election.

[print lines for each of the officials to sign]

Precinct Election Officials Date: _____ Time: _____

c. Reopen polls. The commissioner shall enable the option to reopen the polls, but protect it against unauthorized use.

d. Ballot images. Rescinded IAB 7/23/14, effective 8/27/14.

22.261(4) Ballot printing.

a. Format. The office title, instructions about the maximum number of choices the voter can make for the office, the candidate names and all write-in lines associated with each office on the ballot shall be printed in a single column on the same side of the ballot. When describing the maximum number of choices the voter can make for the office, the following description for each office shall be used: "Vote for no more than xx." Do not include "vote for" language for public measures or judges. All text and the "yes" and "no" choices for each public measure and for each individual judge on a ballot shall be printed in a single column on the same side of the ballot. No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot.

b. Instructions for voters. The following instructions shall be printed on ballots:

(1) Voting mark. "To vote, fill in the oval next to your choice."

(2) Public measures. "Notice to voters. To vote to approve any question on this ballot, fill in the oval in front of the word 'Yes'. To vote against a question, fill in the oval in front of the word 'No'."

22.261(5) System error messages. At the discretion of the commissioner, precinct election officials may be provided with a list of routine error messages, including messages that relate to paper jams, which do not rise to the level of voting equipment malfunctions and the appropriate responses. The officials may be instructed to contact the commissioner or the commissioner's designee on election day for all other messages or routine errors for which appropriate responses have not been provided by the commissioner.

22.261(6) Record retention. The precinct automatic tabulating equipment uses thermal printers. The maximum anticipated life span of the results from each automatic tabulator is only five years. In order to preserve the permanent record of the precinct results required by Iowa Code section 50.19, the commissioner shall print a copy of the results of each precinct on permanent paper and store these copies with the tally lists from precincts where the precinct automatic tabulators were used.

[ARC 9468B, IAB 4/20/11, effective 5/25/11; ARC 0801C, IAB 6/26/13, effective 7/31/13; ARC 1548C, IAB 7/23/14, effective 8/27/14; ARC 3447C, IAB 11/8/17, effective 12/31/17]

721—22.262(52) Premier Election Solutions' AccuVote OS and AccuVote OSX precinct count devices.

22.262(1) Security. The commissioner shall have a written security plan for the voting system. Access to voting equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at polling places shall be changed for each election.

b. For each election, the precinct chairperson shall be responsible for the custody and security of the control card and ballot box keys and the security of the voting system.

22.262(2) Configuration choices. The following selections are mandatory for all elections:

a. Reject settings shall be configured as follows:

(1) Return to voters ballots that include one or more overvoted races and blank-voted ballots. Include on the override log the number of times the override option was used for overvoted and blank-voted ballots.

(2) Divert to the write-in ballot bin only ballots with write-in votes.

(3) Do not include reject settings for blank voted races, undervoted races, or duplicate votes.

b. Tally settings shall be as follows: The write-in setting shall be "Combined."

22.262(3) Zero totals reports. Long form zero totals reports showing all counters at zero shall be printed following memory card programming, before counting ballots in the Pre-Election Mode and as the ballot reader is opened on election day.

22.262(4) Ballot printing. Although the Premier Election Solutions' GEMS voting system software includes choices for variations in ballot layout, all ballots shall be prepared according to the requirements of Iowa Code sections 43.26 through 43.29 and 49.30 through 49.48. For all elections the voting target shall be an oval printed on the left side of each choice on the ballot.

22.262(5) *Preelection testing.* All voting equipment shall be tested pursuant to the provisions of Iowa Code section 52.30 and rule 721—22.42(52). At the commissioner's discretion, the commissioner may conduct additional tests.

22.262(6) *System error messages.* At the discretion of the commissioner, precinct election officials may be provided with a list of routine error messages, including messages that relate to paper jams, which do not rise to the level of voting equipment malfunctions and the appropriate responses. The officials may be instructed to contact the commissioner or the commissioner's designee on election day for all other messages or routine errors for which appropriate responses have not been provided by the commissioner.

[ARC 0801C, IAB 6/26/13, effective 7/31/13; ARC 3447C, IAB 11/8/17, effective 12/31/17]

721—22.263(52) AutoMARK Voter Assist Terminal (VAT).

22.263(1) *Acceptance testing.* Upon receipt of the equipment from the vendor, the commissioner shall subject each AutoMARK VAT to an acceptance test. The test shall be in addition to any testing provided by the vendor and shall include a demonstration of all functionalities of the device.

22.263(2) *Audio ballot preparation.* Each candidate shall have the opportunity to provide a record of the proper pronunciation of the candidate's name. The same voice shall be used for recording the entire ballot including instructions, office titles, candidate names and the full text of all public measures.

22.263(3) *Preelection testing.* Each AutoMARK VAT shall be tested before each election in which it will be used. The commissioner may use the AutoMARK VAT to prepare some ballots for test decks required by rule 721—22.42(52). In addition, the commissioner shall:

- a. Perform the test ballot print, then review the ballot to be sure that all ovals are darkened and the appropriate names are printed on each line.
- b. Calibrate the touchscreen.
- c. Select, then deselect each voting position in each race.
- d. Verify that the overvote and undervote functions are programmed correctly.
- e. Test the write-in function for each office on one ballot, and test all of the letters in the alphabet.
- f. Use the audio ballot function to mark one ballot.
- g. Tabulate the marked ballots from this test on the appropriate optical scanner.
- h. Ensure that the AutoMARK VAT is available for demonstration at public tests.

22.263(4) *Compact flash memory cartridge or memory card.* The compact flash memory cartridge shall be installed before the AutoMARK VAT is locked, sealed and shipped to the polling place for election day. In addition to locking the memory cartridge access door, the commissioner shall seal the door with a numbered seal, record the seal number, and provide the number to the precinct election officials as required by rule 721—22.51(52). From the time the AutoMARK VAT is delivered to the polling place until the time the precinct election officials arrive, the AutoMARK VAT shall be stored securely to prevent tampering. On election day, the precinct election officials shall inspect the seal and verify that the original numbered seal is present and undamaged.

22.263(5) *Calibration testing.* The commissioner may provide for printer and touchscreen calibration testing after delivery of the AutoMARK VAT to the polling place. If calibration testing is performed at the polling place, the delivery staff shall complete the testing before the polls open on election day and shall keep a log for each AutoMARK VAT and record the machine serial number, the precinct name or number, the date and time of the test, the name of the person performing the test, and the lifetime printer counter number at the completion of the test. The ballot to be used in the calibration test shall be provided to the tester and shall be labeled with the precinct name and election date. The completed calibration test ballot shall be returned to the commissioner and kept with the election records.

22.263(6) *AutoMARK VAT keys.* Possession of the AutoMARK VAT keys shall be restricted to precinct election officials and authorized members of the commissioner's staff.

22.263(7) Table. The table used to support the AutoMARK VAT shall meet the following requirements: The table shall be sturdy enough to hold the 40-pound AutoMARK VAT safely. Clearance shall be at least 27 inches high, 30 inches wide, and 26 inches deep. The top of the table shall be from 28 inches to 34 inches above the floor.

22.263(8) Privacy. The commissioner may provide each AutoMARK VAT with a privacy shield to protect the secrecy of each voter's ballot. The commissioner shall instruct the precinct election officials to position the AutoMARK VAT to provide maximum access for voters (especially voters who use wheelchairs) as well as privacy.

22.263(9) Abandoned ballots. If a voter or precinct election official discovers that a voter has left the AutoMARK VAT without printing the voter's ballot, the two precinct election officials designated to assist voters shall print the ballot without reviewing the ballot or making any changes, enclose the ballot in a secrecy folder, and immediately deposit the ballot in the tabulating device.

721—22.264(52) Unisyn OpenElect OVO unit—preparation and use in elections.

22.264(1) Security. The commissioner shall have a written security plan for the voting system. Access to equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at the polling places on election day shall be changed for each election.

b. For each election, the precinct chairperson shall be responsible for the custody and security of the keys for the voting equipment, the ballot boxes and the security of the voting system on election day.

22.264(2) Configuration choices. The following selections are mandatory for all elections:

a. Access, messaging and tabulating selections. In the Election Manager, "Election Options" menu, the following selections shall be made:

(1) "Allow Add Precinct" shall be checked.

(2) "Full Voter Ballot Review" shall not be checked. The commissioner may select either "Alert Print Only" or "Alert on-screen."

(3) "Show Precinct Split Totals" shall not be checked.

(4) "Overvote by Vote For" shall be checked.

(5) "No Undervote Check" shall be selected in the Undervote Checking dropdown menu.

b. Printing selections. In the Election Manager, "Printing Options" menu, the following selections shall be made:

(1) "Auto Print Alerts" may be checked.

(2) "Voter Receipts" shall not be checked.

(3) "Show Contest Results on Election Day" shall be checked.

c. Ballot acceptance by the OVO unit. In an official election, the commissioner shall not program the OVO for unconditional acceptance of all ballots and shall program the OVO unit to accept undervoted ballots. The system shall also be programmed to query the voter and give the voter the on-screen option to "Cast Ballot as Marked" in each of the following situations:

(1) Overvoted ballot.

(2) Blank ballot.

(3) Unreadable ballot.

d. Reports. The following are required reports:

(1) Opening the polls. Print a zero vote totals report.

(2) Closing the polls. The poll report is the official record of the votes cast in the precinct on election day.

(3) Certification text. The following shall appear at the end of the poll report:

We, the undersigned precinct election officials of this precinct, hereby attest that this tape shows the results of all ballots cast and counted on this tabulating device at this election.

(Include signature lines for each of the officials to sign.)

22.264(3) Ballot layout. Although the Unisyn OpenElect voting system software includes choices for variations in ballot layout, all ballots shall be prepared according to the requirements of Iowa Code sections 43.26 through 43.29 and 49.30 through 49.48.

a. Format. The office title, instructions about the maximum number of choices the voter can make for the office, the candidate names and all write-in lines associated with each office on the ballot shall be printed in a single column on the same side of the ballot. All text and the “yes” and “no” choices for each public measure and for each individual judge on a ballot shall be printed in a single column on the same side of the ballot. No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot. For all elections, the voting target shall be printed on the left side of each choice on the ballot.

b. Instructions for voters. The ballots shall contain instructions for voters, including:

- (1) How to mark the ballot;
- (2) Where to find the judicial ballot (if any); and
- (3) Constitutional amendment (if any) as required by Iowa Code section 49.48 and notices to voters on ballots with public measures (if any) as required by Iowa Code section 49.47.

22.264(4) System error messages. Precinct election officials shall be provided with a list of known system error messages and the appropriate responses. The officials shall be instructed to contact the commissioner or the commissioner’s designee for all other messages, errors or voting equipment malfunctions on election day.

22.264(5) Preelection testing. All voting equipment shall be tested pursuant to the provisions of Iowa Code section 52.30 and rule 721—22.42(52). At the commissioner’s discretion, additional logic and accuracy tests may be conducted.

22.264(6) Record retention. The OVO unit uses a thermal printer. The maximum anticipated life span of the results from each OVO unit is only five years. In order to preserve the permanent record of the precinct results required by Iowa Code section 50.19, the commissioner shall print a copy of the results of each precinct on permanent paper and store these copies with the tally lists from precincts where the OVO unit was used.

22.264(7) Central count automatic tabulator configuration choices. The following settings are mandatory for all elections in which the OVCS is used.

a. Ballot control. In an official election, the commissioner shall program the central count automatic tabulator to accept overvoted ballots and undervoted ballots. The commissioner shall program the central count automatic tabulator to sort blank ballots and unreadable ballots as required by Iowa Code section 52.37. Ballots with write-in votes may be sorted for further review by the absentee and special voters precinct board at the commissioner’s discretion.

b. Reports. The following are required reports:

(1) Opening the polls. Before ballots are tabulated in the central count automatic tabulator, a Zero Certification report shall be printed and shall be signed by the members of the absentee and special voters precinct board.

(2) Closing the polls. After all ballots are tabulated by the central count automatic tabulator, a poll report shall be printed. The poll report is the official record of ballots tabulated in the absentee precinct and shall be signed by the members of the absentee and special voters precinct board.

c. Reopen polls. The commissioner shall enable the option to reopen the polls, but protect it against unauthorized use.

[ARC 0238C, IAB 8/8/12, effective 7/11/12; ARC 0801C, IAB 6/26/13, effective 7/31/13; ARC 1548C, IAB 7/23/14, effective 8/27/14; ARC 1746C, IAB 12/10/14, effective 1/14/15; ARC 3447C, IAB 11/8/17, effective 12/31/17]

721—22.265(52) Unisyn OpenElect OVI unit.

22.265(1) Acceptance testing. Upon receipt of the equipment from the vendor, the commissioner shall subject each OVI unit to an acceptance test. The test shall be in addition to any testing provided by the vendor and shall include a demonstration of the functionalities of the device.

22.265(2) *Audio ballot preparation.* Each candidate shall have an opportunity to provide a record of the proper pronunciation of the candidate's name. The same voice shall be used for recording the entire ballot including instructions, office titles, candidate names and the full text of all public measures.

22.265(3) *Timeout value.* The OVI timeout value shall be set to 600 seconds. Precinct election officials shall monitor the use of the OVI unit to ensure that voting sessions are not automatically terminated due to inactivity. If a voter abandons a voting session initiated on the OVI unit without printing a ballot, the two precinct election officials designated to assist voters shall print the ballot without reviewing it or making any changes to the voter's choices before the OVI unit times out due to inactivity, enclose the ballot in a secrecy folder, and immediately deposit the ballot in the tabulating device.

22.265(4) *Preelection testing.* Each OVI unit shall be tested before each election in which it will be used. The commissioner must use the OVI unit to prepare some ballots for the test decks as required by paragraph 22.42(1) "d." In addition, the commissioner shall verify that:

- a. The vote response fields on the screen align with the candidate names or choices.
- b. All contests and candidates appear on the screen for each precinct.
- c. All contests and candidates are included in the audio ballot for each precinct.
- d. All voting positions in each race can be selected, then deselected, using the touchscreen and the keypad.
- e. Selections on the printed ballots accurately reflect the voter's choices.
- f. Overvote and undervote functions are programmed correctly.
- g. The write-in function for each office is working correctly. All letters in the alphabet must be tested.
- h. There is enough paper on the paper roll to print a minimum of ten ballots for the election in which the OVI unit is being used.

22.265(5) *Availability at public test.* The commissioner shall ensure that the OVI unit is available for demonstration at public tests.

22.265(6) *TM.* The TM device used with the OVI unit shall be installed before the OVI unit is locked, sealed and transported to the polling place for election day. The commissioner shall lock and seal the OVI unit, record the seal number and provide the number to the precinct election officials as required by rule 721—22.51(52). From the time the OVI unit is delivered to the polling place until the time the precinct officials arrive, the OVI unit shall be stored securely to prevent tampering. On election day, the precinct election officials shall inspect the seal and verify that the original numbered seal is present and undamaged.

22.265(7) *Touchscreen and printer testing.* The commissioner may provide for printer and touchscreen testing after delivery of the OVI unit to the polling place. If touchscreen testing is performed at the polling place, the delivery staff shall complete the testing before the polls open on election day. Staff shall keep a log for each OVI unit and record the machine serial number, precinct name or number, nature of the test, date and time of the test and name of the person performing the test.

22.265(8) *OVI unit keys.* Possession of the OVI unit keys shall be restricted to the precinct chairperson and authorized members of the commissioner's staff.

22.265(9) *Table or voting booth.* The table or voting booth used to support the OVI unit shall meet the following requirements:

- a. The table shall be sturdy enough to hold the OVI unit safely.
- b. Clearance shall be at least 27 inches high, 30 inches wide, and 26 inches deep.
- c. The top of the table shall be from 28 inches to 34 inches above the floor.

22.265(10) *Privacy.* The commissioner shall instruct the precinct election officials to position the OVI unit to provide maximum privacy and access to voters.

22.265(11) *Abandoned ballots.* If a voter or a precinct election official discovers that a voter has left the voter's ballot at the OVI unit, the two precinct election officials designated to assist voters shall enclose the ballot in a secrecy folder and immediately deposit the ballot in the tabulating device.

22.265(12) *Extra paper rolls.* Each precinct in which an OVI unit is being used shall be equipped with an extra paper roll for the OVI unit, and precinct election officials shall be instructed as to the method of replacing the paper roll.

[ARC 0238C, IAB 8/8/12, effective 7/11/12]

721—22.266(52) Dominion Democracy Suite Voting Systems—preparation and use in elections.

22.266(1) *Security.* The commissioner shall have a written security plan for the voting system. Access to equipment, programs and passwords shall be limited to those persons authorized in writing by the commissioner. The security plan shall be reviewed at least annually.

a. Passwords used at the polling places on election day shall be changed for each election.

b. For each election, the precinct chairperson shall be responsible for the custody and security of the keys for the voting equipment and the ballot boxes and the security of the voting system on election day.

22.266(2) *Precinct automatic tabulator configuration choices.* The following selections are mandatory for all elections.

a. *Access, messaging and tabulating selections.* The Machine Behavioral Settings shall be configured as follows:

(1) The option to allow voters to review ballot selections detected by the precinct automatic tabulator shall be disabled.

(2) Results for each precinct automatic tabulator shall be consolidated by precinct and shall not be reported by split within a precinct.

(3) The automatic tabulators shall be configured to report write-in votes when the oval is darkened, regardless of whether there is text written on the corresponding write-in line.

b. *Ballot acceptance.* In an official election, the commissioner shall not program the precinct automatic tabulators for unconditional acceptance of all ballots and shall program the automatic tabulators to accept undervoted ballots. The automatic tabulators shall also be programmed to query the voter in each of the following situations:

(1) Overvoted ballot.

(2) Blank ballot.

(3) Unreadable ballot.

(4) Ambiguous marks. Ambiguous marks shall be defined as those marks where 5 to 24 percent of the voting target is darkened.

c. *Reports.* The following are required reports:

(1) Opening the polls. Print a zero vote totals report.

(2) Closing the polls. The poll report is the official record of the votes cast in the precinct on election day.

(3) Certification text. Substantially the following text shall appear at the end of the poll report:

We, the undersigned precinct election officials of this precinct, hereby attest that this tape shows the results of all ballots cast and counted on this tabulating device at this election.

(Include signature lines for each of the officials to sign.)

22.266(3) *Central count automatic tabulator configuration choices.* The following settings are mandatory for all elections in which the ImageCast Central automatic tabulator is used.

a. *Ballot control.* In an official election, the commissioner shall program the central count automatic tabulator to accept overvoted ballots and undervoted ballots. The commissioner shall program the central count automatic tabulator to sort or notify the user when blank ballots, unreadable ballots and ballots with write-in votes are detected so such ballots can be separated for further review by the absentee and special voters precinct board as required by Iowa Code section 52.37.

b. Reports. The following are required reports:

(1) Opening the polls. Before ballots are tabulated in the central count automatic tabulator, a Zero Certification report shall be printed and shall be signed by the members of the absentee and special voters precinct board.

(2) Closing the polls. After all ballots are tabulated by the central count automatic tabulator, a poll report shall be printed. The poll report is the official record of ballots tabulated in the absentee precinct and shall be signed by the members of the absentee and special voters precinct board.

c. Reopen polls. The commissioner shall enable this option, but protect it against unauthorized use.

22.266(4) Ballot layout. Although the Dominion Democracy Suite voting system software includes choices for variations in ballot layout, all ballots shall be prepared according to the requirements of Iowa Code sections 43.26 through 43.29 and 49.30 through 49.48.

a. Format. The office title, instructions about the maximum number of choices the voter can make for the office, the candidate names and all write-in lines associated with each office on the ballot shall be printed in a single column on the same side of the ballot. When describing the maximum number of choices the voter can make for the office, the following description for each office shall be used: "Vote for no more than xx." Do not include "vote for" language for public measures or judges. All text and the "yes" and "no" choices for each public measure and for each individual judge on a ballot shall be printed in a single column on the same side of the ballot. No office or public measure on any ballot shall be divided to appear in more than one column or on more than one page of a ballot. For all elections, the voting target shall be printed on the left side of each choice on the ballot.

b. Instructions for voters. The ballots shall contain instructions for voters, including:

- (1) How to mark the ballot;
- (2) Where to find the judicial ballot (if any); and
- (3) Constitutional amendment (if any) as required by Iowa Code section 49.48 and notices to voters on ballots with public measures (if any) as required by Iowa Code section 49.47.

22.266(5) System error messages. At the discretion of the commissioner, precinct election officials may be provided with a list of routine error messages, including messages that relate to paper jams, which do not rise to the level of voting equipment malfunctions and the appropriate responses. The officials may be instructed to contact the commissioner or the commissioner's designee on election day for all other messages or routine errors for which appropriate responses have not been provided by the commissioner.

22.266(6) Preelection testing of automatic tabulators. Each ImageCast Evolution or ImageCast Precinct with or without audio and printer unit shall be tested pursuant to the provisions of Iowa Code section 52.30 and rule 721—22.42(52). At the commissioner's discretion, additional logic and accuracy tests may be conducted.

22.266(7) Audio ballot preparation. Each candidate shall have an opportunity to provide a record of the proper pronunciation of the candidate's name. The same voice shall be used for recording the entire ballot, including instructions, office titles, candidate names and the full text of all public measures.

22.266(8) Preelection testing of accessible components. The accessible components of each ImageCast Evolution or ImageCast Precinct with audio and printer unit shall be tested before each election in which the unit will be used. The commissioner must use the ImageCast Evolution or ImageCast Precinct with audio and printer unit to prepare some ballots for the test decks as required by paragraph 22.42(1)"e." In addition, the commissioner shall verify that:

a. The vote response fields on the screen align with the candidate names or choices on the ImageCast Evolution.

b. All contests and candidates appear on the screen for each precinct on the ImageCast Evolution.

c. All contests and candidates are included in the audio ballot for each precinct on the ImageCast Evolution or ImageCast Precinct with audio and printer unit.

d. All voting positions in each race can be selected, then deselected, using the touchscreen on the ImageCast Evolution and the keypad on the ImageCast Evolution or ImageCast Precinct with audio and printer unit.

e. Selections on the printed ballots accurately reflect the voter's choices.

f. Overvote and undervote functions are programmed correctly.

g. The write-in function for each office is working correctly. All letters in the alphabet must be tested.

22.266(9) *Touchscreen and printer testing.* The commissioner may provide for printer and touchscreen testing after delivery of the ImageCast Evolution or ImageCast Precinct with audio and printer unit to the polling place. If touchscreen testing is performed at the polling place, the delivery staff shall complete the testing before the polls open on election day. Staff shall keep a log for each unit and record the machine serial number, precinct name or number, nature of the test, date and time of the test and name of the person performing the test.

22.266(10) *Table or voting booth.* A table or voting booth shall be available to a voter using the ImageCast Precinct with audio and printer unit. A chair shall be provided for voters using the ImageCast Evolution keypad and headphones components. Any table or voting booth used shall meet the following requirements:

a. Clearance shall be at least 27 inches high, 30 inches wide, and 26 inches deep.

b. The top of the table shall be from 28 inches to 34 inches above the floor.

22.266(11) *Privacy.* The commissioner shall instruct the precinct election officials to position the ImageCast Precinct with audio and printer unit to provide maximum privacy and access to voters.

22.266(12) *Abandoned ballots.* If a voter or a precinct election official discovers that a voter has left the voter's ballot at the ImageCast Precinct with audio and printer unit, the two precinct election officials designated to assist voters shall enclose the ballot in a secrecy folder and immediately deposit the ballot in the tabulating device.

22.266(13) *Ballot stock.* Each precinct in which an ImageCast Precinct with audio and printer unit is being used shall be equipped with ballot stock for the printer. The ballot stock shall be kept in a secure place throughout election day. Precinct election officials shall be instructed as to appropriate methods for securing the ballot stock and shall only place a sheet of ballot stock in the printer when an audio ballot is authorized on the unit.

22.266(14) *Record retention.* The ImageCast Evolution, ImageCast Precinct and ImageCast Precinct with audio and printer unit use thermal printers. The maximum anticipated life span of the results from each unit is only five years. In order to preserve the permanent record of the precinct results required by Iowa Code section 50.19, the commissioner shall print a copy of the results of each precinct on permanent paper and store these copies with the tally lists from precincts where the units were used.

[ARC 0801C, IAB 6/26/13, effective 7/31/13; ARC 1548C, IAB 7/23/14, effective 8/27/14; ARC 3447C, IAB 11/8/17, effective 12/31/17]

721—22.267 to 22.339 Reserved.

OPTICAL SCAN VOTING SYSTEM USED FOR ABSENTEE AND SPECIAL VOTERS PRECINCT

721—22.340(52) *Processing.* All scanners used to tabulate absentee and provisional ballots shall be configured to sort blank ballots and ballots containing marks in write-in vote targets for review by the resolution board. The scanners shall not be configured to sort ballots with overvotes. However, if it is not possible to configure the scanners used to count absentee ballots differently from those used at the polling places, the person operating the scanner shall override the scanner and accept overvoted ballots as they are processed. The resolution board shall follow the requirements of 721—subrule 26.2(2). The commissioner shall provide the resolution board with a copy of 721—Chapter 26, "Counting Votes."

This rule is intended to implement Iowa Code section 52.33 as amended by 2007 Iowa Acts, Senate File 369, section 9.

721—22.341(52) Reporting results from absentee ballots and provisional ballots. Absentee and provisional ballot results shall be reported as a single precinct as required by subrule 22.102(7).

721—22.342(52) Tally list for absentee and special voters precinct.

22.342(1) Write-in votes shall be reported on a separate tally sheet which provides a column for the names of offices, a column for the names of persons receiving votes, space to tally the votes received, and a column in which to report the total number of votes cast for each person. In tally lists provided for primary elections, separate pages shall be provided to tally the write-in votes for each political party. Each member of the board who participated in the count shall attest to each tally sheet for write-in votes.

22.342(2) The officials shall certify the procedures followed. The certification shall be in substantially the following form:

Absentee and Special Voters Tally Certificate

_____ County

We, the undersigned officials of the Absentee and Special Voters Precinct for this county, do hereby certify that all ballots delivered to the Board for this election were tabulated as shown in the attached report.

We further certify that a record of any write-in votes or other votes manually counted pursuant to Iowa Code chapter 52 is included in this Tally List, and that the numbers entered in the column headed "Total Votes" are the correct totals of all votes manually counted by us.

Signed at _____ on ____/____/____, ____:____ a.m./p.m.

[signatures of officials] 1. _____
2. _____ (etc.)

22.342(3) The record generated by the tabulating equipment shall be attached to or enclosed with the tally list and shall constitute the official return of the precinct.

This rule is intended to implement Iowa Code section 52.33 as amended by 2007 Iowa Acts, Senate File 369, section 9.

721—22.343(39A,53) Counting absentee ballots on the day before the general election. When absentee ballots are tabulated on the day before the election as permitted or required by Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670, the absentee and special voters precinct board and county commissioner shall implement the following security precautions:

22.343(1) *Seal and label voted ballot envelopes or other containers with date of tabulation.* The precinct election officials shall seal all ballots tabulated on the day before the election in a voted ballot envelope or other container labeled with the date of tabulation. The precinct election officials shall seal and sign the envelope or other container in a manner that will make it evident if the envelope or other container is opened.

22.343(2) *Ensure secure storage of all ballots.* Before adjourning for the day, the precinct election officials shall transfer custody of all absentee ballots to the commissioner. The commissioner shall ensure all absentee ballots are stored in a secure location until tabulation is resumed on election day.

22.343(3) *Ensure memory card security.* Before the absentee and special voters precinct board adjourns for the day, the memory card used in the tabulator(s) on the day before the election shall be secured by the precinct election officials in one of the following ways:

a. The memory card may be left in the tabulator when a tamper-evident seal is affixed over the memory card in a manner that will make it evident if the seal is removed.

b. The memory card may be removed from the tabulator and placed in an envelope. The precinct election officials shall seal the envelope in a manner that will make it evident if the envelope is opened.

22.343(4) *Ensure security of the tabulator(s).* Before adjourning for the day, the precinct election officials shall ensure the security of the tabulator(s). The tabulator(s) must be stored in a secure location until the absentee and special voters precinct board resumes tabulation on election day.

22.343(5) *No results tape printing on the day before the election.* No results tapes may be printed from the tabulator(s) on the day before the election.

22.343(6) *No upload of results to tabulating software until election day.* No results may be uploaded or input into tabulating software on the day before the election.

22.343(7) *Verify no tampering before resuming tabulation on election day.* Before tabulation resumes on election day, the absentee and special voters precinct board shall verify the tabulator(s), memory card(s) and memory card port(s) have not been obviously tampered with overnight.

22.343(8) *Resume tabulation.* The absentee and special voters precinct board shall resume tabulation using one of the following methods:

a. Using the same memory card(s) used on the day before the election and resuming tabulation.

b. Using a new memory card(s) and compiling the results contained on the memory card(s) used on election day and on the day before the election.

22.343(9) *Print audit logs.* After the election, the audit logs must be printed and be available for public inspection.

This rule is intended to implement Iowa Code section 39A.5, section 1, paragraph “a,” subparagraph (3), and Iowa Code section 53.23 as amended by 2009 Iowa Acts, House File 670.

[ARC 8698B, IAB 4/21/10, effective 6/15/10]

721—22.344 to 22.349 Reserved.

721—22.350(52) Election Systems & Software models. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.351(52) Diebold Election Systems’ AccuVote-OS central count process. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.352 to 22.430 Reserved.

721—22.431(52) Temporary use of printed ballots in voting machine precincts. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.432(52) Abandoned ballots. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.433(52) Prohibited uses for direct recording electronic voting machines. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.434(52) Audio ballot preparation. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.435 to 22.460 Reserved.

721—22.461(52) MicroVote Absentee Voting System. Rescinded IAB 8/1/07, effective 7/13/07.

721—22.462(52) Fidler & Chambers’ Absentee Voting System. Rescinded IAB 10/30/02, effective 1/1/03.

721—22.463(52) Election Systems & Software iVotronic. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.464(52) Diebold Election Systems AccuVote TSX DRE. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.465 to 22.499 Reserved.

721—22.500(52) Blended systems. Rescinded IAB 10/8/08, effective 9/19/08.

721—22.501 to 22.599 Reserved.

These rules are intended to implement Iowa Code chapter 52.

E-POLL BOOKS

721—22.600(47) Revolving loan fund. The purpose of this rule is to establish an e-poll book and polling place modernization panel to review applications submitted to the state commissioner for distribution of moneys from the revolving loan fund created in Iowa Code section 47.11.

22.600(1) Definitions.

“*E-poll book*” is as defined in rule 721—22.1(52).

“*Vendor*,” for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.600(2) In order to ensure that the public funds in this rule are used responsibly and efficiently, this rule creates a panel consisting of designees of the state commissioner of elections, the state auditor, and the director of the department of management. Attendance by two of the three members constitutes a quorum. The panel shall conform to the party balance requirements of Iowa Code section 4A.12.

22.600(3) The state commissioner shall convene the panel whenever necessary to review loan applications received from county commissioners requesting moneys from the fund.

22.600(4) The state commissioner may convene the panel to review proposed expenditures for updating technology standards for elections. If the state commissioner determines that there is an urgent need that an expenditure of moneys from the fund be used to update technology standards, the state commissioner may spend the moneys without convening the panel. In such instance, the state commissioner shall report that expenditure at the next meeting of the panel.

22.600(5) The panel shall create guidelines for loaning moneys from the fund to county commissioners for the updating of polling place technology. The guidelines shall be published on the state commissioner’s website. The panel shall not approve funding for the purchase of e-pollbooks that are not certified by the state commissioner pursuant to Iowa Code section 49.29 unless the e-pollbook’s certification has been waived by the state commissioner.

22.600(6) Before distributing or loaning funds, the panel shall consider the published guidelines, but may take additional factors into consideration. The panel shall not waive any information technology security standards. A majority vote of the panel members present is sufficient to approve funding.

22.600(7) Before any funds from the revolving loan fund are provided for the acquisition of e-poll books, the e-poll book system shall conform to the security requirements within this chapter.

This rule is intended to implement Iowa Code section 47.11.

[ARC 3468C, IAB 11/22/17, effective 12/31/17; ARC 0335D, IAB 6/10/26, effective 7/15/26]

721—22.601(47) Operational requirements of e-poll books.

22.601(1) Definitions.

“*E-poll book*” is as defined in rule 721—22.1(52).

“*Vendor*,” for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.601(2) Operational requirements. When assessing applications for funding from the revolving loan fund established by Iowa Code section 49.11, as implemented in rule 721—22.600(47), the e-poll book and polling place modernization panel shall consider whether the e-poll book sought includes the operational features described in this subrule. The panel shall consider:

a. Whether the e-poll book is able to accept a secure data file that imports voter registration data into the e-poll book application from the statewide voter registration system. This requirement may not be waived by the panel.

b. Whether the e-poll book is able to securely export data files that can be imported into the statewide voter registration system, including a file to update the voter activity portion of the statewide voter registration system.

c. Whether the e-poll book is able to scan the barcodes of driver’s licenses, DOT-issued nonoperator identification cards, and the voter identification card issued pursuant to Iowa Code section 48A.10A.

d. Whether the e-poll book is able to verify the voter against the felon database.

e. Whether the e-poll book is able to process, record, and export the complete range of possible voter registration updates available to voters under Iowa law. The state commissioner shall maintain a form that lists the possible updates that are required by this subrule.

f. Whether the e-poll book is able to complete and print the following forms:

- (1) State of Iowa Official Voter Registration Form.
- (2) Election Day Voter Registration Form, including Voter's Oath and Attester's Oath, if applicable.
- (3) Provisional Ballot Form, including the State of Iowa Official Voter Registration Form and Statement to Person Casting a Provisional Ballot.
- (4) Challenger's Statement.
- (5) Affidavit of Voter Requesting Assistance.

This rule is intended to implement Iowa Code section 47.11.

[ARC 3468C, IAB 11/22/17, effective 12/31/17; ARC 0335D, IAB 6/10/26, effective 7/15/26]

721—22.602(47) Security requirements of e-poll books. All e-poll book systems in use in this state, including those funded by county moneys, shall conform to the following security standards.

22.602(1) Definitions.

"E-poll book" is as defined in rule 721—22.1(47).

"Secure," for purposes of this rule, means "encryption" as defined by Iowa Code section 715C.1(5).

"Vendor," for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.602(2) Encryption of data at rest. The e-poll book system shall ensure that all voter data is encrypted at rest. "Encrypted at rest" includes encryption of the whole hard drive, database, application data deemed confidential, and removable media. The data encryption keys shall be stored separately from the e-poll book hardware and software.

22.602(3) Encryption of data in transit. The e-poll book system shall ensure that all voter data is encrypted in transit via secure transfer protocols.

22.602(4) Security updates. The commissioner shall ensure that the computer maintains the most recent security updates available for the computer's operating system. The vendor shall ensure that the e-poll book software remains compatible with all security updates issued for the computer's operating system. An e-poll book system in use in Iowa shall not be installed on an operating system that is no longer supported by the developer.

22.602(5) Authentication. Every e-poll book system shall require authentication to the operating system and to the e-poll book application separately through a minimum of a username-password combination. A commissioner shall use a unique username-password combination for each precinct.

22.602(6) Decommissioning. At the time of decommissioning, the hard drive from the computer shall be destroyed by the owner of the hardware. This shall occur before the commissioner or vendor resells, gifts, repurposes, or otherwise disposes of the equipment. A record of the destruction shall be kept by the owner.

22.602(7) Notification. A vendor upon offering a new e-poll book platform, or upon making a change to the security requirements of an existing e-poll book, shall notify the state commissioner of the changes in sufficient detail for the state commissioner to determine whether reasonable security features are in place to protect the e-poll book and related data.

This rule is intended to implement Iowa Code sections 47.11 and 49.29.

[ARC 3468C, IAB 11/22/17, effective 12/31/17; ARC 0335D, IAB 6/10/26, effective 7/15/26]

721—22.603(47) Certification of e-poll books. All e-poll book systems in use in this state, including those funded by county moneys, shall conform to the following certification procedure.

22.603(1) Definitions.

"E-poll book" means the same as defined in rule 721—22.1(47).

"Vendor," for purposes of this rule, means a person or representative of a person developing, offering, or supporting an e-poll book.

22.603(2) Temporary certification application.

a. A vendor providing or wanting to provide an e-poll book platform in this state may apply for certification on the form prescribed by the state commissioner. The vendor shall certify in writing to

the state commissioner that the requirements of rules 721—22.601(47) and 721—22.602(47) are met. If any of the requirements are not met, the vendor shall note the exceptions conspicuously.

b. A vendor operating in this state on or after [the effective date of this rule] shall apply as provided above. Applications received for e-poll book versions currently operating in the state may be approved.

c. Upon adoption of the rule for permanent certification application, all vendors will need to reapply for certification within the time permitted by that rule to continue offering their products in the state.

This rule is intended to implement Iowa Code section 49.29.

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 511
SPECIAL PERMITS FOR OPERATION AND MOVEMENT OF
VEHICLES AND LOADS OF EXCESS SIZE AND WEIGHT

[Appeared as Ch 2, Highway Commission, 1973 IDR; amended in July 1974 and January and July 1975 Supplements]

[Previously numbered as (07,E) Ch 12, transferred at the request of the department on 10/8/75]

[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 2]

Chapter rescission date pursuant to Iowa Code section 17A.7: 9/24/30

761—511.1(321E) Definitions. As used in this chapter, unless the context otherwise requires:

“Compacted rubbish vehicle” means any vehicle hauling rubbish that has been mechanically compacted with a hydraulic, electric, or air-operated ram.

“Designated truck route” when used in relation to the all-systems overweight permit in Iowa Code section 321E.8(2) means one or more of the following:

1. A route designated in a city’s code of ordinances as a truck route.
2. A route physically signed as a truck route.
3. A route designated by a city as valid for this permit, whether for a single occurrence or on a short-term or long-term basis.

“Dimensions” or *“size”* means length, width or height limits.

“Emergency interstate permit” means a permit issued under Iowa Code section 321E.27.

“Fluid milk product” means the same as defined in Iowa Code section 321E.29B(3).

“Indivisible load” means any load or vehicle exceeding applicable length or weight limits that, if separated into smaller loads or vehicles, would:

1. Compromise the intended use of the vehicle, i.e., make it unable to perform the function for which it was intended;
2. Destroy the value of the load or vehicle, i.e., make it unusable for its intended purpose; or
3. Require more than eight work hours to dismantle using appropriate equipment. The applicant for an indivisible load permit has the burden of proof as to the number of work hours required to dismantle the load.

“Overdimensional” or *“oversize”* means the exceeding of statutory length, width or height limits.

“Permit” means a permit issued under Iowa Code chapter 321E for the movement of an overdimensional or overweight vehicle, combination of vehicles, or vehicle with load. The term includes any additions or supplements thereto issued by the permit-issuing authority.

“Permit-issuing authority” means the:

1. Department’s motor vehicle division for permits for movement on the primary road system.
2. Authority responsible for the maintenance of a nonprimary system of highways or streets for permits for movement on that system. However, the motor vehicle division may issue single-trip permits on primary road extensions in cities in conjunction with movement on the rural primary road system. The department may also issue all-systems permits on the secondary road and municipal systems.

“Primary roads” or *“primary road system”* means the same as defined in Iowa Code section 306.3. The primary road system includes the interstate road system.

“Raw forest products” means the same as defined in Iowa Code section 321E.26.

“Rubbish” means any unwanted or useless material that has no commercial or practical value or use and that would normally be discarded.

“Special or emergency situation” means one or more of the following:

1. Circumstances where the movement is necessary to cooperate with cities, counties, other state agencies or other states in response to a national or other disaster.
2. Circumstances where the movement is necessary to cooperate with national defense officials.
3. Circumstances where the movement is necessary to cooperate with public or private utilities in order to maintain their public services.

4. Circumstances where the movement is essential to ensure safety and protection of any person or property due to an event such as but not limited to pollution of natural resources, a potential fire or an explosion.

5. Circumstances where weather or transportation problems create an undue hardship for citizens of the state of Iowa.

6. Circumstances where the movement involves emergency-type vehicles.

7. Uncommon or extraordinary circumstances where the movement is essential to the existence of an Iowa business and the move may be accomplished without causing undue hazards to the safety of the traveling public or undue damage to private or public property.

8. Other unique circumstances that warrant the issuance of a permit as determined by the permit-issuing authority.

“*Stafford Act*” means the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law No. 93-288, as amended, 42 U.S.C. §5121 et seq.

“*Statutory*” when used with size or weight limits refers to those limits found in Iowa Code chapter 321.

This rule is intended to implement Iowa Code sections 321E.9, 321E.15, 321E.26, 321E.29, 321E.29B, 321E.30 and 321E.34.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.2(321E) General information.

511.2(1) Permits may be obtained electronically upon making application to the motor vehicle division at iowadot.gov/motor-carriers. Applications, forms, instructions and restrictions are also available by mail from the Motor Vehicle Division, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; in person at 6310 SE Convenience Boulevard, Ankeny, Iowa; by telephone at 515.237.3264; or by facsimile at 515.237.3257.

511.2(2) No overdimensional or overweight vehicle, combination of vehicles, or vehicle with load shall be moved on the highways of this state without permit except as provided in Iowa Code section 321.453.

511.2(3) Except as provided in rule 761—511.10(312,321,321E) or 761—511.18(321,321E), permits may be issued only for the transporting of a single article that exceeds statutory size or weight limits, or both, and that cannot reasonably be divided or reduced to statutory size and weight limits. However, permits may be issued for the transporting of property consisting of more than one article when:

- a. The statutory weight limits are not exceeded,
- b. One of the articles exceeds the statutory size limits, and
- c. The inclusion of other articles does not cause the statutory size limits to be exceeded by an additional amount.

511.2(4) Nothing in the permit shall be construed as waiving any load limits that have been or that might be established on any bridge or any road that is posted with embargo signs unless specifically stated on the permit.

511.2(5) The state of Iowa, the department, and any other permit-issuing authority assume no responsibility for the property of the permit holder. Permit holders shall hold permit-issuing authorities harmless of any damages that may be sustained by the traveling public, adjacent property owners or the highways of this state on account of movements made under permit.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.3(321E) Movement under permit.

511.3(1) During the movement of a vehicle or object under permit, the permit holder shall comply with the terms and conditions of the permit and take all reasonable precautions to protect and safeguard the lives and property of the traveling public and adjacent property owners.

511.3(2) Movement shall be made only when roads are clear of ice and snow and visibility is at least one-quarter mile. Snow removal equipment operating under permit is exempt from this restriction while snow removal operations are conducted. Nothing in this subrule shall be construed to mean that the movement of a compacted rubbish vehicle permitted under rule 761—511.12(321E) is subject to this restriction.

511.3(3) Movement will be permitted only during the hours from one-half hour before sunrise to one-half hour after sunset unless the permit qualifies for continuous movement under subrule 511.3(5) or it is established by the permit-issuing authority that the movement can be better accomplished at another period of time.

511.3(4) Except as provided in Iowa Code section 321.457, no movement will be permitted on the holidays of Memorial Day, Independence Day and Labor Day, after 12 noon on days preceding these holidays and holiday weekends, during holiday weekends, or during special events when abnormally high traffic volumes can be expected. A holiday weekend occurs when the holiday falls on Friday, Saturday, Sunday or Monday. No movement will be permitted until one-half hour before sunrise on the day after the holiday or holiday weekend.

511.3(5) Vehicles and loads may travel by permit between one-half hour after sunset and one-half hour before sunrise if, in addition to the general provisions and general requirements specified by the permit, the following conditions are met.

- a. Dimensions do not exceed:
 - (1) Width. 12 feet.
 - (2) Height. 14 feet, 6 inches.
 - (3) Length. 100 feet.
 - (4) Weight. Legal axle limits.
- b. Travel occurs on roadways with a minimum width of 22 feet and minimum lane width of 11 feet.
- c. Safety lighting is provided at the widest part of a load. The lamps may be placed at the outer ends of the load itself or on appurtenances that are equal in width to the widest part of the load and positioned at both the extreme front and rear of the vehicle or trailer as follows:
 - (1) One lighted red lamp on each side at the rear of the load.
 - (2) One lighted yellow or amber lamp on each side at the front of the load.

This rule is intended to implement Iowa Code sections 321E.2, 321E.11 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.4(321E) Permits. The department may issue permits in writing or in electronic format, including single-trip, multitrip, annual oversize, annual oversize/overweight, annual raw forest products, annual small crane, compacted rubbish, emergency interstate, annual fluid milk products, annual all-systems oversize, or annual all-systems overweight permits.

511.4(1) *Methods of issuance.* Permits for movement on the primary road system may be obtained in person, by facsimile, online, or by mail at the address in subrule 511.2(1).

511.4(2) *Forms.*

a. The department will accept applications for permits for movement on the primary road system online or in the form and manner prescribed by the department.

b. Other permit-issuing authorities receiving applications made upon department forms must deem the applications sufficient and properly made.

c. Subject to the preceding paragraph, permit-issuing authorities may adopt, amend or modify department forms provided that the amended or modified forms adequately identify the applicant, the hauling vehicle and load, the manner and extent that the vehicle with load exceeds the statutory size and weight limits, the route, and the authorization of the issuing authority. However, the load for a multitrip permit does not have to be identified but the vehicle and load cannot exceed either the weight per axle or the total weight identified on the multitrip permit. Axle spacings cannot change.

511.4(3) *Validity.*

a. Annual oversize, annual oversize/overweight, annual raw forest products, annual small crane, compacted rubbish, annual fluid milk products, annual all-systems oversize, and annual all-systems overweight permits expire one year from the date of issuance.

b. A single-trip permit is effective for five days.

c. The validity of a multitrip permit does not exceed 60 calendar days.

d. Emergency interstate permits issued under Iowa Code section 321E.27 are effective for 30 calendar days. However, the permit will not be valid past the expiration of the applicable governor's proclamation of disaster emergency issued under Iowa Code section 29C.6 in conjunction with the presidential declaration allowing interstate travel under the Stafford Act or the expiration of the declaration of major disaster under the Stafford Act, whichever expires first.

511.4(4) Duplicate permit. If a permit is lost or destroyed before it has expired, a duplicate permit may be issued at the discretion of the permit-issuing authority. The expiration date on the duplicate permit will be the same as on the original permit.

This rule is intended to implement Iowa Code sections 321E.2, 321E.3, 321E.8, 321E.9, 321E.15 and 321E.29B.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.5(321,321E) Fees and costs.

511.5(1) Issuance and payment. A permit will not be issued until the required fees and costs are paid in the manner and format prescribed by the department.

511.5(2) Special or emergency oversize permit for certain divisible loads. The fee for each single-trip permit issued pursuant to Iowa Code section 321E.9 is \$35.

511.5(3) Permit transfers. The department may allow transfer of the following permit types to a replacement vehicle when the original vehicle has been damaged in an accident, junked or sold:

a. Annual oversize/overweight.

b. Annual all-systems overweight.

c. Annual small crane.

511.5(4) Duplicate permit. The fee for a duplicate permit is \$2.

511.5(5) Registration fee for single-trip permits. A vehicle traveling under a single-trip permit may register with the department for the combined gross weight of the vehicle and load on a single-trip basis, upon payment of the applicable statutory fees, pursuant to Iowa Code section 321E.12. The department may access Iowa registration records to determine the weight for which the vehicle is currently registered prior to assessing the statutory fee under this subrule. The fee for single-trip registration is \$4 per ton exceeding 40 tons.

511.5(6) Registration fee for vehicles transporting buildings other than mobile homes or factory-built structures. A registration fee will be charged for vehicles transporting buildings, except mobile homes and factory-built structures, on a single-trip basis. The vehicle shall be registered for the combined gross weight of the vehicle and load, and the fee is 5 cents per ton exceeding the weight registered under Iowa Code section 321.122 per mile of travel. Fees will not be prorated for fractions of miles.

511.5(7) Fair and reasonable costs. Permit-issuing authorities may charge any permit applicant:

a. A fair and reasonable cost for the removal and replacement of natural obstructions or official signs and signals.

b. A fair and reasonable cost for measures necessary to avoid damage to public property including structures and bridges.

This rule is intended to implement Iowa Code sections 321.12, 321.122, 321E.8, 321E.9, 321E.12, 321E.14, 321E.15, 321E.29, 321E.29A and 321E.30.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.6(321E) Insurance and bonds.

511.6(1) Insurance.

a. Permittees must maintain, and carry in the permitted vehicle a copy of the current insurance certificate as proof of, public liability insurance in the amounts of \$100,000 bodily injury each person, \$200,000 bodily injury each occurrence, and \$50,000 property damage with an expiration date to cover the tenure of the annual oversize, annual oversize/overweight, annual raw forest products, annual small crane, annual all-systems oversize, annual all-systems overweight, multitrip, emergency interstate, annual fluid milk products or single-trip permit. Proof of liability insurance may be either in writing or in electronic format.

b. Notwithstanding paragraph 511.6(1)“*a.*,” a carrier may act as a self-insurer if an application for self-insurance is filed with and approved by the department.

511.6(2) Bond.

a. The permit-issuing authority may require the applicant to file a bond, certified check or other assurance in an amount sufficient to cover the reasonably anticipated cost of damage or loss to private property, either real or personal, likely to be caused by or arising out of the movement of the vehicle and load or to ensure compliance with permit provisions.

b. The amount in the preceding paragraph may be reduced either in whole or in part by the applicant’s submission to the permit-issuing authority of written permission from an affected third party stating in substance that the third party either owns or has the right of exclusive possession and control over the affected property, does by the party’s signature consent to the move and that the applicant has in hand paid or secured the payment of the anticipated cost of loss or damage to the party’s property.

This rule is intended to implement Iowa Code sections 321E.8, 321E.9, 321E.13, 321E.15 and 321E.29B.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.7(321,321E) Annual oversize permits. Annual oversize permits are issued for indivisible vehicles or indivisible loads for travel when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The owner or operator shall select a route using the vertical clearance map and road construction and travel restrictions map provided by the department for state roads. If the owner or operator is operating under an all-systems permit, the owner or operator shall also review the road construction and travel restrictions map provided by the Iowa county engineers service bureau. Route, detour and road embargo information may be found online at www.511ia.org or the department’s website for the embargo bridge maps at www.iowadot.gov/mvd/motorcarriers/bridgemap.pdf. County restriction information may be found online at www.iceasb.org/roads. Annual oversize permits are issued for the following:

511.7(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

a. Width. 12 feet 5 inches including appurtenances.

b. Length. 120 feet 0 inches overall.

c. Height. 13 feet 10 inches.

d. Weight. Information contained in rule 761—511.17(321,321E).

e. Distance. Movement is allowed for unlimited distance; routing through the motor vehicle division is not required.

511.7(2) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

a. Width. 14 feet 6 inches.

b. Length. 120 feet 0 inches overall.

c. Height. 15 feet 5 inches.

d. Weight. Information contained in rule 761—511.17(321,321E).

e. Distance. Movement is restricted to 50 miles unless trip routes are obtained from the motor vehicle division or the route continues on at least four-lane roads. Trip routes are valid for five days.

511.7(3) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

- a. *Width.* 16 feet 0 inches.
- b. *Length.* 120 feet 0 inches.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* Information contained in rule 761—511.17(321,321E).
- e. *Distance.* Trip routes must be obtained from the motor vehicle division.

511.7(4) Truck trailers manufactured or assembled in the state of Iowa provided the following are met.

- a. *Width.* Not to exceed 10 feet 0 inches.
- b. *Length.* Overall combination length must comply with Iowa Code section 321.457.
- c. *Height.* Statutory: Not to exceed 13 feet 6 inches.
- d. *Weight.* Information contained in rule 761—511.17(321,321E).
- e. *Roadway width.* At least 24 feet 0 inches.
- f. *Limited movement.* Only movement limited to the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and on the most direct route necessary for the movement is allowed.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10, 321E.15 and 321E.29A.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.8(321,321E) Annual oversize/overweight permits. Annual oversize/overweight permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. Travel is not allowed on the interstate. However, a carrier moving under this annual oversize/overweight permit may operate under the same restrictions as an annual oversize permit under rule 761—511.7(321,321E) when the vehicle meets the dimensions required by that rule. Routing is subject to embargoed bridges and roads and posted speed limits. Annual oversize/overweight permits are issued for the following:

511.8(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

- a. *Width.* 13 feet 5 inches.
- b. *Length.* 120 feet 0 inches.
- c. *Height.* 15 feet 5 inches.
- d. *Weight.* Information contained in rule 761—511.17(321,321E).
- e. *Routing.* The owner or operator shall select a route using a vertical clearance map, bridge embargo map, pavement restrictions map, and construction and travel restrictions map provided by the department. Route, detour and road embargo information may be found online at www.511ia.org or the department's website for the embargo bridge maps at www.iowadot.gov/mvd/motorcarriers/bridgemap.pdf.

511.8(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.9 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.9(321,321E) Annual all-systems oversize permits. Annual all-systems oversize permits are issued by the motor vehicle division for indivisible vehicles or indivisible loads for travel on the primary road system and specified city streets and county roads when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The department will provide a map of the authorized city streets and county roads. Permit holders shall check the county 511 map available online at www.iceasb.org/roads and consult with local officials when traveling on county roads or city streets

for bridge embargo, vertical clearance, detour, and road construction information. These permits are issued for the following:

511.9(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

- a. Width.* 12 feet 5 inches including appurtenances.
- b. Length.* 120 feet 0 inches overall.
- c. Height.* 13 feet 10 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Distance.* Movement is allowed for unlimited distance; routing through the motor vehicle division and city and county jurisdictions is not required.

511.9(2) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

- a. Width.* 14 feet 6 inches.
- b. Length.* 120 feet 0 inches overall.
- c. Height.* 15 feet 5 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the motor vehicle division and city and county jurisdictions or the route continues on at least four-lane roads. Trip routes are valid for five days.

511.9(3) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

- a. Width.* 16 feet 0 inches.
- b. Length.* 120 feet 0 inches.
- c. Height.* 15 feet 5 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Distance.* Trip routes must be obtained from the motor vehicle division and city and county jurisdictions.

511.9(4) Truck trailers manufactured or assembled in the state of Iowa provided the following are met.

- a. Width.* Not to exceed 10 feet 0 inches.
- b. Length.* Overall combination length complies with Iowa Code section 321.457.
- c. Height.* Statutory: Not to exceed 13 feet 6 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Roadway width.* At least 24 feet 0 inches.
- f. Limited movement.* Only movement limited to the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and on the most direct route necessary for the movement is allowed.

511.9(5) Necessary trip routes must be obtained from the appropriate city and county jurisdictions.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.10(312,321,321E) Annual all-systems overweight permits.

511.10(1) Issuance. Annual all-systems overweight permits are issued by the department for indivisible vehicles or indivisible or divisible loads for travel on the primary road system and specified city streets and county roads when the weight of the vehicle or load exceeds statutory limits but the dimensions are within statutory limits. Routing is subject to embargoed bridges and roads, including highways restricted by a local authority pursuant to Iowa Code section 321.473, and posted speed limits. The department will provide a map of the authorized city streets and county roads. Permit holders shall review route, detour and road embargo information online at www.511ia.org, check

the county 511 map available online at www.iceasb.org/roads, and consult with local officials when traveling on county roads or city streets for bridge embargo, vertical clearance, detour, and road construction information. These permits are issued for vehicles with divisible or indivisible loads provided the following are not exceeded.

- a. Width.* Statutory: 8 feet 6 inches including appurtenances.
- b. Length.* Statutory: 75 feet 0 inches overall.
- c. Height.* Statutory: 13 feet 6 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Distance.* Movement is allowed for unlimited distance; routing through the motor vehicle division and city and county jurisdictions is not required.

511.10(2) *Distribution of monthly credit.* In accordance with Iowa Code section 312.2(18), the department will divide the monthly credit among the counties as determined by the department after consultation with county officials through their representative organizations.

511.10(3) *Route exemption justification determinations, submittals, reviews and appeals.* If a local authority determines that a road segment needs to be designated as not valid for a permit issued under this rule, a written exemption justification must be provided to the department explaining the local authority's determination. The department will accept the submittal of exemption justifications in the form and manner prescribed by the department, including via communications between electronic systems. Criteria for exemption justifications and processes for disputes and appeals regarding the department's approval of submitted exemption justifications are determined by the department after consultation with county and city officials through their representative organizations. Additional guidance is published on the department's website.

a. For paved farm-to-market (FM) routes, designated truck routes, non-paved FM routes and non-FM routes, the exemption justification submittal, review and appeal process is as follows:

(1) The local authority will provide the justification and any necessary explanation for exempting the road segment.

(2) The department will either approve or deny the local authority's exemption request.

(3) If the department denies the exemption request, the local authority may appeal the department's decision. If the local authority appeals the department's decision or requests further consideration, the department will gather additional information, if possible, and may consult with additional stakeholders, including but not limited to the representative organizations for county and city officials, before making a final decision.

b. Exemption approvals are reviewed periodically at a frequency determined by the department. The local authority is to submit exemption justification renewals and updates in the form and manner described by the department.

511.10(4) *Alternate route requests.* When a permit holder is unable to reach a loading or unloading destination because all routes leading to said destination have been designated as not valid, the permit holder may request establishment of an alternate route to provide access to the loading or unloading destination via the permit. The department, after consultation with county and city officials through their representative organizations, establishes a procedure for alternate route requests. The alternate route procedure is as follows:

a. The permit holder will contact the local authority to request an alternate route. Contact information for each local public agency is obtained by clicking on the desired route in the all-systems overweight permit map found on the department's website for motor carriers.

(1) If, upon further evaluation, the local authority chooses to designate the requested route as valid, the local authority must contact the department to remove the non-valid designation. The local authority will notify the permit holder of the removal of the non-valid designation.

(2) If the local authority establishes an alternate route, the local authority must provide written notice to the permit holder of the approved alternate route and the dates for which the route is valid. The written notice is given in the form and manner prescribed by the department or in an alternate form and manner approved by the department.

b. If the local authority does not respond to the request to establish an alternate route after five business days, or if the local authority does not make the existing route valid, provide an acceptable alternate route, or resolve the situation within seven business days, the permit holder may contact the department to request the department establish an alternate route.

(1) In establishing the alternate route, the department will consult with the local authority, if responsive, and may consult with stakeholders, including but not limited to the permit holder, and county and city officials through their representative organizations.

(2) Once the department has established an alternate route, the department will provide written notice to the permit holder and the local authority of the established alternate route and the dates for which the alternate route is valid.

Additional guidance is published on the department's website.

This rule is intended to implement Iowa Code sections 312.2, 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

761—511.11(321,321E) Multitrip permits. Multitrip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit allows unlimited trips along a specific route between one point of origin and one point of destination. Additional routes will require a new permit. Multitrip permits are issued for the following:

511.11(1) Multitrip permits may be issued for vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

- a. Width.* 16 feet.
- b. Length.* 120 feet.
- c. Height.* 15 feet 5 inches.
- d. Weight.* 156,000 pounds total gross weight.
- e. Distance.* On routes specified by the permit-issuing authority.

511.11(2) Multitrip permits may be issued for all movements allowed under the single-trip permit provisions of rule 761—511.13(321,321E) provided the movement is within the size and weight limitations of subrule 511.11(1).

511.11(3) The dimensions listed on the permit are considered maximums. The movement is legal as long as the vehicle and load do not exceed these dimensions and the movement meets all other requirements of Iowa Code chapter 321E and this chapter.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.9A and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.12(321E) Compacted rubbish vehicle permits. All compacted rubbish vehicle permits issued by the department are subject to the following criteria:

511.12(1) Permits are issued in writing or in an electronic format and are to be carried in the vehicle for which the permit has been issued and made available for inspection by any peace officer or authorized agent of any permit-granting authority.

511.12(2) Movements by permit are allowed day and night, seven days a week, including holidays.

511.12(3) Vehicles traveling under permit are registered for the gross weight or combined gross weight of the vehicle and load.

511.12(4) Vehicles under permit are in compliance with posted bridge and road embargoes and speed limits.

511.12(5) Maximum axle weight allowed on the interstate system is 20,000 pounds on a single axle and 34,000 pounds on a tandem axle.

This rule is intended to implement Iowa Code sections 321E.15 and 321E.30.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.13(321,321E) Single-trip permits. Single-trip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit is for a specific route between an origin and destination. Single-trip permits are issued for the following:

511.13(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded.

a. Width. Limited to the maximum physical limitations and clearances of the roadway and infrastructure along the intended route of travel.

b. Length. Limited to the maximum physical limitations and clearances of the roadway along the intended route of travel.

c. Height. Limited only to the height of underpasses, bridges, power lines, and other established height restrictions. The carrier is required to contact affected public utilities when the height of the vehicle with load exceeds 16 feet 0 inches. At the discretion of the permit-issuing authority, a written verification may be required from the affected utility.

d. Weight. Information contained in rule 761—511.17(321,321E).

e. Distance. Limited at the discretion of the permit-issuing authority. The following factors will be considered:

- (1) Road conditions.
- (2) Road width.
- (3) Traffic volume.
- (4) Weather conditions.
- (5) Roadside obstructions, including bridges, signs and overhead obstructions.

511.13(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.9 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.14(321,321E) Annual raw forest products permits. Annual raw forest products permits are issued for vehicles transporting divisible loads of raw forest products when the weight exceeds statutory limits. Travel is not allowed on the interstate. The owner or operator shall select a route using the vertical clearance map, bridge embargo map, pavement restrictions map, and construction and travel restrictions map provided by the department. The owner or operator must contact the appropriate local authority for route approval to use this permit on county roads or city streets. Detour and road embargo information may be found online at: www.511ia.org. Routing is subject to embargoed bridges and roads and posted speed limits. Annual raw forest products permits are issued for the following:

511.14(1) Vehicles with divisible loads of raw forest products provided the following are not exceeded.

a. Width. Statutory: 8 feet 6 inches.

b. Length. Limited to the maximum dimensions in Iowa Code section 321.457.

c. Height. Statutory: 13 feet 6 inches.

d. Weight. Information contained in rule 761—511.17(321,321E).

e. Distance. Unlimited.

511.14(2) Reserved.

This rule is intended to implement Iowa Code sections 321.463, 321E.2, 321E.3, 321E.15 and 321E.26.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.15(29C,321,321E) Emergency interstate permit. Emergency interstate permits are issued for vehicles transporting divisible loads of relief supplies when the weight exceeds statutory limits.

Routing is subject to embargoed bridges and roads and posted speed limits. The owner or operator shall select a route using the vertical clearance map and road construction and travel restrictions map provided by the department. Route, detour, and road embargo information may be found online at www.511ia.org or the department's website for the embargo bridge maps at www.iowadot.gov/mvd/motorcarriers/bridgemap.pdf. The owner or operator must contact the appropriate local authority for route approval to determine if additional permits are necessary for county roads or city streets. Emergency interstate permits are issued for the following:

511.15(1) Vehicles with divisible loads of relief supplies, which may exceed the weight limits established under Iowa Code section 321.463 on the interstate highway system, provided the following are not exceeded.

- a. Width.* Statutory: 8 feet 6 inches including appurtenances.
- b. Length.* Limited to the maximum dimensions in Iowa Code section 321.457.
- c. Height.* Statutory: 13 feet 6 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Distance.* Movement is allowed for unlimited distance on the interstate for 30 days not

to exceed the expiration of the applicable governor's proclamation issued in conjunction with the applicable declaration under the Stafford Act, or expiration of the applicable declaration under the Stafford Act, whichever expires sooner. In the event that more than one proclamation issued under Iowa Code section 29C.6 is in effect, only the proclamation issued in conjunction with the same event that caused the major disaster declaration under the Stafford Act governs the expiration date. Separate permits may be required for roads other than the interstate unless the governor, under the authority in Iowa Code section 29C.6, suspends applicable permitting provisions under proclamation for the same event.

511.15(2) Reserved.

This rule is intended to implement Iowa Code sections 29C.6, 321.457, 321.463, 321E.15 and 321E.29B.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.16(321,321E) Annual fluid milk products permits. Annual fluid milk products permits are issued for indivisible loads of fluid milk products for travel when the weight of the vehicle or load exceeds statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The owner or operator shall select a route using the vertical clearance map and road construction and travel restrictions map provided by the department. Route, detour and road embargo for fluid milk products information may be found online at www.511ia.org or the department's website for the embargo bridge maps at www.iowadot.gov/mvd/motorcarriers/bridgemap.pdf. Annual fluid milk products permits are issued for the following:

511.16(1) Vehicles with indivisible loads of fluid milk products provided the following are not exceeded.

- a. Width.* Statutory: 8 feet 6 inches including appurtenances.
- b. Length.* Statutory: 75 feet 0 inches overall.
- c. Height.* Statutory: 13 feet 6 inches.
- d. Weight.* Information contained in rule 761—511.17(321,321E).
- e. Distance.* Movement is allowed for unlimited distance on the primary road system, including

the interstate, provided the vehicle is transporting fluid milk products to or from a milk plant, receiving station, or transfer station; routing through the motor vehicle division is not required.

511.16(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10, 321E.15 and 321E.29A.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.17(321,321E) Maximum axle weights and maximum gross weights for vehicles and loads moved under permit.

511.17(1) *Annual oversize, annual all-systems oversize, and annual all-systems overweight permits.*

a. For movement under an annual oversize or annual all-systems oversize permit, the axle weight and combined gross weight cannot exceed the limits found in Iowa Code section 321.463(3).

b. For movement under an all-systems overweight permit, the axle weight cannot exceed the limits found in Iowa Code sections 321.463(3) and 321E.8. The combined gross weight cannot exceed the gross weight authorized under Iowa Code section 321E.8(2).

511.17(2) *Annual oversize/overweight permits or annual raw forest products permits.* For movement under an annual oversize/overweight permit or an annual raw forest products permit, the gross weight on any axle cannot exceed 20,000 pounds, with a maximum of 156,000 pounds total gross weight.

511.17(3) *Multitrip permits.* For movement under a multitrip permit, the gross weight on any axle cannot exceed 20,000 pounds with a maximum of 156,000 pounds total gross weight.

511.17(4) *Single-trip permits.*

a. For movement under a single-trip permit, the gross weight on any axle cannot exceed 20,000 pounds unless authorized under Iowa Code section 321E.9(2).

b. If the combined gross weight exceeds 100,000 pounds, a single-trip permit may be issued for the movement only if the permit-issuing authority determines that it would not cause undue damage to the road and is in the best interest of the public.

c. Cranes may have a maximum of 24,000 pounds per axle for movement under a single-trip permit. Routes must be reviewed by the permit-issuing authority prior to issuance.

511.17(5) *Emergency interstate permits.*

a. For movement under this permit, the gross weight on any axle cannot exceed 20,000 pounds with a maximum of 90,000 pounds total gross weight.

b. The maximum weight on any single axle cannot exceed by more than 12.5 percent the maximum axle weight limit in the nonprimary highway maximum gross weight table in Iowa Code section 321.463(6) “b” and must comply with posted limits on roads and bridges.

511.17(6) *Annual fluid milk products permits.* For movement under an annual fluid milk products permit, the gross weight on any axle cannot exceed 20,000 pounds with a maximum of 96,000 pounds total gross weight.

511.17(7) *Annual small crane permit.* For movement under an annual small crane permit, the gross weight on any axle cannot exceed 24,000 pounds with a maximum of 80,000 pounds total gross weight.

511.17(8) *Special mobile equipment.* Special mobile equipment may have a gross weight of 36,000 pounds on any single axle equipped with minimum size 26.5-inch by 25-inch flotation pneumatic tires and a maximum gross weight of 20,000 pounds on any single axle equipped with minimum size 18-inch by 25-inch flotation pneumatic tires, provided that the total gross weight of the vehicle or a combination of vehicles does not exceed a maximum of 80,000 pounds for movement under an annual oversize or all-systems oversize permit and 126,000 pounds for movement under a single-trip, multitrip or annual oversize/overweight permit.

For tire sizes and weights allowed between the maximum and minimum indicated, the following formula shall apply: Axle weight = 20,000 pounds + (tire width - 18) × 1,882 pounds.

511.17(9) *Permitted tandem axle weights.*

a. Vehicles operating under an annual oversize permit, annual oversize/overweight permit, annual raw forest products permit, single-trip permit, or multitrip permit may have a gross weight not to exceed 46,000 pounds on a single-tandem axle of the truck tractor and a gross weight not to exceed 46,000 pounds on a single-tandem axle of the trailer or semitrailer if each axle of each tandem group has at least four tires.

b. The maximum weight of any single axle within a permitted tandem axle group is 24,000 pounds.

c. A permitted tandem axle cannot be a part of a larger group of axles whose centers are greater than 96 inches apart.

This rule is intended to implement Iowa Code sections 321.463, 321E.7, 321E.8, 321E.9, 321E.9A, 321E.15, 321E.26, 321E.29B and 321E.32.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.18(321,321E) Movement of vehicles with divisible loads exceeding statutory size or weight limits.

511.18(1) Vehicles with divisible loads exceeding statutory size or weight limits may be moved under a single-trip permit if the permit-issuing authority determines that a special or emergency situation warrants its issuance.

511.18(2) At the discretion of the permit-issuing authority, the combined gross weight may exceed the statutory weight, but the axle weights shall be subject to rule 761—511.17(321,321E).

511.18(3) Movement is subject to the routes established by the permit-issuing authority.

This rule is intended to implement Iowa Code sections 321.463, 321E.15 and 321E.29.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.19(321,321E) Towing units. Only a truck or truck tractor with dual wheels and with a gross vehicle weight rating of at least 10,000 pounds is an acceptable towing unit for towing mobile homes or loads exceeding 10,000 pounds.

This rule is intended to implement Iowa Code sections 321.457 and 321E.15.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.20(321E) Escorting.

511.20(1) *Escort qualifications.* To qualify as an escort or an escorting vehicle, the following requirements apply:

a. The escort is a person aged 18 or over who possesses a valid driver's license that allows driving unaccompanied and who carries proof of public liability insurance in the amounts of \$100,000/\$200,000/\$50,000.

b. The escorting vehicle is a midsize automobile or motor truck with sufficient mobility to be able to assist in an emergency and designed to afford clear and unobstructed vision both front and rear. The escorting vehicle cannot be used to tow a trailer while performing escorting duties. In questionable cases, the permit-issuing authority is authorized to determine if a vehicle meets these conditions.

c. The escorting vehicle has a flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning. While escorting a permit load, the light is mounted on top of the escort vehicle and is burning. Additional escort vehicle markings may be approved or required by the permit-issuing authority.

d. An 18-inch by 18-inch red or orange fluorescent flag is mounted on each corner of the front bumper of the escorting vehicle.

e. The escort remains a distance of approximately 300 feet in front or to the rear of the load. However, when traveling within the corporate limits of a city, the escort maintains a reasonable and proper distance consistent with existing traffic conditions.

f. A separate escort accompanies each load hauled under escort.

g. The escort obeys all traffic laws and provisions of the oversize permit for the load.

h. The escort shall not assume responsibility for stopping traffic. An on-duty peace officer, as defined in Iowa Code section 321.1, shall be contacted to provide any necessary traffic control.

i. Immediately prior to an escorting trip, the escort determines that the escorting vehicle is in a safe operational condition and that the dimensions of the vehicle and load are in compliance with the permit issued.

j. A pole used for measuring vertical clearances is mounted on the front escorting vehicle. The escort is required to measure all vertical clearances whenever the height of the permitted vehicle exceeds 14 feet 6 inches up to and including 20 feet.

511.20(2) *Minimum escort and warning device requirements.* The following chart explains the minimum escort and warning devices required for vehicles operating under permit.

Minimum Warning Devices and Escort Requirements
For Vehicles Operating Under Permit

	Flags/Signs	Lights	Escorts	
			4-Lane	2-Lane
Length				
75'1" up to and including 85'	yes	not required	not required	not required
Over 85' up to and including 120'	yes	yes	not required	not required
Over 120'	yes	not required	rear	rear
Projections				
Front: over 25'	not required	yes	not required	not required
Rear: over 4' up to and including 10'	flags only	not required	not required	not required
Rear: over 10'	flags only	yes	not required	not required
Height				
Over 14'6" up to and including 20'	yes	not required	front with a height pole	front with a height pole
Weight				
Over 80,000 lbs	not required	not required	not required	not required
Width				
Over 8'6" up to 12'0"	yes	not required	not required	not required
Over 12'0" up to and including 14'6"	yes	not required	rear *	front *
Over 14'6" up to and including 16'6"	yes	not required	rear *	front
Over 16'6" up to and including 18'	yes	not required	rear	front

*In lieu of an escort, a carrier can display an amber light or strobe light on the power unit and on the rear extremity of the vehicle or load.

yes = required

511.20(3) *Flags, lights and signs.* The following criteria apply to the required flags, signs and lights on an escorting vehicle:

a. Red or orange fluorescent flags at least 18" square are mounted as follows: one flag at each front corner of the towing unit, one flag at each rear corner of the load, and a flag at any additional protrusion in the width of the load.

b. A sign reading "Oversize Load," which is at least 18" high by 7' long with a minimum of 10" black letters, with a 1½" stroke, on a yellow background is used. The sign is mounted on the front bumper and on the rear of the load unless a mobile home or factory-built structure, in which case, the rear sign is mounted at least 7' above the highway surface, measuring from the bottom of the sign.

c. A flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning is mounted on the towing unit and is visible from front and rear. More than one light may be necessary.

d. The flags, lights and signs are removed or covered when the vehicle is within legal dimensions.

511.20(4) *Additional escorts.* The permit-issuing authority may require additional escorts when deemed necessary.

This rule is intended to implement Iowa Code sections 321E.8, 321E.14, 321E.15, 321E.24 and 321E.34.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.21(321,321E) Permit violations. Permit violations are to be reported to the permit-issuing authority by the arresting officer and the permit holder. If a permit holder is found to have willfully violated permit provisions, the motor vehicle division may, after notice and hearing, suspend, modify or revoke the permit privileges of the permit holder consistent with Iowa Code section 321E.20. If the permit that is suspended, modified, or revoked is an emergency interstate permit that is issued for a fleet operating under the permit holder's interstate or intrastate motor carrier number, the department may issue emergency interstate permits to individual vehicles operating under the interstate or intrastate motor carrier number.

This rule is intended to implement Iowa Code sections 321.492, 321E.15, 321E.16, 321E.20 and 321E.29B.

[ARC 9512C, IAB 8/20/25, effective 9/24/25]

761—511.22(321) Movement of combination vehicles on economic export corridors.

511.22(1) *Designation of economic export corridors.*

a. The department may in its discretion establish economic export corridors for the transportation of goods or products manufactured in Iowa to or through the state of South Dakota and for the return of unladen semitrailers or unladen full trailers used for the transportation of those goods or products. An economic export corridor does not include any segment of the interstate system or any part of the national network of highways identified pursuant to 23 CFR Part 658, effective April 1, 2025. However, if appropriate, the department may petition the Federal Highway Administration to remove a road or road segment from the national network of highways for the purpose of including it in an economic export corridor.

b. The department may initiate designation of economic export corridors, or a request for economic export corridor designation may be submitted to the department by an interested party. If a proposed economic export corridor includes any roads or road segments that are under the jurisdiction of a city or a county, a resolution from all relevant local jurisdictions is to be submitted to the department indicating jurisdiction support for economic export corridor designation. The resolution is to include a description of the proposed economic export corridor under local jurisdiction.

c. The department will exercise due regard for the safety of the traveling public and the protection of the highway surfaces and structures when establishing an economic export corridor. Factors to be considered include ability of the proposed economic export corridor to safely accommodate combinations of vehicles described in subrule 511.22(2), taking into account physical configurations and restrictions and traffic demands and capacity, as well as connection to markets that will benefit from the established economic export corridor.

d. The department will post established economic export corridors on the department's website.

511.22(2) *Combination vehicles that may be operated on an economic export corridor.*

a. In addition to combinations of vehicles lawful for operation on roads or road segments not designated as an economic export corridor, the following combinations of vehicles may be operated on an economic export corridor designated under subrule 511.22(1) if the combinations of vehicles meet the requirements in paragraph 511.22(2) "b":

(1) A truck tractor-semitrailer-semitrailer converted to a full trailer by use of a dolly equipped with a fifth wheel that is considered a part of the trailer for all purposes, and not a separate unit.

(2) A truck tractor-semitrailer-full trailer.

(3) A truck tractor-semitrailer-semitrailer combination, where the semitrailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

b. The combination of vehicles shall meet all of the following requirements:

(1) The length of the combination of vehicles, excluding the length of the truck tractor, does not exceed 81½ feet.

(2) The length of either semitrailer or full trailer does not exceed 45 feet.

(3) The weight of the second semitrailer or full trailer does not exceed the weight of the first semitrailer by more than 3,000 pounds.

(4) The gross weight of the combination of vehicles does not exceed 80,000 pounds and the combination of vehicles does not exceed the gross axle weight limits of Iowa Code section 321.463(2).

(5) The load on each semitrailer or full trailer in the combination is an indivisible load. For the purpose of issuing permits for height or width under Iowa Code chapter 321E, the combination of vehicles will be considered an indivisible load so long as the load on each semitrailer or full trailer in the combination remains an indivisible load.

c. The length of the frame extension is not included when determining the overall length of the first semitrailer in a truck tractor-semi-trailer-semi-trailer combination in which the semi-trailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

d. For purposes of this subrule, “full trailer” means the same as defined in 49 CFR Section 390.5, effective October 1, 2025.

This rule is intended to implement Iowa Code section 321.457(2) “n.”

[ARC 9512C, IAB 8/20/25, effective 9/24/25; ARC 0327D, IAB 6/10/26, effective 7/15/26]

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[Filed ARC 0327D (Notice ARC 0069D, IAB 2/18/26), IAB 6/10/26, effective 7/15/26]

¹ Effective date of 511.2(1), 511.4(1)“a,” 511.4(2)“a” and “b,” 511.5(1), 511.5(6)“b”(3), 511.7, 511.8, 511.9(1) to 511.9(5), 511.14(2)“g” and “i,” 511.14(3)“e,” delayed 70 days by the Administrative Rules Review Committee at its meeting held May 12, 1993; delay lifted by this Committee June 8, 1993, effective June 9, 1993.

CHAPTERS 925 to 2505
Reserved

CHAPTER 2506 CONTESTED CASES

Chapter rescission date pursuant to Iowa Code section 17A.7: 6/30/31

The Uniform Rules on Agency Procedure, 7—Chapters 2500 through 2506, are rules generally applicable to agencies pursuant to Iowa Code section 17A.24. Additions, exceptions, or amendments to the corresponding chapter are below.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.3(17A) Time obligations.

2506.3(3) In lieu of the requirements set forth in this chapter, these requirements shall be construed to supersede or constrain the required time frames in which a person must file an appeal request found in rules 761—400.44(17A,321), 761—401.9(17A,307,321), 761—411.6(17A,321,321L), 761—505.6(452A), 761—524.14(325A) and 761—540.8(321N); 761—subrules 425.17(5), 431.4(3) and 451.4(3); and 761—paragraph 601.4(8) “h.”

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.4(17A) Submission of request for informal settlement or hearing.

2506.4(1) A person who is aggrieved by an action of the department and who is entitled to a contested case hearing may:

- a. Unless prohibited by statute, request an informal settlement.
- b. Initiate a contested case by submitting a request for a contested case hearing.
- c. Use both procedures.

2506.4(2) A request for an informal settlement or a contested case hearing shall be submitted in writing to the director of the bureau or division of the department that administers the matter at issue.

2506.4(3) The request shall include complete names, mailing addresses to be used for communications with the department, and telephone numbers for all persons involved and any attorneys representing them.

2506.4(4) A statute or rule may provide for submission of requests within a specified time period. A request shall be considered timely submitted if it is postmarked or delivered to the appropriate bureau or division of the department within the time period specified. Timely submission of a request shall be jurisdictional.

2506.4(5) An informal settlement may be handled by telephone.

2506.4(6) If an informal settlement cannot be reached within a reasonable period of time, the department will notify the person in writing that there has been a failure to reach an informal settlement, that the department’s action or decision is sustained, and that the person may request a contested case hearing.

2506.4(7) The department may initiate a contested case proceeding. Prior to initiating the contested case proceeding, the department, unless disallowed by statute, may attempt to settle the matter informally.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.5(17A) Notice of hearing.

2506.5(1) Delivery. The agency will deliver notice of a hearing in accordance with rule 761—2506.12(17A).

7—paragraphs 2506.5(1) “a” through “d” are not adopted.

2506.5(2) Contents. The notice of hearing must state:

- g. The procedural rules governing informal settlement, if applicable;
- i. This paragraph is not adopted.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.6(17A) Presiding officer. This rule is not adopted.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.12(17A) Electronic service and filing of pleadings and other papers.

2506.12(1) Each party to a contested case is to keep the department informed of the party's current address and telephone number; the name, address and telephone number of the party's attorney, if any; and the mailing address to be used for communications from the department.

2506.12(2) Mailed notices, communications and decisions regarding the contested case are to be sent by first class or certified mail to the latest address that each party has provided to the department.

2506.12(3) Notwithstanding subrule 2506.12(2), the department of inspections, appeals, and licensing may communicate with the party or the party's attorney by email and may file and serve documents through the division of administrative hearings' administrative electronic management system.

7—subrules 2506.12(4) through 2506.12(7) are not adopted.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.13(17A) Discovery. This rule is not adopted.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.20(17A) Hearing procedures.

2506.20(8) The department may be represented by legal assistants, paralegals, or designated attorney general staff at contested case hearings. Any such person is under the supervision of the attorney general transportation section chief.

2506.20(9) The department may designate staff not under the supervision of the attorney general's office to appear at contested case hearings as witnesses. Staff so designated may appear to testify about matters including but not limited to clarifying the record, providing additional information, providing justification for the department's action, or answering questions of the appellants and presiding officer.

2506.20(10) The department may submit certified copies of records admitted pursuant to Iowa Code section 321.10 in lieu of either legal representation or participation by a department employee.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.22(17A) Default.

2506.22(1) A party may move for default against another party that has requested the contested case proceeding and that has failed to appear after proper service is served.

2506.22(2) Notwithstanding any rule to the contrary, no default may be entered against the department for failure to appear; rather, the presiding officer may either continue the matter or proceed with the hearing and render a decision in the absence of the department.

2506.22(3) A default decision or a decision rendered on the merits after a party has failed to appear or participate in a contested case proceeding becomes final agency action unless, within 20 days after the date of the decision, either a motion to vacate is filed and served on the presiding officer and the other parties or an appeal of a decision on the merits is timely submitted in accordance with rule 761—2506.27(17A). A motion to vacate is to state all facts relied upon by the moving party that establish that good cause existed for that party's failure to appear or participate.

2506.22(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

2506.22(5) Timely filed motions to vacate are to be granted only for good cause shown. The burden of proof is on the moving party. Adverse parties have ten days to respond to a motion to vacate.

2506.22(6) "Good cause," for the purpose of this rule, means surprise, excusable neglect or unavoidable casualty.

2506.22(7) A decision denying a motion to vacate is subject to further appeal in accordance with rule 761—2506.27(17A).

2506.22(8) A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party in accordance with rule 761—2506.27(17A).

2506.22(9) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer is to issue another notice of hearing and the contested case will proceed accordingly.

7—subrule 2506.22(10) is not adopted.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.26(17A) Final decision. This rule is not adopted.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.27(17A) Appeals and review.

2506.27(1) A decision by a presiding officer shall become the final decision of the department and is binding on the department and the party whose legal rights, duties and privileges are being determined unless either appeals the decision as provided in this subrule.

2506.27(2) No additional evidence is to be presented on appeal that is decided on the basis of the record made before the presiding officer in the contested case hearing.

2506.27(3) The appeal is to include a statement of the specific issues presented for review and the precise ruling or relief requested.

2506.27(4) An appeal of a presiding officer's decision is to be submitted in writing to the director of the bureau or division that administers the matter being contested. The appeal is deemed timely submitted if it is postmarked or delivered to the director of the appropriate bureau or division of the department within 20 days after the date of the presiding officer's decision unless otherwise provided in rule or statute.

2506.27(5) The director of the administering bureau or division will forward the appeal to the director.

2506.27(6) Failure to timely appeal a presiding officer's decision is considered a failure to exhaust administrative remedies.

2506.27(7) The director may make a decision affirming, modifying or reversing the presiding officer's decision or may remand the case to the presiding officer.

2506.27(8) The decision of the director is the final decision of the department and constitutes final agency action for purposes of judicial review. No further steps are necessary to exhaust administrative remedies.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

761—2506.32(17A) Additional procedures when the department is not a party.

2506.32(1) *Jurisdiction.* When the department is obligated by statute to administer a controversy to which it is not a party, the following additional procedures apply.

2506.32(2) *Request.*

a. A person who has an interest in a controversy and who is entitled to a contested case hearing may submit a written request to the department to resolve the controversy.

b. An acceptable request will contain a statement of facts alleged and the relief sought by the requestor, the name and address of the persons involved and any attorneys representing them, the requestor's telephone number, and the mailing address to be used for all communications to the requestor from the department.

2506.32(3) *Informal settlement.*

a. The department will contact the persons involved, either by telephone or letter, and will offer to assist the parties to reach an informal settlement of the controversy.

b. A controversy may be settled informally by the persons involved.

c. When a controversy is settled informally, the persons involved will each notify the department by telephone and confirming letter that the controversy has been resolved.

2506.32(4) *Contested case.* When the department is notified by a person involved in the controversy that there has been a failure to reach an informal settlement, or when the department determines that no progress toward a settlement is being made, the department will send a written notice to the persons involved specifying that if the department is not notified of a settlement within 20 days after the notice is mailed, the department will initiate a contested case proceeding.

[ARC 0338D, IAB 6/10/26, effective 6/30/26]

[Filed Emergency ARC 0338D, IAB 6/10/26, effective 6/30/26]

CHAPTER 8 SUBSTANTIVE AND INTERPRETIVE RULES

[Prior to 9/24/86 see Industrial Commissioner[500]]
[Prior to 1/29/97 see Industrial Services Division[343]]
[Prior to 7/29/98 see Industrial Services Division[873]Ch 8]

Chapter rescission date pursuant to Iowa Code section 17A.7: 1/1/28

876—8.1(85) Transportation expense. Transportation expense as provided in Iowa Code sections 85.27 and 85.39 shall include but not be limited to the following:

1. The cost of public transportation if tendered by the employer or insurance carrier.
2. All mileage incident to the use of a private auto. The per-mile rate shall be the rate allowed by the Internal Revenue Service for the business standard mileage rate in effect on July 1 of each year.
3. Meals and lodging if reasonably incident to the examination.
4. Taxi fares or other forms of local transportation if incident to the use of public transportation.
5. Ambulance service or other special means of transportation if deemed necessary by competent medical evidence or by agreement of the parties.

Transportation expenses in the form of reimbursement for mileage which is incurred in the course of treatment or an examination, except under Iowa Code section 85.39, shall be payable at such time as 50 miles or more have accumulated or upon completion of medical care, whichever occurs first. Reimbursement for mileage incurred under Iowa Code section 85.39 shall be paid within a reasonable time after the examination.

The workers' compensation commissioner or a deputy workers' compensation commissioner may order transportation expenses to be paid in advance of an examination or treatment. The parties may agree to the advance payment of transportation expenses.

This rule is intended to implement Iowa Code sections 85.27 and 85.39.

[ARC 6841C, IAB 2/8/23, effective 3/15/23]

876—8.2(85) Overtime. The word "overtime" as used in Iowa Code section 85.61 means amounts due in excess of the straight time rate for overtime hours worked. Such excess amounts shall not be considered in determining gross weekly wages within Iowa Code section 85.36. Overtime hours at the straight time rate are included in determining gross weekly earnings.

This rule is intended to implement Iowa Code sections 85.36 and 85.61.

876—8.3 Reserved.

876—8.4(85) Salary in lieu of compensation. The excess payment made by an employer in lieu of compensation which exceeds the applicable weekly compensation rate shall not be construed as advance payment with respect to either future temporary disability, healing period, permanent partial disability, permanent total disability or death.

This rule is intended to implement Iowa Code sections 85.31, 85.34, 85.36, 85.37 and 85.61.

876—8.5(85) Appliances. Appliances are defined as hearing aids, corrective lenses, orthodontic devices, dentures, orthopedic braces, or any other artificial device used to provide function or for therapeutic purposes.

Appliances which are for the correction of a condition resulting from an injury or appliances which are damaged or made unusable as a result of an injury or avoidance of an injury are compensable under Iowa Code section 85.27.

876—8.6(85,85A) Calendar days—decimal equivalent. Weekly compensation benefits payable under Iowa Code chapters 85 and 85A are based upon a seven-day calendar week. Each day of weekly compensation benefits due may be paid by multiplying the employee's weekly compensation benefit rate by the decimal equivalents of the number of days as follows:

1 day	=	.143	×	weekly rate
2 days	=	.286	×	weekly rate
3 days	=	.429	×	weekly rate
4 days	=	.571	×	weekly rate
5 days	=	.714	×	weekly rate
6 days	=	.857	×	weekly rate

This rule is intended to implement Iowa Code sections 85.31, 85.33 and 85.34.

876—8.7(86) Short paper. All paper filings before the workers' compensation commissioner shall be on white paper measuring 8½ inches by 11 inches.

This rule is intended to implement Iowa Code section 86.18.

[ARC 6841C, IAB 2/8/23, effective 3/15/23]

876—8.8(85,17A) Payroll tax tables. Tables for determining payroll taxes to be used for the period July 1, 2022, through June 30, 2023, are the tables in effect on July 1, 2022, for computation of:

1. Federal income tax withholding according to the percentage method of withholding for weekly payroll period. (Federal Income Tax Withholding Methods, Publication 15-T [2021].)
2. Iowa individual income tax withholding formula. (Iowa Department of Revenue [Effective January 1, 2022].)
3. Social Security and Medicare withholding (FICA) at the rate of 7.65 percent. (Internal Revenue Service, Circular E, Employer's Tax Guide, Publication 15 [2021].)

This rule is intended to implement Iowa Code section 85.61(6).

[ARC 7947B, IAB 7/15/09, effective 7/1/09; ARC 8943B, IAB 7/28/10, effective 7/1/10; ARC 9586B, IAB 6/29/11, effective 7/1/11; ARC 0222C, IAB 7/25/12, effective 7/1/12; ARC 0835C, IAB 7/10/13, effective 6/30/13; ARC 1517C, IAB 7/9/14, effective 7/1/14; ARC 2611C, IAB 7/6/16, effective 7/1/16; ARC 3044C, IAB 4/26/17, effective 5/31/17; ARC 3884C, IAB 7/4/18, effective 8/8/18; ARC 4415C, IAB 4/24/19, effective 5/29/19; ARC 5042C, IAB 5/20/20, effective 6/24/20; ARC 5630C, IAB 5/19/21, effective 6/23/21; ARC 6318C, IAB 5/18/22, effective 6/22/22]

876—8.9(85) Rate determination. When determining the rate of weekly compensation benefits for a contested case proceeding, the parties to the case shall use the ratebook in effect on the date of the claimant's injury published by the division of workers' compensation at dial.iowa.gov/hearings/workers-comp/rates.

This rule is intended to implement Iowa Code chapter 85.

[ARC 6841C, IAB 2/8/23, effective 3/15/23; Editorial change: IAC Supplement 6/10/26]

876—8.10(85,86) Exchange of records. Whether or not a contested case has been commenced, upon the written request of an employee or the representative of an employee who has alleged an injury arising out of and in the course of employment, an employer or insurance carrier shall provide the claimant a copy of all records and reports in its possession generated by a medical provider.

Whether or not a contested case has been commenced, upon the written request of the employer or insurance carrier against which an employee has alleged an injury arising out of and in the course of employment, the employee shall provide the employer or insurance carrier with a patient's waiver. See rules 876—3.1(17A) and 876—4.6(85,86,17A) for the waiver form used in contested cases. Claimant shall cooperate with the employer and insurance carrier to provide patients' waivers in other forms and to update patients' waivers where requested by a medical practitioner or institution.

A medical provider or its agent shall furnish an employer or insurance carrier copies of the initial as well as final clinical assessment without cost when the assessments are requested as supporting documentation to determine liability or for payment of a medical provider's bill for medical services. When requested, a medical provider or its agent shall furnish a legible duplicate of additional records or reports. Except as otherwise provided in this rule, the amount to be paid for furnishing duplicates of records or reports shall be the actual expense to prepare duplicates not to exceed: \$20 for 1 to 20 pages; \$20 plus \$1 per page for 21 to 30 pages; \$30 plus \$.50 per page for 31 to 100 pages; \$65 plus

\$.25 per page for 101 to 200 pages; \$90 plus \$.10 per page for more than 200 pages, and the actual expense of postage. No other expenses shall be allowed.

EXAMPLE 1. For 7 pages of records the amount to be paid for furnishing duplicates shall not exceed \$20.

EXAMPLE 2. For 28 pages of records the amount to be paid for furnishing duplicates shall not exceed \$28 (\$20 plus (8 times \$.10)).

EXAMPLE 3. For 41 pages of records the amount to be paid for furnishing duplicates shall not exceed \$35.50 (\$30 plus (11 times \$.50)).

EXAMPLE 4. For 127 pages of records the amount to be paid for furnishing duplicates shall not exceed \$71.75 (\$65 plus (27 times \$.25)).

EXAMPLE 5. For 210 pages of records the amount to be paid for furnishing duplicates shall not exceed \$91 (\$90 plus (10 times \$.10)).

This rule is intended to implement Iowa Code sections 85.27, 85.31, 85.33 to 85.37, 85.39, 85.61, 86.8, 86.10, 86.18 and 86.39.

[ARC 6841C, IAB 2/8/23, effective 3/15/23]

876—8.11(85B) Apportionment of age-related loss for occupational hearing loss claims.

8.11(1) *Effective date.* This rule is effective for claims for occupational hearing loss filed on or after July 1, 1998.

8.11(2) *Purpose.* The purposes of this rule are to adopt tables and the method for calculating age-related hearing loss and to adopt a worksheet for apportionment of age-related hearing loss for occupational hearing loss claims.

8.11(3) *Table.* In 1972 the National Institute for Occupational Safety and Health (NIOSH) published the Criteria for a Recommended Standard: Occupational Exposure to Noise (NIOSH Publication No.73-11001). Table B-1, page I-16, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Males and Table B-2, page I-17, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Females. These NIOSH tables are used to calculate the correction value for age for males and females for 500, 1000, 2000 and 3000 hertz.

For example, the age correction for a male 21 years of age is 10 decibels at 500 hertz, 5 decibels at 1000 hertz, 3 decibels at 2000 hertz and 4 decibels at 3000 hertz. The correction for age is 5.50 decibels (the sum of 10+5+3+4 divided by 4).

The following table is to be used to determine an employee's age-related change in hearing level during the period of employment. To determine the age-related change in hearing level in decibels during the period of employment, subtract the value shown in the table for the employee's age at the beginning of employment from the value shown in the table for the employee's age on the date of injury.

NOTE: This table should not be used to compute standard threshold shift as required by rules of the Occupational Safety and Health Administration or Iowa occupational safety and health administration.

<u>Age in Years</u>	<u>Correction in dB</u>	
	<u>Males</u>	<u>Females</u>
20 or younger	5.50	7.25
21	5.50	7.75
22	5.50	7.75
23	5.50	8.00
24	5.75	8.00
25	6.00	8.25
26	6.25	8.50
27	6.50	8.75
28	6.75	8.75
29	6.75	8.75
30	6.75	9.00

<u>Age in Years</u>	<u>Correction in dB</u>	
	<u>Males</u>	<u>Females</u>
31	7.25	9.25
32	7.50	9.50
33	7.50	9.75
34	7.75	9.75
35	8.00	10.00
36	8.25	10.25
37	8.75	10.25
38	8.75	10.50
39	9.00	11.00
40	9.00	11.00
41	9.25	11.25
42	10.00	11.50
43	10.25	11.75
44	10.25	12.00
45	10.50	12.25
46	10.75	12.50
47	11.00	12.50
48	11.50	13.00
49	12.00	13.25
50	12.25	13.50
51	12.25	13.75
52	12.75	13.75
53	13.25	14.25
54	13.50	14.50
55	14.00	15.00
56	14.25	15.00
57	14.50	15.25
58	15.25	15.75
59	15.50	16.00
60 or older	16.00	16.25

8.11(4) *Apportionment.* The apportionment of age-related hearing loss shall be made by reducing the total binaural percentage hearing loss as calculated pursuant to Iowa Code section 85B.9(3) by the same percentage as the decibels of age-related change in hearing level occurring during the period of employment bears to the total decibel hearing level in each ear.

Age-related hearing loss is apportioned using the results of the audiogram determined to be the proper audiogram for measurement of the employee's hearing loss on the date of injury by using the following steps:

1. Separately for each ear, compute the average of the employee's decibel hearing levels at 500, 1000, 2000, and 3000 hertz for that ear.
2. Separately for each ear, compute the percentage loss for each ear.
3. Compute the employee's age-related change in hearing level in decibels during the period of employment using the table in subrule 8.10(3).
4. Separately for each ear, divide the result of step 3 by the result of step 1 to compute the age-correction factor for that ear.
5. Separately for each ear, multiply the total percentage hearing loss in that ear calculated pursuant to Iowa Code section 85B.9 by the age-correction factor for that ear.
6. Separately for each ear, subtract the result obtained in step 5 from the total percentage hearing loss in that ear to obtain the age-corrected hearing loss for that ear.
7. Multiply the age-corrected hearing loss in the better ear as calculated in step 6 by 5 and add the percentage hearing loss in the worse ear.

8. Divide the result obtained in step 7 by 6 to obtain the age-corrected binaural percentage hearing loss.

8.11(5) Worksheet. The following worksheet is used to calculate the percentage of age-corrected binaural hearing loss.

APPORTIONMENT OF PERCENT HEARING LOSS FOR AGE		
Left Ear <u>Hearing Level</u>	Frequency <u>in Hertz</u>	Right Ear <u>Hearing Level</u>
1. _____	500	_____
2. _____	1000	_____
3. _____	2000	_____
4. _____	3000	_____
5. _____	total of lines 1 through 4	_____
divide by 4	(divide the "total" by 4)	divide by 4
6. _____	equals average equals	_____
minus 25	subtract "low fence"	minus 25
7. _____	equals "Excess"	_____
multiply by 1.5	multiply % factor	multiply by 1.5
8. _____	equals % loss each ear	_____
(% loss left ear)		(% loss right ear)
9. Age on date of injury	_____	
10. Age at beginning of employment	_____	
11. _____	correction for age on date of injury in dB from table minus	
12. _____	correction for age at beginning of employment in dB from table equals	
13. _____	age-related change in hearing level during employment in dB	
<u>LEFT EAR</u>		<u>RIGHT EAR</u>
Divide age-related change in hearing level from line 13 by average hearing level from line 6		
To obtain		
14. _____	age correction factor	_____
multiply % loss from line 8 by age-correction factor from line 14		
To obtain		
15. _____	deduction for age-correction	_____
subtract line 15 from line 8		
To obtain		
16. _____	age-corrected percent hearing loss	_____
<u>BINAURAL PERCENTAGE LOSS</u>		
17. _____	% loss better ear (smaller amount) from line 16, multiplied by 5	
plus		
18. _____	% loss worse ear (larger amount) from line 16	
19. _____	equals	
divided by 6		
equals		
20. _____	% age-corrected binaural hearing loss	

This rule is intended to implement Iowa Code sections 85B.9A and 86.8.
[ARC 6841C, IAB 2/8/23, effective 3/15/23]

876—8.12(85) Offer of suitable work. The employer shall communicate an offer of temporary work to the employee in writing, including the details of lodging, meals, and transportation. With each offer of temporary work, the employer shall notify the employee in writing that:

1. If the employee refuses the offer of temporary work, the employee shall communicate the refusal and the reason for the refusal to the employer in writing;
2. During the period of refusal, the employee will not be compensated with temporary partial, temporary total, or healing period benefits unless the work refused is not suitable; and
3. Failure to communicate the reason for the refusal to the employer in writing precludes the employee from raising suitability of the work as the reason for the refusal until such time as the reason for the refusal is communicated in writing to the employer.

This rule is intended to implement Iowa Code section 85.33.

[ARC 3528C, IAB 12/20/17, effective 1/24/18; ARC 6841C, IAB 2/8/23, effective 3/15/23]

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◇ Two or more ARCs

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