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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

Editor's telephone (515) 281-3355 or (515) 281-8157

Iowa Finance Authority[265]

Replace Analysis
Replace Chapter 9
Replace Chapter 12
Replace Chapter 29
Insert Reserved Chapters 32 to 34
Insert Chapters 35 and 36

Human Services Department[441]

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Replace Chapter 65
Replace Chapter 75
Replace Chapter 77
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Iowa Public Employees' Retirement System[495]

Replace Chapter 4
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Natural Resource Commission[571]

Replace Chapters 51 and 52
Replace Chapter 95
Replace Chapter 99
Replace Chapter 106
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Nursing Board[655]

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Replace Chapter 10
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Public Safety Department[661]

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Replace Chapter 7 with Reserved Chapter 7
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Replace Chapter 4
Replace Chapter 529
Replace Chapters 601 and 602
Replace Chapters 604 and 605
Replace Chapter 607
Replace Chapters 610 and 611
Replace Chapter 615
Replace Chapter 640
Replace Chapter 801 with Reserved Chapter 801
Insert Chapter 822
Replace Reserved Chapters 822 to 909 with Reserved Chapters 823 to 909

Railway Finance Authority[765]

Replace Analysis
Replace Chapters 1 to 5 with Reserved Chapters 1 to 5

Veterans Affairs, Iowa Department of[801]

Replace Chapter 10

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Replace Chapters 1 to 3
Replace Chapters 5 and 6
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Replace “P”

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CHAPTER 9
TITLE GUARANTY DIVISION

265—9.1(16) Purpose. This chapter describes the mission, organization, programs and operations of the title guaranty division (division) of the Iowa finance authority (authority), including the office where and the means by which interested persons may obtain information and make submissions or requests.

265—9.2(16) Mission. The mission of the division is to operate a program that offers guaranties of real property titles in order to provide, as an adjunct to the abstract-attorney's title opinion system, a low-cost mechanism to facilitate mortgage lenders' participation in the secondary market and add to the integrity of the land-title transfer system in the state. Surplus funds in the title guaranty fund shall be transferred to the authority's housing program fund after providing for adequate reserves and for the operating expenses of the division.

265—9.3(16) Definitions. The following words and phrases, when used in this chapter, shall have the meanings set forth below unless a meaning is inconsistent with the manifest intent or the context of a particular rule:

"Abstract of title" or *"abstract,"* for the purposes of the title guaranty program, means a written or electronic summary of all matters of record including, but not limited to, grants, conveyances, easements, encumbrances, wills, and judicial proceedings affecting title to a specific parcel of real estate, together with a statement including, but not limited to, all liens, judgments, taxes and special assessments affecting the property and a certification by a participating abstractor that the summary is complete and accurate; provided, however, that for purposes of issuance of a title guaranty certificate covering a nonpurchase product, and for only such purposes, the "abstract of title" or "abstract" may also mean a title guaranty report of title.

"Certificate" means the title guaranty certificate including any part or schedule and any endorsements.

"Commitment" means the commitment to insure title including any part or schedule and any endorsements.

"Electronic record," for the purposes of the title guaranty program, means a record created, generated, sent, communicated, received, or stored by electronic means that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

"Nonpurchase product," for the purposes of the title guaranty program, means a refinanced or junior mortgage securing an amount not more than $500,000 for a residential property.

"Participant" means a participating attorney and a participating abstractor.

"Participating abstractor" means an abstractor who is authorized to participate in the title guaranty program and who is in full compliance with the abstractor's participation agreement, the Code of Iowa, these rules, manuals, and guides and any other written or oral instructions or requirements given by the division.

"Participating attorney" means an attorney who is authorized to participate in the title guaranty program and who is in full compliance with the attorney's participation agreement, the Code of Iowa, these rules, manuals, and guides and any other written or oral instructions or requirements given by the division and who is not subject to current disciplinary proceedings by the Iowa supreme court.

"Residential property," for the purposes of the title guaranty program, means residential real estate consisting of single-family housing or multifamily housing of no more than six units.

"Supervision and control," for the purposes of the title guaranty program, means that a participant's shareholders, partners, associates, secretaries, paralegals, and other persons under the participant's supervision or control who transact the business of abstracting, which includes but is not limited to any manner of title search or review, opining on titles to real estate, or issuing commitments or certificates at the direction of or in the name of the participant, shall comply with the requirements of the contracts, forms, manuals, instructions, and guides and any other written or oral instructions given by the division. A participant shall be liable to the division for loss or damage suffered by the division resulting from

acts or omissions of the participant's shareholders, partners, associates, secretaries, paralegals, and other persons under the participant's supervision or control who transact the business of abstracting, which includes but is not limited to any manner of title search or review, opining on titles to real estate, or issuing commitments or certificates at the direction of or in the name of the participant as an agent of the division as though the act or omission were that of the participant.

"Title guaranty report of title," for the purposes of the title guaranty program, means a short form of the abstract of title that is in writing or an electronic summary covering:

1. The last deed of a sales transaction for the approximate full value determined from the county records by document stamps, purchase money mortgage or other recorded evidence (not including family transactions, contract vendee deeds, gift deeds, tax deeds, probates, foreclosures, and no value or partial value transfers) provided, however, no search may cover less than two years prior to the certification date;
2. All liens, judgments, taxes and special assessments affecting the property;
3. An update known as the postclosing title report which extends the search through the refinanced or junior mortgage including releases by addendum; and
4. Certifications by the participating abstractor that the search and its extension are complete and accurate.

"Title search(es)" or *"search(es),"* for the purposes of the title guaranty program, means the abstract of title.

265—9.4(16) Organization.

9.4(1) *Location.* The office of the division is located at 2015 Grand Avenue, Des Moines, Iowa 50312. Office hours are 8 a.m. to 4:30 p.m. Monday through Friday, excluding legal holidays. The division's Web site address is www.iowafinanceauthority.gov, and the division's telephone and facsimile numbers are as follows: (515)725-4900 (general telephone number); 1-800-432-7230 (toll-free telephone number); 1-800-618-4718 (TTY); and (515)725-4901 (facsimile).

9.4(2) *Division board and staff.* The powers of the division are vested in and exercised by a board of five members, appointed by the governor and subject to confirmation by the senate. The board membership includes an attorney, an abstractor, a real estate broker, a representative of a mortgage lender, and a representative of the housing development industry. A chair and vice-chair are elected annually by the members, generally at the first meeting following July 1 of each year, which is the beginning of the fiscal year. Division staff consists of a director and additional staff as approved by the executive director of the authority.

9.4(3) *Division director.* The executive director of the authority appoints the director of the division. The division director shall be an attorney licensed to practice law in the state of Iowa and in good standing with the Iowa supreme court at all times while acting as the division director. The appointment of and compensation for the division director are exempt from the merit system provisions of Iowa Code chapter 19A. The division director serves as an ex-officio member of the division board and as secretary to the division board.

9.4(4) *Meetings.* Meetings of the division board are held quarterly on the date and time determined by the board. Meetings of the division board may also be held at the call of the chair or on written request of two members. The division will give advance public notice of the specific date, time and place of each division board meeting, and will post the tentative agenda for each meeting at least 24 hours before commencement of the meeting at the division office and at the main office of the authority, as well as on the authority's Web site. Meetings may occasionally be conducted by electronic means. Any interested party may attend and observe board meetings except for any portion of a meeting that may be closed pursuant to Iowa Code section 21.5. The minutes of the board meetings are available for viewing at the division's office or via the authority's Web site. Three members of the division board constitute a quorum. An affirmative vote of a majority of the appointed members is necessary for any substantive action taken by the division board. The majority shall not include any board member who has a conflict of interest, and a statement of a conflict of interest shall be conclusive for this purpose.

265—9.5(16) Location where public may obtain information. Requests for information, inquiries, submissions, petitions and other requests may be directed to the division at the address set forth in subrule 9.4(1). Requests may be made personally, by telephone, mail, E-mail or any other medium available.

265—9.6(16) Title guaranty program.

9.6(1) *General.* The division operates a program to offer guaranties of real property titles in the state through the issuance of title guaranty certificates. Title guaranty certificates may be issued by the division, by participating abstractors for the division pursuant to subrule 9.6(3), paragraph *"f,"* herein, or by participating attorneys pursuant to Iowa Code section 16.91(7).

9.6(2) *Participating attorneys.* An attorney licensed to practice law in the state of Iowa may participate in the title guaranty program upon approval by the division director of an application to the division and upon execution and acceptance by the division director of an attorney's participation agreement.

a. Authority of participating attorney. A participating attorney is authorized to act as an agent of the division but only for the purposes and in the manner set forth in the attorney's participation agreement, the Code of Iowa, these rules, manuals, requirements and any other written or oral instructions given by the division and in no other manner whatsoever. The authority of the participating attorney under the preceding sentence is not exclusive and is subject to the rights of the authority, of the division and of other participants, agents, or representatives of the division to transact the business of opining on titles to real estate or issuing commitments or certificates and is further subject to the right of the division to appoint other participants.

b. License. A participating attorney shall be licensed to practice law in the state of Iowa and shall be in good standing with the Iowa supreme court at all times while acting as an agent of the division.

c. Errors and omissions insurance. A participating attorney shall maintain errors and omissions insurance at all times while acting as an agent of the division, with such coverage and in such amounts as the division board may direct from time to time by resolution.

The division will inform the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information of any proposed change in the amount of required errors and omissions insurance at least 30 days prior to the date of the meeting at which the matter will be considered. Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

d. Participation fees. A participating attorney shall pay participation fees in such amounts and at such times as the division board may set from time to time by resolution. Participation fees set by the division board are subject to the approval of the authority board.

The division will inform the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information of any proposed change in the amount of attorney participation fees at least 30 days prior to the date of the meeting at which the matter will be considered. Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

e. Training. A participating attorney shall complete division forms and procedures training prior to issuing title guaranty certificates as an agent of the division.

f. Underwriting determinations. A participating attorney shall make all underwriting determinations prior to or at the closing. If the participating attorney does not attend the closing and is not available by telephone during the closing, all underwriting determinations must have been made by the participating attorney issuing the opinion, commitment or certificate prior to closing. For purposes of this rule, the term "underwriting determinations" includes, but is not limited to, insuring access, reviewing gap searches, possible judgments, survey matters (including encroachments), unreleased mortgages or other liens, and any other matters disclosed by the opinion, commitment or other sources of title information. A participating attorney who causes or allows an erroneous underwriting determination to be made by someone other than a member of the division's legal staff or the participating attorney who issued the opinion, commitment or certificate shall be strictly liable

to the division for loss or damage the division may suffer as a result of the erroneous underwriting determination.

A participating attorney shall make all underwriting determinations arising out of the issuance of an attorney title opinion or a title commitment using both:

(1) Generally accepted and prudent title examining methods; and

(2) Procedures implemented by the division and outlined in these rules, manuals, and guides and any other written or oral instructions or requirements given by the division.

Any underwriting determination about which there may be a bona fide difference of opinion among local lawyers and that is not specifically covered by materials provided by the division shall be approved by division legal staff.

g. Title files. A participating attorney shall maintain separate title files or maintain client files in such a manner that information pertaining to activities of the participating attorney as an agent and underwriter for the division are readily available to the division. A participating attorney shall maintain title files and the title portion of client files for a period of ten years after the effective date of the certificate or certificates.

h. Forms. The division will provide forms to a participating attorney for use in acting as an agent of the division. A participating attorney may not alter any form supplied by the division, or use a form supplied by another person or entity to bind the division, or otherwise bind the division to liability with a form, other writing or representation not supplied or authorized by the division.

A participating attorney who obtains serialized forms from the division must maintain a forms register, in a format approved or supplied by the division, in which the participating attorney shall enter a record of and show the disposition of all serialized forms. In addition, the participating attorney shall:

(1) Return the original of any damaged, spoiled, or otherwise unusable serialized form to the division;

(2) Return the original of any unused serialized form to the division at the request of the division; and

(3) Not transfer or attempt to transfer unissued serialized forms to another participant or other person or entity unless authorized in writing by the division.

If a participating attorney fails to comply with the requirements of this rule, in addition to the division's other rights and remedies, the division may refuse to supply any forms to the participating attorney until the participating attorney complies with the requirements of this rule to the satisfaction of the division.

The participating attorney shall be liable to the division for loss or damage sustained by the division by reason of the loss of, misuse of, or inability of the participating attorney to account for any form supplied by the division, or the failure of the participating attorney to comply with the requirements of this rule.

i. Certificate amount limitations. A participating attorney shall obtain the written authorization of the division's legal staff prior to issuing a commitment or certificate which exceeds such amounts as the division board may set from time to time by resolution. If any authorization required under this rule is not obtained through the act or omission of the participating attorney, the participating attorney shall be strictly liable to the division for any loss or damage resulting from issuance of the commitment or certificate.

9.6(3) *Participating abstractors.* An abstractor or abstracting concern may participate in the title guaranty program upon approval by the division director of an application to the division and upon execution and acceptance by the division director of an abstractor's participation agreement.

a. Authority of participating abstractor. A participating abstractor is authorized to act as an agent of the division but only for the purposes and in the manner set forth in the abstractor's participation agreement, the Code of Iowa, these rules, manuals, requirements and any other written or oral instructions given by the division and in no other manner whatsoever. The authority of the participating abstractor under the preceding sentence is not exclusive and is subject to the rights of the authority, of the division and of other participating abstractors, agents, or representatives of the division to transact the business

of abstracting, which includes but is not limited to any manner of title search or review of titles to real estate, and is further subject to the right of the division to appoint other participating abstractors.

b. Title plant. Participating abstractors shall own or lease, and maintain and use in the preparation of abstracts, an up-to-date abstract title plant including tract indices for real estate for each county in which abstracts are prepared for titles to real property guaranteed by the division. Each of the tract indices shall be designated to encompass a geographical area of not more than one block in the case of platted real estate, nor more than one section in the case of unplatted real estate. The tract indices shall include a reference to all of the instruments affecting real estate recorded in the office of the county recorder, and the tract indices shall commence not less than 40 years prior to the effective date of the abstractor's participation in the title guaranty program.

c. Exempt attorneys. Participating attorneys who have been providing abstract services continuously from November 12, 1986, to the date of application to be a participating abstractor, either personally or through persons under their supervision and control, shall be exempt from the requirement to own or lease a title plant. This exemption is a personal exemption of the individual participating attorney, is not transferable, and terminates at such time as the individual ceases providing abstracting services or upon the death or incapacity of the individual.

d. Errors and omissions insurance. A participating abstractor shall maintain errors and omissions insurance at all times while acting as an agent of the division, with such coverage and in such amounts as the division board may direct from time to time by resolution.

The division will inform the Iowa Land Title Association, the Iowa State Bar Association, and any person requesting such information of any proposed change in the amount of required errors and omissions insurance at least 30 days prior to the date of the meeting at which the matter will be considered. Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

e. Participation fees. A participating abstractor shall pay participation fees in such amounts and at such times as the division board may set from time to time by resolution. Participation fees set by the division board are subject to the approval of the authority board.

The division will inform the Iowa Land Title Association, the Iowa State Bar Association, and any person requesting such information of any proposed change in the amount of abstractor participation fees at least 30 days prior to the date of the meeting at which the matter will be considered. Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

f. Issuing title guaranty. A participating abstractor may be authorized pursuant to a written contract with the division director to issue a title guaranty commitment or certificate for the division when the participating attorney who prepares the opinion allows issuance by the participating abstractor. Written contractual approval by the division director for division issuance will be based upon the completion of a division request form by a participating abstractor and the attachment of all disclosures required by the division. A participating abstractor authorized to process a title guaranty commitment or certificate must comply with the Code of Iowa, these rules, manuals, requirements, and any other written or oral instructions given by the division and in no other manner whatsoever. The rights of the participating abstractor under the preceding sentence are not exclusive and are subject to the rights of the authority, the division and of other participants of the division to issue commitments or certificates and are further subject to the right of the division to appoint other participants. A participating abstractor's right to process commitments and certificates is a privilege for the convenience of the division and may be terminated pursuant to the written contract with the division.

g. Training. A participating abstractor authorized to process title guaranty commitments and certificates for division issuance shall complete division forms and procedures training prior to processing title guaranty commitments and certificates for division issuance.

h. Title files. A participating abstractor authorized to process title guaranty commitments and certificates for division issuance shall maintain separate title files or maintain client files in such a manner that information pertaining to the preparation of the commitments and certificates and all underwriting determinations made by the participating attorney as an agent and underwriter for the

division are readily available for review by the division. A participating abstractor shall maintain title files and the title portion of client files for a period of ten years after the effective date of the certificate or certificates.

i. Forms. The division may provide forms to a participating abstractor for use in processing commitments and certificates for division issuance. The participating abstractor may not alter any form supplied by the division, or use a form supplied by another person or entity to bind the division, or otherwise bind the division to liability with a form, other writing or representation not supplied or authorized by the division. A participating abstractor who obtains serialized forms from the division must maintain a forms register, in a format approved or supplied by the division, in which the participating abstractor shall enter a record of and show the disposition of all serialized forms. In addition, the participating abstractor shall:

(1) Return the original of any damaged, spoiled, or otherwise unusable serialized form to the division;

(2) Return the original of any unused serialized form to the division at the request of the division;

(3) Not transfer or attempt to transfer unissued serialized forms to another participant or other person or entity unless authorized in writing by the division.

If the participating abstractor fails to comply with the requirements of this rule, in addition to the division's other rights and remedies, the division may refuse to supply any forms to the participating abstractor and, upon written request from the division, the participating abstractor must deliver immediately all division forms and pending title guaranty files to the division.

The participating abstractor shall be liable to the division for loss or damage sustained by the division by reason of the loss of, misuse of, or inability of the participating abstractor to account for any form supplied by the division or by reason of the failure of the participating abstractor to comply with the requirements of this rule.

9.6(4) *Abstract of title.*

a. Preparation. An abstract of title shall be brought up to date and certified by a participating abstractor prior to the issuance of a title guaranty certificate.

b. Compliance. All abstracts of title shall be prepared and conducted in compliance with division procedures in effect at the time of the updating of the abstract. A participating abstractor shall retain a written or electronic copy of each abstract of title prepared for a title guaranty certificate and shall provide such copy to the division upon request.

9.6(5) *Attorney title opinion.* All attorney title opinions shall be prepared and issued in compliance with division procedures in effect at the time of issue. A participating attorney shall retain a written or electronic copy of each attorney title opinion and shall provide such copy to the division upon request. Participating attorneys who are issuing agents for the division may issue a commitment as the preliminary attorney title opinion and the title guaranty certificate as the final attorney title opinion in compliance with division procedures in effect at the time of issue.

9.6(6) *Participant's interest in property.* No participant shall prepare an abstract of title or issue attorney title opinions, commitments, or certificates upon property in which the participant has an interest without prior authorization of the division.

265—9.7(16) Waiver of up-to-date title plant requirement. The division board shall consider an application by an attorney or abstractor for waiver of the use of an up-to-date title plant requirement described in Iowa Code Supplement section 16.91(5)*"a"*(2).

9.7(1) *Mission.* The division is authorized under Iowa Code chapter 16 to issue title guaranties throughout the state. The division's public purpose is to facilitate lenders' participation in the secondary market and to promote land title stability through use of the abstract-attorney opinion system. The division recognizes the 40-year title plant as the preferred method of providing title evidence for the purpose of issuing title guaranties. The division must weigh the benefits of the traditional title plant with other alternatives to ensure buyers and lenders high quality of title guaranties throughout the state, rapid service, and a competitive price. To assist the division in this mission, Iowa Code Supplement section 16.91(5)*"b"* expressly allows the division to waive the up-to-date title plant requirement.

9.7(2) *Definitions.* The following words and phrases, when used in this rule, shall have the meanings set forth below unless a meaning is inconsistent with the manifest intent or the context of a particular rule:

"Availability of title guaranties" means that title guaranties are uniformly accessible throughout the state to buyers and lenders with competitive pricing, service, and quality and that there are two or more abstractors physically located in all 99 counties.

"Exempt attorney-abstractor," as it relates to the title plant requirement, means a grandfathered attorney or a waived attorney.

"Grandfathered attorney" means a participating attorney who has been providing abstract services continuously from November 12, 1986, to the date of application to be a participating abstractor, either personally or through persons under the participating attorney's supervision and control, who is exempt from the requirement to own or lease a title plant. This exemption is a personal exemption of the individual participating attorney, is not transferable, and terminates at such time as the participating attorney ceases providing abstracting services or upon the death or incapacity of the participating attorney.

"Hardship" means deprivation, suffering, adversity, or long-term adverse financial impact in complying with the title plant requirement that is more than minimal when considering all the circumstances. Financial hardship alone may constitute a hardship.

"Interested person" means a person requesting a plant waiver, all division board members, all participating abstractors in the county for which the waiver is requested, the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information that an application for waiver has been made to the division.

"Person" means an individual, including a corporation, limited liability company, government or governmental subdivision or agency, business trust, trust, partnership or association, or any other legal entity.

"Public interest" means that which is beneficial to the public as a whole, including but not limited to increasing competition among abstractors, encouraging the use of title guaranties throughout the state, making title guaranties more competitive than out-of-state title insurance, increasing the division's market share, improving the quality of land titles, protecting consumers, and encouraging maximum participation by participating abstractors and participating attorneys physically located in all 99 counties.

"Waiver" or *"variance"* means an action by the division which suspends in whole or in part the requirement of the use of a current tract index described in Iowa Code Supplement section 16.91(5) as applied to an abstractor.

9.7(3) *Filing of application.* An applicant must submit a plant waiver application in writing to the attention of the director of the Title Guaranty Division of the Iowa Finance Authority, 2015 Grand Avenue, Des Moines, Iowa 50312.

9.7(4) *Content of application.* The title guaranty division may provide an application form on the division's Web site. A plant waiver application shall include, at a minimum, the following information where applicable and known to the applicant:

a. The name, business address, E-mail address, and telephone number of the abstractor for whom a waiver is being requested;

b. The type of waiver being requested, as described in subrule 9.7(8);

c. A general description of the applicant's business;

d. A description of intention to develop a 40-year tract index;

e. The relevant facts that the applicant believes would justify a waiver under subrules 9.7(7) and 9.7(8); and

f. A signed statement from the applicant attesting to the accuracy of the facts provided in the application.

9.7(5) *Notification and response.*

a. The division director shall acknowledge an application upon receipt. All interested persons shall be contacted by E-mail and Web-site posting, and notice shall be given by United States first-class mail to any party requesting the same in writing. Notice shall be given within 14 days of the receipt of

the application by the division director. Notification to an interested person is not a requirement for the division board to consider the waiver, and failure to inform an interested person of an application for waiver shall not void or otherwise nullify any action or decision of the division board.

b. Any person may submit a written statement in support of or in opposition to the application.

c. The application shall be placed on the agenda for the next scheduled division board meeting which is at least 30 days after the application is filed unless a special meeting is requested by the chairperson of the board or by written request of two board members.

9.7(6) *Board meeting action.*

a. The informal review of the waiver is not a contested case proceeding but other agency action wherein the rules of evidence are not applicable.

b. To preserve order, the chairperson of the board may set reasonable limitations upon the number of persons who may appear before the division board and the time allotted for presentations in favor of and against the requested waiver.

c. Title guaranty director review. The title guaranty director shall investigate and review the petition and its supporting documentation and, at the waiver meeting before the board, shall give the board a recommendation to grant or deny the waiver.

d. The board shall consider the application, the criteria and type of waiver set forth in subrules 9.7(7) and 9.7(8), and then vote on the application.

9.7(7) *Criteria for waiver or variance.* In response to an application completed pursuant to subrule 9.7(4), the division board may issue a ruling permanently or provisionally waiving the requirement set forth in Iowa Code Supplement section 16.91(5)*"a"*(2) of an up-to-date title plant requirement, if the board finds both of the following:

a. The title plant requirement described in Iowa Code Supplement section 16.91(5)*"a"*(2) imposes a hardship to the abstractor or attorney; and

b. The waiver is:

(1) Clearly in the public interest; or

(2) Absolutely necessary to ensure availability of title guaranties throughout the state.

9.7(8) *Type of waiver or variance granted.* Provisional and permanent waivers described in this subsection may be granted by the division board. Guidelines for provisional and permanent waivers are as follows:

a. Provisional waivers. The division board may grant a provisional waiver of one year or less to an applicant intending to build a title plant. If such time period is not sufficient, the applicant may reapply to the division board for an extension of the waiver up to one additional year at the discretion of the division board. The division board may grant a provisional waiver when the applicant provides the following:

(1) Evidence that a title plant will be built for a specified county;

(2) Evidence of significant financial loss due to the inability to provide abstracts for the division;

(3) Evidence that the provisional waiver is necessary in order to produce a revenue stream to justify the expense associated with building a title plant; and

(4) Professional references from two licensed Iowa attorneys or one participating plant-abstractor attesting to the applicant's ability to abstract.

b. Permanent waivers for attorneys. The division board may grant a permanent waiver to an Iowa-licensed attorney.

(1) Attorneys granted a permanent waiver hold the same status as grandfathered attorneys and, absent express legislative authority to the contrary, the board will not limit geographically an attorney's ability to abstract for the division. However, the applicant may by contract with the division board agree voluntarily to limit the applicant's abstracting for the division to one or more specified counties.

(2) A permanent waiver is personal in nature and nontransferable. An attorney granted a permanent waiver shall be personally liable for abstracting conducted on behalf of the division. Although an attorney may abstract through a separate entity, such liability cannot be transferred to a corporate entity nor may an attorney utilize a corporate structure which would shield the attorney from personal liability.

(3) Permanent waivers are predicated upon the attorney's retaining an Iowa license to practice law. An attorney whose license is suspended shall reapply to the division director upon reinstatement by the Iowa Supreme Court. The division director has the discretion to refer the matter to the division board.

(4) There are two circumstances when an attorney may be granted a permanent waiver:

1. For attorney applicants with experience abstracting under the supervision and control of an exempt attorney-abstractor, the board shall consider, at a minimum, the following:

- The applicant's abstract experience. The board shall give considerable weight to an applicant's experience abstracting under the personal supervision and control of an exempt attorney-abstractor with whom the applicant has had a close working relationship or with whom the applicant is a legal partner or associate.
- Professional references. The board shall give considerable weight to a recommendation from the exempt attorney-abstractor or grandfathered attorney who personally supervised the applicant's abstracting for a period of two years or more and who attests in writing or in person before the division board regarding the applicant's ability to abstract.
- Samples of abstracts prepared by the applicant.
- The division board shall give consideration to the number of participating abstractors physically located in the county or counties where the applicant seeks to abstract in determining whether a waiver should be granted.

2. For attorney applicants without experience working under the supervision and control of an exempt attorney-abstractor, the board shall consider, at a minimum, the following:

- The applicant's abstract experience;
- Professional references;
- Samples of abstracts prepared by the applicant;
- The applicant's business plan;
- Evidence of clients and volume of additional transactions that will be brought into the title guaranty abstract/attorney system as a result of the waiver;
- The number, availability, service and quality of other abstractors available to perform abstracting and whether the grant of a permanent waiver will adversely impact the business of other participating abstractors;
- Whether the applicant demonstrates the inability to abstract under the supervision and control of an exempt attorney.

c. Permanent waivers for non-attorneys.

(1) The board may grant a permanent waiver with limitations as to county, or transaction type, or both.

(2) In determining whether to grant a waiver, the board shall consider, at a minimum, the following:

1. The applicant's abstract experience, maintenance of a title plant by the applicant in any other county, and degree of participation by the applicant in the title guaranty division standards in excellence program;
2. Professional references;
3. Samples of abstracts prepared by the applicant;
4. The applicant's business plan;
5. Evidence of clients and volume of additional transactions that will be brought into the title guaranty abstract/attorney system as a result of the waiver;
6. The number, availability, service and quality of other abstractors available to perform abstracting and whether the grant of a permanent waiver will adversely impact the business of other participating abstractors.

9.7(9) *Ruling.* The division board shall direct the division director to prepare, or cause to be prepared, a proposed written ruling setting forth the board's rationale for granting or denying the waiver. Action to adopt or direct changes to the proposed ruling will be taken by the division board at a subsequent meeting. However, if the board directs the division director to prepare a proposed ruling granting the waiver, the applicant may start abstracting while the ruling is being prepared, and staff shall issue a new participating abstractor number to the applicant immediately.

a. The ruling granting or denying a waiver shall contain a reference to the particular applicant, discuss the application of subrules 9.7(7) and 9.7(8), and describe how granting the waiver would or would not advance the division's statutory mission described in subrule 9.7(1). The ruling will summarize the relevant facts and reasons upon which the action is based and include a description of the precise scope and duration of the waiver if the waiver contains limitations, restrictions or requirements.

b. The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the division board upon consideration of all relevant factors. Relevant factors to be considered are the unique circumstances set out in the application, presentations given before the board, the professional knowledge and expertise of the board members and division staff, and any other resources available to the entire division board. Consideration should be afforded to rulings on prior plant waiver requests, but the division board shall not be bound by such rulings.

c. Within seven days of its issuance, any ruling issued under subrule 9.7(9) shall be transmitted to the applicant, the Iowa State Bar Association and the Iowa Land Title Association.

d. The decision of the division board shall be final agency action and all appeals shall be filed with the Iowa District Court for Polk County.

9.7(10) *Title plant certification.* For applicants granted a provisional waiver, division staff shall inspect the title plant and certify to the division board that the title plant is complete before the board may grant up-to-date title plant status to the applicant. Upon certification of up-to-date title plant status, the applicant must obtain approval from the division to conduct business under a name other than the entity to which the provisional waiver was granted. Any transfer of a title plant must be approved by division staff in order for the title plant to be a title guaranty abstractor.

9.7(11) *Public availability.* Applications for waivers and rulings on waiver applications are public records under Iowa Code chapter 22. Some applications or rulings may contain information the division is authorized or required to keep confidential. Division staff may accordingly redact confidential information from applications or rulings prior to public inspection or dissemination.

9.7(12) *Voiding or cancellation.* A waiver or variance is voidable if material facts upon which the petition is based are not true or if material facts have been withheld. A waiver or variance issued by the division board may be withdrawn, canceled, or modified if, after appropriate notice and meeting, the division board issues a ruling finding any of the following:

a. That the petitioner or the applicant who was the subject of the waiver ruling withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or

b. That the alternative search method assuring that the public interest will be adequately protected after issuance of the ruling has been demonstrated to be insufficient; or

c. That the subject of the waiver ruling has failed to comply with all conditions contained in the ruling.

[**ARC 7892B**, IAB 7/1/09, effective 8/5/09]

265—9.8(16) Application for title guaranty certificates. The division may authorize entities engaged in the real estate industry to apply directly to the division, to a participating attorney pursuant to Iowa Code section 16.91(7), or to a participating abstractor approved to issue title guaranty pursuant to subrule 9.6(3), paragraph *"f,"* for a title guaranty commitment or certificate. The applicant shall complete and submit such forms and other information as the division may require and pay the appropriate fee. Entities engaged in the real estate industry which the division may authorize include, but are not limited to, mortgage lenders as defined in Iowa Code section 16.1(27), and closing and escrow companies.

265—9.9(16) Contracts, forms, manuals, instructions, and guides. The division shall adopt and issue such contracts, forms, manuals, instructions, and guides as the division deems necessary to set out participation standards and requirements, and such other matters that the division deems necessary for implementation and effective administration of the title guaranty program. The provisions of the manuals, instructions, and guides shall be applicable to participants in the title guaranty program.

9.9(1) *Adoption.* The contracts, forms, manuals, instructions, and guides will be adopted or revised or amended on approval of a majority vote of the division board, without publication of notice and

without providing an opportunity for public comment. In accordance with Iowa Code section 17A.4(2), the contracts, forms, manuals, instructions, and guides are a classification of rule making for which notice and public participation are impracticable and unnecessary because:

a. Iowa Code section 16.2 vests the powers of the division relating to the issuance of title guaranties in the division board, and Iowa Code section 16.91 authorizes the division board to operate the title guaranty program and adopt contracts and forms and set fees;

b. Such contracts, forms, manuals, instructions, and guides may need to be amended quickly to address title underwriting standards and procedures, to protect the division and its programs, and to ensure the efficient operation of the division; and

c. Participants are agents or quasi agents of the division and the contracts, forms, manuals, instructions, and guides are intra-agency directives.

The division will inform the Iowa State Bar Association, the Iowa Land Title Association, and any person requesting such information of any proposed change in the contracts, forms, manuals, instructions, and guides at least 30 days prior to the date of the division board meeting at which the matter will be considered. Interested parties may submit evidence or statements in support of or in opposition to the proposal in writing or by personal appearance before the division board.

9.9(2) *Availability.* The contracts, forms, manuals, instructions, and guides are furnished to participants in the title guaranty program at no charge. They may be reviewed and copied in their entirety from the division's Web site. Copies shall be deposited with the administrative rules coordinator and at the state law library. Copies of paper editions for nonparticipants are available from the division upon request for a fee. The division will charge a fee to recover the costs of the binder, contents, and mailing for the paper editions. Current price information is available upon request from the division.

265—9.10(16) Rates. The division board shall fix the rate or fee, if any, for the owner's guaranty, the lender's guaranty, the various endorsements, the closing protection letter and any other product or service that will be offered by the division. The division shall set the rates by resolution and may change the rates from time to time in the same manner.

265—9.11(16) Fees and premiums. No participant in the title guaranty program shall charge or receive any portion of the fee for the guaranty or the fee for any other product or service that is paid to the division.

9.11(1) A participant shall calculate the title certificate fees according to the applicable rate schedule in effect on the effective date of the commitment or of the certificate, whichever is earlier. A participant shall collect the fee in effect for any other product or service offered by the division at the time the product or service is sold.

9.11(2) A participant may charge and collect fees that are customarily charged for services or other products provided as part of a real property transaction.

9.11(3) All fees collected by a participant payable to the division shall be held for the use and benefit of the division until paid to the division. The participant shall remit the fees payable to the division at the time and in the manner directed by the division from time to time, but in no event later than the date of the issuance of the guaranty.

265—9.12(16) Audit procedures.

9.12(1) *Serialized forms audit.* The division will periodically supply to a participant who issues title guaranty certificates a list of all serialized forms that, according to the division's records, are in the custody and control of the participant. The participant shall, within 15 days of receipt of the list of serialized forms, return the list to the division either with a certification that it is correct or with an explanation of any discrepancies between the records of the division and those of the participant.

9.12(2) *Office audits.* The division may, with or without notice to a participating abstractor or participating attorney, audit the participant at the participant's office. This audit may include, but need not be limited to, a review of the participant's commitment and policy issuance procedures, an audit of serialized forms, an audit and test of title plants and tract indices, and verification of the participant's

compliance with participation agreements, the Code of Iowa, these rules, manuals, and guides and any other written or oral instructions or requirements of the division.

265—9.13(16) Claims.

9.13(1) *Claim procedures.* In the event of loss or damage or potential loss or damage arising by reason of a matter actually, possibly, or allegedly within the coverage of a commitment or certificate or by reason of any other matter for which the division is actually, possibly, or allegedly liable (referred to herein as a "claim"), the rights and responsibilities of the division and the participating abstractor and participating attorney are as follows:

a. Upon receipt of notice by a participant of a claim, the participant must notify the division in writing, setting forth and including at a minimum:

(1) The name, address, and telephone number of the claimant and the claimant's attorney, if any;

(2) The number assigned to the commitment and certificate and a copy of the commitment and certificate if not previously forwarded to the division; and

(3) A description of the claim and copies of any documents, correspondence, surveys, title searches, or other writings, and other information supplied to or available to the participant relevant to the claim.

Under this rule, the participant shall notify the division within three business days of receipt of information about a claim by the participant and shall mail notification to the division by first-class mail at the division's address in subrule 9.4(1). In addition to the notice required by the preceding sentence, if the nature of the claim is such that the insured claimant or the division, or both, may suffer loss or damage that might be reduced or avoided by notice given more promptly than required by the preceding sentence, the participant shall notify the division by telephone, facsimile transmission, overnight mail or other overnight delivery service, or any combination of these methods.

b. When a participant receives a request from the division for information with respect to a claim, the participant shall supply to the division any documents, correspondence, surveys, abstracts of title, title searches, other writings, or other information known by or available to the participant and relevant to the claim, even if not specifically requested by the division. The participant's response to the division under this paragraph must be made within three days of the participant's receipt of the request and must be sent by first-class mail to the division employee, agent, or other authorized person who requested the information. In addition to the participant's response as required by the preceding sentence, if the nature of the claim is such that the insured claimant or the division, or both, may suffer loss or damage that might be reduced or avoided by a response quicker than that required by the preceding sentence, or if the division requests a quicker response, the participant shall respond by telephone, facsimile transmission, overnight mail or other overnight delivery service, or any combination of these methods, to the division employee, agent, or other authorized person requesting the information.

c. A participant shall cooperate fully in the investigation and resolution of a claim and shall supply any additional, new information that may come to the participant's attention with such promptness as the circumstances permit.

d. The division may, with or without prior notice to the participant or participants involved, investigate and resolve any claim in any manner that, in the division's sole discretion, the division may deem advisable. Investigation and resolution may include, but are not limited to, determinations of liability, retention of counsel for the division or for the insured claimant, settlement with the insured claimant or other party, and recovery of amounts paid.

9.13(2) *Claim loss recovery from participants.*

a. Amounts paid by the division in the investigation and resolution of a claim, hereinafter referred to as a "claim loss," including, but not limited to, payments to the insured, payments to adverse claimants, attorneys' fees, and all other expenses and costs related to or arising from the claim in accordance with the provisions of this rule, are recoverable from a participant by the division.

b. In the absence of knowledge by the participant about the title defect or other matter causing the claim loss, the division shall not seek recovery from the participant when a claim loss arises from one or more of the following:

(1) Hidden defects, including, but not limited to, forged deeds and mortgages, false affidavits, and false statements of marital status;

(2) Errors by public officials in maintaining and indexing the public records including, but not limited to, errors by county assessors, recorders, clerks, and treasurers;

(3) Errors in these rules, the division's manuals, guides, procedures, and any other written or oral instructions or requirements given by the division that the participant relies upon in issuing an abstract of title, opinion, commitment, certificate, or endorsement;

(4) Errors in surveys provided by registered Iowa land surveyors that the participant relies upon in giving survey coverage or issuing an endorsement or endorsements; or

(5) Underwriting determinations or title risks approved by the division prior to issuance of the abstract of title, opinion, commitment, certificate, or endorsement.

c. The participant shall reimburse the division for a claim loss when the division determines, in accordance with 9.13(2)*"d,"* that the participant is liable and when the claim loss arises from one or more of the following:

(1) Errors by the participant in the title search and report of information in the public record;

(2) Reliance by the participant upon sources of title searches and other title information that had not been approved by the division at the time of the reliance;

(3) Errors made by the participant in examining the title information provided in an abstract of title, survey, affidavit, or other source of title information;

(4) Errors made by the participant in the preparation or review of an abstract of title, opinion, commitment or certificate;

(5) Knowing issuance of an abstract of title, opinion, commitment or certificate by the participant upon a defective title; or

(6) Failure of the participant to follow these rules, the division's manuals, guides, procedures, or any other written or oral instructions or requirements given by the division with respect to any other matters not included within 9.13(2)*"c."*

d. Unless another rule, the Code of Iowa, a procedure, or a guideline provides for a different standard of liability or other rule for determining whether the participant shall be liable for a claim loss, the division shall apply the following standards:

(1) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(1), the division may demand reimbursement from the participant if the participant was grossly negligent in conducting the title search. Gross negligence includes the failure to make a search or the use of inadequate search procedures. Gross negligence under the preceding sentence includes but is not limited to failure to search certain indices, failure to search all names of parties with an interest in the real estate, or failure to search in all public offices required by the division search procedures or procedures used by prudent title searchers if the division has not established specific search procedures. In making its determination whether to seek recovery, the division may consider the complexity of the public record, the reliance of the participant upon division-approved search procedures, the training and experience of the person who made the error, and the existence or nonexistence of previous search errors by the participant.

(2) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(2), the division may demand reimbursement from the participant if the participant relied upon sources of title searches or other title information that had not been approved by the division at the time of the reliance.

(3) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(3), the division may demand reimbursement from the participant if the participant negligently examined the title information used in making a title determination, failed to raise an appropriate exception, waived an exception, or endorsed a title commitment or certificate. The division may make full review of local county abstracting standards and bar title rules as a guide to determine whether the participant has failed to meet the standard of skill and competence of an abstractor who prepares an abstract of title or a lawyer who examines titles in the community where the claim arose. The division may also consider whether the participant followed these rules, the division's

manuals, guides, procedures, or any other written or oral instructions or requirements given by the division in examining the title. In addition, the division may seek input from other participants in the community in which the claim arose as to the standard of care of an abstractor who prepares an abstract of title or of a lawyer who examines titles in that community.

(4) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(4), the division may demand reimbursement from the participant if the participant negligently prepared and reviewed an abstract of title, opinion, commitment or certificate.

(5) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(5), the division may demand reimbursement from the participant if the issuance of the abstract of title, opinion, commitment or certificate constituted fraud, concealment or dishonesty, or if the issuance of the abstract of title, opinion, commitment or certificate was based upon an underwriting decision on an unusual risk that was made without contacting the division for approval.

(6) In the event that a claim loss occurs for which the division may seek recovery from the participant under 9.13(2)*"c"*(6), the division may demand reimbursement from the participant if the participant failed to follow these rules, the division's manuals, guides, procedures, or any other written or oral instructions or requirements given by the division with respect to the matter causing the claim loss.

(7) In the event the division seeks reimbursement from a participant, the division shall state the basis of the reimbursement as indicated in 9.13(2)*"c"* and 9.13(2)*"d"*(1) to (6).

e. The division board may, from time to time by resolution, establish levels of authority, including dollar amounts, for the board, the director and division staff for the settlement of claims made under the title guaranty certificates.

265—9.14(16) Rules of construction. In the construction of these rules, the following rules shall be observed, unless either the rules of the Iowa Code chapter 4, Construction of Statutes, or the following rules are inconsistent with the manifest intent or the context of the rule:

The word "shall" means mandatory and not permissive and the word "may" means permissive and not mandatory.

The word "closing" includes, but is not limited to, the recording of a deed executed and delivered in lieu of a mortgage foreclosure or pursuant to a mortgage foreclosure proceeding and also includes the entry into a binding agreement and transfer of possession by a seller to a buyer on a contract sale of land.

Nothing contained in these rules shall be construed to require a participating attorney to disclose privileged information of a client to the division or to any other party.

Any rule that provides a specific remedy or sanction for violation of the rule shall not be construed as limiting the ability of the division to pursue and enforce other penalties or sanctions under these rules, or otherwise, against the participating abstractor, participating attorney or other person responsible or liable, either separately, concurrently, cumulatively, or in any combination, at the sole discretion of the division.

The failure of the division to enforce a right or remedy under these rules, a statute, or the common law shall not be construed as a waiver of such right or remedy either in the specific instance or in any other instance.

265—9.15(16) Implementation. The provisions for abstracting requirements in the event of refinancing a mortgage or granting a second mortgage set out in subrule 9.6(4), first unnumbered paragraph, shall be implemented upon the issuance of a manual, instruction or guide by the division board.

265—9.16(16) Forms, endorsements, and manuals. Rescinded IAB 8/4/04, effective 9/8/04.

265—9.17(16) Application for waiver of participation requirements. Rescinded IAB 8/4/04, effective 9/8/04.

265—9.18(16) Rates. Rescinded IAB 8/4/04, effective 9/8/04.

265—9.19(16) Charges. Rescinded IAB 8/4/04, effective 9/8/04.

265—9.20(16) Mortgage release certificate.

9.20(1) *Definitions.* As used in this rule, unless the context otherwise requires:

"Authority" means the Iowa finance authority described in Iowa Code chapter 16.

"Certificate" means the certificate of release or partial release of mortgage issued by the division.

"Claim for damages" means a claim for actual money damages against the division caused by the division's wrongfully or erroneously, through an act of negligence, filing a certificate while the staff of the division are acting within the scope of their office or employment.

"Division" means the title guaranty division in the Iowa finance authority.

"Effective release or satisfaction" means a release or satisfaction of mortgage pursuant to Iowa Code chapter 655.

"Mortgage" means a mortgage or mortgage lien on an interest in real property in this state given to secure a loan in an original principal amount, including any future advances, equal to or less than:

1. For mortgages paid off by the division staff, $20,000,000.
2. For mortgages paid off by a division closer within a division closing, $20,000,000.
3. For all other mortgages, without prior division written approval, $1,000,000.

"Mortgagee" means the grantee of a mortgage. If a mortgage has been assigned of record, the mortgagee is the last person to whom the mortgage is assigned of record.

"Mortgage servicer" means the mortgagee or a person other than the mortgagee to whom a mortgagor or the mortgagor's successor in interest is instructed by the mortgagee to send payments on a loan secured by the mortgage. A person transmitting a payoff statement for a mortgage is the mortgage servicer for purposes of such mortgage.

"Mortgagor" means the grantor of a mortgage.

"Payoff statement" means a written statement furnished by the mortgage servicer which sets forth all of the following:

1. The unpaid balance of the loan secured by a mortgage, including principal, interest, and any other charges properly due under or secured by the mortgage, or the amount required to be paid in order to release or partially release the mortgage.
2. Interest on a per-day basis for an amount set forth pursuant to "1" above.
3. The address where payment is to be sent or other specific instructions for making a payment.
4. If, after payment of the unpaid balance of the loan secured by the mortgage, the mortgage continues to secure any unpaid obligation due the mortgagee or any unfunded commitment by the mortgagor to the mortgagee, the legal description of the property that will be released from the mortgage.

"Person" shall have the same meaning as in Iowa Code chapter 4.

"Prior mortgage" means a mortgage for which an effective release or satisfaction has not been filed of record which was either paid in full by someone other than the real estate lender or closer or was paid by the real estate lender or closer under a previous transaction.

"Real estate lender or closer" means a person licensed to regularly lend moneys in Iowa to be secured by a mortgage on real property in this state, a licensed real estate broker, a participating abstractor or a licensed attorney.

9.20(2) *Request for certificate.*

a. A real estate lender or closer may request a certificate from the division by submitting:

(1) A fully and accurately completed request form.

(2) All necessary documents and information to support the certifications made on the request form, if required to be submitted.

(3) Payment, if required by the division, of the filing fee by check or money order made payable to the filing officer of the county in which the certificate is to be recorded in the amount of the filing fee imposed by the filing officer of the county in which the certificate is to be recorded. If duplicate certificates are to be recorded in more than one county, additional checks or money orders payable to the filing officer of such counties shall be submitted.

b. A certificate which is not a full release but is executed and recorded to release part of the security described in a mortgage shall be issued only when the real estate lender or closer has paid the mortgage servicer for the partial release. A certificate shall not be issued for a partial release if the real estate lender or closer is requesting a release pursuant to Iowa Code section 16.92(7).

c. In the event a person requesting a certificate fails to complete any of the steps or include any of the required information described in this rule, the division may reject the request for a certificate and require the person to refile or amend the request so that it conforms to the provisions of the law or this rule.

9.20(3) *Forms.*

a. Requests for mortgage release certificates shall be made on forms developed and provided by the division. The forms may be obtained from the division or from the authority's Internet Web site located at www.iowafinanceauthority.gov. The real estate lender or closer must use the forms developed and provided by the division; however, it is permissible to use reproductions of the forms, including reproductions placed in a word processing program. A reproduced form must substantially conform to the forms provided by the division. A nonconforming form may be rejected by the division.

b. The forms to request a certificate of release shall identify the mortgage to be released and shall contain sufficient information to identify that the requester is a real estate lender or closer; establish that the time requirements have elapsed; establish the party or parties to receive notice of the request; indicate that the debt secured by the mortgage to be released has been paid and the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1); and, in the case of requests for partial releases, include the legal description of the property that will be released from the mortgage.

c. The forms giving notice of the request shall be directed to the last-known mortgage servicer and shall contain sufficient information to identify the mortgage to be released; inform the mortgage servicer what is required to prevent the filing of a certificate of release; establish a time limit for the mortgage servicer to respond; and, in the case of requests for partial releases, include the legal description of the property that will be released from the mortgage.

d. The certificate of release form shall contain sufficient information to identify the mortgage released; recite the authority for the certificate; recite that the substantive and procedural requirements as to the amount of debt, payment, notice, or other requirements of the division have been met; and, in the case of partial releases, include the legal description of the property that will be released from the mortgage.

e. The notice by publication form shall contain sufficient information to identify the mortgage to be released; inform the mortgage servicer what is required to prevent the filing of a certificate of release; establish a time limit for the mortgage servicer to respond; and, in the case of requests for partial releases, include the legal description of the property that will be released from the mortgage.

f. All forms may require real estate lenders or closers to provide other information as may be required by law or this rule.

9.20(4) *Certification to the division—mortgages paid by real estate lender or closer.* To obtain a certificate for a mortgage which the mortgage lender or closer has paid and an effective release or partial release has not been filed of record, the mortgage lender or closer shall certify to the division in writing on the form provided:

a. That more than 30 days have elapsed since the date the payment was sent.

b. That, as of the date of the request for a certificate, no effective mortgage release or partial release appears of record.

c. That the payoff statement satisfies one of the following:

(1) The statement does not indicate that the mortgage continues to secure an unpaid obligation due the mortgagee or an unfunded commitment by the mortgagor to the mortgagee; or

(2) The statement contains the legal description of the property to be released from the mortgage.

d. That payment was made in accordance with the payoff statement, including a statement as to the date the payment was received by the mortgagee or mortgage servicer, as evidenced by one or more of the following in the records of the real estate lender or closer or its agent:

(1) A bank check, certified check, escrow account check, real estate broker trust account check, or attorney trust account check that was negotiated by the mortgagee or mortgage servicer.

(2) Other documentary evidence satisfactory to the division of payment to the mortgagee or mortgage servicer.

e. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

f. That the information provided to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer and last-known mailing address, the date of the mortgage, the date of recording, the county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

g. That any documents or other information attached to or included in the form and submitted in support of the request are original documents or are true and accurate reproductions and that the subject matter contained in the documents is true and correct.

h. If the last-known address of the mortgage servicer is unknown and the real estate lender or closer requesting the certificate is unable to locate an address for the last mortgage servicer of record, the real estate lender or closer may attach an affidavit to the request that service by certified mail on the mortgage servicer is not possible because the last-known address of the mortgage servicer is unknown and the real estate lender or closer, after exercising due diligence, is unable to locate an address for the last mortgage servicer of record.

9.20(5) *Certification to the division—prior mortgages.* To obtain a release of a mortgage that has been paid in full by someone other than the real estate lender or closer, or was paid by the real estate lender or closer under a previous transaction, and an effective release has not been filed of record, the mortgage lender or closer shall certify to the division in writing on the form provided:

a. That the mortgage was paid in full in accordance with one of the following:

(1) By someone other than the real estate lender or closer requesting the certificate.

(2) By the real estate lender or closer under a previous transaction.

b. That, as of the date of the request for a certificate, no effective mortgage release appears of record.

c. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

d. That the information provided to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer and last-known mailing address, the date of the mortgage, the date of recording, the county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

e. That any documents or other information attached to or included in the form and submitted in support of the request are original documents or are true and accurate reproductions and that the subject matter contained in the documents is true and correct.

f. If the last-known address of the mortgage servicer is unknown and the real estate lender or closer requesting the certificate is unable to locate an address for the last mortgage servicer of record, the real estate lender or closer may attach an affidavit to the request that service by certified mail on the mortgage servicer is not possible because the last-known address of the mortgage servicer is unknown and the real estate lender or closer, after exercising due diligence, is unable to locate an address for the last mortgage servicer of record.

9.20(6) *Division determination to give notice—reliance on information submitted.*

a. Upon receipt of a request for issuance of a certificate, the division shall determine that an effective release has not been executed and recorded within 30 days after the date payment was sent or otherwise made in accordance with a payoff statement based upon the information submitted by the person seeking the certificate.

b. The division may use discretion in determining whether an effective release has been executed and recorded and shall rely on the information contained in the request in determining whether further inquiry may be required before giving notice of intent to issue a certificate.

c. The division shall not be required to make a physical search of the real property records in the county or counties where the certificate is to be recorded nor will the division be required to obtain any formal report such as a lien search, abstract opinion, or attorney's opinion. The division may, but is not required to, verify the status of an effective release by contacting the officer responsible for maintaining the real property records of the county in which the certificate is to be recorded; however, if such verification is determined to be necessary, the division may rely on information from the filing officer obtained by telephone, facsimile, electronic mail, or other such means.

d. The division shall not be required to verify or research the accuracy or status of a title to any legal descriptions which are requested to be partially released. The division shall rely on the descriptions certified to the division in the request for a certificate of partial release.

9.20(7) *Contested case proceeding.* In the event a person who is seeking a certificate is aggrieved by the decision of the division not to issue a certificate and wishes to challenge that decision, the person must request a contested case proceeding pursuant to the rules described in 265—Chapter 7. The request for a contested case proceeding must be filed with the division within ten days from the date of the division's decision not to issue a certificate. An aggrieved person must exhaust all administrative remedies before that person may file a proceeding in any court.

9.20(8) *Notice of intent to issue certificate and recording.*

a. Upon determination that an effective release or partial release has not been executed and recorded within 30 days after the date payment was sent or otherwise made in accordance with a payoff statement, the division shall send written notice of intent to execute a certificate by certified mail to the last-known address of the last mortgage servicer of record. If the real estate lender or closer requesting the certificate has attached an affidavit to the request that service by certified mail on the mortgage servicer is not possible because the last-known address of the mortgage servicer is unknown and the real estate lender or closer is unable to locate an address for the last mortgage servicer of record, the division shall proceed pursuant to paragraph 9.20(8)*"e."*

b. The notice shall be given by certified mail and the 30-day period shall begin on the date the notice is placed in the custody of the United States Postal Service for delivery to the mortgage servicer.

c. The notice shall state that a certificate shall be recorded by the division after 30 days from the date the notice was mailed unless the mortgage servicer notifies the division of any reason the certificate of release should not be executed and recorded.

d. In the event the notice sent by certified mail to the last-known mortgage servicer of record is returned to the division for the reason that the mortgage servicer is no longer at the address or the certificate of receipt is not returned within 30 days of mailing, the division shall proceed pursuant to paragraph 9.20(8)*"e."*

e. In the event the division is unable to serve the mortgage servicer, the division shall prepare a notice for publication and send it to the real estate lender or closer for publication in a newspaper of general circulation in the county in which the mortgage to be released is recorded. Notice by publication shall be once each week for three consecutive weeks and shall provide for a 20-day period following the last publication for the mortgage servicer to respond to the division. A copy of the notice together with a certificate of publication shall be submitted to the division after the last publication date. Upon receipt of the certified notice and expiration of the time to respond, the division shall file the certificate of release provided that the mortgage servicer has not notified the division of any satisfactory reason the certificate of release should not be executed and recorded. The notice shall also be posted to the authority's Web page.

f. If, prior to executing and recording the certificate of release, the division receives written notification setting forth reasons satisfactory to the division why the certificate of release should not be executed and recorded by the division, the division shall not execute and record the certificate of release. The division may use its discretion in determining whether a satisfactory reason not to record the certificate has been given depending upon the facts. A satisfactory reason not to record the certificate includes, but is not limited to:

(1) Evidence of an unpaid balance under the terms of any loan secured by the mortgage.

(2) Evidence that a release or satisfaction of mortgage pursuant to Iowa Code chapter 655 has been placed of record.

(3) Failure to submit any information requested by the division or required by the law or this rule.

g. In the event the division determines that a certificate should not be recorded, the division shall return the check or money order, which was made payable to the county filing officer, to the real estate lender or closer that requested the certificate.

h. If the division does not receive written notification setting forth a reason satisfactory to the division why the certificate of release should not be executed and recorded, the division shall proceed to execute and record the certificate. The certificate shall be delivered, along with proper recording fees, to the filing officer in the county where the subject property is located.

i. If duplicate certificates were requested, the division will also deliver the duplicate certificates to the filing officer of those counties.

j. If duplicate certificates were not requested, the real estate lender or closer may record a certified copy of the certificate in another county with the same effect as the original.

9.20(9) *Certificate—mortgages paid by real estate lender or closer.* Certificates issued on mortgages paid by the real estate lender or closer shall contain substantially the following information:

a. That the division sent the 30-day notice required by Iowa Code section 16.92(2)*"c"* and that more than 30 days have elapsed since the date the notice was sent.

b. That the division did not receive written notification setting forth a reason satisfactory to the division why the certificate of release should not be executed and recorded.

c. A statement indicating one of the following:

(1) That the mortgage servicer provided a payoff statement that was used to make payment, and it does not indicate that the mortgage continues to secure an unpaid obligation due the mortgagee or an unfunded commitment by the mortgagor to the mortgagee.

(2) That the mortgage release certificate is a partial release of the mortgage and contains the legal description of the property that will continue to be subject to the mortgage.

d. That payment was made in accordance with the payoff statement including the date the payment was received by the mortgagee or mortgage servicer as evidenced by a bank check, certified check, escrow account check, real estate broker trust account check, or attorney trust account check that was negotiated by the mortgagee or mortgage servicer or other documentary evidence of payment to the mortgagee or mortgage servicer.

e. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

f. Information to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer, the date of the mortgage, the date of recording, county of recording, volume and page, or other applicable recording information in the real property records where the mortgage is to be released, and the same information for the last recorded assignment of record.

g. That the person executing the certificate is a duly authorized officer or employee of the division.

9.20(10) *Certificate—prior mortgages.* Certificates issued on mortgages that have been paid in full by someone other than the real estate lender or closer or were paid by the real estate lender or closer under a previous transaction shall contain substantially the following information:

a. That the division sent the 30-day notice required by Iowa Code section 16.92(2)*"c"* and that more than 30 days have elapsed since the date the notice was sent.

b. That the division did not receive written notification setting forth a reason satisfactory to the division why the certificate of release should not be executed and recorded.

c. A statement indicating the mortgage was paid in full in accordance with one of the following:

(1) By someone other than the real estate lender or closer requesting the certificate.

(2) By the real estate lender or closer under a previous transaction.

d. That the mortgage to be released meets the definition of "mortgage" set forth in subrule 9.20(1).

e. Information to identify the mortgage to be released includes the name of the mortgagor, the name of the original mortgagee, the mortgage servicer, the date of the mortgage, the date of recording, county of recording, volume and page, or other applicable recording information in the real property

records where the mortgage is to be released, and the same information for the last recorded assignment of record.

f. That the person executing the certificate is a duly authorized officer or employee of the division.

9.20(11) *Authority to sign certificate.* The board of directors of the division may, by resolution, authorize such personnel within the division as the board should determine to execute and record the certificates pursuant to Iowa Code section 16.92 and this rule.

9.20(12) *Records—return to the division.* The certificate of release shall contain instructions to the filing officer(s) to return the document to the division, once file-stamped and entered in the real estate records of the county.

9.20(13) *Photocopy.* The division shall transmit a copy of the recorded certificate to the real estate lender or closer that requested the certificate.

9.20(14) *Effect of filing of the certificate of release.* For purposes of a release or partial release of a mortgage, a certificate of release executed under this rule that contains the information and statements required under Iowa Code section 16.92 and this rule is prima facie evidence of the facts contained in such release or partial release, is entitled to be recorded with the county recorder where the mortgage is recorded, operates as a release or partial release of the mortgage described in the certificate of release, and may be relied upon by any person who owns or subsequently acquires an interest in the property released from the mortgage. The county recorder shall rely upon the certificate of release to release the mortgage.

9.20(15) *Effect of wrongful or erroneous recording of a certificate of release.* A wrongful or erroneous recording of a certificate of release by the division or the authority shall not relieve the mortgagor, or the mortgagor's successors or assigns on the debt, from personal liability on the loan or on other obligations secured by the mortgage.

9.20(16) *Liability of the division.* In addition to any other remedy provided by law, if the division or the authority through an act of negligence wrongfully or erroneously records a certificate of release pursuant to this rule, the division is liable to the mortgagee and mortgage servicer for actual damages sustained due to the recording of the certificate of release. Prior to any such satisfaction or resolution of a claim for wrongful or erroneous filing of a certificate of release, the division will inform the real estate lender or closer that requested the certificate about the proposed terms and allow it a reasonable opportunity to resolve or satisfy the claim on other terms.

9.20(17) *Subrogation.* Upon payment of a claim relating to the recording of a certificate, the division is subrogated to the rights of the claimant against all persons relating to the claim including, but not limited to, the real estate lender or closer that requested the certificate.

9.20(18) *Additional remedies.* In addition to any other remedy provided by law, the division may recover from the real estate lender or closer who requested the certificate all expenses incurred, and all damages including punitive or exemplary damages paid to the mortgagee or mortgage service provider, in satisfaction or resolution of a claim for wrongful or erroneous filing of a certificate of release.

9.20(19) *Record keeping.* The original certificate of release document shall remain in the records of the division or the authority for the minimum period of one year after execution. After this time, records may be stored by electronic or other means. Requests and other documents generated or received under this system shall be indexed in such a manner as to allow their retrieval at a future date.

This rule is intended to implement Iowa Code Supplement section 16.92 as amended by 2008 Iowa Acts, House File 2700.

265—9.21(16) Seal. The division shall have a corporate seal that may be altered from time to time. The seal shall impress the words "Title Guaranty Division Iowa Finance Authority" and may be used to authenticate acts and legal instruments of the division.

265—9.22(16) Closing protection letters.

9.22(1) *Definitions.* The following words and phrases, when used in this rule and in the program requirements, applications and instructions adopted by the division board pursuant thereto, shall have the meanings set forth below unless inconsistent with the manifest intent or the context of the rules:

"Certificate" means division certificate, including any part or schedule thereof and any endorsements thereto.

"Closing protection letter" means an agreement by the division to indemnify a lender or owner or both for loss caused by a division closer's theft of settlement funds or failure to comply with written closing instructions relating to title certificate coverage when agreed to by the division closer.

"Commitment" means division commitment to guarantee title, including any part or schedule thereof and any endorsements thereto.

"Division" means title guaranty division, a division of the Iowa finance authority.

"Division board" means the board of the title guaranty division created pursuant to Iowa Code section 16.2(1).

"Division closer" means a participating attorney, a participating abstractor, or an independent closer who is currently authorized by the division to close division commitments under protection of a closing protection letter.

"Division closing" means a settlement in which a division closer is appointed to finalize a real estate transaction in accordance with general and specific instructions prior to disbursement of the loan proceeds and for which a closing protection letter is issued.

"Division escrow account" means, in conjunction with division closings, escrows, settlements, and title indemnities, any checking account utilized for the purpose of handling:

1. Deposits including, but not limited to, the acceptance of incoming funds from the lender or borrower or both; and
2. Disbursements including, but not limited to, sellers' proceeds, mortgage payoffs, expenses of sale, and professional fees.

However, "division escrow account" shall not include client trust accounts subject to the requirements of chapter 45 of the Iowa Court Rules.

"Form" or *"forms"* means printed instruments used in guaranteeing title to Iowa real estate that, when completed and executed, create contractual obligations or rights affecting the division.

"Independent closer" means a person or entity, other than a participating attorney or participating abstractor, conducting real estate closings and authorized to close transactions under protection of closing protection letters from the division.

9.22(2) *Issuance of closing protection letters.* Division closers may be authorized to receive a closing protection letter when:

a. A division closer has completed division forms and procedures training,

b. The division director has approved the application, and

c. A division commitment is issued.

9.22(3) *Application.* Application for designation of division closer status shall be on forms provided by the division, and all requested information shall be provided with the application form. The division may consider an application withdrawn if it does not contain all of the information required and the information is not submitted to the division within 30 days after the division requests the information. The application shall be accompanied by a fee to be set by the division board. The division director shall approve or deny the application within 90 days after the application has been accepted for processing and send written notice thereof to the applicant.

9.22(4) *Additional requirements.* The division board may adopt program guidelines and application requirements such as indemnity agreements, criminal background checks, and bonding and insurance requirements.

9.22(5) *Guidelines.* In determining whether to approve or deny an application for designation of division closer status, the division director may consider the following factors, including but not limited to:

a. Needs of the public and existing or potential customers of the applicant to be served by a designation of division closer status.

b. A history of operation and management of the applicant's business.

c. Character, fitness, financial responsibility and experience of the applicant and the applicant's employees.

d. Criminal background checks for felony or misdemeanor convictions of the applicant or the applicant's employees involving moral turpitude.

e. A record of defaulting by the applicant or the applicant's employees in payment of moneys collected for others in this state or other states.

f. A history of discharge of debts by the applicant or the applicant's employees through bankruptcy proceedings.

g. The applicant's credit report, which is to be submitted directly to the division director at the expense of the applicant.

h. Other factors as determined by the division director to be relevant.

9.22(6) *Investigation.* The division director may conduct an investigation as deemed necessary. The division director may solicit, by whatever manner deemed appropriate, comments from other persons conducting closings, or from any other person or entity which may be affected by or have an interest in the pending application.

9.22(7) *Revocation.* The division director has discretion to revoke a division closer's status for reasons including but not limited to the following:

a. The financial condition of the division closer deteriorates.

b. The division director determines that the division closer's activities are being conducted unlawfully or in an unsafe or unsound manner.

9.22(8) *Authority of division closer.*

a. A division closer is authorized to conduct division closings only for the purposes and in the manner set forth in the division closer's agreement, the Code of Iowa, these rules, manuals, requirements and any other instructions given by the division and in no other manner whatsoever. The authority of the division closer under the preceding sentence is not exclusive and is subject to the rights of the authority, the division and other division closers to transact the business of guaranteeing titles to real estate in Iowa and is further subject to the right of the division to appoint other division closers.

b. A division closer shall obtain the written authorization of the division's legal staff prior to issuing a commitment or certificate which exceeds such amounts as the division board may set from time to time by resolution. If any authorization required under this rule is not obtained through the act or omission of the division closer, the division closer shall be strictly liable to the division for any resulting loss or damage.

9.22(9) *Division escrow accounts.* The division board shall approve procedures and requirements for the maintenance of division escrow accounts. Division closers shall comply with the rules and requirements set by the division board with respect to the procedures, format, and style for maintaining the division escrow accounts. The division board may require the division closer to provide an irrevocable letter of direction to the institution at which each division escrow account is established, authorizing the division to review and audit the institution's records of such account at any such time that the division, in its discretion, deems necessary.

9.22(10) *Division forms.* A division closer shall not change preprinted portions of the division forms without the division's prior written authorization. A division closer shall not use a form supplied by another person or entity to bind the division, or otherwise bind the division to liability with a form, other writing or representation not supplied or authorized by the division, and any attempt to do so shall be ineffective.

9.22(11) *Title/closing files.* A division closer shall maintain files in such a manner that information pertaining to closings and issuance of division commitments, certificates, and endorsements is readily available to the division. A division closer shall maintain title files and the title portion of client files for a period of ten years after the effective date of the certificate(s).

9.22(12) *Training.* The division director may require a division closer and the division closer staff to attend training sessions or continuing education seminars as deemed necessary by the division director in order to ensure compliance with division procedures.

9.22(13) *Office audits.*

a. In accordance with subrule 9.12(2), the division may, with or without notice to a division closer, audit the division closer at the division closer's office. This audit may include a review of the

division closer's division escrow account(s) and closing procedures, including verification of the division closer's compliance with division rules, participation agreements, manuals, and any other written or oral instructions given by the division.

b. The division may, with or without notice, audit the division closer's division escrow account(s).

c. Procedures for audits shall be conducted pursuant to standards and procedures approved by the division board.

These rules are intended to implement Iowa Code sections 17A.3, 17A.9, 17A.10, and 535.8(10), 2007 Iowa Code Supplement sections 16.1, 16.2, 16.3, 16.5, 16.40, and 16.91, and Iowa Code section 16.93 as amended by 2008 Iowa Acts, Senate File 2117.

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◊ Two or more ARCs

1 Effective date of 9.7(2), definition of "Title plant" delayed 70 days by the Administrative Rules Review Committee at its meeting held December 9, 2008.

CHAPTER 12
LOW-INCOME HOUSING TAX CREDITS

265—12.1(16) Qualified allocation plan. The qualified allocation plan entitled Iowa Finance Authority Low-Income Housing Tax Credit Program 2009 Second Amended Qualified Allocation Plan shall be the qualified allocation plan for the allocation of 2009 low-income housing tax credits consistent with IRC Section 42 and the applicable Treasury regulations and Iowa Code section 16.52. The qualified allocation plan includes the plan, application, and the application instructions. The qualified allocation plan is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2). The qualified allocation plan does not include any amendments or editions created subsequent to September 3, 2008.

265—12.2(16) Location of copies of the plan. The qualified allocation plan can be reviewed and copied in its entirety on the authority's Web site at http://www.iowafinanceauthority.gov. Copies of the qualified allocation plan, application, and all related attachments and exhibits shall be deposited with the administrative rules coordinator and at the state law library and shall be available on the authority's Web site. The plan incorporates by reference IRC Section 42 and the regulations in effect as of September 3, 2008. Additionally, the plan incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and information about these statutes, regulations and rules is on the authority's Web site.

265—12.3(16) Compliance manual. The Low Income Housing Tax Credit Program Compliance Monitoring Manual, dated January 31, 2009, is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).
[**ARC 7700B**, IAB 4/8/09, effective 3/19/09; **ARC 7891B**, IAB 7/1/09, effective 8/5/09]

265—12.4(16) Location of copies of the manual. The compliance manual can be reviewed and copied in its entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the compliance manual shall be deposited with the administrative rules coordinator and at the state law library. The compliance manual incorporates by reference IRC Section 42 and the regulations in effect as of February 27, 2009. Additionally, the compliance manual incorporates by reference Iowa Code section 16.52. These documents are available from the state law library, and links to these statutes, regulations and rules are on the authority's Web site. Copies are available from the authority upon request at no charge.
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These rules are intended to implement Iowa Code section 16.52.

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CHAPTER 29
JUMP-START HOUSING ASSISTANCE PROGRAM

265—29.1(16) Purpose. This chapter defines and structures the jump-start housing assistance program to aid individuals whose homes, located in parts of Iowa declared by the President of the United States to be disaster areas, were destroyed or damaged by the natural disasters of 2008. Under the program, the authority may grant funds in accordance with this chapter to local government participants, including certain Iowa councils of governments, cities, and counties. The local government participants shall, in turn, loan funds to eligible residents under the conditions specified in this chapter to assist those eligible residents in purchasing homes generally comparable to those they lived in prior to the occurrence of the natural disasters of 2008, in repairing or rehabilitating disaster-affected homes, and in making mortgage payments and paying for other eligible property-carrying costs while the eligible residents await a property acquisition of their disaster-affected homes.

265—29.2(16) Definitions. For purposes of this chapter, the following definitions apply.

"Authority" means the Iowa finance authority.

"COG" means an Iowa council of governments as identified by Iowa Code chapter 28H.

"Disaster-affected home" means a primary residence that was destroyed or damaged by the natural disasters of 2008.

"Disaster compensation" means moneys received by an eligible resident as a result of damage caused to the eligible resident's disaster-affected home by the natural disasters of 2008 from any of the following sources: (1) FEMA, (2) any other governmental assistance, or (3) proceeds of any insurance policy. "Disaster compensation" shall not include rental assistance received from FEMA or other sources.

"Eligible energy-efficient home appliances and improvements" means energy-efficient furnaces, boilers, appliances, air conditioners, hot water heaters, windows, and insulation that meet standards set by the office of energy independence.

"Eligible property-carrying costs" means the following expenses associated with the ownership of a disaster-affected home: liability insurance premiums, flood insurance premiums, property tax payments, installment payments on a real estate purchase contract for the disaster-affected home provided that the real estate purchase contract was executed prior to the first date on which the disaster-affected home sustained damage as a result of the natural disasters of 2008, and special assessments.

"Eligible repair expenses" means the reasonable cost of repairing damage to a disaster-affected home necessitated by the natural disasters of 2008. "Eligible repair expenses" shall not include additions to or expansions of a disaster-affected home or the purchase or installation of luxury items that were not part of the disaster-affected home prior to the natural disasters of 2008.

"Eligible resident" means an individual or family who resided in a disaster-affected home at the time of the natural disasters of 2008 and who:

1. Is the owner of record of a right, title or interest in the disaster-affected home; and
2. Has been approved by FEMA for housing assistance as a result of the natural disasters of 2008.

In cases where multiple persons own a disaster-affected home together, such as by a tenancy in common or joint tenancy, such persons will generally be deemed collectively to be the "eligible resident," provided the requirements set forth above are met. In the event that multiple persons assert inconsistent claims as to who the owner of a disaster-affected home is, the local government participant shall review the facts and, if necessary, make an allocation among the various applicants.

"FEMA" means the Federal Emergency Management Agency.

"Forgivable loan" means a loan made to an eligible resident pursuant to the requirements of this chapter.

"Local government participant" means:

1. Any of the following Iowa cities: Ames, Cedar Falls, Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City, Waterloo, and West Des Moines;

2. Any COG whose territory encompasses one or more Iowa counties that have been declared by the President of the United States to be disaster areas; and

3. Any county that is not part of any Iowa council of governments and has been declared by the President of the United States to be a disaster area.

"Natural disasters of 2008" means the severe storms, tornadoes, and flooding that occurred in Iowa between May 25, 2008, and August 13, 2008, and designated by FEMA as FEMA-1763-DR.

"Program" means the jump-start housing assistance program described in this chapter.

"Retention agreement" means an agreement, to be recorded as a lien against the property for which assistance is provided, requiring that if an eligible resident sells a home that was purchased or repaired or for which a mortgage loan was paid with the assistance of a loan made under this chapter, then that portion of the original principal amount that has not been forgiven, if any, shall be repaid.

265—29.3(16) Grants to local government participants.

29.3(1) *Allocation criteria.*

a. Initial allocation, loans to local government participants. The authority shall make an initial allocation of the funds made available for the program to the local government participants pro rata based on the funds awarded by FEMA under its housing assistance program to each local government participant's jurisdiction as a percentage of the total amount of funds awarded as a result of the natural disasters of 2008. The authority shall enter into a grant agreement with each local government participant, pursuant to which the authority may disburse funds to the local government participant for the purposes described in this chapter. The grant agreement shall be prepared by the authority and may contain such terms and conditions, in addition to those specified in this chapter, as the executive director may deem to be necessary and convenient to the administration of the program and to the efficient and responsible use of the granted funds.

b. Funds made available pursuant to 2009 Iowa Acts, Senate File 376. The authority shall allocate program funds made available under 2009 Iowa Acts, Senate File 376, section 29, Disaster Damage Housing Assistance Grant Fund [creating new Iowa Code section 16.186], by inviting local government participants to submit an application for funding. The authority shall award program funding made available under this paragraph based upon priority criteria to be specified in the application form including, but not limited to, the following:

(1) The applicant's demonstrated maximum use and leverage of other disaster recovery resources; and

(2) Provision of program assistance to the maximum number of potential eligible residents with priority given to eligible residents who:

1. Have not received any moneys under the program;

2. Are in need of an interim mortgage assistance extension meeting the conditions specified in subrule 29.5(2); and

3. Are not eligible for assistance under the requirements of other available disaster recovery assistance programs.

29.3(2) *Review of requests for assistance.* The local government participant shall accept and review each request for assistance and shall determine whether the requesting party is an eligible resident. If the requesting party is determined an eligible resident, the local government participant shall determine whether the funds are being requested for a use permitted under the program and the amount available to the eligible resident under the terms of the program.

29.3(3) *Coordination with the jump-start business assistance program.* For presidentially declared disaster areas outside a COG region, counties may elect to apply singly, join with other counties, or join with an adjacent COG region. Likewise, a city named in the definition of "local government participant" in rule 265—29.2(16) may join with a COG, county, or multicounty entity. To the extent local government participants act jointly or cooperatively in their participation in the small business disaster recovery financial assistance program administered by the Iowa department of economic development pursuant to 261—Chapter 78, Iowa Administrative Code, the authority may require the

local government participants to similarly act jointly or cooperatively in their participation under this chapter.

29.3(4) *Reallocation of unused funds.* Following one year, or following any three-month period during which a local government participant has requested no draws, the authority may reallocate all or part of any remaining portion of funds allocated to that local government participant to another local government participant with a demonstrated need for program funds.

29.3(5) *Administrative fees.* Each local government participant shall be entitled to receive an administrative fee equal to 5 percent of its initial disbursement, which shall consist of 30 percent of the local government participant's initial allocation. Subsequent thereto, each local government participant shall receive 5 percent of the funds loaned by the local government participant to eligible residents under the program from subsequent disbursements. The administrative fee shall be paid from the allocation made to each such local government participant by the authority pursuant to subrule 29.3(1).

29.3(6) *Proceeds of repayments.* All loan amounts repaid to a local government participant by an eligible resident pursuant to this chapter shall be returned to the authority's housing assistance fund created by Iowa Code Supplement section 16.40.

[**ARC 7899B**, IAB 7/1/09, effective 6/10/09]

265—29.4 Reserved.

265—29.5(16) Eligible uses.

29.5(1) *Forgivable loans.* Local government participants may make forgivable loans, pursuant to the conditions set forth in rule 265—29.7(16), to eligible residents for the following eligible uses:

a. Down payment assistance. An eligible resident whose disaster-affected home was destroyed or damaged beyond reasonable repair may be provided down payment assistance for the purchase of replacement housing located within the local government participant's jurisdiction and, if necessary, for the cost of making reasonable repairs to the home being purchased to make it safe, decent, and habitable. The amount of down payment assistance available to an eligible resident shall generally not exceed 25 percent of the purchase price of the home being purchased and, in no event, shall the down payment assistance and any amount allowed for repairs collectively exceed $50,000.

(1) For purposes of calculating the amount of down payment assistance available to the eligible resident, the amount of the down payment assistance shall be reduced by the amount of any disaster compensation received by the eligible resident in excess of any amount necessary to pay off a mortgage or real estate purchase contract on the disaster-affected home.

(2) As a condition of receiving down payment assistance, the eligible resident shall agree that any disaster compensation received subsequent to the closing of the forgivable loan, if not applied toward repayment of a mortgage on the disaster-affected home, shall be used by the eligible resident to pay down the balance of the forgivable loan outstanding at the time the eligible resident receives such disaster compensation.

(3) Down payment assistance shall be allowed only for the purchase of a primary residence by means of a fully amortized mortgage loan from a regulated lender featuring a rate of interest that is fixed for at least 5 years and that has a term not to exceed 30 years.

(4) Eligible residents who receive down payment assistance under this subrule may also receive the assistance available under subrule 29.5(2), but not the assistance available under paragraph 29.5(1)*"b."*

(5) An eligible resident shall not use the assistance allowed under this subrule for the purchase of more than one home.

b. Housing repair or rehabilitation. An eligible resident whose disaster-affected home is not proposed, or located in an area proposed, by a municipality or county to the Iowa homeland security and emergency management division for property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or under any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008) may receive financial assistance to pay for eligible repair expenses up to an amount not to exceed the lesser of $50,000 or 60 percent of the latest available assessed value of the disaster-affected home, not including the assessed value of the land on

which it is situated, dated prior to the natural disasters of 2008; provided, however, that for application purposes under paragraph 29.3(1)*"b"* allocating program funds under 2009 Iowa Acts, Senate File 376, section 29, the local government participant may elect to establish its own measure of housing repair or rehabilitation financial feasibility in lieu of 60 percent of the latest available assessed value of the disaster-affected home, not including the assessed value of the land on which it is situated, dated prior to the natural disasters of 2008. The eligible resident shall establish the necessity and reasonable cost of the repairs or rehabilitation to the reasonable satisfaction of the local government participant.

(1) For purposes of calculating the amount of assistance available to the eligible resident pursuant to this paragraph, the cost of repairs to, or rehabilitation of, the disaster-affected home shall be reduced by the amount of any disaster compensation received.

(2) As a condition of receiving assistance pursuant to this paragraph, the eligible resident shall agree that any disaster compensation received subsequent to the closing of the forgivable loan shall be used by the eligible resident to pay down the balance of the forgivable loan outstanding at the time the eligible resident receives such disaster compensation.

(3) An eligible resident who receives assistance pursuant to this paragraph shall not be eligible for assistance under either paragraph 29.5(1)*"a"* or subrule 29.5(2).

29.5(2) *Interim mortgage assistance loans.* An eligible resident whose disaster-affected home is proposed, or is located in an area proposed, by a municipality or county to the Iowa homeland security and emergency management division for property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008) may receive financial assistance equivalent to an amount of up to $1,000 per month for the purpose of paying mortgage payments and other eligible property-carrying costs for the disaster-affected home for a period not to exceed 12 months. An eligible resident who receives assistance pursuant to this subrule shall not be eligible for assistance under paragraph 29.5(1)*"a."* If, however, it subsequently is determined by the Iowa homeland security and emergency management division that the disaster-affected home of the eligible resident will not be acquired under the hazard mitigation grant program, then the eligible resident shall be eligible for assistance under paragraph 29.5(1)*"a"* on the condition that the amount of assistance available under that paragraph shall be reduced by the amount of assistance received by the eligible resident under subrule 29.5(2). Financial assistance provided pursuant to this subrule shall be in the form of a forgivable loan.

a. Notwithstanding the foregoing, with the approval of the applicable local government participant, an eligible resident may receive financial assistance under this subrule for up to an additional 6 months (beyond the usual 12-month limit set forth above), provided that all of the following conditions are met:

(1) The eligible resident must reapply for or request an extension of financial assistance on forms to be provided by the applicable local government participant;

(2) The disaster-affected home for which an extension of financial assistance is sought must continue to be on the current hazard mitigation grant program (or comparable program) property acquisition list (i.e., it must continue to be proposed for buyout);

(3) The disaster-affected home for which an extension of financial assistance is sought must have been destroyed or damaged beyond reasonable repair such that the eligible resident is displaced from the home;

(4) The eligible resident must have contacted or must agree to contact the mortgage holder or an Iowa Mortgage Help counseling agency (Web site: www.iowamortgagehelp.com) to discuss the situation and, if possible, negotiate better terms.

b. Local government participants may fund extensions of financial assistance only from funds already allocated to their region. Local government participants shall give priority for extensions of financial assistance to those eligible residents who are supporting the costs of both the disaster-affected home and a new primary residence through a second mortgage payment or a rental payment.

29.5(3) *Energy efficiency assistance.* An eligible resident who receives either down payment assistance pursuant to paragraph 29.5(1)*"a"* or housing repair or rehabilitation assistance pursuant to

paragraph 29.5(1)*"b"* shall also be eligible to receive an additional loan amount, up to a maximum of $10,000, as reimbursement for the purchase and installation costs for eligible energy-efficient home appliances and improvements. Any amount allowed pursuant to this subrule shall be added to the principal balance of the forgivable loan. Amounts loaned pursuant to this subrule may be loaned either at the time the forgivable loan is first made or subsequent thereto within three months.

29.5(4) *Expenses incurred prior to September 19, 2008.* In the event an eligible resident purchased a home, made or caused to be made repairs to a disaster-affected home, or made mortgage payments (or paid for other eligible property-carrying costs) for a disaster-affected home located within the jurisdiction of a local government participant prior to September 19, 2008 (the effective date of this chapter), the eligible resident shall be eligible for reimbursement therefor under this chapter as though the purchase, repairs, or payments had taken place following September 19, 2008.

29.5(5) *Applications for assistance.* To apply for down payment assistance or down payment assistance plus interim mortgage assistance, the eligible resident shall apply to the local government participant in whose jurisdiction the home being purchased is located. To apply for assistance for repair or rehabilitation of a disaster-affected home, the eligible resident shall apply to the local government participant in whose jurisdiction the disaster-affected home is located. To apply for interim mortgage assistance only, the eligible resident shall apply to the local government participant in whose jurisdiction the disaster-affected home is located.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 7899B**, IAB 7/1/09, effective 6/10/09]

265—29.6(16) Loan terms. Loans made under the program shall, at a minimum, contain the following terms:

29.6(1) *Forgivability.* Forgivable loans made pursuant to the program shall be forgivable over a five-year period. One-fifth of the total principal amount loaned shall be forgiven following each full year the eligible resident owns the home for which the loan was made, beginning on the date of the final disbursement of forgivable loan proceeds.

29.6(2) *Zero percent interest.* Loans made pursuant to the program shall bear no interest.

29.6(3) *Five-year term.* All loans made pursuant to the program shall be for a term of five years.

29.6(4) *Repayment due upon sale of home.* Any principal of a forgivable loan that has not yet been forgiven at the time the home for which the forgivable loan was made is sold by the eligible resident (including property acquisitions) shall be due and payable upon such sale.

29.6(5) *Retention agreement.* Each loan made pursuant to this program shall be secured by a retention agreement which shall constitute a lien on the title of the real property for which the forgivable loan is made until such time as the forgivable loan has either been fully forgiven or paid in full.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09]

265—29.7(16) Financial assistance subject to availability of funding. All financial assistance authorized pursuant to this chapter shall be subject to funds being made available to the authority for the purposes set forth herein.

265—29.8(16) Funds allocated pursuant to 2009 Iowa Acts, House File 64, division I. Notwithstanding the foregoing, the following additional restrictions shall apply to loans made pursuant to program funding allocated under 2009 Iowa Acts, House File 64, division I:

29.8(1) *Income.* An eligible resident must have a family income equal to or less than 150 percent of the area median family income.

29.8(2) *Application deadline.* An eligible resident must submit an application for assistance by September 1, 2009.

29.8(3) *Priorities.* Forgivable loans awarded under this rule shall be awarded pursuant to the following priorities:

a. First priority. First priority shall be given to eligible residents who have not received any moneys under the program.

b. Second priority. Second priority shall be given to eligible residents who have received less than $24,999 under the program.

c. Third priority. Third priority shall be given to eligible residents who have received $24,999 under the program and who continue to have unmet needs for down payment assistance, emergency housing repair or rehabilitation, interim mortgage assistance, or energy efficiency assistance. An eligible resident shall not receive more than an additional $24,999 under this paragraph.

29.8(4) *Maximum assistance.* Except as provided in paragraph 29.8(3)*"c,"* an eligible resident who meets the area median family income requirement shall not receive more than $24,999 under the program. [**ARC 7899B**, IAB 7/1/09, effective 6/10/09]

These rules are intended to implement Iowa Code sections 16.5(1)*"r"* and 16.40 and 2009 Iowa Acts, Senate File 376, section 29.

[Filed emergency 9/19/08—published 10/8/08, effective 9/19/08]
[Filed emergency 10/1/08—published 10/22/08, effective 10/1/08]
[Filed Emergency ARC 7842B, IAB 6/17/09, effective 5/14/09]
[Filed Emergency ARC 7899B, IAB 7/1/09, effective 6/10/09]

CHAPTERS 32 to 34
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CHAPTER 35
AFFORDABLE HOUSING ASSISTANCE GRANT FUND

265—35.1(16,83GA,SF376) Affordable housing assistance grant fund allocation plan. The affordable housing assistance grant fund allocation plan entitled Iowa Finance Authority Affordable Housing Assistance Grant Fund Allocation Plan dated June 2009 shall be the allocation plan for the award, pursuant to the affordable housing assistance grant fund program, of funds held within the affordable housing assistance grant fund established in 2009 Iowa Acts, Senate File 376, section 30. The allocation plan for the affordable housing assistance grant fund program is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).
[**ARC 7897B**, IAB 7/1/09, effective 6/10/09]

265—35.2(16,83GA,SF376) Location of copies of the plan. The allocation plan for the affordable housing assistance grant fund program may be reviewed and copied in its entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the allocation plan for the affordable housing assistance grant fund program, the application forms, and all related attachments and exhibits, if any, shall be deposited with the administrative rules coordinator and at the state law library. The plan incorporates by reference 2009 Iowa Acts, Senate File 376, section 30.
[**ARC 7897B**, IAB 7/1/09, effective 6/10/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2009 Iowa Acts, Senate File 376, section 30.

[Filed Emergency ARC 7897B, IAB 7/1/09, effective 6/10/09]

CHAPTER 36
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265—36.1(16,83GA,SF376) Public service shelter grant fund allocation plan. The allocation plan entitled Iowa Finance Authority Public Service Shelter Grant Fund Allocation Plan dated June 2009 shall be the allocation plan for the award, pursuant to the public service shelter grant fund program, of funds held within the public service shelter grant fund established in 2009 Iowa Acts, Senate File 376, section 28. The allocation plan for the public service shelter grant fund program is incorporated by reference pursuant to Iowa Code section 17A.6 and 265—subrules 17.4(2) and 17.12(2).
[**ARC 7894B**, IAB 7/1/09, effective 6/10/09]

265—36.2(16,83GA,SF376) Location of copies of the plan. The allocation plan for the public service shelter grant fund program may be reviewed and copied in its entirety on the authority's Web site at www.iowafinanceauthority.gov. Copies of the allocation plan for the public service shelter grant fund program, the application forms, and all related attachments and exhibits, if any, shall be deposited with the administrative rules coordinator and at the state law library. The plan incorporates by reference 2009 Iowa Acts, Senate File 376, section 28.
[**ARC 7894B**, IAB 7/1/09, effective 6/10/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2009 Iowa Acts, Senate File 376, section 28.

[Filed Emergency ARC 7894B, IAB 7/1/09, effective 6/10/09]

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 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

[Prior to 7/1/83, Social Services[770] Ch 65]
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

The basis for the food assistance program is as provided in Title 7 of the Code of Federal Regulations. The purpose of this chapter is to provide for adoption of new and amended federal regulations as they are published, to establish a legal basis for Iowa's choice of administrative options when administrative options are given to the state in federal regulations, to implement the policy changes that the United States Department of Agriculture (USDA) directs states to implement that are required by law but are not yet included in federal regulations, and to implement USDA-approved demonstration projects and waivers of federal regulations.

DIVISION I

441—65.1(234) Definitions.

"Department" means the Iowa department of human services.

"Food assistance" means benefits provided by the federal program administered through Title 7, Chapter II of the Code of Federal Regulations, Parts 270 through 283.

"Notice of expiration" means either a message printed on an application for continued program participation, Review/Recertification Eligibility Document (RRED), Form 470-2881, which is automatically issued to the household, or a hand-issued Form 470-0325, Notice of Expiration.

"Parent" means natural, legal, or stepmother or stepfather.

"Sibling" means biological, legal, step- , half- , or adoptive brother or sister.

441—65.2(234) Application.

65.2(1) *Application filing.* Persons in need of food assistance benefits may file an application at any local department office in Iowa or over the Internet.

a. An application is filed the day a local department office receives an application for food assistance benefits that contains the applicant's name and address and is signed by either a responsible member of the household or the household's authorized representative. The application may be filed on:

(1) Form 470-0306 or 470-0307 (Spanish), Application for Food Assistance;

(2) Form 470-0462 or Form 470-0466 (Spanish), Health and Financial Support Application; or

(3) Form 470-4080 or 470-4080(S), Electronic Food Assistance Application.

b. When an application is delivered to a closed office, it will be considered received on the first day that is not a weekend or state holiday following the day that the office was last open. An electronic application is considered received on the first department workday following the date the department office received the application.

c. A household shall complete a Health and Financial Support Application when any person in the household is applying for or receiving aid through the family investment program, family medical assistance program (FMAP)-related Medicaid, or the refugee resettlement assistance programs.

d. The application is complete when a completed application form is submitted.

e. Households receiving food assistance benefits in Iowa may apply for continued participation by submitting Form 470-2881, Review/Recertification Eligibility Document.

65.2(2) *Failure to provide verification.* When a household files an initial application and the department requests additional verification, the applicant shall have ten days to provide the requested verification. If the applicant fails to provide the verification within ten days, the department may deny the application immediately. If the applicant provides the department with the requested verification prior to the thirtieth day from the date of application, the department shall reopen the case and provide benefits from the date of application. If the household provides the verification in the second 30 days

after the date of the application, the department shall reopen the case and provide benefits from the date the verification was provided.

441—65.3(234) Administration of program. The food assistance program shall be administered in accordance with the Food and Nutrition Act of 2008, 7 U.S.C. 2011 et seq., and in accordance with federal regulation, Title 7, Parts 270 through 283 as amended to June 19, 2006. A copy of the federal law and regulations may be obtained at no more than the actual cost of reproduction by contacting the Division of Financial, Health, and Work Supports, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, (515)281-3133.

441—65.4(234) Issuance. The department shall issue food assistance benefits by electronic benefits transfer (EBT).

65.4(1) *Schedule.* Benefits for ongoing certifications shall be made available to households on a staggered basis during the first ten calendar days of each month.

65.4(2) *EBT cards.* EBT cards shall be mailed to clients.

a. Personal identification number selection. When a client receives the EBT card, the client shall call the automated response unit to select a personal identification number. The client must provide proof of identity before selecting the personal identification number.

b. Replacement of EBT cards. EBT cards shall be replaced within five business days after the client notifies the EBT customer service help desk of the need for replacement.

65.4(3) *Client training.* Written client training materials may either be mailed to clients or be handed to the clients if they visit the local office. Clients will be given in-person training upon request or if they are identified as having problems using the EBT system.

65.4(4) *Point-of-sale terminals.* Point-of-sale terminals allow clients to access food assistance benefits and retailers to redeem food sales.

a. Redemption threshold. The department will not place point-of-sale terminals with any authorized retailer with less than $100 in monthly food assistance redemptions. Those retailers may participate through a manual voucher process described in paragraph 65.4(5)*"b."*

b. Shipping. Government-supplied point-of-sale terminals may be shipped to authorized retailers along with instructions for installation of the equipment and training materials. A toll-free number is available for retailers needing assistance.

c. Replacement. The department shall ensure that government-supplied point-of-sale terminals that are not operating properly are repaired or replaced within 48 hours.

65.4(5) *Voucher processing.*

a. Emergency vouchers. Authorized retailers may use an emergency manual voucher if they cannot access the EBT host system.

(1) The client shall sign Form 470-2827, Offline Food Stamp Voucher, to authorize a debit of the household's EBT account.

(2) The retailer shall clear the manual transaction as soon as the host system becomes operational.

(3) The retailer shall receive a payment of the actual amount of the voucher, up to a maximum of $50.

b. Manual vouchers. Authorized retailers without point-of-sale terminals and retailers whose equipment fails may use a manual voucher. If a manual voucher is used:

(1) The client shall sign Form 470-3980, Offline Food Stamp Voucher: Non Equipped Retailer (No POS), to authorize a debit of the household's EBT account.

(2) The retailer shall obtain a telephone authorization from the EBT retailer help desk before finalizing the purchase.

(3) The retailer shall clear the manual transaction within 30 days.

(4) If there are insufficient funds in the client's account when the voucher is presented, the client's account shall be debited for the amount in the account. The remainder of the amount owed shall be deducted from benefits issued for subsequent months. If the next month's allotment is less than $50, the deduction shall not exceed $10.

441—65.5(234) Simplified reporting.

65.5(1) *Identification.* All households are subject to simplified reporting requirements.

65.5(2) *Determination of eligibility and benefits.* Eligibility and benefits for simplified reporting households shall be determined on the basis of the household's prospective income and circumstances.

65.5(3) *Certification periods.* Households shall be certified as follows:

a. Households that have no earned income and in which all adult members are elderly or disabled shall be assigned certification periods of 12 months.

b. All other households shall be assigned certification periods of six months.

c. Exceptions:

(1) A household that has unstable circumstances or that includes an able-bodied adult without dependents shall be assigned a shorter certification period consistent with the household's circumstances, but generally no less than three months.

(2) A shorter certification period may be assigned at application or recertification to match the food assistance recertification date to the family investment program or medical assistance annual review date.

65.5(4) *Reporting responsibilities.* Simplified reporting households are required to report changes as follows:

a. The household shall report if the household's total gross income exceeds 130 percent of the federal poverty level for the household size. The household must report this change within ten days of the end of the month in which the income exceeds this level. A categorically eligible household that reports income over 130 percent of the federal poverty level and that remains eligible for benefits shall not be required to make any additional report of changes.

b. A household containing an able-bodied adult without dependents shall report any change in work hours that brings that adult below 20 hours of work per week, averaged monthly. The household must report this change within ten days of the end of the month in which the change in work hours occurs.

65.5(5) *Verification submitted with report form.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(6) *Additional information and verification.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(7) *Action on reported changes.* The department shall act on all reported changes for households regardless of the household's reporting requirements.

65.5(8) *Entering or leaving simplified reporting.* Rescinded IAB 9/10/08, effective 10/1/08.

65.5(9) *Reinstatement.* Rescinded IAB 9/10/08, effective 10/1/08.

441—65.6(234) Delays in certification.

65.6(1) When by the thirtieth day after the date of application the agency cannot take any further action on the application due to the fault of the household, the agency shall give the household an additional 30 days to take the required action. The agency shall send the household a notice of pending status on the thirtieth day.

65.6(2) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is complete enough to determine eligibility, the application shall be processed. For subsequent months of certification, the agency may require a new application form to be completed when household circumstance indicates changes have occurred or will occur.

65.6(3) When there is a delay beyond 60 days from the date of application and the agency is at fault and the application is not complete enough to determine eligibility, the application shall be denied. The household shall be notified to file a new application and that it may be entitled to retroactive benefits.

441—65.7(234) Expedited service. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.8(234) Deductions.

65.8(1) *Standard allowance for households with heating or air-conditioning expenses.* When a household is receiving heating or air-conditioning service for which it is required to pay all or part of the expense or receives assistance under the Low-Income Home Energy Assistance Act (LIHEAA) of 1981, the heating or air-conditioning standard shall be allowed.

a. The standard allowance for utilities which include heating or air-conditioning costs is $276 effective March 1, 2005.

b. This allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for fuels and other utilities for the average percent increases for the prior year for all urban consumers United States city average.

(1) Any numeral after the second digit following the decimal point will be dropped in this calculation.

(2) Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar.

(3) The cent amount will be included when calculating the next year's increase.

(4) Effective October 1, 2007, two dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction. Effective October 1, 2008, an additional two dollars, for a total of four dollars, will be subtracted from this amount to achieve continued cost neutrality.

65.8(2) *Heating expense.* Heating expense is the cost of fuel for the primary heating service normally used by the household.

65.8(3) *Telephone standard.* When a household is receiving a standard utility allowance under subrule 65.8(1) or 65.8(5) or is solely responsible for telephone expenses, a standard allowance shall be allowed.

a. This standard shall be $36 effective March 1, 2005.

b. This allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for telephone service for the average percent increases for the prior year for all urban consumers United States city average.

(1) Any numeral after the second digit following the decimal point will be dropped in this calculation.

(2) Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar.

(3) The cent amount will be included when calculating the next year's increase.

65.8(4) *Energy assistance payments.* For purposes of prorating the low income energy assistance payments to determine if households have incurred out-of-pocket expenses for utilities, the heating period shall consist of the months from October through March.

65.8(5) *Standard allowance for households without heating or air-conditioning expenses.* When a household is receiving some utility service other than heating or air-conditioning for which it is responsible to pay all or part of the expense, the nonheating or air-conditioning standard shall be allowed. These utility expenses cannot be solely for telephone.

a. This standard is $103 effective August 1, 1991.

b. Beginning October 1, 1992, this allowance shall change annually effective each October 1 using the percent increase reported in the consumer price index monthly periodical for January for electric service for the average percent increases for the prior year for all urban consumers United States city average.

(1) Any numeral after the second digit following the decimal point will be dropped in this calculation.

(2) Any decimal amount of .49 or under will be rounded down. Any decimal of .50 or more will be rounded up to the nearest dollar.

(3) The cent amount will be included when calculating the next year's increase.

(4) Effective October 1, 2007, two dollars will be subtracted from this amount to allow for cost neutrality necessary for the standard medical expense deduction. Effective October 1, 2008, an additional two dollars, for a total of four dollars, will be subtracted from this amount to achieve continued cost neutrality.

65.8(6) *Excluded payments.* A utility expense which is reimbursed or paid by an excluded payment, including HUD or FmHA utility reimbursements, shall not be deductible.

65.8(7) *Excess medical expense deduction.* Notwithstanding anything to the contrary in these rules or regulations, at certification, households having a member eligible for the excess medical expense deduction shall be allowed to provide verification of expenses so that a reasonable projection of the member's medical expenses anticipated to occur during the household's certification period can be made. The household may choose to claim actual expenses or to use the standard medical expense deduction.

a. Actual medical expense.

(1) The projection may be based on available information about the member's medical condition, public or private medical insurance coverage, and current verified medical expenses.

(2) Households that choose to claim actual medical expenses shall not be required to report changes in medical expenses that were anticipated to occur during the certification period.

b. Standard medical expense.

(1) A household may choose a standard medical expense deduction of $105 if the household incurs more than $35 per month in medical expenses.

(2) A household that chooses the standard deduction shall not be required to report changes in medical expenses during the certification period.

c. Rescinded IAB 8/1/07, effective 10/1/07.

65.8(8) *Child support payment deduction.* Rescinded IAB 5/2/01, effective 6/1/01.

65.8(9) *Standard deduction.* Each household will receive a standard deduction from income equal to 8.31 percent of the net income limit for food assistance eligibility. No household will receive an amount less than $144 or more than 8.31 percent of the net income limit for a household of six members. The amount of the standard deduction is adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.8(10) *Sharing utility standards.* Rescinded IAB 9/4/02, effective 10/1/02.

65.8(11) *Excess shelter cap.* Rescinded IAB 5/2/01, effective 6/1/01.

This rule is intended to implement Iowa Code section 234.12.

441—65.9(234) Treatment centers and group living arrangements. Alcohol or drug treatment or rehabilitation centers and group living arrangements shall complete Form 470-2724, Monthly Facility Report, on a monthly basis and return the form to the local department office where the center is assigned.

441—65.10(234) Reporting changes. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.11(234) Discrimination complaint. Individuals who feel that they have been subject to discrimination may file a written complaint with the Diversity Programs Unit, Department of Human Services, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

441—65.12(234) Appeals. Fair hearings and appeals are provided according to the department's rules, 441—Chapter 7.

441—65.13(234) Joint processing.

65.13(1) *Joint processing with SSI.* The department will handle joint processing of supplemental security income and food assistance applications by having the social security administration complete and forward food assistance applications.

65.13(2) *Joint processing with public assistance.* The department shall jointly process public assistance and food assistance applications.

65.13(3) *Single interview for assistance.* In joint processing of public assistance and food assistance applications, the department shall conduct a single interview at initial application for both purposes.

441—65.14(234) Rescinded, effective 10/1/83.

441—65.15(234) Proration of benefits. Benefits shall be prorated using a 30-day month.

This rule is intended to implement Iowa Code section 234.12.

441—65.16(234) Complaint system. Clients wishing to file a formal written complaint concerning the food assistance program may submit Form 470-0323, or 470-0327 (Spanish), Food Assistance Complaint, to the office of field support. Department staff shall encourage clients to use the form.

441—65.17(234) Involvement in a strike. An individual is not involved in a strike at the individual's place of employment when the individual is not picketing and does not intend to picket during the course of the dispute, does not draw strike pay, and provides a signed statement that the individual is willing and ready to return to work but does not want to cross the picket line solely because of the risk of personal injury or death or trauma from harassment. The service area manager shall determine whether such a risk to the individual's physical or emotional well-being exists.

441—65.18(234) Rescinded, effective 8/1/86.

441—65.19(234) Monthly reporting/retrospective budgeting. Rescinded IAB 9/10/08, effective 10/1/08.

441—65.20(234) Notice of expiration issuance.

65.20(1) Issuance of the automated Notice of Expiration will occur with the mailing of Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document, or a hand-issued Form 470-0325, Notice of Expiration.

65.20(2) Issuance of the Notice of Expiration, Form 470-0325, will occur at the time of certification if the household is certified for one month, or for two months, and will not receive the automated Notice of Expiration.

441—65.21(234) Claims.

65.21(1) *Time period.* Inadvertent household error claims shall be calculated back to the month the error originally occurred to a maximum of three years before the month of discovery of the overissuance. Agency error claims shall be calculated back to the month the error originally occurred to a maximum of one year before the month of discovery of the overissuance.

65.21(2) *Suspension status.* Rescinded IAB 7/1/98, effective 8/5/98.

65.21(3) *Application of restoration of lost benefits.* Rescinded IAB 3/6/02, effective 5/1/02.

65.21(4) *Demand letters.* Households that have food assistance claims shall return the repayment agreement no later than 20 days after the date the demand letter is mailed.

a. For agency error and inadvertent household error, when households do not return the repayment agreement by the due date or do not timely request an appeal, allotment reduction shall occur with the first allotment issued after the expiration of the Notice of Adverse Action time period.

b. For intentional program violation, when households do not return the repayment agreement by the due date, allotment reduction shall occur with the next month's allotment.

65.21(5) *Adjustments for claim repayment.* A household or authorized representative may initiate a claim repayment by using benefits in an EBT account. The client or authorized representative shall complete Form 470-2574, EBT Adjustment Request, to authorize adjustments to a household's EBT account.

65.21(6) *Collection of claims.* Rescinded IAB 5/30/01, effective 8/1/01.

[**ARC 7928B**, IAB 7/1/09, effective 9/1/09]

441—65.22(234) Verification.

65.22(1) *Required verification.*

a. Income. Households shall be required to verify income at time of application, recertification and when income is reported or when income changes with the following exceptions:

1. Households are not required to verify the public assistance grant.

2. Households are not required to verify job insurance benefits when the information is available to the department from the department of employment services.

3. Households are only required to verify interest income at the time of application and recertification.

b. Dependent care costs. Households shall be required to verify dependent care costs at the time of application and recertification and whenever a change is reported.

c. Medical expenses. Households shall be required to verify medical expenses at the time of application and whenever a change is reported. For recertification:

(1) A household that chose to claim actual expenses must verify medical expenses.

(2) A household that chose the standard medical expense deduction shall be required to declare only if the excess expense still exists.

d. Shelter costs. Households shall be required to verify shelter costs (other than utility expenses) at the time of application and recertification and whenever the household reports moving or a change in its shelter costs.

e. Utilities. Households eligible for a utility standard shall verify responsibility for the utility expense that makes them eligible for that standard when not previously verified, whenever the household has moved or a change in responsibility for utility expenses is reported.

f. Telephone expense. Rescinded IAB 5/2/01, effective 6/1/01.

g. Child support payment deduction. Households shall be required to verify legally obligated child support and child medical support payments made to a person outside of the food assistance household only at certification and recertification and whenever the household reports a change.

65.22(2) *Failure to verify.* When the household does not verify an expense as required, no deduction for that expense will be allowed.

65.22(3) *Special verification procedures.* Persons whose applications meet the initial criteria for error-prone cases may be subject to special verification procedures, including a second face-to-face interview and additional documentation requirements in accordance with department of inspections and appeals' rules 481—Chapter 72.

Clients are required to cooperate with the investigation division of the department of inspections and appeals in establishing eligibility factors, including attending requested interviews. Refusal to cooperate will result in denial or cancellation of the household's food assistance benefits. Once denied or terminated for refusal to cooperate, the household may reapply but shall not be determined eligible until cooperation occurs.

441—65.23(234) Prospective budgeting.

65.23(1) *Weekly or biweekly income.* The department shall convert income and deductions that occur on a weekly or biweekly basis to monthly figures using family investment program procedures.

65.23(2) *Income averaging.* The department shall average income by anticipating income fluctuations over the certification period. The number of months used to arrive at the average income should be the number of months that are representative of the anticipated income fluctuation.

441—65.24(234) Inclusion of foster children in household. Foster children living with foster parents will not be considered to be members of the food assistance household unless the household elects to include the foster children in the household. Foster care payments received for foster children not included in the household will be excluded from the income of the household receiving the payment.

441—65.25(234) Effective date of change. A food assistance change caused by, or related to, a public assistance grant change will have the same effective date as the public assistance change.

441—65.26(234) Eligible students. A student who is enrolled in an institution of higher education shall meet student eligibility criteria if the student:

1. Is employed for an average of 20 hours per week and is paid for this employment; or

2. Is self-employed for an average of 20 hours per week and receives average weekly earnings at least equal to the federal minimum wage multiplied by 20 hours.

441—65.27(234) Voluntary quit or reduction in hours of work.

65.27(1) *Applicant households.* A member of an applicant household who without good cause voluntarily quits a job or reduces hours of work to less than 30 hours weekly within 30 days before the date the household applies for benefits shall be disqualified from participating in the food assistance program according to the provisions of paragraphs 65.28(12)*"a"* and *"b."*

65.27(2) *Participating individuals.* Participating individuals are subject to the same disqualification periods as provided under subrule 65.28(12) when the participating individuals voluntarily quit employment without good cause or voluntarily reduce hours of work to less than 30 hours per week, beginning with the month following the adverse notice period.

441—65.28(234) Work requirements.

65.28(1) *Persons required to register.* Each household member who is not exempt by subrule 65.28(2) shall be registered for employment at the time of application, and once every 12 months after initial registration, as a condition of eligibility. Registration is accomplished when the applicant signs an application form that contains a statement that all members in the household who are required to register for work are willing to register for work. This signature registers all members of that food assistance household that are required to register.

65.28(2) *Exemptions from work registration.* The following persons are exempt from the work registration requirement:

a. A person younger than 16 years of age or a person 60 years of age or older. A person aged 16 or 17 who is not a head of a household or who is attending school, or is enrolled in an employment training program on at least a half-time basis is exempt.

b. A person physically or mentally unfit for employment.

c. A household member subject to and complying with any work requirement under Title IV of the Social Security Act including mandatory PROMISE JOBS referral.

d. A parent or other household member who is responsible for the care of a dependent child under age six or an incapacitated person.

e. A person receiving unemployment compensation.

f. A regular participant in a drug addiction or alcohol treatment and rehabilitation program which is certified by the Iowa department of public health, division of substance abuse.

g. A person who is employed or self-employed and working a minimum of 30 hours weekly or receiving weekly earnings at least equal to the federal minimum wage multiplied by 30 hours.

h. A student enrolled at least half-time in any recognized school, recognized training program, or an institution of higher education (provided that students have met the requirements of federal regulation, Title 7, Part 273.5, as amended to December 31, 1986).

65.28(3) *Losing exempt status.* Persons who lose exempt status due to any change in circumstances that is subject to the reporting requirements shall register for employment when the change is reported. Persons who lose exempt status due to a change in circumstances that is not subject to the reporting requirements for that household shall register for employment no later than at the household's next recertification.

65.28(4) *Registration process.* Upon reaching a determination that an applicant or a member of the applicant's household is required to register, the pertinent work requirements, the rights and responsibilities of work-registered household members, and the consequences of failure to comply shall be explained to the applicant. A written statement of the above shall be provided to each registrant in the household. The written statement shall also be provided at recertification and when a previously exempt member or a new household member becomes subject to work registration.

Registration for all nonexempt household members required to work register is accomplished when the applicant or recipient signs an application, recertification, or reporting form containing an affirmative response to the question, "Do all members who are required to work register and participate in job search agree to do so?" or similarly worded statement.

65.28(5) *Deregistration.* Work registrants who obtain employment or otherwise become exempt from the work requirement subsequent to registration or who are no longer certified for participation are no longer considered registered.

65.28(6) *Work registrant requirements.* Work registrants shall:

a. Participate in an assigned employment and training program.

b. Respond to a request from the department or its designee for supplemental information regarding employment status or availability for work.

c. Report to an employer to whom referred by the department or its designee if the potential employment meets the suitability requirements described in subrule 65.28(15).

d. Accept a bona fide offer of suitable employment at a wage not less than the federal minimum wage.

65.28(7) *Employment and training programs.* Persons required to register for work and not exempted by subrule 65.28(9) from placement in a component shall be subject to employment and training requirements. If all nonexempt mandatory registrants cannot be served because minimum federal participation standards have been met, registrants will be randomly selected for referral up to the minimum standard. Requirements may vary among participants.

The department or its designee shall serve as the provider of employment and training services for nonexempt registrants.

The department or its designee can require participants to engage in vocational testing activities when deemed necessary.

Participants shall report for all scheduled employment interviews and accept bona fide offers of suitable employment as defined in subrule 65.28(15).

Participants who, for any reason, are absent from any scheduled employment and training appointment shall be required to reschedule a like appointment. Absence includes missing more than 30 minutes of a scheduled appointment.

65.28(8) *Employment and training components.* Employment and training components include individual job search, job club, educational services (GED/ABE/ESL), and Workforce Investment Act of 1998 (WIA) activities. The department shall offer employment and training components in counties having a monthly average of 500 or more mandatory work registrants. The department shall offer components in additional counties subject to the availability of sufficient state and federal funding to cover program costs. Availability of components may vary among the areas where employment and training is offered.

a. Job club. The employment and training job club shall be modeled after the family investment program's PROMISE JOBS job club. Employment and training service provider staff may require a participant who, for any reason, is absent during the classroom portion of job club to repeat the entire period of classroom training. Additional allowances as provided for by subrule 65.28(11) shall not be paid to these individuals.

Each job club participant shall be required to read and sign Form 62-2053, Your Rights and Responsibilities, acknowledging that a complete explanation of the program and what constitutes noncompliance and the sanctions for noncompliance has been provided.

b. Educational services (GED/ABE/ESL). Persons referred to the job club component may elect to be referred to the educational services program. Educational services offered include General Educational Development (GED), Adult Basic Education (ABE), or English as a Second Language (ESL).

(1) The employment and training service provider shall individually assess persons requesting referral to this program. If it is determined that obtaining educational services would directly enhance the person's likelihood of obtaining employment, the employment and training service provider shall refer the person to this program subject to available funds.

(2) Participation in the educational services program for eight consecutive weeks is equivalent to participation in two four-week employment and training components.

(3) The employment and training service provider shall assign to the job club component persons who fail to begin or to continue the educational program during the two four-week components.

c. Workforce Investment Act of 1998 (WIA). Persons electing to participate in and selected for participation in WIA are participating in an employment and training component.

d. Individual job search (IJS). Participants in IJS shall receive information about the program. At a minimum, the orientation shall include an explanation of services provided, of participation requirements, and of each participant's rights and responsibilities. Employment services staff shall require each participant to read and sign Form 62-2053,Your Rights and Responsibilities, at the conclusion of the presentation, acknowledging that a complete explanation of the program and what constitutes noncompliance and the sanctions for noncompliance has been provided.

Employment services staff shall give each participant a job search assignment. Employment services staff shall require the participant to contact up to 24 employers, face-to-face, for the purpose of submitting employment applications and arranging for employment interviews. To qualify as a job contact, the participants must present themselves to prospective employers as available for work.

The prospective employer must ordinarily employ persons in areas of work for which the applicant is reasonably qualified based on the participant's skills, prior work experience and level of education. The participant may not contact the same employer more than once during the component unless the initial contact indicated that vacancies in suitable positions might soon exist. Employment services staff shall require each participant to submit written documentation of employer contacts made using Form 60-0259, Job Service Work Search Record. The participant shall provide documentation in person to employment services staff at a scheduled meeting at the conclusion of the four-week participation period. At the beginning of the period, employment services staff shall give each participant written notice of the time, date, and location of this meeting.

65.28(9) *Exemptions from employment and training programs.* The department may exempt certain individuals and categories of individuals from employment and training participation. Exempt status of individuals shall be reviewed at recertification to determine if the exemption is still valid. Exempt classifications include:

a. Pregnant women in the second or third trimester of pregnancy. Department staff are authorized to require medical documentation.

b. Strikers and persons who are unemployed because of lockout.

c. Persons who are laid off or temporarily unemployed and expect to be recalled within the next 90 days (job attached).

d. Rescinded IAB 12/13/89, effective 2/1/90.

e. Persons with no mailing address available other than general delivery.

f. Victims of spouse abuse receiving employment-related services from a shelter for battered women or other spousal abuse organization.

g. Persons who have accepted a job that will exempt them and that will begin within 60 days. The person shall provide verification that a legitimate job offer and acceptance has been made.

h. Rescinded IAB 3/6/02, effective 5/1/02.

i. Rescinded IAB 12/13/89, effective 2/1/90.

j. Mandatory work registrants who are employed 60 or more hours per month.

k. Persons whose daily commuting time exceeds two hours per day, not including the transporting of a child to and from a child care facility, or the distance to the component site prohibits walking and neither public nor private transportation is available to transport the person.

l. Persons who are assigned to a job or training component, but who do not commence the component and are determined to have good cause as defined in subrule 65.28(17), may be considered exempted if the reason for good cause will last for 60 days or longer. When the reason for the exemption is no longer applicable, the person may be placed in a component.

65.28(10) *Time spent in an employment and training program.* A participant may be placed in two different components from October 1 through September 30.

The total hours of participation for any household member individually in any month together with any hours worked for compensation (in cash or in kind) shall not exceed 120.

65.28(11) *Participation allowance and dependent care reimbursements.*

a. The department shall provide participants in employment and training programs an allowance for costs of transportation or other costs (other than dependent care costs) reasonably necessary and directly related to participation in the components of a minimum of $25 to a maximum of $50 for each four-week component in which the participant is placed. The amount of the allowance is dependent on sufficient state and federal funding to cover the costs.

EXCEPTION: Participation in WIA (65.28(8), paragraph *"c"*) does not entitle the person to a participation allowance. The department shall authorize the employment and training service provider to provide the allowance on the first day of each component in which the person participates. The department shall authorize the employment and training service provider to provide the allowance only once per component in each federal fiscal year. Participation in educational services (65.28(8), paragraph *"b"*) is considered participation in two consecutive four-week components.

b. The department shall authorize the employment and training service provider to reimburse the provider of care directly for the actual costs of dependent care expenses that the employment and training service provider determines to be necessary for the participation of a person in the components. Reimbursement shall not exceed $200 for each child under two years of age and $175 for each other dependent per four-week component. The employment and training service provider shall only reimburse a person not included in the food assistance household. The employment and training service provider shall only reimburse participants in the IJS component during the regular school term to the extent that the contacts required in this component cannot be made while dependent children who attend school are in school. The employment and training service provider shall defer a person from participation in a component if the dependent care expenses exceed the dependent care reimbursement. Deferment shall continue until a suitable component is available or circumstances change and monthly dependent care expenses no longer exceed the reimbursement amount. Reimbursement is dependent on sufficient state and federal funding to cover the costs.

EXCEPTION: The caretaker relative of a dependent in a family receiving FIP is not eligible for the dependent care reimbursement. Participation in WIA (65.28(8), paragraph *"c"*) does not entitle the person to a dependent care reimbursement. The department shall authorize the employment and training service provider to provide the reimbursement after the last day of each component in which the person participates upon presentation of proof of the expense incurred and hours of care for each dependent. The department shall authorize the employment and training service provider to provide reimbursement only once per component in each federal fiscal year. Participation in educational services (65.28(8), paragraph *"b"*) is considered participation in two consecutive four-week components.

65.28(12) *Failure to comply.* This subrule does not apply to persons electing to participate in the employment and training components of educational services and WIA (see paragraphs 65.28(8)*"b"* and *"c"*).

a. When a person has refused or failed without good cause to comply with the work registration or employment and training requirements in this rule, that person shall be ineligible to participate in the food assistance program as follows:

(1) First violation: The later of (1) the date the individual complies with the requirement; or (2) two months.

(2) Second violation: The later of (1) the date the individual complies with the requirement; or (2) three months.

(3) Third and subsequent violations: The later of (1) the date the individual complies with the requirement; or (2) six months.

b. The disqualification period shall begin with the first month following the expiration of the adverse notice period, unless a fair hearing is requested.

c. Participants shall be notified of probation status in writing. Probation shall last for the duration of the component. In addition to other work requirements in this chapter, employment and training participants are subject to the following specific requirements:

(1) Participants who are absent without good cause shall be placed on probation. A second absence without good cause shall result in disqualification.

(2) Participants who are absent without good cause at the time they are scheduled to present their job search documentation shall be disqualified.

(3) Participants who fail to make the required number of employer contacts without good cause shall be disqualified. Participants who fail to complete the required number of job contacts with good cause shall be excused from completion of the job search requirements for that component.

(4) Participants who exhibit disruptive behavior shall be placed on probation; a second offense shall result in disqualification. Disruptive behavior means the participant hinders the performance of other participants or staff, refuses to follow instructions, or uses abusive language.

(5) Participants will be allowed an additional two weeks to make up employer contacts which have been disallowed by employment services. Qualifying job contacts are defined in paragraph 65.28(8)*"e."* Failure to make up employer contacts will result in disqualification. Employment services will disallow employer contacts when it has been determined that the participant failed to make a face-to-face contact or the requirements of the job applied for far exceed the applicant's level of experience, education, or abilities.

(6) Participants who make physical threats to other participants or staff shall be disqualified.

65.28(13) *Noncompliance with comparable requirements.* The department shall treat failure to comply with an unemployment compensation requirement that is comparable to a food assistance work registration or employment and training requirement as a failure to comply with the corresponding food assistance requirement. Disqualification procedures in subrule 65.28(12) shall be followed.

65.28(14) *Ending disqualification.* Following the end of the disqualification periods for noncompliance and as provided in rules 441—65.27(234) and 441—65.28(234), participation may resume.

a. An applicant disqualified under subrule 65.27(1) may be approved for benefits after serving the minimum disqualification period and complying with the work requirement, as follows:

(1) If the applicant voluntarily quit a job, the applicant must obtain a job comparable to the one that the applicant quit.

(2) If the applicant voluntarily reduced hours of employment to less than 30 hours per week, the applicant must start working 30 or more hours per week.

b. A disqualified individual who is a member of a currently participating eligible household shall be added to the household after the minimum disqualification period has been served and the person has complied with the failed requirement as follows:

(1) If the member failed or refused to register for work with the department, the member complies by registering.

(2) If the member failed or refused to respond to a request from the department or its designee requiring supplemental information regarding employment status or availability for work, the member must comply with the request.

(3) If the member failed or refused to report to an employer to whom referred, the member must report to that employer if work is still available or report to another employer to whom referred.

(4) If the member failed or refused to accept a bona fide offer of suitable employment to which referred, the member must accept the employment if still available to the participant, or secure other employment which yields earnings per week equivalent to the refused job, or secure any other employment of at least 30 hours per week or secure employment of less than 30 hours per week but with weekly earnings equal to the federal minimum wage multiplied by 30 hours.

(5) If the member failed or refused to attend a scheduled employment and training interview, the member must arrange and attend a scheduled interview.

(6) If the member failed or refused to participate in instruction, training or testing activities, the member must participate in the activities.

(7) If the member failed or refused to complete assigned job search requirements, the member must complete the job search requirements.

(8) Rescinded IAB 2/9/00, effective 4/1/00.

(9) If the member voluntarily quit a job, the individual must obtain a job comparable to the one quit.

(10) If the member voluntarily reduced hours of employment to less than 30 hours per week, the individual must start working 30 or more hours per week.

c. An individual may reestablish eligibility during a disqualification period by becoming exempt from the work requirement as provided in subrule 65.28(2).

65.28(15) *Suitable employment.* Employment shall be considered unsuitable if:

a. The wage offered is less than the highest of the applicable federal minimum wage, the applicable state minimum wage, or 80 percent of the federal minimum wage if neither the federal nor state minimum wage is applicable.

b. The employment offered is on a piece-rate basis and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wages specified in paragraph *"a"* above.

c. The household member, as a condition of employment or continuing employment, is required to join, resign from, or refrain from joining a legitimate labor organization.

d. The work offered is at a site subject to a strike or lockout at the time of the offer unless the strike has been enjoined under Section 208 of the Labor-Management Relations Act (29 U.S.C. 78A) (commonly known as the Taft-Hartley Act), or unless an injunction has been issued under Section 10 of the Railway Labor Act (45 U.S.C. 160).

e. The household member involved can demonstrate or the department otherwise becomes aware that:

(1) The degree of risk to health and safety is unreasonable.

(2) The member is physically or mentally unfit to perform the employment, as documented by medical evidence or by reliable information from other sources.

(3) The employment offered within the first 30 days of registration is not in the member's major field of experience.

(4) The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. Employment shall not be considered suitable if daily commuting time exceeds two hours per day, not including the transporting of a child to and from a child care facility. Employment shall also not be considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.

(5) The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.

65.28(16) *Applicants for supplemental security income (SSI) and food assistance.* Household members who are jointly applying for SSI and for food assistance shall have the requirements for work registration waived until:

a. They are determined eligible for SSI and thereby become exempt from work registration, or

b. They are determined ineligible for SSI whereupon a determination of work registration status will be made.

65.28(17) *Determining good cause.* The department or its designee shall determine whether good cause exists for failure to comply with the work registration, employment and training, and voluntary quit requirements in 441—Chapter 65. In determining whether good cause exists, the facts and circumstances shall be considered, including information submitted by the household member involved and the employer.

Good cause shall include circumstances beyond the member's control, such as, but not limited to, illness of the registrant or of another household member requiring the presence of the registrant, a household emergency, the unavailability of transportation, or the lack of adequate child care for children who have reached age 6 but are under age 12.

65.28(18) *Measuring the three-year period for able-bodied nonexempt adults without dependents.* The three-year period as provided for in federal regulations at 7 CFR 273.24 as amended to June 19, 2002, starts on December 1, 2002, and ends November 30, 2005. Subsequent three-year periods start with the month of December following the end of the previous period.

65.28(19) *Mini-simplified food stamp program.*

a. Scope. The department operates a mini-simplified food stamp program for households that:

(1) Also receive benefits under the family investment program; and

(2) Include a parent who is exempt from food assistance requirements for work registration due to caring for a child under the age of six.

b. Effect. The mini-simplified food stamp program allows replacement of certain food stamp program work rules with work rules of the Temporary Assistance to Needy Families program. The value of the household's monthly food assistance benefits shall be combined with the household's monthly family investment program benefit amount to determine the maximum number of hours the department can require a household member under the family investment program to participate in an unpaid work activity that is subject to the federal Fair Labor Standards Act. Maximum required hours of participation for a month are determined by dividing the total amount of benefits by the state or federal minimum wage, whichever wage is higher.

441—65.29(234) Income.

65.29(1) *Uneven proration of self-employment income.* Once a household with self-employment income is determined eligible based on its monthly net self-employment income, the household has the following options for computation of the benefit level:

a. Using the same net monthly self-employment income which was used to determine eligibility, or

b. Unevenly prorating the household's annual self-employment income over the period for which the household's self-employment income was averaged to more closely approximate the time when the income is actually received. If this option is chosen, the self-employment income assigned in any month together with other income and deductions at the time of certification cannot result in the household's exceeding the maximum monthly net income eligibility standards for the household's size.

65.29(2) *Job insurance benefits.* When the department of human services uses information provided by the department of workforce development to verify job insurance benefits, the benefits shall be considered received the second day after the date that the check was mailed. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

When the client notifies the agency that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. A benefit adjustment shall be made when indicated. The client must report the discrepancy before the benefit month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the benefit month, whichever is later, in order to receive corrected benefits.

65.29(3) *Exclusion of income from 2000 census employment.* Rescinded IAB 9/4/02, effective 10/1/02.

65.29(4) *Interest income.* Prorate interest income by dividing the amount anticipated during the certification period by the number of months in the certification period.

65.29(5) *Social security plans for achieving self-support (PASS).* Notwithstanding anything to the contrary in these rules or regulations, exclude income amounts necessary for fulfillment of a plan for achieving self-support (PASS) under Title XVI of the Social Security Act.

65.29(6) *Student income.* In determining eligibility, the department shall exclude educational income, including any educational loans on which payment is deferred, grants, scholarships, fellowships, veterans' educational benefits, and the like excluded under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

a. Notwithstanding anything to the contrary in these rules or regulations, the department shall exclude educational income based on amounts earmarked by the institution, school, program, or other grantor as made available for the specific costs of tuition, mandatory fees, books, supplies, transportation and miscellaneous personal expenses (other than living expenses).

b. If the institution, school, program, or other grantor does not earmark amounts made available for the allowable costs involved, students shall receive an exclusion from educational income for educational assistance verified by the student as used for the allowable costs involved. Students can also verify the allowable costs involved when amounts earmarked are less than amounts that would be excluded by a strict earmarking policy.

c. For the purpose of this rule, mandatory fees include the rental or purchase of equipment, materials and supplies related to the course of study involved.

65.29(7) *Elementary and high school student income.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(8) *Vendor payments.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(9) *HUD or FmHA utility reimbursement.* Rescinded IAB 5/2/01, effective 6/1/01.

65.29(10) *Welfare reform and regular household honorarium income.* All moneys paid to a food assistance household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

65.29(11) *Income of ineligible aliens.* The department shall use all but a pro-rata share of ineligible aliens' income and deductible expenses to determine eligibility and benefits of any remaining household members.

441—65.30(234) Resources.

65.30(1) *Jointly held resources.* When property is jointly held it shall be assumed that each person owns an equal share unless the intent of the persons holding the property can be otherwise established.

65.30(2) *Resource limit.* The resource limit for a household that includes a person aged 60 or over or a disabled person is $3000. The resource limit for other households is $2000. These amounts are adjusted for inflation annually as directed by the Food and Nutrition Service of the U.S. Department of Agriculture.

65.30(3) *Resources of SSI and FIP household members.* Notwithstanding anything to the contrary in these rules or in federal regulations, all resources of SSI or FIP recipients are excluded. For food assistance purposes, those members' resources, if identified, cannot be included when a household's total resources are calculated.

65.30(4) *Earned income tax credits.* Notwithstanding anything to the contrary in these rules or in federal regulations, earned income tax credits (EITC) shall be excluded from consideration as a resource for 12 months from the date of receipt if:

a. The person receiving the EITC was participating in the food assistance program at the time the credits were received; and

b. The person participated in the program continuously during the 12-month period.

65.30(5) *Student income.* Exclude from resources any income excluded by subrule 65.29(6).

65.30(6) *Motor vehicles.* One motor vehicle per household shall be excluded without regard to its value. The value of remaining motor vehicles shall be determined using federal regulations at 7 CFR 273.8, as amended to April 29, 2003.

65.30(7) *Retirement accounts.* Exclude from resources the value of:

a. Any funds in a plan, contract, or account described in Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c)(18) of the Internal Revenue Code of 1986.

b. Any funds in a Federal Thrift Savings Plan account as provided in Section 8439 of Title 5, United States Code.

c. Any retirement program or account included in any successor or similar provision that may be enacted and determined to be exempt from tax under the Internal Revenue Code of 1986.

d. Any other retirement plans, contracts, or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

65.30(8) *Education accounts.* Exclude from resources the value of:

a. Any funds in a qualified tuition program described in Section 529 of the Internal Revenue Code of 1986 or in a Coverdell Education Savings Account under Section 530 of the Internal Revenue Code.

b. Any other education plans, contracts or accounts determined to be exempt by the Secretary of the U.S. Department of Agriculture.

441—65.31(234) Homeless meal providers. When a local office of the department is notified that an establishment or shelter has applied to be able to accept food assistance benefits for homeless persons, staff shall obtain a written statement from the establishment or shelter. The statement must contain information on how often meals are served by the establishment or shelter, the approximate number of

meals served per month, and a statement that the establishment or shelter does serve meals to homeless persons. This information must be dated and signed by a person in charge of the administration of the establishment or shelter and give the person's title or function with the establishment.

The establishment or shelter shall cooperate with agency staff in the determination of whether or not meals are served to the homeless.

441—65.32(234) Basis for allotment. The minimum benefit amount for all eligible one-member and two-member households shall be 8 percent of the maximum monthly allotment for a household size of one member.

441—65.33(234) Dependent care deduction. Households shall be allowed a deduction for the amount of verified monthly dependent care expenses.

441—65.34(234) Exclusion of advance earned income tax credit payments from income. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.35(234) Migrant and seasonal farm worker households. Rescinded IAB 10/30/91, effective 1/1/92.

441—65.36(234) Electronic benefit transfer (EBT) of food stamp benefits. Rescinded IAB 3/5/03, effective 5/1/03.

441—65.37(234) Eligibility of noncitizens. The following groups of aliens who are lawfully residing in the United States and are otherwise eligible are eligible for food assistance benefits:

65.37(1) Aliens who are receiving benefits or assistance for blindness or disability as specified in 7 CFR 271.2, as amended to April 6, 1994, regardless of their immigration date.

65.37(2) Aliens who have been residing in the United States for at least five years as legal permanent residents.

65.37(3) Aliens who hold one of the following statuses:

a. A refugee admitted under Section 207 of the Immigration and Nationality Act.

b. A Cuban or Haitian entrant admitted under Section 501(e) of the Refugee Education Assistance Act of 1980.

c. An Amerasian immigrant admitted under Section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act.

d. An asylee admitted under Section 208 of the Immigration and Nationality Act.

e. An alien whose deportation or removal has been withheld under Section 243(h) or 2411(b)(3) of the Immigration and Nationality Act.

65.37(4) Aliens aged 18 or under, regardless of their immigration date. The department shall exclude the income and resources of a sponsor when determining food assistance eligibility and benefits for an alien aged 18 or under.

441—65.38(234) Income deductions. Notwithstanding anything to the contrary in these rules or regulations, student households cannot receive an income deduction for dependent care expenses that were excluded from educational income.

441—65.39(234) Categorical eligibility. Notwithstanding anything to the contrary in these rules or in federal regulations, recipients of state or local general assistance (GA) programs are subject to categorical eligibility provisions of the food assistance program provided that the state or local program:

1. Has income limits at least as stringent as the food assistance gross income test; and
2. Gives assistance other than one-time emergency payments that cannot be given for more than one continuous month.

441—65.40(234) Head of the household. Rescinded IAB 8/11/99, effective 11/1/99.

441—65.41(234) Actions on changes increasing benefits. Action on changes resulting in an increase in benefits will take place after the verification is received.

441—65.42(234) Work transition period. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.43(234) Household composition. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.44(234) Reinstatement. The department shall reinstate assistance without a new application when the element that caused termination of a case no longer exists and eligibility can be reestablished prior to the effective date of cancellation.

441—65.45(234) Conversion to the X-PERT system. Rescinded IAB 3/6/02, effective 5/1/02.

441—65.46(234) Disqualifications. Notwithstanding anything to the contrary in these rules, food assistance program violation disqualifications for persons who are not participating in the food assistance program shall be imposed in the same manner as program violation disqualifications are imposed for persons who are participating in the food assistance program.

65.46(1) *First and second violations.* Notwithstanding anything to the contrary in these rules or regulations, the disqualification penalty for a first intentional program violation shall be one year except for those first violations involving a controlled substance. The disqualification penalty for a second intentional violation and any first violation involving a controlled substance shall be two years.

65.46(2) *Conviction on trafficking in food assistance benefits.* The penalty for any individual convicted of trafficking in food assistance benefits of $500 or more shall be permanent disqualification.

65.46(3) *Receiving or attempting to receive multiple benefits.* An individual found to have made a fraudulent statement or representation with respect to identity or residency in order to receive multiple benefits shall be ineligible to participate in the food assistance program for a period of ten years.

65.46(4) *Fleeing felons and probation or parole violators.* Rescinded IAB 10/3/01, effective 10/1/01.

65.46(5) *Conviction of trading firearms, ammunition or explosives for benefits.* The penalty for any individual convicted of trading firearms, ammunition or explosives for food assistance benefits shall be permanent disqualification.

441—65.47(234) Eligibility of noncitizens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.48(234) Sponsored aliens. Rescinded IAB 5/2/01, effective 6/1/01.

441—65.49(234) Providing information to law enforcement officials. Rescinded IAB 10/3/01, effective 10/1/01.

441—65.50(234) No increase in benefits. When a household's means-tested federal, state, or local public assistance cash benefits are reduced because of a failure to perform an action required by the public assistance program, the department shall reduce the household's food assistance benefit allotment by 10 percent as provided for in federal regulations at 7 CFR 273.11(j), (k), and (l) as amended to June 1, 2001, for the duration of the other program's penalty.

441—65.51(234) State income and eligibility verification system. The department shall maintain and use an income and eligibility verification system (IEVS) as specified in 7 CFR 272.8 as amended to November 21, 2000.

441—65.52(234) Systematic alien verification for entitlements (SAVE) program. The department shall participate in the SAVE program established by the U.S. Bureau of Citizenship and Immigration Service (BCIS) as specified in 7 CFR 272.11 as amended to November 21, 2000, in order to verify the

validity of documents provided by aliens applying for food assistance benefits with the central data files maintained by BCIS.

These rules are intended to implement Iowa Code section 234.12.

441—65.53 to **65.100** Reserved.

DIVISION II
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1 Amendments to subrules 65.30(5) and 65.130(7) and rules 65.32(234) and 65.132(234) effective 10/1/96.

2 Subrules 65.8(11) and 65.108(11) effective 1/1/97.

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 75
CONDITIONS OF ELIGIBILITY

[Ch 75, 1973 IDR, renumbered as Ch 90]
[Prior to 7/1/83, Social Services[770] Ch 75]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

441—75.1(249A) Persons covered.

75.1(1) *Persons receiving refugee cash assistance.* Medical assistance shall be available to all recipients of refugee cash assistance. Recipient means a person for whom a refugee cash assistance (RCA) payment is received and includes persons deemed to be receiving RCA. Persons deemed to be receiving RCA are:

a. Persons denied RCA because the amount of payment would be less than $10.

b. Rescinded IAB 7/30/08, effective 10/1/08.

c. Persons who are eligible in every respect for refugee cash assistance (RCA) as provided in 441—Chapter 60, but who do not receive RCA because they did not make application for the assistance.

75.1(2) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(3) *Persons who are ineligible for Supplemental Security Income (SSI) because of requirements that do not apply under Title XIX of the Social Security Act.* Medicaid shall be available to persons who would be eligible for SSI except for an eligibility requirement used in that program which is specifically prohibited under Title XIX.

75.1(4) *Beneficiaries of Title XVI of the Social Security Act (supplemental security income for the aged, blind and disabled) and mandatory state supplementation.* Medical assistance will be available to all beneficiaries of the Title XVI program and those receiving mandatory state supplementation.

75.1(5) *Persons receiving care in a medical institution who were eligible for Medicaid as of December 31, 1973.* Medicaid shall be available to all persons receiving care in a medical institution who were Medicaid members as of December 31, 1973. Eligibility of these persons will continue as long as they continue to meet the eligibility requirements for the applicable assistance programs (old-age assistance, aid to the blind or aid to the disabled) in effect on December 31, 1973.

75.1(6) *Persons who would be eligible for supplemental security income (SSI), state supplementary assistance (SSA), or the family medical assistance program (FMAP) except for their institutional status.* Medicaid shall be available to persons receiving care in a medical institution who would be eligible for SSI, SSA, or FMAP if they were not institutionalized.

75.1(7) *Persons receiving care in a medical facility who would be eligible under a special income standard.*

a. Subject to paragraphs *"b"* and *"c"* below, Medicaid shall be available to persons who:

(1) Meet level of care requirements as set forth in rules 441—78.3(249A), 441—81.3(249A), and 441—82.7(249A).

(2) Receive care in a hospital, nursing facility, psychiatric medical institution, intermediate care facility for the mentally retarded, or Medicare-certified skilled nursing facility.

(3) Have gross countable monthly income that does not exceed 300 percent of the federal supplemental security income benefits for one.

(4) Either meet all supplemental security income (SSI) eligibility requirements except for income or are under age 21. FMAP policies regarding income and age do not apply when determining eligibility for persons under the age of 21.

b. For all persons in this coverage group, income shall be considered as provided for SSI-related coverage groups under subrule 75.13(2). In establishing eligibility for persons aged 21 or older for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2).

c. Eligibility for persons in this group shall not exist until the person has been institutionalized for a period of 30 consecutive days and shall be effective no earlier than the first day of the month in which the 30-day period begins. A "period of 30 days" is defined as being from 12 a.m. of the day of admission to the medical institution, and ending no earlier than 12 midnight of the thirtieth day following the beginning of the period.

(1) A person who enters a medical institution and who dies prior to completion of the 30-day period shall be considered to meet the 30-day period provision.

(2) Only one 30-day period is required to establish eligibility during a continuous stay in a medical institution. Discharge during a subsequent month, creating a partial month of care, does not affect eligibility for that partial month regardless of whether the eligibility determination was completed prior to discharge.

(3) A temporary absence of not more than 14 full consecutive days during which the person remains under the jurisdiction of the institution does not interrupt the 30-day period. In order to remain "under the jurisdiction of the institution" a person must first have been physically admitted to the institution.

75.1(8) *Certain persons essential to the welfare of Title XVI beneficiaries.* Medical assistance will be available to the person living with and essential to the welfare of a Title XIX beneficiary provided the essential person was eligible for medical assistance as of December 31, 1973. The person will continue to be eligible for medical assistance as long as the person continues to meet the definition of "essential person" in effect in the public assistance program on December 31, 1973.

75.1(9) *Individuals receiving state supplemental assistance.* Medical assistance shall be available to all recipients of state supplemental assistance as authorized by Iowa Code chapter 249. Medical assistance shall also be available to the individual's dependent relative as defined in 441—subrule 51.4(4).

75.1(10) *Individuals under age 21 living in a licensed foster care facility or in a private home pursuant to a subsidized adoption arrangement for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for foster care payment for a child pursuant to Iowa Code section 234.35 and rule 441—156.20(234) or has negotiated an agreement to pay an adoption subsidy for a child pursuant to rule 441—201.5(600), medical assistance shall be available to the child if:

a. The child lives in Iowa and is not otherwise eligible under a category for which federal financial participation is available; or

b. The child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act, notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A).

75.1(11) *Individuals living in a court-approved subsidized guardianship home for whom the department has financial responsibility in whole or in part.* When Iowa is responsible for a subsidized guardianship payment for a child pursuant to 441—Chapter 204, medical assistance will be available to the child under this subrule if the child is living in a court-approved subsidized guardianship home and either:

a. The child lives in Iowa and is not eligible for medical assistance under a category for which federal financial participation is available due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements; or

b. Notwithstanding the residency requirements of 441—75.10(249A) and 441—75.53(249A), the child lives in another state and is not eligible for benefits from the other state pursuant to a program funded under Title XIX of the federal Social Security Act due to reasons other than:

(1) Failure to provide information, or

(2) Failure to comply with other procedural requirements.

75.1(12) *Persons ineligible due to October 1, 1972, social security increase.* Medical assistance will be available to individuals and families whose assistance grants were canceled as a result of the increase in social security benefits October 1, 1972, as long as these individuals and families would be eligible for an assistance grant if the increase were not considered.

75.1(13) *Persons who would be eligible for supplemental security income or state supplementary assistance but for social security cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions:

a. They were entitled to and received concurrently in any month after April 1977 supplemental security income and social security or state supplementary assistance and social security, and

b. They subsequently lost eligibility for supplemental security income or state supplementary assistance, and

c. They would be eligible for supplemental security income or state supplementary assistance if all of the social security cost-of-living increases which they and their financially responsible spouses, parents, and dependent children received since they were last eligible for and received social security and supplemental security income (or state supplementary assistance) concurrently were deducted from their income. Spouses, parents, and dependent children are considered financially responsible if their income would be considered in determining the applicant's eligibility.

75.1(14) *Family medical assistance program (FMAP).* Medicaid shall be available to children who meet the provisions of rule 441—75.54(249A) and to the children's specified relatives who meet the provisions of subrule 75.54(2) and rule 441—75.55(249A) if the following criteria are met.

a. In establishing eligibility of specified relatives for this coverage group, resources are considered in accordance with the provisions of rule 441—75.56(249A) and shall not exceed $2,000 for applicant households or $5,000 for member households. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded.

b. Income is considered in accordance with rule 441—75.57(249A) and does not exceed needs standards established in rule 441—75.58(249A).

c. Rescinded IAB 11/1/00, effective 1/1/01.

75.1(15) *Child medical assistance program (CMAP).* Medicaid shall be available to persons under the age of 21 if the following criteria are met:

a. Financial eligibility shall be determined for the family size of which the child is a member using the income standards in effect for the family medical assistance program (FMAP) unless otherwise specified. Income shall be considered as provided in rule 441—75.57(249A). Additionally, the earned income disregards as provided in paragraphs 75.57(2)*"a," "b," "c,"* and *"d"* shall be allowed for those persons whose income is considered in establishing eligibility for the persons under the age of 21 and whose needs must be included in accordance with paragraph 75.58(1)*"a"* but who are not eligible for Medicaid. Resources of all persons in the eligible group, regardless of age, shall be disregarded. Unless a family member is voluntarily excluded in accordance with the provisions of rule 441—75.59(249A), family size shall be determined as follows:

(1) If the person under the age of 21 is pregnant and the pregnancy has been verified in accordance with rule 441—75.17(249A), the unborn child (or children if more than one) is considered a member of the family for purposes of establishing the number of persons in the family.

(2) A "man-in-the-house" who is not married to the mother of the unborn child is not considered a member of the unborn child's family for the purpose of establishing the number of persons in the family. His income and resources are not automatically considered, regardless of whether or not he is the legal or natural father of the unborn child. However, income and resources made available to the mother of the unborn child by the "man-in-the-house" shall be considered in determining eligibility for the pregnant individual.

(3) Unless otherwise specified, when the person under the age of 21 is living with a parent(s), the family size shall consist of all family members as defined by the family medical assistance program in accordance with paragraph 75.57(8)*"c"* and subrule 75.58(1).

Application for Medicaid shall be made by the parent(s) when the person is residing with them. A person shall be considered to be living with the parent(s) when the person is temporarily absent from the parent's(s') home as defined in subrule 75.53(4). If the person under the age of 21 is married or has been married, the needs, income and resources of the person's parent(s) and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person is living with a spouse the family size shall consist of that person, the spouse and any of their children, including any unborn children.

(5) Siblings under the age of 21 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this rule unless one sibling is married or has been married, in which case, the married sibling shall be considered separately unless the marriage was annulled.

(6) When a person is residing in a household in which some members are receiving FMAP under the provisions of subrule 75.1(14) or MAC under the provisions of subrule 75.1(28), and when the person is not included in the FMAP or MAC eligible group, the family size shall consist of the person and all other family members as defined above except those in the FMAP or MAC eligible group.

b. Rescinded IAB 9/6/89, effective 11/1/89.

c. Rescinded IAB 11/1/89, effective 1/1/90.

d. A person is eligible for the entire month in which the person's twenty-first birthday occurs unless the birthday falls on the first day of the month.

e. Living with a specified relative as provided in subrule 75.54(2) shall not be considered when determining eligibility for persons under this coverage group.

75.1(16) *Children receiving subsidized adoption payments from states providing reciprocal medical assistance benefits.* Medical assistance shall be available to children under the age of 21 for whom an adoption assistance agreement with another state is in effect if all of the following conditions are met:

a. The child is residing in Iowa in a private home with the child's adoptive parent or parents.

b. Benefits funded under Title IV-E of the Social Security Act are not being paid for the child by any state.

c. Another state is currently paying an adoption subsidy for the child.

d. The state paying the adoption subsidy:

(1) Is a member of the interstate compact on adoption and medical assistance (ICAMA); and

(2) Provides medical assistance benefits pursuant to a program funded under Title XIX of the Social Security Act, under the optional group at Section 1902(a)(10)(A)(ii)(VIII) of the Act, to children residing in that state (at least until age 18) for whom there is a state adoption assistance agreement in effect with the state of Iowa other than under Title IV-E of the Social Security Act.

75.1(17) *Persons who meet the income and resource requirements of the cash assistance programs.* Medicaid shall be available to the following persons who meet the income and resource guidelines of supplemental security income or refugee cash assistance, but who are not receiving cash assistance:

a. Aged and blind persons, as defined at subrule 75.13(2).

b. Disabled persons, as defined at rule 441—75.20(249A).

In establishing eligibility for children for this coverage group based on eligibility for SSI, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered as provided for SSI-related coverage groups under subrule 75.13(2) or as under refugee cash assistance.

75.1(18) *Persons eligible for waiver services.* Medicaid shall be available to recipients of waiver services as defined in 441—Chapter 83.

75.1(19) *Persons and families terminated from aid to dependent children (ADC) prior to April 1, 1990, due to discontinuance of the $30 or the $30 and one-third earned income disregards.* Rescinded IAB 6/12/91, effective 8/1/91.

75.1(20) *Newborn children of Medicaid-eligible mothers.* Medicaid shall be available without an application to newborn children of women who are determined eligible for Medicaid for the month of the child's birth or for three-day emergency services for labor and delivery for the child's birth. Eligibility begins with the month of the birth and continues through the month of the first birthday as long as the child remains an Iowa resident.

a. The department shall accept any written or verbal statement as verification of the newborn's birth date unless the birth date is questionable.

b. In order for Medicaid to continue after the month of the first birthday, a redetermination of eligibility shall be completed.

75.1(21) *Persons and families ineligible for the family medical assistance program (FMAP) in whole or in part because of child or spousal support.* Medicaid shall be available for an additional four months to persons and families who become ineligible for FMAP because of income from child support, alimony, or contributions from a spouse if the person or family member received FMAP in at least three of the six months immediately preceding the month of cancellation.

a. The four months of extended Medicaid coverage begin the day following termination of FMAP eligibility.

b. When ineligibility is determined to occur retroactively, the extended Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted.

c. Rescinded IAB 10/11/95, effective 10/1/95.

75.1(22) *Refugee spenddown participants.* Rescinded IAB 10/11/95, effective 10/1/95.

75.1(23) *Persons who would be eligible for supplemental security income or state supplementary assistance but for increases in social security benefits because of elimination of the actuarial reduction formula and cost-of-living increases received.* Medical assistance shall be available to all current social security recipients who meet the following conditions. They:

a. Were eligible for a social security benefit in December of 1983.

b. Were eligible for and received a widow's or widower's disability benefit and supplemental security income or state supplementary assistance for January of 1984.

c. Became ineligible for supplemental security income or state supplementary assistance because of an increase in their widow's or widower's benefit which resulted from the elimination of the reduction factor in the first month in which the increase was paid and in which a retroactive payment of that increase for prior months was not made.

d. Have been continuously eligible for a widow's or widower's benefit from the first month the increase was received.

e. Would be eligible for supplemental security income or state supplementary assistance benefits if the amount of the increase from elimination of the reduction factor and any subsequent cost-of-living adjustments were disregarded.

f. Submit an application prior to July 1, 1988, on Form 470-0442, Application for Medical Assistance or State Supplementary Assistance.

75.1(24) *Postpartum eligibility for pregnant women.* Medicaid shall continue to be available, without an application, for 60 days beginning with the last day of pregnancy and throughout the remaining days of the month in which the 60-day period ends, to a woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for Medicaid for the month in which the pregnancy ended.

a. Postpartum Medicaid shall only be available to a woman who is not eligible for another coverage group after the pregnancy ends.

b. The woman shall not be required to meet any income or resource criteria during the postpartum period.

c. When the sixtieth day is not on the last day of the month the woman shall be eligible for Medicaid for the entire month.

75.1(25) *Persons who would be eligible for supplemental security income or state supplementary assistance except that they receive child's social security benefits based on disability.* Medical assistance shall be available to persons who receive supplemental security income (SSI) or state supplementary assistance (SSA) after their eighteenth birthday because of a disability or blindness which began before age 22 and who would continue to receive SSI or SSA except that they become entitled to or receive an increase in social security benefits from a parent's account.

75.1(26) Rescinded IAB 10/8/97, effective 12/1/97.

75.1(27) *Widows and widowers who are no longer eligible for supplemental security income or state supplementary assistance because of the receipt of social security benefits.* Medicaid shall be available to widows and widowers who meet the following conditions:

a. They have applied for and received or were considered recipients of supplemental security income or state supplementary assistance.

b. They apply for and receive Title II widow's or widower's insurance benefits or any other Title II old age or survivor's benefits, if eligible for widow's or widower's benefits.

c. Rescinded IAB 5/1/91, effective 4/11/91.

d. They were not entitled to Part A Medicare hospital insurance benefits at the time of application and receipt of Title II old age or survivor's benefits. They are not currently entitled to Part A Medicare hospital insurance benefits.

e. They are no longer eligible for supplemental security income or state supplementary assistance solely because of the receipt of their social security benefits.

75.1(28) *Pregnant women, infants and children (Mothers and Children (MAC)).* Medicaid shall be available to all pregnant women, infants (under one year of age) and children who have not attained the age of 19 if the following criteria are met:

a. Income.

(1) Family income shall not exceed 300 percent of the federal poverty level for pregnant women and for infants (under one year of age). Family income shall not exceed 133 percent of the federal poverty level for children who have attained one year of age but who have not attained 19 years of age. Income to be considered in determining eligibility for pregnant women, infants, and children shall be determined according to family medical assistance program (FMAP) methodologies except that the three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply. "Family income" is the income remaining after disregards and deductions have been applied as provided in rule 441—75.57(249A).

(2) Moneys received as a lump sum, except as specified in subrules 75.56(4) and 75.56(7) and paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with paragraphs 75.57(9)*"b"* and *"c."*

(3) Unless otherwise specified, when the person under the age of 19 is living with a parent or parents, the family size shall consist of all family members as defined by the family medical assistance program.

Application for Medicaid shall be made by the parents when the person is residing with them. A person shall be considered to be living with the parents when the person is temporarily absent from the parent's home as defined in subrule 75.53(4). If the person under the age of 19 is married or has been married, the needs, income and resources of the person's parents and any siblings in the home shall not be considered in the eligibility determination unless the marriage was annulled.

(4) When a person under the age of 19 is living with a spouse, the family size shall consist of that person, the spouse, and any of their children.

(5) Siblings under the age of 19 who live together shall be considered in the same filing unit for the purpose of establishing eligibility under this subrule unless one sibling is married or has been married, in which case the married sibling shall be considered separately unless the marriage was annulled.

b. For pregnant women, resources shall not exceed $10,000 per household. In establishing eligibility for infants and children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for pregnant women for this coverage group, resources shall be considered in accordance with department of public health 641—subrule 75.4(2).

c. Rescinded IAB 9/6/89, effective 11/1/89.

d. Eligibility for pregnant women under this rule shall begin no earlier than the first day of the month in which conception occurred and in accordance with 441—76.5(249A).

e. The unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household.

f. An infant shall be eligible through the month of the first birthday unless the birthday falls on the first day of the month. A child shall be eligible through the month of the nineteenth birthday unless the birthday falls on the first day of the month.

g. Rescinded IAB 11/1/89, effective 1/1/90.

h. When determining eligibility under this coverage group, living with a specified relative as specified at subrule 75.54(2) and the student provisions specified in subrule 75.54(1) do not apply.

i. A woman who had applied for Medicaid prior to the end of her pregnancy and was subsequently determined eligible for assistance under this coverage group for the month in which her pregnancy ended shall be entitled to receive Medicaid through the postpartum period in accordance with subrule 75.1(24).

j. If an infant loses eligibility under this coverage group at the time of the first birthday due to an inability to meet the income limit for children or if a child loses eligibility at the time of the nineteenth birthday, but the infant or child is receiving inpatient services in a medical institution, Medicaid shall continue under this coverage group for the duration of the time continuous inpatient services are provided.

75.1(29) *Persons who are entitled to hospital insurance benefits under Part A of Medicare (Qualified Medicare Beneficiary program).* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part A and B premiums, coinsurance and deductibles, providing the following conditions are met:

a. The person's monthly income does not exceed the following percentage of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved:

(1) 85 percent effective January 1, 1989.

(2) 90 percent effective January 1, 1990.

(3) 100 percent effective January 1, 1991, and thereafter.

(4) Rescinded IAB 1/9/91, effective 1/1/91.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty line is published.

c. The effective date of eligibility is the first of the month after the month of decision.

75.1(30) *Presumptive eligibility for pregnant women.* A pregnant woman who is determined by a qualified provider to be presumptively eligible for Medicaid, based only on her statements regarding family income, shall be eligible for ambulatory prenatal care. Eligibility shall continue until the last day of the month following the month of the presumptive eligibility determination unless the pregnant woman is determined to be ineligible for Medicaid during this period based on a Medicaid application filed either before the presumptive eligibility determination or during this period. In this case, presumptive eligibility shall end on the date Medicaid ineligibility is determined. A pregnant woman who files a Medicaid application but withdraws that application before eligibility is determined has not been determined ineligible for Medicaid. The pregnant woman shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. The qualified provider shall complete Form 470-2629, Presumptive Medicaid Income Calculation, in order to establish that the pregnant woman's family income is within the prescribed limits of the Medicaid program.

If the pregnant woman files a Medicaid application in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, Medicaid shall continue until a decision of ineligibility is made on the application. Payment of claims for ambulatory prenatal care services provided to a pregnant woman under this subrule is not dependent upon a finding of Medicaid eligibility for the pregnant woman.

a. A qualified provider is defined as a provider who is eligible for payment under the Medicaid program and who meets all of the following criteria:

(1) Provides one or more of the following services:

1. Outpatient hospital services.

2. Rural health clinic services (if contained in the state plan).

3. Clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

(2) Has been specifically designated by the department in writing as a qualified provider for the purposes of determining presumptive eligibility on the basis of the department's determination that the provider is capable of making a presumptive eligibility determination based on family income.

(3) Meets one of the following:

1. Receives funds under the Migrant Health Centers or Community Health Centers (subsection 329 or subsection 330 of the Public Health Service Act) or the Maternal and Child Health Services Block Grant Programs (Title V of the Social Security Act) or the Health Services for Urban Indians Program (Title V of the Indian Health Care Improvement Act).

2. Participates in the program established under the Special Supplemental Food Program for Women, Infants, and Children (subsection 17 of the Child Nutrition Act of 1966) or the Commodity Supplemental Food Program (subsection 4(a) of the Agriculture and Consumer Protection Act of 1973).

3. Participates in a state perinatal program.

4. Is an Indian health service office or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.

b. The provider shall complete Form 470-2579, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations, and submit it to the department for approval in order to become certified as a provider qualified to make presumptive eligibility determinations. Once the provider has been approved as a provider qualified to make presumptive Medicaid eligibility determinations, Form 470-2582, Memorandum of Understanding Between the Iowa Department of Human Services and a Qualified Provider, shall be signed by the provider and the department.

c. Once the qualified provider has made a presumptive eligibility determination for a pregnant woman, the provider shall:

(1) Contact the department to obtain a state identification number for the pregnant woman who has been determined presumptively eligible.

(2) Notify the department in writing of the determination within five working days after the date the presumptive determination is made. A copy of the Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580 or 470-2580(S), shall be used for this purpose.

(3) Inform the pregnant woman in writing, at the time the determination is made, that if she chose not to apply for Medicaid on the Health Services Application, Form 470-2927 or 470-2927(S), she has until the last day of the month following the month of the preliminary determination to file an application with the department. A Presumptive Medicaid Eligibility Notice of Decision, Form 470-2580, shall be issued by the qualified provider for this purpose.

(4) Forward copies of the Health Services Application, Form 470-2927 or 470-2927(S), to the appropriate offices for eligibility determinations if the pregnant woman indicated on the application that she was applying for any of the other programs listed on the application. These copies shall be forwarded within two working days from the date of the presumptive determination.

d. In the event that a pregnant woman needing prenatal care does not appear to be presumptively eligible, the qualified provider shall inform the pregnant woman that she may file an application at the local department office if she wishes to have a formal determination made.

e. Presumptive eligibility shall end under any of the following conditions:

(1) The woman fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

(2) The woman files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and has been found ineligible for Medicaid.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

f. The adequate and timely notice requirements and appeal rights associated with an application that is filed pursuant to rule 441—76.1(249A) shall apply to an eligibility determination made on the Medicaid application. However, notice requirements and appeal rights of the Medicaid program shall not apply to a woman who is:

(1) Issued a presumptive eligibility decision by a qualified provider.

(2) Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the woman fails to file an application by the last day of the month following the month of the initial presumptive eligibility determination.

(3) Rescinded IAB 5/1/91, effective 7/1/91.

g. A woman shall not be determined to be presumptively eligible for Medicaid more than once per pregnancy.

75.1(31) *Persons and families canceled from the family medical assistance program (FMAP) due to the increased earnings of the specified relative in the eligible group.* Medicaid shall be available for a period of up to 12 additional months to families who are canceled from FMAP as provided in subrule 75.1(14) because the specified relative of a dependent child receives increased income from employment.

For the purposes of this subrule, "family" shall mean individuals living in the household whose needs and income were included in determining the FMAP eligibility of the household members at the time that the FMAP benefits were terminated. "Family" also includes those individuals whose needs and income would be taken into account in determining the FMAP eligibility of household members if the household were applying in the current month.

a. Increased income from employment includes:

(1) Beginning employment.

(2) Increased rate of pay.

(3) Increased hours of employment.

b. In order to receive transitional Medicaid coverage under these provisions, an FMAP family must have received FMAP during at least three of the six months immediately preceding the month in which ineligibility occurred.

c. The 12 months' Medicaid transitional coverage begins the day following termination of FMAP eligibility.

d. When ineligibility is determined to occur retroactively, the transitional Medicaid coverage begins with the first month in which FMAP eligibility was erroneously granted, unless the provisions of paragraph *"f"* below apply.

e. Rescinded IAB 8/12/98, effective 10/1/98.

f. Transitional Medicaid shall not be allowed under these provisions when it has been determined that the member received FMAP in any of the six months immediately preceding the month of cancellation as the result of fraud. Fraud shall be defined in accordance with Iowa Code Supplement section 239B.14.

g. During the transitional Medicaid period, assistance shall be terminated at the end of the first month in which the eligible group ceases to include a child, as defined by the family medical assistance program.

h. If the family receives transitional Medicaid coverage during the entire initial six-month period and the department has received, by the twenty-first day of the fourth month, a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), Medicaid shall continue for an additional six months, subject to paragraphs *"g"* and *"i"* of this subrule.

(1) If the department does not receive a completed form by the twenty-first day of the fourth month, assistance shall be canceled.

(2) A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

i. Medicaid shall end at the close of the first or fourth month of the additional six-month period if any of the following conditions exists:

(1) The department does not receive a complete Notice of Decision/Quarterly Income Report, Form 470-2663 or 470-2663(S), by the twenty-first day of the first month or the fourth month of the additional six-month period as required in paragraph 75.1(31)*"h,"* unless the family establishes good cause for failure to report on a timely basis. Good cause shall be established when the family demonstrates that one or more of the following conditions exist:

1. There was a serious illness or death of someone in the family.

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

3. The family offers a good cause beyond the family's control.

4. There was a failure to receive the department's notification for a reason not attributable to the family. Lack of a forwarding address is attributable to the family.

(2) The specified relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to an involuntary loss of employment, illness, or there were instances when problems could negatively impact the client's achievement of self-sufficiency as described at 441—subrule 93.133(4).

(3) It is determined that the family's average gross earned income, minus child care expenses for the children in the eligible group necessary for the employment of the specified relative, during the immediately preceding three-month period exceeds 185 percent of the federal poverty level as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

j. These provisions apply to specified relatives defined at paragraph 75.55(1)*"a,"* including:

(1) Any parent who is in the home. This includes parents who are included in the eligible group as well as those who are not.

(2) A stepparent who is included in the eligible group and who has assumed the role of the caretaker relative due to the absence or incapacity of the parent.

(3) A needy specified relative who is included in the eligible group.

k. The timely notice requirements as provided in 441—subrule 76.4(1) shall not apply when it is determined that the family failed to meet the eligibility criteria specified in paragraph *"g"* or *"i"* above. Transitional Medicaid shall be terminated beginning with the first month following the month in which the family no longer met the eligibility criteria. An adequate notice shall be provided to the family when any adverse action is taken.

75.1(32) *Persons and families terminated from refugee cash assistance (RCA) because of income earned from employment.* Refugee medical assistance (RMA) shall be available as long as the eight-month limit for the refugee program is not exceeded to persons who are receiving RMA and who are canceled from the RCA program solely because a member of the eligible group receives income from employment.

a. An RCA recipient shall not be required to meet any minimum program participation time frames in order to receive RMA coverage under these provisions.

b. A person who returns to the home after the family became ineligible for RCA may be included in the eligible group for RMA coverage if the person was included on the assistance grant the month the family became ineligible for RCA.

75.1(33) *Qualified disabled and working persons.* Medicaid shall be available to cover the cost of the premium for Part A of Medicare (hospital insurance benefits) for qualified disabled and working persons.

a. Qualified disabled and working persons are persons who meet the following requirements:

(1) The person's monthly income does not exceed 200 percent of the federal poverty level applicable to the family size involved.

(2) The person's resources do not exceed twice the maximum amount allowed under the supplemental security income (SSI) program.

(3) The person is not eligible for any other Medicaid benefits.

(4) The person is entitled to enroll in Medicare Part A of Title XVIII under Section 1818A of the Social Security Act (as added by Section 6012 of OBRA 1989).

b. The amount of the person's income and resources shall be determined as under the SSI program.

75.1(34) *Specified low-income Medicare beneficiaries.* Medicaid shall be available to persons who are entitled to hospital insurance under Part A of Medicare to cover the cost of the Medicare Part B premium, provided the following conditions are met:

a. The person's monthly income exceeds 100 percent of the federal poverty level but is less than the following percentage of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved:

(1) 110 percent effective January 1, 1993.

(2) 120 percent effective January 1, 1995, and thereafter.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

c. The amount of income and resources shall be determined as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(35) *Medically needy persons.*

a. Coverage groups. Subject to other requirements of this chapter, Medicaid shall be available to the following persons:

(1) Pregnant women. Pregnant women who would be eligible for FMAP-related coverage groups except for excess income or resources. For FMAP-related programs, pregnant women shall have the unborn child or children counted in the household size as if the child or children were born and living with them.

(2) FMAP-related persons under the age of 19. Persons under the age of 19 who would be eligible for an FMAP-related coverage group except for excess income.

(3) CMAP-related persons under the age of 21. Persons under the age of 21 who would be eligible in accordance with subrule 75.1(15) except for excess income.

(4) SSI-related persons. Persons who would be eligible for SSI except for excess income or resources.

(5) FMAP-specified relatives. Persons whose income or resources exceed the family medical assistance program's limit and who are a specified relative as defined at subrule 75.55(1) living with a child who is determined dependent.

b. Resources and income of all persons considered.

(1) Resources of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)*"b"*(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility of adults. Resources of all specified relatives and of all potentially eligible individuals living together shall be disregarded in determining eligibility of children. Income of all specified relatives and of all potentially eligible individuals living together, except as specified at subparagraph 75.1(35)*"b"*(2) or who are excluded in accordance with the provisions of rule 441—75.59(249A), shall be considered in determining eligibility.

(2) The amount of income of the responsible relative that has been counted as available to an FMAP household or SSI individual shall not be considered in determining the countable income for the medically needy eligible group.

(3) The resource determination shall be according to subrules 75.5(3) and 75.5(4) when one spouse is expected to reside at least 30 consecutive days in a medical institution.

c. Resources.

(1) The resource limit for adults in SSI-related households shall be $10,000 per household.

(2) Disposal of resources for less than fair market value by SSI-related applicants or members shall be treated according to policies specified in rule 441—75.23(249A).

(3) The resource limit for FMAP- or CMAP-related adults shall be $10,000 per household. In establishing eligibility for children for this coverage group, resources of all persons in the eligible group, regardless of age, shall be disregarded. In establishing eligibility for adults for this coverage group, resources shall be considered according to department of public health 641—subrule 75.4(2).

(4) The resources of SSI-related persons shall be treated according to SSI policies.

(5) When a resource is jointly owned by SSI-related persons and FMAP-related persons, the resource shall be treated according to SSI policies for the SSI-related person and according to FMAP policies for the FMAP-related persons.

d. Income. All unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted shall be considered in determining initial and continuing eligibility.

(1) Income policies specified in subrules 75.57(1) through 75.57(8) and paragraphs 75.57(9)*"b," "c," "g," "h,"* and *"i"* regarding treatment of earned and unearned income are applied to FMAP-related and CMAP-related persons when determining initial eligibility and for determining continuing eligibility unless otherwise specified. The three-step process for determining initial eligibility and the two-step process for determining ongoing eligibility, as described at rule 441—75.57(249A), shall not apply to medically needy persons.

(2) Income policies as specified in federal SSI regulations regarding treatment of earned and unearned income are applied to SSI-related persons when determining initial and continuing eligibility.

(3) The monthly income shall be determined prospectively unless actual income is available.

(4) The income for the certification period shall be determined by adding both months' net income together to arrive at a total.

(5) The income for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

e. Medically needy income level (MNIL).

(1) The MNIL is based on 133 1/3 percent of the schedule of basic needs, as provided in subrule 75.58(2), with households of one treated as households of two, as follows:

Number of Persons	1	2	3	4	5	6	7	8	9	10
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158

Each additional person $116

(2) When determining household size for the MNIL, all potential eligibles and all individuals whose income is considered as specified in paragraph 75.1(35)*"b"* shall be included unless the person has been excluded according to the provisions of rule 441—75.59(249A).

(3) The MNIL for the certification period shall be determined by adding both months' MNIL to arrive at a total.

The MNIL for the retroactive certification period shall be determined by adding each month of the retroactive period to arrive at a total.

(4) The total net countable income for the certification period shall be compared to the total MNIL for the certification period based on family size as specified in subparagraph (2).

If the total countable net income is equal to or less than the total MNIL, the medically needy individuals shall be eligible for Medicaid.

If the total countable net income exceeds the total MNIL, the medically needy individuals shall not be eligible for Medicaid unless incurred medical expenses equal or exceed the difference between the net income and the MNIL.

(5) Effective date of approval. Eligibility during the certification period or the retroactive certification period shall be effective as of the first day of the first month of the certification period or the retroactive certification period when the medically needy income level (MNIL) is met.

f. Verification of medical expenses to be used in spenddown calculation. The applicant or member shall submit evidence of medical expenses that are for noncovered Medicaid services and for covered services incurred prior to the certification period to the department on a claim form, which shall be completed by the medical provider. In cases where the provider is uncooperative or where returning to the provider would constitute an unreasonable requirement on the applicant or member, the form shall be completed by the worker. Verification of medical expenses for the applicant or member that are covered Medicaid services and occurred during the certification period shall be submitted by the provider to the Iowa Medicaid enterprise on a claim form. The applicant or member shall inform the provider of the applicant's or member's spenddown obligation at the time services are rendered or at the time the applicant or member receives notification of a spenddown obligation. Verification of allowable expenses incurred for transportation to receive medical care as specified in rule 441—78.13(249A) shall be verified on Form 470-0394, Medical Transportation Claim.

Applicants who have not established that they met spenddown in the current certification period shall be allowed 12 months following the end of the certification period to submit medical expenses for that period or 12 months following the date of the notice of decision when the certification period had ended prior to the notice of decision.

g. Spenddown calculation.

(1) Medical expenses that are incurred during the certification period may be used to meet spenddown. Medical expenses incurred prior to a certification period shall be used to meet spenddown if not already used to meet spenddown in a previous certification period and if all of the following requirements are met. The expenses:

1. Remain unpaid as of the first day of the certification period.

2. Are not Medicaid-payable in a previous certification period or the retroactive certification period.

3. Are not incurred during any prior certification period with the exception of the retroactive period in which the person was conditionally eligible but did not meet spenddown.

Notwithstanding numbered paragraphs "1" through "3" above, paid medical expenses from the retroactive period can be used to meet spenddown in the retroactive period or in the certification period for the two months immediately following the retroactive period.

(2) Order of deduction. Spenddown shall be adjusted when a bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a bill for a covered service incurred prior to the certification period is subsequently received. Spenddown shall also be adjusted when a bill for a noncovered Medicaid service is subsequently received with a service date prior to the Medicaid-covered service. Spenddown shall be adjusted when an unpaid bill for a Medicaid-covered service incurred during the certification period has been applied to meet spenddown if a paid bill for a covered service incurred in the certification period is subsequently received with a service date prior to the date of the notice of spenddown status.

If spenddown has been met and a bill is received with a service date after spenddown has been met, the bill shall not be deducted to meet spenddown.

Incurred medical expenses, including those reimbursed by a state or political subdivision program other than Medicaid, but excluding those otherwise subject to payment by a third party, shall be deducted in the following order:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges.

EXCEPTION: When some of the household members are eligible for full Medicaid benefits under the Health Insurance Premium Payment Program (HIPP), as provided in rule 441—75.21(249A), the health insurance premium shall not be allowed as a deduction to meet the spenddown obligation of those persons in the household in the medically needy coverage group.

2. An average statewide monthly standard deduction for the cost of medically necessary personal care services provided in a licensed residential care facility shall be allowed as a deduction for spenddown. These personal care services include assistance with activities of daily living such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication.

The average statewide monthly standard deduction for personal care services shall be based on the average per day rate of health care costs associated with residential care facilities participating in the state supplementary assistance program for a 30.4-day month as computed in the Compilation of Various Costs and Statistical Data (Category: All; Type of Care: Residential Care Facility; Location: All; Type of Control: All). The average statewide standard deduction for personal care services used in the medically needy program shall be updated and effective the first day of the first month beginning two full months after the release of the Compilation of Various Costs and Statistical Data for the previous fiscal year.

3. Medical expenses for necessary medical and remedial services that are recognized under state law but not covered by Medicaid, chronologically by date of submission.

4. Medical expenses for acupuncture, chronologically by date of submission.

5. Medical expenses for necessary medical and remedial services that are covered by Medicaid, chronologically by date of submission.

(3) When incurred medical expenses have reduced income to the applicable MNIL, the individuals shall be eligible for Medicaid.

(4) Medical expenses reimbursed by a public program other than Medicaid prior to the certification period shall not be considered a medical deduction.

h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

i. Reviews. Reviews of eligibility shall be made for SSI-related, CMAP-related, and FMAP-related medically needy members with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related, CMAP-related, and FMAP-related medically needy persons shall complete Form 470-3118 or 470-3118(S), Medicaid Review, as part of the review process when requested to do so by the department.

j. Redetermination. When an SSI-related, CMAP-related, or FMAP-related member who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the member's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Health Services Application, Form 470-2927 or 470-2927(S), or the Health and Financial Support Application, Form 470-0462 or Form 470-0466(Spanish), shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on redeterminations of eligibility.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medicaid Review, Form 470-3118 or 470-3118(S), to be recertified.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, the applicant or the applicant's authorized representative shall complete, sign and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

1. Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or
2. Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations

of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in subparagraph (2).

75.1(36) *Expanded specified low-income Medicare beneficiaries.* As long as 100 percent federal funding is available under the federal Qualified Individuals (QI) Program, Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person is not otherwise eligible for Medicaid.

b. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

c. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

d. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) *Home health specified low-income Medicare beneficiaries.* Rescinded IAB 10/30/02, effective 1/1/03.

75.1(38) *Continued Medicaid for disabled children from August 22, 1996.* Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

75.1(39) *Working persons with disabilities.*

a. Medical assistance shall be available to all persons who meet all of the following conditions:

(1) They are disabled as determined pursuant to rule 441—75.20(249A), except that being engaged in substantial gainful activity will not preclude a determination of disability.

(2) They are less than 65 years of age.

(3) They are members of families (including families of one) whose income is less than 250 percent of the most recently revised official federal poverty level for the family. Family income shall include gross income of all family members, less supplemental security income program disregards, exemptions, and exclusions, including the earned income disregards.

(4) They receive earned income from employment or self-employment or are eligible under paragraph *"c."*

(5) They would be eligible for medical assistance under another coverage group set out in this rule (other than the medically needy coverage groups at subrule 75.1(35)), disregarding all income, up to $10,000 of available resources, and any additional resources held by the disabled individual in a retirement account, a medical savings account, or an assistive technology account. For this purpose, disability shall be determined as under subparagraph (1) above.

(6) They have paid any premium assessed under paragraph *"b"* below.

b. Eligibility for a person whose gross income is greater than 150 percent of the federal poverty level for an individual is conditional upon payment of a premium. Gross income includes all earned and unearned income of the conditionally eligible person. A monthly premium shall be assessed at the time of application and at the annual review. The premium amounts and the federal poverty level increments above 150 percent of the federal poverty level used to assess premiums will be adjusted annually on August 1.

(1) Beginning with the month of application, the monthly premium amount shall be established for a 12-month period based on projected average monthly income for the 12-month period. The monthly premium established shall not be increased for any reason during the 12-month period. The premium

shall not be reduced due to a change in the federal poverty level but may be reduced or eliminated prospectively during the 12-month period if a reduction in projected average monthly income is verified.

(2) Eligible persons are required to complete and return Form 470-3118 or 470-3118(S), Medicaid Review, with income information during the twelfth month of the annual enrollment period to determine the premium to be assessed for the next 12-month enrollment period.

(3) Premiums shall be assessed as follows:

IF THE INCOME OF THE APPLICANT IS ABOVE:	THE MONTHLY PREMIUM IS:
150% of Federal Poverty Level	$25
180% of Federal Poverty Level	$40
220% of Federal Poverty Level	$55
250% of Federal Poverty Level	$70
280% of Federal Poverty Level	$85
310% of Federal Poverty Level	$100
340% of Federal Poverty Level	$120
370% of Federal Poverty Level	$140
400% of Federal Poverty Level	$165
430% of Federal Poverty Level	$190
460% of Federal Poverty Level	$220
490% of Federal Poverty Level	$255
530% of Federal Poverty Level	$295
575% of Federal Poverty Level	$340
620% of Federal Poverty Level	$390
670% of Federal Poverty Level	$452

(4) Eligibility is contingent upon the payment of any assessed premiums. Medical assistance eligibility shall not be made effective for a month until the premium assessed for the month is paid. The premium must be paid within three months of the month of coverage or of the month of initial billing, whichever is later, for the person to be eligible for the month.

(5) When the department notifies the applicant of the amount of the premiums, the applicant shall pay any premiums due as follows:

1. The premium for each month is due the fourteenth day of the month the premium is to cover. EXCEPTIONS: The premium for the month of initial billing is due the fourteenth day of the following month; premiums for any months prior to the month of initial billing are due on the fourteenth day of the third month following the month of billing.

2. If the fourteenth day falls on a weekend or a state holiday, payment is due the first working day following the holiday or weekend.

3. When any premium payment due in the month it is to cover is not received by the due date, Medicaid eligibility shall be canceled.

(6) Payments received shall be applied in the following order:

1. To the month in which the payment is received if the premium for the current calendar month is unpaid.

2. To the following month when the payment is received after a billing statement has been issued for the following month.

3. To prior months when a full payment has not been received. Payments shall be applied beginning with the most recent unpaid month before the current calendar month, then the oldest unpaid prior month and forward until all prior months have been paid.

4. When premiums for all months above have been paid, any excess shall be held and applied to any months for which eligibility is subsequently established, as specified in numbered paragraphs "1," "2," and "3" above, and then to future months when a premium becomes due.

5. Any excess on an inactive account shall be refunded to the client after two calendar months of inactivity or of a zero premium or upon request from the client.

(7) An individual's case may be reopened when Medicaid eligibility is canceled for nonpayment of premium. However, the premium must be paid in full within the calendar month following the month the payment was due for reopening.

(8) Premiums may be submitted in the form of cash, money orders, or personal checks to the department at the following address: Department of Human Services, Supply Unit A-Level, Room 77, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319.

(9) Once an individual is canceled from Medicaid due to nonpayment of premiums, the individual must reapply to establish Medicaid eligibility unless the reopening provisions of this subrule apply.

(10) When a premium due in the month it is to cover is not received by the due date, a notice of decision will be issued to cancel Medicaid. The notice will include reopening provisions that apply if payment is received and appeal rights.

(11) Form 470-3694, Billing Statement, shall be used for billing and collection.

c. Persons receiving assistance under this coverage group who become unable to work due to a change in their medical condition or who lose employment shall remain eligible for a period of six months from the month of the change in their medical condition or loss of employment as long as they intend to return to work and continue to meet all other eligibility criteria under this subrule.

d. For purposes of this subrule, the following definitions apply:

"Assistive technology" is the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with disabilities in areas that include education, rehabilitation, technology devices and assistive technology services.

"Assistive technology accounts" include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology devices or assistive technology services. Assistive technology accounts must be held separate from other accounts and funds and must be used to purchase, lease or otherwise acquire assistive technology, assistive technology services or assistive technology devices for the working person with a disability when a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist has established the medical necessity of the device, technology, or service and determined the technology, device, or service can reasonably be expected to enhance the individual's employment.

"Assistive technology device" is any item, piece of equipment, product system or component part, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities or address or eliminate architectural, communication, or other barriers confronted by persons with disabilities.

"Assistive technology service" means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

"Family," if the individual is under 18 and unmarried, includes parents living with the individual, siblings under 18 and unmarried living with the individual, and children of the individual who live with the individual. If the individual is 18 years of age or older, or married, "family" includes the individual's spouse living with the individual and any children living with the individual who are under 18 and unmarried. No other persons shall be considered members of an individual's family. An individual living alone or with others not listed above shall be considered to be a family of one.

"Medical savings account" means an account exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220).

"Retirement account" means any retirement or pension fund or account, listed in Iowa Code section 627.6(8)*"f"* as exempt from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account.

75.1(40) *People who have been screened and found to need treatment for breast or cervical cancer.*

a. Medical assistance shall be available to people who:

(1) Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act and have been found to need treatment for either breast or cervical cancer (including a precancerous condition);

(2) Do not otherwise have creditable coverage, as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. Section 300gg(c)(1)), and are not eligible for medical assistance under Iowa Code section 249A.3(1); and

(3) Are under the age of 65.

b. Eligibility established under paragraph *"a"* continues until the person is:

(1) No longer receiving treatment for breast or cervical cancer;

(2) No longer under the age of 65; or

(3) Covered by creditable coverage or eligible for medical assistance under Iowa Code section 249A.3(1).

c. Presumptive eligibility. A person who has been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, who has been found to need treatment for either breast or cervical cancer (including a precancerous condition), and who is determined by a qualified provider to be presumptively eligible for medical assistance under paragraph *"a"* shall be eligible for medical assistance until the last day of the month following the month of the presumptive eligibility determination if no Medicaid application is filed in accordance with rule 441—76.1(249A) by that day or until the date of a decision on a Medicaid application filed in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination, whichever is earlier.

The person shall complete Form 470-2927 or 470-2927(S), Health Services Application, in order for the qualified provider to make the presumptive eligibility determination. Presumptive eligibility shall begin no earlier than the date the qualified Medicaid provider determines eligibility.

Payment of claims for services provided to a person under this paragraph is not dependent upon a finding of Medicaid eligibility for the person.

(1) A provider who is qualified to determine presumptive eligibility is defined as a provider who:

1. Is eligible for payment under the Medicaid program; and

2. Either:

- Has been named lead agency for a county or regional local breast and cervical cancer early detection program under a contract with the department of public health; or
- Has a cooperative agreement with the department of public health under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act to receive reimbursement for providing breast or cervical cancer screening or diagnostic services to participants in the Care for Yourself Breast and Cervical Cancer Early Detection Program; and

3. Has made application and has been specifically designated by the department in writing as a qualified provider for the purpose of determining presumptive eligibility under this rule.

(2) The provider shall complete Form 470-3864, Application for Authorization to Make Presumptive Medicaid Eligibility Determinations (BCCT), and submit it to the department for approval in order to be designated as a provider qualified to make presumptive eligibility determinations. Once the department has approved the provider's application, the provider and the department shall sign Form 470-3865, Memorandum of Understanding with a Qualified Provider for People with Breast or Cervical Cancer Treatment. When both parties have signed the memorandum, the department shall designate the provider as a qualified provider and notify the provider.

(3) When a qualified provider has made a presumptive eligibility determination for a person, the provider shall:

1. Contact the department to obtain a state identification number for the person who has been determined presumptively eligible.

2. Notify the department in writing of the determination within five working days after the date the presumptive eligibility determination is made. The provider shall use a copy of Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

3. Inform the person in writing, at the time the determination is made, that if the person has not applied for Medicaid on Form 470-2927 or 470-2927(S), Health Services Application, the person has until the last day of the month following the month of the preliminary determination to file the application with the department. The qualified provider shall use Form 470-2580 or 470-2580(S), Presumptive Medicaid Eligibility Notice of Decision, for this purpose.

4. Forward copies of Form 470-2927 or 470-2927(S), Health Services Application, to the appropriate department office for eligibility determination if the person indicated on the application that the person was applying for any of the other programs. The provider shall forward these copies and proof of screening for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program within two working days from the date of the presumptive eligibility determination.

(4) In the event that a person needing care does not appear to be presumptively eligible, the qualified provider shall inform the person that the person may file an application at the county department office if the person wishes to have an eligibility determination made by the department.

(5) Presumptive eligibility shall end under either of the following conditions:

1. The person fails to file an application for Medicaid in accordance with rule 441—76.1(249A) by the last day of the month following the month of the presumptive eligibility determination.

2. The person files a Medicaid application by the last day of the month following the month of the presumptive eligibility determination and is found ineligible for Medicaid.

(6) Adequate and timely notice requirements and appeal rights shall apply to an eligibility determination made on a Medicaid application filed pursuant to rule 441—76.1(249A). However, notice requirements and appeal rights of the Medicaid program shall not apply to a person who is:

1. Denied presumptive eligibility by a qualified provider.

2. Determined to be presumptively eligible by a qualified provider and whose presumptive eligibility ends because the person fails to file an application by the last day of the month following the month of the presumptive eligibility determination.

(7) A new period of presumptive eligibility shall begin each time a person is screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act, is found to need treatment for breast or cervical cancer, and files Form 470-2927 or 470-2927(S), Health Services Application, with a qualified provider.

75.1(41) *Women eligible for family planning services under demonstration waiver.* Medical assistance for family planning services only shall be available to women as provided in this subrule.

a. Eligibility. The following are eligible for assistance under this coverage group:

(1) Women who were Medicaid members when their pregnancy ended and who are capable of bearing children but are not pregnant. Eligibility for these women extends for 12 consecutive months after the month when their 60-day postpartum period ends.

(2) Women who are of childbearing age, are capable of bearing children but are not pregnant, and have income that does not exceed 200 percent of the federal poverty level, as determined according to paragraph 75.1(41)*"c."*

b. Application.

(1) Women eligible under subparagraph 75.1(41)*"a"*(1) are not required to file an application for assistance under this coverage group. The department will automatically redetermine eligibility pursuant to rule 441—76.11(249A) upon loss of other Medicaid eligibility within 12 months after the month when the 60-day postpartum period ends.

(2) Women requesting assistance based on subparagraph 75.1(41)*"a"*(2) shall file an application as required in rule 441—76.1(249A).

c. Determining income eligibility. The department shall determine the countable income of a woman applying under subparagraph 75.1(41)*"a"*(2) as follows:

(1) Household size. The household size shall include the applicant or member, any dependent children as defined in 441—subrule 75.54(1) living in the same home as the applicant or member, and any spouse living in the same home as the applicant or member, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act.

(2) Earned income. All earned income as defined in 441—subrule 75.57(2) that is received by a member of the household shall be counted except for the earnings of a child who is a full-time student as defined in 441—paragraph 75.54(1)*"b."*

(3) Unearned income. The following unearned income of all household members shall be counted:

1. Unemployment compensation.
2. Child support.
3. Alimony.
4. Social security and railroad retirement benefits.
5. Worker's compensation and disability payments.
6. Benefits paid by the Department of Veterans Affairs to disabled members of the armed forces or survivors of deceased veterans.

(4) Deductions. Deductions from income shall be made for any payments made by household members for court-ordered child support, alimony, or spousal support to non-household members and as provided in 441—subrule 75.57(2).

(5) Disregard of changes. A woman found to be income-eligible upon application or annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

d. Effective date. Assistance for family planning services under this coverage group shall be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later. Notwithstanding 441—subrule 76.5(1), assistance shall not be available under this coverage group for any months preceding the month of application.

75.1(42) *Medicaid for independent young adults.* Medical assistance shall be available, as assistance related to the family medical assistance program, to a person who left a foster care placement on or after May 1, 2006, and meets all of the following conditions:

a. The person is at least 18 years of age and under 21 years of age.

b. On the person's eighteenth birthday, the person resided in foster care and Iowa was responsible for the foster care payment pursuant to Iowa Code section 234.35.

c. The person is not a mandatory household member or receiving Medicaid benefits under another coverage group.

d. The person has income below 200 percent of the most recently revised federal poverty level for the person's household size.

(1) "Household" shall mean the person and any of the following people who are living with the person and are not active on another Medicaid case:

1. The person's own children;
2. The person's spouse; and
3. Any children of the person's spouse who are under the age of 18 and unmarried.

No one else shall be considered a member of the person's household. A person who lives alone or with others not listed above, including the person's parents, shall be considered a household of one.

(2) The department shall determine the household's countable income pursuant to rule 75.57(249A). Twenty percent of earned income shall be disregarded.

(3) A person found to be income-eligible upon application or upon annual redetermination of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

75.1(43) *Medicaid for children with disabilities.* Medical assistance shall be available to children who meet all of the following conditions on or after January 1, 2009:

a. The child is under 19 years of age.

b. The child is disabled as determined pursuant to rule 441—75.20(249A) based on the disability standards for children used for Supplemental Security Income (SSI) benefits under Title XVI of the Social Security Act, but without regard to any income or asset eligibility requirements of the SSI program.

c. The child is enrolled in any group health plan available through the employer of a parent living in the same household as the child if the employer contributes at least 50 percent of the total cost of annual premiums for that coverage. The parent shall enroll the child and pay any employee premium required to maintain coverage for the child.

d. The child's household has income at or below 300 percent of the federal poverty level applicable to a family of that size.

(1) For this purpose, the child's household shall include any of the following persons who are living with the child and are not receiving Medicaid on another case:

1. The child's parents.
2. The child's siblings under the age of 19.
3. The child's spouse.
4. The child's children.
5. The children of the child's spouse.

(2) Only those persons identified in subparagraph (1) shall be considered a member of the child's household. A person who receives medically needy coverage with a spenddown or limited benefits such as Medicare savings programs or family planning services only is not considered to be "receiving Medicaid" for the purposes of subparagraph (1). A child who lives alone or with persons not identified in subparagraph (1) shall be considered as having a household of one.

(3) For this purpose, income shall include all earned and unearned income as defined for purposes of the Supplemental Security Income program by 20 CFR Sections 416.1102, 416.1103, 416.1110, 416.1111, and 416.1120 to 416.1123 as amended to August 20, 2008, without regard to exclusions or deductions from income applied in determining eligibility for Supplemental Security Income.

(4) The federal poverty levels used to determine eligibility shall be revised annually on April 1.

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7833B**, IAB 6/3/09, effective 8/1/09; **ARC 7929B**, IAB 7/1/09, effective 7/1/09; **ARC 7931B**, IAB 7/1/09, effective 7/1/09]

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare), and other resources for meeting the cost of medical care which may be available to the member. These resources must be used when reasonably available.

75.2(1) The department shall approve payment only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable.

a. Persons who have been approved by the Social Security Administration for supplemental security income shall complete Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information, and return it to the department.

b. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form 470-2304, 470-2304(S), 470-0364, or 470-0364(S), SSI Medicaid Information.

75.2(2) As a condition of eligibility for medical assistance, a person who has the legal capacity to execute an assignment shall do all of the following:

a. Assign to the department any rights to payments of medical care from any third party to the extent that payment has been made under the medical assistance program. The applicant's signature on any form listed in 441—subrule 76.1(1) shall constitute agreement to the assignment. The assignment shall be effective for the entire period for which medical assistance is paid.

b. Cooperate with the department in obtaining third-party payments. The member or one acting on the member's behalf shall:

(1) File a claim or submit an application for any reasonably available medical resource, and

(2) Cooperate in the processing of the claim or application.

c. Cooperate with the department in identifying and providing information to assist the department in pursuing any third party who may be liable to pay for medical care and services available under the medical assistance program.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the member, or one acting on behalf of a minor, or of a legally incompetent adult member, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the member for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult member, for whom medical resources are being sought.

75.2(4) Failure to cooperate as required in subrule 75.2(2) without good cause as defined in subrule 75.2(3) shall result in the termination of medical assistance benefits. The department shall make the determination of good cause based on information and evidence provided by the member or by one acting on the member's behalf.

a. The medical assistance benefits of a minor or a legally incompetent adult member shall not be terminated for failure to cooperate in reporting medical resources.

b. When a parent or payee acting on behalf of a minor or legally incompetent adult member fails to file a claim or application for reasonably available medical resources or fails to cooperate in the processing of a claim or application without good cause, the medical assistance benefits of the parent or payee shall be terminated.

75.2(5) When the department receives information through a cross-match with Iowa workforce development department and child support recovery files which indicates the absent parent of a Medicaid-eligible child is employed, the department shall send Form 470-0413, Obligor Insurance Questionnaire, to the absent parent in order to obtain health insurance coverage information. If the absent parent does not respond within 15 days from the date Form 470-0413 is sent, the department shall send Form 470-2240, Employer Insurance Questionnaire, to the employer in order to obtain the health insurance coverage information.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

[**ARC 7546B**, IAB 2/11/09, effective 4/1/09]

441—75.3(249A) Acceptance of other financial benefits. An applicant or member shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or member may qualify, unless the applicant or member can show an incapacity to do so. Sources of benefits may be, but are not limited to, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or member may be entitled to other cash benefits, the department shall send a Notice Regarding Acceptance of Other Benefits, Form 470-0383, to the applicant or member.

75.3(2) The SSI-related applicant or member must express an intent to apply or refuse to apply for other benefits within ten calendar days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or member is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or member is physically or mentally incapable of filing the claim for other cash benefits, the department shall request the person acting on behalf of the member to pursue the potential benefits.

75.3(4) The SSI-related applicant or member shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or member shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a member, the department shall have a lien, to the extent of those payments, to all monetary claims which the member may have against third parties.

a. A lien is not effective unless the department files a notice of lien with the clerk of the district court in the county where the member resides and with the member's attorney when the member's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the member, the member's attorney, or other representative.

b. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final.

(1) A compromise, including, but not limited to, notification, settlement, waiver or release of a claim, does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended.

(2) A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a member or on behalf of a member which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the member's claim.

c. All notifications to the department required by law shall be directed to the Iowa Medicaid Enterprise, Revenue Collection Unit, P.O. Box 36475, Des Moines, Iowa 50315. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid, in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any member. If a member incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the member. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the member. An attorney acting on behalf of a member for the purpose of enforcing a claim to which the department has a lien shall not collect from the member any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected member or the member's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the member or one acting on the member's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult member shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical

resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through the Department of Veterans Affairs, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the member, or one acting on the member's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the member, or one acting on the member's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The member may report the change in person, by telephone, by mail or by using the Ten-Day Report of Change, Form 470-0499 or 470-0499(S), which is mailed with the Family Investment Program warrants and is issued to the client when Medicaid applications are approved, when annual reviews are completed, when a completed Ten-Day Report of Change is submitted, and when the client requests a form.

d. The member, or one acting on the member's behalf, shall complete the Priority Leads Letter, Form 470-0398, when the department has reason to believe that the member has sustained an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. When the recovery rights of the department are adversely affected by the actions of a parent or payee acting on behalf of a minor or legally incompetent adult member, the Medicaid benefits of the parent or payee shall be terminated. When a parent or payee fails to cooperate in completing or returning the Priority Leads Letter, Form 470-0398, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult member, the department shall terminate the Medicaid benefits of the parent or payee.

f. The member, or one acting on the member's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the member to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on behalf of a minor or legally incompetent adult member, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Health Insurance Claim, Form CMS-1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a member, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for medical assistance or a past or present Medicaid member on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, before filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or local office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the member is receiving medical assistance from the department and only to the extent that the attorney,

insurer or third party has not made payment to the member or an assignee of the member prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the member or the member's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing a member on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a member's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer, is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule, the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for medical assistance or a past or present Medicaid member.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in

subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When determined. The department shall determine the attribution of resources between spouses at the earlier of the following:

(1) When either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility prior to an application for Medicaid benefits. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) When the institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)*"a"* live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is $1500 or less per spouse.

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized spouse and the community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half of the resources attributed to the community spouse exceeds the maximum amount allowed as a community spouse resource allowance by Section 1924(f)(2)(A)(i) of the Social Security Act (42 U.S.C. § 1396r-5(f)(2)(A)(i)), the amount over the maximum shall be attributed to the institutionalized spouse. (The maximum limit is indexed annually according to the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice and appeal rights. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect, or

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

If an attribution has not previously been appealed, either spouse may appeal the attribution upon the denial of an application for Medicaid benefits based on the attribution.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse. For an applicant who became an institutionalized spouse on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse pursuant to 75.16(2)*"d"* shall be treated as countable income of the community spouse when the attribution decision was made on or after February 8, 2006.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain one estimate of the cost of the annuity.

(5) The estimated cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the estimated

cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the estimated cost of an annuity, there shall be no substitution for the cost of the annuity, and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from an insurance company that it will not provide an estimate due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the

facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a precertified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules 191—Chapter 72. A person 65 years of age or older who is either the beneficiary of a certified long-term care policy or enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 72 and who is eligible for medical assistance under 75.1(3), 75.1(4), 75.1(5), 75.1(6), 75.1(7), 75.1(9), 75.1(12), 75.1(13), 75.1(17), 75.1(18), 75.1(23) or 75.1(27) except for excess resources may be eligible for medical assistance under this subrule if the excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule. "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's long-term care policy for qualified Medicaid long-term care services.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4 and chapter 249G.

441—75.6(249A) Entrance fee for continuing care retirement community or life care community. When an individual resides in a continuing care retirement community or life care community that collects an entrance fee on admission, the entrance fee paid shall be considered a resource available to the individual for purposes of determining the individual's Medicaid eligibility and the amount of benefits to the extent that:

1. The individual has the ability to use the entrance fee, or the contract between the individual and the community provides that the entrance fee may be used to pay for care should the individual's other resources or income be insufficient to pay for such care;
2. The individual is eligible for a refund of any remaining entrance fee when the individual dies or when the individual terminates the community contract and leaves the community; and
3. The entrance fee does not confer an ownership interest in the community.

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

441—75.7(249A) Furnishing of social security number. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term "well-established religious objections" means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

75.7(3) Social security account numbers may be requested for people in the eligible group for whom Medicaid is not being requested or received, but provision of the number shall not be a condition of eligibility for the people in the eligible group for whom Medicaid is being requested or received.

This rule is intended to implement Iowa Code section 249A.3.

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

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

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

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

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.*

"Incapable of expressing intent" shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

"Institution" shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) *Determining residency.* Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person's state of residence is:

1. That of the parent applying for Medicaid on the person's behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
2. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
4. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person's parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

2. The current state of residence of the parent or legal guardian who files the application if the person is in institutionalized or in foster care in that state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

(1) The other state does not issue medical cards.

(2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.

(3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

This rule is intended to implement Iowa Code section 249A.3.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.*

"Care and services necessary for the treatment of an emergency medical condition" shall mean services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" shall mean a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to

have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).

7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general of the United States in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, that:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies;
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.

9. Means-tested programs under the Elementary and Secondary Education Act of 1965.

10. Benefits under the Head Start Act.

11. Benefits funded through an employment and training program of the U.S. Department of Labor.

"Qualified alien" means an alien who is:

1. Lawfully admitted for permanent residence under the Immigration and Nationality Act;
2. Granted asylum under Section 208 of the Immigration and Nationality Act;
3. A refugee and who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
4. Paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year;
5. An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or
6. Granted conditional entry pursuant to Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to April 1, 1980.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien residing in the United States before August 22, 1996.

(3) An alien child under the age of 19 who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

(4) A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act.

(5) An alien who has been granted asylum under Section 208 of the Immigration and Nationality Act.

(6) An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act.

(7) A qualified alien veteran who has an honorable discharge that is not due to alienage.

(8) A qualified alien who is on active duty in the Armed Forces of the United States other than active duty for training.

(9) A qualified alien who is the spouse or unmarried dependent child of a qualified alien described in subparagraph (7) or (8), including a surviving spouse who has not remarried.

(10) A qualified alien who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each member shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the member's citizenship or alien status. When the member is incompetent or deceased, the form shall be signed by someone acting responsibly on the member's behalf. An adult shall sign the form for dependent children.

(1) As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship status by signing the application form which contains the same declaration.

(2) As a condition of continued eligibility, SSI-related Medicaid members not actually receiving SSI who have been continuous members since August 1, 1988, shall attest to their citizenship status by signing the application form which contains a similar declaration at time of review.

c. Except as provided in paragraph *"f,"* applicants or members for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* shall present satisfactory documentation of citizenship or nationality as defined in paragraph *"d"* or *"e."* An applicant or member shall have a reasonable period to obtain and provide proof of citizenship or nationality.

(1) For the purposes of this requirement, the "reasonable period" begins on the date a written request to obtain and provide proof is issued to an applicant or member and continues to the date when the proof is provided or the date when the department establishes that the applicant or member is no longer making a good-faith effort to obtain the proof, whichever is earlier.

(2) Medicaid eligibility shall continue for members during the reasonable period. Medicaid shall not be approved for applicants until acceptable documentary evidence is provided.

(3) A reference to a form in paragraph *"d"* or *"e"* includes any successor form.

d. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A United States passport.

(2) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(3) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(4) A valid state-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act, but only if the state issuing the license or document either:

1. Requires proof of United States citizenship before issuance of the license or document; or

2. Obtains a social security number from the applicant and verifies before certification that the number is valid and is assigned to the applicant who is a citizen.

(5) Another document that provides proof of United States citizenship or nationality and provides a reliable means of documentation of personal identity, as the secretary of the U.S. Department of Health and Human Services may specify by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v).

e. Satisfactory documentation of citizenship or nationality may also be demonstrated by the combination of:

(1) Any identity document described in Section 274A(b)(1)(D) of the United States Immigration and Nationality Act or any other documentation of personal identity that provides a reliable means of identification, as the secretary of the U.S. Department of Health and Human Services finds by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(D)(ii), and

(2) Any one of the following:

1. A certificate of birth in the United States.

2. Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

3. Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

4. Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

5. Another document that provides proof of United States citizenship or nationality, as the secretary of the U.S. Department of Health and Human Services may specify pursuant to 42 U.S.C. Section 1396b(x)(3)(C)(v).

f. A person for whom an attestation of United States citizenship has been made pursuant to paragraph *"b"* is not required to present documentation of citizenship or nationality for Medicaid eligibility if any of the following circumstances apply:

(1) The person is entitled to or enrolled for benefits under any part of Title XVIII of the federal Social Security Act (Medicare).

(2) The person is receiving federal social security disability insurance (SSDI) benefits under Title II of the federal Social Security Act, Section 223 or 202, based on disability (as defined in Section 223(d)).

(3) The person is receiving supplemental security income (SSI) benefits under Title XVI of the federal Social Security Act.

(4) The person is a child in foster care who is eligible for child welfare services funded under Part B of Title IV of the federal Social Security Act.

(5) The person is eligible for adoption or foster care assistance funded under Part E of Title IV of the federal Social Security Act; or

(6) The person has previously presented satisfactory documentary evidence of citizenship or nationality, as specified by the United States Secretary of Health and Human Services.

g. If no other identity documentation allowed by subparagraph 75.11(2)*"e"*(1) is available, identity may be documented by affidavit as described in this paragraph. However, affidavits cannot be used to document both identity and citizenship.

(1) For children under the age of 16, identity may be documented using Form 470-4386 or 470-4386(S), Affidavit of Identity, signed by the child's parent, guardian, or caretaker relative under penalty of perjury.

(2) For disabled persons who live in a residential care facility, identity may be documented using form 470-4386 or 470-4386(S), Affidavit of Identity, signed by a residential care facility director or administrator under penalty of perjury.

h. If no other documentation that provides proof of United States citizenship or nationality allowed by subparagraph 75.11(2)*"e"*(2) is available, United States citizenship or nationality may be documented using Form 470-4373 or 470-4373(S), Affidavit of Citizenship. However, affidavits cannot be used to document both identity and citizenship.

(1) Two affidavits of citizenship are required. The person who signs the affidavit must provide proof of citizenship and identity. A person who is not related to the applicant or member must sign at least one of the affidavits.

(2) When affidavits of citizenship are used, Form 470-4374 or 470-4374(S), Affidavit Concerning Documentation of Citizenship, or an equivalent affidavit explaining why other evidence of citizenship does not exist or cannot be obtained must also be submitted and must be signed by the applicant or member or by another knowledgeable person (guardian or representative).

75.11(3) *Deeming of sponsor's income and resources.*

a. In determining the eligibility and amount of benefits of an alien, the income and resources of the alien shall be deemed to include the following:

(1) The income and resources of any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act (as implemented by the Personal Responsibility and Work Reconciliation Act of 1996) on behalf of the alien.

(2) The income and resources of the spouse of the person who executed the affidavit of support.

b. When an alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act or has worked 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with qualifying quarters as defined at subrule 75.11(1) and, in the case of any qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any federal means-tested public benefits, as defined in subrule 75.11(1), during any period, deeming of the sponsor's income and resources no longer applies.

75.11(4) *Eligibility for payment of emergency medical services.* Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alien status are eligible to receive Medicaid for care and services necessary for the treatment of an emergency medical condition as defined in subrule 75.11(1). To qualify for payment under this provision:

a. The alien must meet all other eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A), with the exception of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3).

b. The medical provider who treated the emergency medical condition or the provider's designee must submit verification of the existence of the emergency medical condition on either:

(1) Form 470-4299, Verification of Emergency Health Care Services; or

(2) A signed statement that contains the same information as requested by Form 470-4299.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7932B**, IAB 7/1/09, effective 7/1/09]

441—75.12(249A) Inmates of public institutions. A person is not eligible for medical assistance for any care or services received while the person is an inmate of a public institution. For the purpose of this rule, the phrase "inmate of a public institution" is defined by 42 CFR Section 435.1009, as amended on November 10, 1994.

This rule is intended to implement Iowa Code section 249A.3.

441—75.13(249A) Categorical relatedness.

75.13(1) *FMAP-related Medicaid eligibility.* Medicaid eligibility for persons who are under the age of 21, pregnant women, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) *SSI-related Medicaid.* Except as otherwise provided in 441—Chapters 75 and 76, persons who are 65 years of age or older, blind, or disabled are eligible for Medicaid only if eligible for the Supplemental Security Income (SSI) program administered by the United States Social Security Administration.

a. SSI policy reference. The statutes, regulations, and policy governing eligibility for SSI are found in Title XVI of the Social Security Act (42 U.S.C. Sections 1381 to 1383f), in the federal regulations promulgated pursuant to Title XVI (20 CFR 416.101 to 416.2227), and in Part 5 of the Program Operations Manual System published by the United States Social Security Administration. The Program Operations Manual System is available at Social Security Administration offices in Ames, Burlington, Carroll, Cedar Rapids, Clinton, Council Bluffs, Creston, Davenport, Decorah, Des Moines, Dubuque, Fort Dodge, Iowa City, Marshalltown, Mason City, Oskaloosa, Ottumwa, Sioux City, Spencer, Storm Lake, and Waterloo, or through the Department of Human Services, Division of Financial, Health, and Work Supports, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

b. Income considered. For SSI-related Medicaid eligibility purposes, income shall be considered prospectively.

c. Trust contributions. Income that a person contributes to a trust as specified at 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

d. Conditional eligibility. For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process, by which a client may receive SSI benefits while attempting to sell excess resources, found at 20 CFR 416.1240 to 416.1245, is not considered an eligibility methodology.

e. Valuation of life estates and remainder interests. In the absence of other evidence, the value of a life estate or remainder interest in property shall be determined using the following table by multiplying the fair market value of the entire underlying property (including all life estates and all remainder interests) by the life estate or remainder interest decimal corresponding to the age of the life estate holder or other person whose life controls the life estate.

If a Medicaid applicant or recipient disputes the value determined using the following table, the applicant or recipient may submit other evidence and the value of the life estate or remainder interest shall be determined based on the preponderance of all the evidence submitted to or obtained by the department, including the value given by the following table.

Age	Life Estate	Remainder	Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.51441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43569	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.343902	104	.17856	.82144
31	.95254	.04746	68	.63610	.363690	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

75.13(3) *Resource eligibility for SSI-related Medicaid for children.* Resources of all household members shall be disregarded when determining eligibility for children under any SSI-related coverage

group except for those groups at subrules 75.1(3), 75.1(4), 75.1(6), 75.1(9), 75.1(10), 75.1(12), 75.1(13), 75.1(23), 75.1(25), 75.1(29), 75.1(33), 75.1(34), 75.1(36), 75.1(37), and 75.1(38).

This rule is intended to implement Iowa Code section 249A.3.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, Medicaid applicants and members in households with an absent parent shall cooperate in obtaining medical support for each applicant or member as well as for any other person in the household for whom Medicaid is requested and for whom the applicant or member can legally assign rights for medical support, except when good cause as defined in subrule 75.14(8) for refusal to cooperate is established.

a. The applicant or member shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

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

(3) Obtaining medical support and payments for medical care for the applicant or member and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

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

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

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

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

c. The applicant or member shall cooperate with the department in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

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

e. The income maintenance unit shall make the determination of whether or not the applicant or member has cooperated.

75.14(2) Failure of the applicant or member to cooperate shall result in denial or cancellation of the person's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be allowed when otherwise applicable.

75.14(3) Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each Medicaid applicant or member shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or member's own behalf or on behalf of any other family member for whom the applicant or member is applying. An assignment is effective the same date the eligibility information is entered into the automated benefit calculation system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Referrals to the child support recovery unit for Medicaid applicants or members. The department shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child with a parent who is absent from the home or when any member of the eligible group is entitled to support payments.

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

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

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. However, when a pregnant woman who is subject to these provisions fails to cooperate, the woman shall lose eligibility under her current coverage group and her eligibility for Medicaid shall be automatically redetermined under subrule 75.1(28).

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) and 75.14(5) which require the applicant or member to assign any rights to medical support and payments for medical care and to be referred to the child support recovery unit.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The income maintenance unit shall determine that cooperation is against the child's best interest when the applicant's or member's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or

(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

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

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or member is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

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

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

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

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

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each Medicaid applicant or member who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Before requiring cooperation, the department shall notify the applicant or member using Form 470-0169 or 470-0169(S), Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or member of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or member that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

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

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

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

c. When the applicant or member makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the income maintenance unit shall issue a second notice, Form 470-0170, Requirements of Claiming Good Cause. To claim good cause, the applicant or member shall sign and date Form 470-0170 and return it to the income maintenance unit. This form:

(1) Indicates that the applicant or member must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

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

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

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

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

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

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

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

(2) Corroborate the good cause circumstances.

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

75.14(10) Determination of good cause. The income maintenance unit shall determine whether good cause exists for each Medicaid applicant or member who claims to have good cause.

a. The income maintenance unit shall notify the applicant or member of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

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

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The income maintenance unit may exceed this time standard only when:

(1) The case record documents that the income maintenance unit needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

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

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

(2) Continued refusal to cooperate will result in the loss of Medicaid for the person who refuses to cooperate.

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

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

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

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or member's appeal of an agency action with respect to a decision on a claim of good cause.

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

h. The income maintenance unit shall:

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

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

75.14(11) Proof of good cause. The applicant or member who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the income maintenance unit determines that the applicant or member requires additional time because of the difficulty in obtaining the corroborative evidence, the income maintenance unit shall allow a reasonable additional period upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence:

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

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

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

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

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

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

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

c. When the applicant or member requests assistance in securing evidence, the income maintenance unit shall:

(1) Advise the applicant or member how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or member is not reasonably able to obtain without assistance.

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

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

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or member has good cause for refusing to cooperate.

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

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

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

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

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

75.14(12) Enforcement without specified relative's cooperation. When the income maintenance unit makes a determination that good cause exists, the unit shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. The child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the income maintenance unit shall consider any recommendations from the child support recovery unit.

b. The determination shall be in writing, contain the income maintenance unit's findings and basis for the determination, and be entered into the case record.

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

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.15(249A) Disqualification for long-term care assistance due to substantial home equity. Notwithstanding any other provision of this chapter, if an individual's equity interest in the individual's home exceeds $500,000, the individual shall not be eligible for medical assistance with

respect to nursing facility services or other long-term care services except as provided in 75.15(2). This provision is effective for all applications or requests for payment of long-term care services filed on or after January 1, 2006.

75.15(1) The limit on the equity interest in the individual's home for purposes of this rule shall be increased from year to year, beginning with 2011, based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

75.15(2) Disqualification based on equity interest in the individual's home shall not apply when one of the following persons is lawfully residing in the home:

a. The individual's spouse; or

b. The individual's child who is under age 21 or is blind or disabled as defined in Section 1614 of the federal Social Security Act.

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

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. SSI-related clients returning home within three months. If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain $50 of their monthly income for a personal needs allowance. (See rules 441—81.23(249A), 441—82.19(249A), and 441—85.47(249A) regarding potential state-funded personal needs supplements.)

(1) If the client is a veteran or a surviving spouse of a veteran who receives a pension subject to limitation of $90 after the month of entry pursuant to 38 U.S.C. Section 5503, the veteran or the surviving spouse of a veteran shall retain $90 from the veteran's pension beginning the month after entry

to a medical institution. The $90 allowance from a veteran's pension is in addition to the $50 allowance from any other income.

(2) If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

(3) Rescinded IAB 7/4/07, effective 7/1/07.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from the maximum amount allowed as a minimum monthly maintenance needs allowance for the community spouse by Section 1924(d)(3)(C) of the Social Security Act (42 U.S.C. § 1396r-5(d)(3)(C)). (This amount is indexed for inflation annually according to the consumer price index.)

However, if either spouse has established through the appeal process that the community spouse needs income above the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party. This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, the applicant's self-declaration of the pregnancy and the date of conception shall serve as verification of pregnancy, unless questionable.

75.17(1) *Multiple pregnancy.* If the pregnant woman claims to be carrying more than one fetus, a medical professional who has examined the woman must verify the number of fetuses in order for more than one to be considered in the household size.

75.17(2) *Cost of examination.* When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

This rule is intended to implement Iowa Code section 249A.3.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

This rule is intended to implement Iowa Code section 249A.3.

441—75.19(249A) Continuous eligibility for children. A child under the age of 19 who is determined eligible for ongoing Medicaid shall retain that eligibility for up to 12 months regardless of changes in family circumstances except as described in this rule.

75.19(1) *Exceptions to coverage.* This rule does not apply to the following children:

a. Children whose eligibility was determined under the newborn coverage group described at subrule 75.1(20).

b. Children whose eligibility was determined under the medically needy coverage group described at subrule 75.1(35).

c. Children whose medical assistance is state-funded only.

75.19(2) *Duration of coverage.* Coverage under this rule shall extend through the earliest of the following months:

a. The month of the household's annual eligibility review;

b. The month when the child reaches the age of 19; or

c. The month when the child moves out of Iowa.

75.19(3) *Assignment of review date.* Children entering an existing Medicaid household shall be assigned the same annual eligibility review date as that established for the household.

This rule is intended to implement Iowa Code Supplement section 249A.3 as amended by 2008 Iowa Acts, House File 2539.

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services. The applicant or the applicant's authorized representative shall complete and submit Form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Department of Human Services, and either:

(1) Form 470-2465, Disability Report for Adults, if the applicant is aged 18 or over; or

(2) Form 470-3912, Disability Report for Children, if the applicant is under the age of 18.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Redeterminations of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the member's medical condition will be necessary for periodic redeterminations of eligibility. When reexamination is required, the member or the member's authorized representative shall complete and submit the same forms as required in paragraph 75.20(2)*"b."*

75.20(5) *Members whose disability was determined by the department.* When a Medicaid member has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the member shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days,

the member shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

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

441—75.21(249A) Health insurance premium payment (HIPP) program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care through Medicaid. Payment shall include only the cost to the Medicaid member or household.

75.21(1) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

(1) There was a serious illness or death of the parent or a member of the parent's family.

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

(3) The parent offers a good cause beyond the parent's control.

(4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *Individual health plans.* Participation in an individual health plan is not a condition of Medicaid eligibility. The department shall pay for the cost of premiums, coinsurance, and deductibles of individual health insurance plans for a Medicaid member if:

a. A household member is currently enrolled in the plan; and

b. The health plan is cost-effective as defined in subrule 75.21(3).

75.21(3) *Cost-effectiveness.* Cost-effectiveness for both group and individual health plans shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under the health plan for those services. When determining the cost-effectiveness of the health plan, the following data shall be considered:

a. The cost to the Medicaid member or household of the insurance premium, coinsurance, and deductibles. No cost paid by an employer or other plan sponsor shall be considered in the cost-effectiveness determination.

b. The scope of services covered under the health plan, including but not limited to exclusions for preexisting conditions.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for members covered under the health plan.

d. The specific health-related circumstances of the members covered under the health plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. When the information indicates any health conditions that could be expected to result in higher than average bills for any Medicaid member:

(1) If the member is currently covered by the health plan, the department shall obtain from the insurance company a summary of the member's paid claims for the previous 12 months. If there is sufficient evidence to indicate that such claims can be expected to continue in the next 12 months, the claims will be considered in determining the cost-effectiveness of the plan. The cost of providing the health insurance is compared to the actual claims to determine the cost-effectiveness of providing the coverage.

(2) If the member was not covered by the health plan in the previous 12 months, paid Medicaid claims may be used to project the cost-effectiveness of the plan.

e. Annual administrative expenditures of $50 per Medicaid member covered under the health plan.

f. Whether the estimated savings to Medicaid for members covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.*

a. When a group health plan is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However:

(1) The needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness, and

(2) Payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

b. When an individual health plan is determined cost-effective, the department shall pay for the portion of the premium necessary to cover the Medicaid-eligible family members. If the portion of the premium to cover the Medicaid-eligible family members cannot be established, the department shall pay the entire premium. The family members who are not Medicaid-eligible shall not be considered when determining cost-effectiveness.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the case is not Medicaid-eligible on the date of decision.

g. The person is eligible only for a coverage group that does not provide full Medicaid services, such as the specified low-income Medicare beneficiary (SLMB) coverage group in accordance with subrule 75.1(34) or the IowaCare program in accordance with the provisions of 441—Chapter 92. Members under the medically needy coverage group who must meet a spenddown are not eligible for HIPP payment.

h. Insurance coverage is being provided through the Health Insurance Plan of Iowa (HIPIOWA), in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. The person has health coverage through Medicare. If other Medicaid members in the household are covered by the health plan, cost-effectiveness is determined without including the Medicare-covered member.

l. The health plan does not provide major medical coverage but pays only for specific situations (i.e., accident plans) or illnesses (i.e., cancer policy).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the health plan are currently in foster care.

o. All Medicaid members covered by the health plan are eligible for Medicaid only under subrule 75.1(43). This coverage group requires the parent to apply for, enroll in, and pay for coverage available from the employer as a condition of Medicaid eligibility for the children.

75.21(6) *Duplicate policies.* When more than one cost-effective health plan is available, the department shall pay the premium for only one plan. The member may choose the cost-effective plan in which to enroll.

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, the department shall complete a review in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If the department determines that the health plan is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the household ten calendar days in which to provide it.

d. If the policyholder leaves the Medicaid household, premium payments shall be discontinued pending timely and adequate notice.

e. If the health plan is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for a cost-effective health plan shall be determined as follows:

a. Premium payments shall begin no earlier than the later of:

(1) The first day of the month in which the Employer's Statement of Earnings, Form 470-2844, the Health Insurance Premium Payment Application, Form 470-2875, or the automated HIPP referral, Form H301-1, is received by the HIPP unit; or

(2) The first day of the first month in which the health plan is determined to be cost-effective.

b. If the person is not enrolled in the health plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the health plan is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time before the current effective date of coverage.

d. In no case shall payments be made for premiums that were used as a deduction to income when determining client participation or the amount of the spenddown obligation.

e. The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

f. The effective date of coverage for individual health plans or for group health plans not obtained through an employer shall be verified by a copy of the certificate of coverage for the plan or by some other verification from the insurer.

75.21(9) *Method of premium payment.* Payments of premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to an employer in order to circumvent a payroll deduction.

b. When an employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the employee directly for payroll deductions or for payments made directly to the employer for the payment of premiums. The department shall issue reimbursement to the employee five working days before the employee's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for those withdrawals.

d. Payments for COBRA coverage shall be made directly to the insurance carrier or the former employer. Payments may be made directly to the former employee only in those cases where:

(1) Information cannot be obtained for direct payment, or

(2) The department pays for only part of the total premium.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness and eligibility.* Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

b. For individual health plans, the client shall complete HIPP Individual Policy Review, Form 470-3017, for the review.

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

d. Redeterminations shall be completed whenever:

(1) A premium rate, deductible, or coinsurance changes,

(2) A person covered under the policy loses full Medicaid eligibility,

(3) Changes in employment or hours of employment affect the availability of health insurance,

(4) The insurance carrier changes,

(5) The policyholder leaves the Medicaid home, or

(6) There is a decrease in the services covered under the policy.

e. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person. The department sends a HIPP Change Report, Form 470-3007, with all premium payments.

f. If a change in the number of members in the Medicaid household causes the health plan not to be cost-effective, lesser health plan options, as defined in paragraph 75.21(16)*"a,"* shall be considered if available and cost-effective.

g. When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of the group health plan occurs, the department shall verify whether coverage may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other coverage continuation provisions.

(1) The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose.

(2) If cost-effective to do so, the department shall pay premiums to maintain insurance coverage for Medicaid members after the occurrence of the event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the health plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule

75.21(8)) is received. Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

(3) The health plan is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the health plan lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the member's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs, if all other eligibility factors are met.

75.21(16) *Amount of premium paid.*

a. For group health plans, the individual eligible to enroll in the plan shall provide verification of the cost of all possible health plan options (i.e., single, employee/children, family).

(1) The HIPP program shall pay only for the option that provides coverage to the Medicaid-eligible family members in the household and is determined to be cost-effective.

(2) The HIPP program shall not pay the portion of the premium cost which is the responsibility of the employer or other plan sponsor.

b. For individual health plans, the HIPP program shall pay the cost of covering the Medicaid members covered by the plan.

c. For both group and individual health plans, if another household member must be covered to obtain coverage for the Medicaid members, the HIPP program shall pay the cost of covering that household member if the coverage is cost-effective as determined pursuant to subrules 75.21(3) and 75.21(4).

75.21(17) *Reporting changes.* Failure to report and verify changes may result in cancellation of Medicaid benefits.

a. The client shall verify changes in an employer-sponsored health plan by providing a pay stub reflecting the change or a statement from the employer.

b. Changes in employment or the employment-related insurance carrier shall be verified by the employer.

c. The client shall verify changes in individual policies, such as premiums or deductibles, with a statement from the insurance carrier.

d. Any benefits paid during a period in which there was ineligibility for HIPP due to unreported changes shall be subject to recovery in accordance with the provisions of 441—Chapter 11.

e. Any underpayment that results from an unreported change shall be paid effective the first day of the month in which the change is reported.

This rule is intended to implement Iowa Code section 249A.3.

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09]

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141A.1.

75.22(1) *Conditions of eligibility.* The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, 1305 East Walnut, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant

will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) *Effective date of premium payment.* Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code section 141A.9. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Obtain and Release Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

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

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75 and 83, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.* When an individual or spouse has transferred or disposed of assets for less than fair market value as defined in 75.23(11) on or after the look-back date specified in 75.23(2), the individual shall be ineligible for medical assistance as provided in this subrule.

a. Institutionalized individual. When an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the institutionalized individual is ineligible for medical assistance payment for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving nursing facility services, a level of care in any institution equivalent to that of nursing facility services, or home- and community-based waiver services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

b. Noninstitutionalized individual. When a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date, the individual is ineligible for medical assistance payment for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services. The period of ineligibility is equal to the number of months specified in 75.23(3). The department shall determine the beginning of the period of ineligibility as follows:

(1) Transfer before February 8, 2006. When the transfer of assets was made before February 8, 2006, the period of ineligibility shall begin on the first day of the first month during which the assets were transferred, except as provided in subparagraph (3).

(2) Transfer on or after February 8, 2006. Within the limits of subparagraph (3), when the transfer of assets was made on or after February 8, 2006, the period of ineligibility shall begin on the later of:

1. The first day of the first month during which the assets were transferred; or

2. The date on which the individual is eligible for medical assistance under this chapter and would be receiving home health care services, home and community care for functionally disabled elderly individuals, personal care services, or other long-term care services, based on an approved application for such care, but for the application of this rule.

(3) Exclusive period. The period of ineligibility due to the transfer shall not begin during any other period of ineligibility under this rule.

75.23(2) *Look-back date.*

a. Transfer before February 8, 2006. For transfers made before February 8, 2006, the look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

b. Transfer on or after February 8, 2006. For transfers made on or after February 8, 2006, the look-back date is the date that is 60 months before:

(1) The date an institutionalized individual is both an institutionalized individual and has applied for medical assistance; or

(2) The date a noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private-pay rate for nursing facility services at the time of application. The department shall determine the average statewide cost to a private-pay resident for nursing facilities and update the cost annually. For the period from July 1, 2009, through June 30, 2010, this average statewide cost shall be $4,598.61 per month or $151.27 per day.

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

(3) All assets transferred for less than fair market value have been returned to the individual.

d. The denial of eligibility would work an undue hardship. Undue hardship shall exist only when all of the following conditions are met:

(1) Application of the transfer of asset penalty would deprive the individual of medical care such that the individual's health or life would be endangered or of food, clothing, shelter, or other necessities of life.

(2) The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

(3) The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident, counting the value of all resources except for:

1. The home if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
2. Household goods.
3. A vehicle required by the client for transportation.
4. Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for long-term care services.

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.
2. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.
3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

"Transfer or disposal of assets" means any transfer or assignment of any legal or equitable interest in any asset as defined above, including:

1. Giving away or selling an interest in an asset;
2. Placing an interest in an asset in a trust that is not available to the grantor (see 75.24(2)*"b"*(2));
3. Removing or eliminating an interest in a jointly owned asset in favor of other owners;
4. Disclaiming an inheritance of any property, interest, or right pursuant to Iowa Code section 633.704 on or after July 1, 2000 (see Iowa Code section 249A.3(11)*"c"*);

5. Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") on or after July 1, 2000, to the extent that the value received by taking against the will would have exceeded the value of the inheritance received under the will (see Iowa Code section 249A.3(11)*"d"*); or

6. Transferring or disclaiming the right to income not yet received.

75.23(9) *Purchase of annuities.*

a. The entire amount used to purchase an annuity on or after February 8, 2006, shall be treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in subparagraphs (1) through (4) of this paragraph.

(1) The annuity is an annuity described in Subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.

(2) The annuity is purchased with proceeds from:

1. An account or trust described in Subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

2. A simplified employee pension (within the meaning of Section 408(k) of the United States Internal Revenue Code of 1986); or

3. A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.

(3) The annuity:

1. Is irrevocable and nonassignable;

2. Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration); and

3. Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(4) Iowa is named as the remainder beneficiary either:

1. In the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or

2. In the second position after the community spouse or minor or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.

b. Funds used to purchase an annuity for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The annuity was purchased before February 8, 2006; or

(2) The annuity was purchased on or after February 8, 2006, and a condition described in 75.23(9)*"a"*(1) to (4) was met.

75.23(10) *Purchase of promissory notes, loans, or mortgages.*

a. Funds used to purchase a promissory note, loan, or mortgage after February 8, 2006, shall be treated as assets transferred for less than fair market value in the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance for services described in 75.23(1), unless the note, loan, or mortgage meets all of the following conditions:

(1) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(2) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(3) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

b. Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The note, loan, or mortgage was purchased before February 8, 2006; or

(2) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in 75.23(9)*"a"* were met.

75.23(11) *Purchase of life estates.*

a. The entire amount used to purchase a life estate in another individual's home after February 8, 2006, shall be treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

b. Funds used to purchase a life estate in another individual's home for less than its fair market value shall be treated as assets transferred for less than fair market value regardless of whether:

(1) The life estate was purchased before February 8, 2006; or

(2) The life estate was purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09]

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if any of the following individuals established the trust other than by will: the individual, the individual's spouse, a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse), or a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of

assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) Any portion of the trust from which, or any income on the principal from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual.

For disposition of trust amounts pursuant to Iowa Code sections 633C.1 to 633C.5, the average statewide charges and Medicaid rates for the period from July 1, 2009, to June 30, 2010, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $4,189 per month.

(2) and (3) Rescinded IAB 7/7/04, effective 7/1/04.

(4) The maximum statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is $20,960 per month.

(5) The average statewide charge to a resident of a mental health institute is $17,758 per month.

(6) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $5,044 per month.

(7) The average statewide charge to a home- and community-based waiver applicant or recipient shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

(2) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

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

[**ARC 7834B**, IAB 6/3/09, effective 7/8/09]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

"Aged" shall mean a person 65 years of age or older.

"Applicant" shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Break in assistance" for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Central office" shall mean the state administrative office of the department of human services.

"Certification period" for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

"Client" shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

"CMAP-related medically needy" shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

"Community spouse" shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Conditionally eligible" shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

"Coverage group" shall mean a group of persons who meet certain common eligibility requirements.

"Department" shall mean the Iowa department of human services.

"Disabled" shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

"Institutionalized person" shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

"Institutionalized spouse" shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

"Local office" shall mean the county office of the department of human services or the mental health institute or hospital school.

"Medically needy income level (MNIL)" shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

"Member" shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, "member" shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. "Member" may be used interchangeably with "recipient." This definition does not apply to the phrase "household member."

"Necessary medical and remedial services" for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

"Noncovered Medicaid services" for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"Nursing facility services" shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

"Obligated medical expense" for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

"Ongoing eligibility" for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

"Pay and chase" shall mean that the state pays the total amount allowed under the agency's payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

"Recertification" in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Recipient" shall mean a person who is receiving assistance including receiving assistance for another person.

"Responsible relative" for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

"Spenddown" shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

"SSI-related medically needy" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

"Supply" shall mean the requested information is received by the department by the specified due date.

"Transfer of assets" shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

"Unborn child" shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

[**ARC 7935B**, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28 to **75.49** Reserved.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions. The following definitions apply to this division in addition to the definitions in rule 441—75.25(249A).

"Applicant" shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Application period" means the months beginning with the month in which the application is considered to be filed, through and including the month in which an eligibility determination is made.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked or rate of pay, any change in the amount of unearned income, or the beginning or ending of any income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Department" shall mean the Iowa department of human services.

"Dependent" means an individual who can be claimed by another individual as a dependent for federal income tax purposes.

"Dependent child" or *"dependent children"* means a child or children who meet the nonfinancial eligibility requirements of the applicable FMAP-related coverage group.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Needy specified relative" means a nonparental specified relative, listed in 75.55(1), who meets all the eligibility requirements of the FMAP coverage group, listed in 75.1(14).

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means a legally recognized parent, including an adoptive parent, or a biological father if there is no legally recognized father.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is not the parent of the dependent child, but is the legal spouse of the dependent child's parent by ceremonial or common-law marriage.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Eligibility for the family medical assistance program (FMAP) and FMAP-related programs shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished, except as provided in the transitional Medicaid program in accordance with subparagraph 75.1(31)*"j"*(2).

75.51(1) *Exception to time limit.* Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

75.51(2) *Cancellation for failure to return review form.* When all eligibility factors are met, assistance shall be reinstated when a completed Review/Recertification Eligibility Document (RRED), Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), is received by the department within ten days of the date a cancellation notice is sent to the member because the form was incomplete or not returned.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least annually for the FMAP-related programs.

a. Reviews shall be conducted using information contained in and verification supplied with Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document.

b. Family medical assistance-related medically needy recertifications shall be conducted using information contained in and verification supplied with Form 470-3118 or 470-3118(S), Medicaid Review.

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The member reports a change in circumstances (for example, a change in income, as defined at rule 441—75.50(249A)), or

b. A change in the member's circumstances comes to the attention of a staff member.

75.52(3) *Forms.* Information for the annual review shall be submitted on Form 470-2881, 470-2881(M), 470-4083 (Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), with the following exceptions:

a. When the client has completed Form 470-0462 or 470-0466 (Spanish), Health and Financial Support Application, for another purpose, this form may be used as the review document for the semiannual or annual review.

b. Information for recertification of family medical assistance-related medically needy shall be submitted on Form 470-3118 or 470-3118(S), Medicaid Review.

75.52(4) *Client responsibilities.* For the purposes of this subrule, "clients" shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The client shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The client shall complete Form 470-2881, 470-2881(M), 470-4083(Spanish), or 470-4083(M), Review/Recertification Eligibility Document (RRED), or Form 470-3118 or 470-3118(S), Medicaid Review, when requested by the department in accordance with these rules. The department shall supply the form to the client as needed, or upon request, and shall pay the cost of postage to return the form.

(1) When the form is issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the fifth calendar day of the review month.

(2) When the form is not issued in the department's regular end-of-month mailing, the client shall return the completed form to the department by the seventh day after the date it is mailed by the department.

(3) If the department does not receive a completed form, assistance shall be canceled. A completed form is one that has all items answered, is signed, is dated, and is accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

(4) A copy of a form received by fax or electronically shall have the same effect as an original form.

c. The client shall report any change in the following circumstances at the annual review or upon the addition of an individual to the eligible group:

(1) Income from all sources, including any change in care expenses.
(2) Resources.
(3) Members of the household.
(4) School attendance.
(5) A stepparent recovering from an incapacity.
(6) Change of mailing or living address.
(7) Payment of child support.
(8) Receipt of a social security number.
(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*
(10) Health insurance premiums or coverage.

d. All clients shall timely report any change in the following circumstances at any time:

(1) Members of the household.
(2) Change of mailing or living address.
(3) Sources of income.
(4) Health insurance premiums or coverage.

e. Clients described at subrule 75.1(35) shall also timely report any change in income from any source and any change in care expenses at any time.

f. A report shall be considered timely when made within ten days from the date:

(1) A person enters or leaves the household.
(2) The mailing or living address changes.
(3) A source of income changes.
(4) A health insurance premium or coverage change is effective.
(5) Of any change in income.
(6) Of any change in care expenses.

g. When a change is not reported as required in paragraphs 75.52(4)*"c"* through *"e,"* any excess Medicaid paid shall be subject to recovery.

h. When a change in any circumstance is reported, its effect on eligibility shall be evaluated and eligibility shall be redetermined, if appropriate, regardless of whether the report of the change was required in paragraphs 75.52(4)*"c"* through *"e."*

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. When the change creates ineligibility, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. Rescinded IAB 10/4/00, effective 10/1/00.

c. When an individual included in the eligible group becomes ineligible, that individual's Medicaid shall be canceled effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

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

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

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Absence from the home.*

a. An individual who is absent from the home shall not be included in the eligible group, except as described in paragraph *"b."*

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

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

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

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

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

(2) An individual is out of the home to secure education or training as defined for children in paragraph 75.54(1)*"b"* as long as the child remains a dependent and as defined for adults in 441—subrule 93.114(1), first sentence.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Rescinded IAB 11/1/00, effective 1/1/01.

75.54(4) *Continuous eligibility for children.* Rescinded IAB 11/5/08, effective 11/1/08.

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

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

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the department shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

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

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, a client may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit when determining eligibility for adults. All resources shall be disregarded when determining eligibility for children.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the client. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. Except as described at paragraph 75.56(1)*"n"* or *"o,"* the net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

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

d. One motor vehicle per household. If the household includes more than one adult or working teenaged child whose resources must be considered as described in subrule 75.56(2), an equity not to exceed a value of $3,000 in one additional motor vehicle shall be disregarded for each additional adult or working teenaged child.

(1) The disregard for an additional motor vehicle shall be allowed when a working teenager is temporarily absent from work.

(2) The equity value of any additional motor vehicle in excess of $3,000 shall be counted toward the resource limit in paragraph 75.56(1)*"e."* When a motor vehicle is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle.

(3) Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for member assistance units. EXCEPTION: Applicant assistance units that contain at least one person who was a Medicaid member in Iowa in the month before the month of application are subject to the $5,000 limit. Resources of the assistance unit shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income for the month and that part of lump-sum income defined at paragraph 75.57(9)*"c"* reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

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

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Federal or state earned income tax credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal or state income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph *"e."*

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

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but who is not eligible for Medicaid shall be considered in the same manner as if the parent were eligible for Medicaid.

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

d. The resources of supplemental security income (SSI) members shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid member in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

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

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the member is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

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

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

Payments from property sold under an installment contract are exempt as income as specified in paragraphs 75.57(1)*"d"* and 75.57(7)*"ag."* The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

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

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

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

b. Rescinded IAB 6/30/99, effective 9/1/99.

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

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

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or member the month following the month the payment was received. When the applicant or member signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

(1) Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

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

(3) Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available.

(4) Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When

self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3). The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 3). Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"* 75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided. The department shall return all verification to the applicant or member.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income, from investment and nonrecurring lump sum payments, shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the client sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payments reported by child support recovery during a past month for which eligibility is being determined shall be used to determine eligibility for the month. Support payments anticipated to be received in future months shall be used to determine eligibility for future months. When support payments terminate in the month of decision of an FMAP-related Medicaid application, both support

payments already received and support payments anticipated to be received in the month of decision shall be used to determine eligibility for that month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The client shall cooperate in supplying verification of all unearned income and of any change in income, as defined at rule 441—75.50(249A).

(1) When the information is available, the department shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the department uses this information as verification, job insurance benefits shall be considered received the second day after the date that the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day.

(2) When the client notifies the department that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy before the eligibility month or within ten days of the date on the Notice of Decision, Form 470-0485, 470-0486, or 470-0486(S), applicable to the eligibility month, whichever is later.

75.57(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the net profit from self-employment, defined as gross income less the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

(1) Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

(2) Stepparents as described at paragraph 75.57(8)*"b"* and self-supporting parents on underage parent cases as described at paragraph 75.57(8)*"c"* shall be allowed incapacitated adult care or child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(3) Unless both parents are in the home and one parent is physically and mentally able to provide the care, child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of each child or incapacitated adult, not to exceed $175 per month, or $200 per month for a child under the age of two, or the going rate in the community, whichever is less.

(4) If both parents are in the home, adult or child care expenses shall not be allowed when one parent is unemployed and is physically and mentally able to provide the care.

(5) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(6) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(7) The expense shall be verified by a receipt or a statement from the provider of care and shall be allowed when paid to any person except a parent or legal guardian of the child or another member of the eligible group, or to any person whose needs are met by diversion of income from any person in the eligible group.

c. Work incentive disregard. After deducting the allowable work-related expenses as defined at paragraphs 75.57(2)*"a"* and *"b"* and income diversions as defined at subrule 75.57(4), 58 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each person whose income must be considered is disregarded in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A).

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

(2) Initial eligibility under the first two steps of the three-step process is determined without the application of the work incentive disregard as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(3) A person who is not eligible for Medicaid because the person has refused to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), is eligible for the work incentive disregard.

d. Rescinded IAB 6/30/99, effective 9/1/99.

e. A person is considered self-employed when the person:

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

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

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

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

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

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

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

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

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

(6) The cost of any repairs needed.

(7) The cost of any travel required.

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

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) $41 plus an amount equivalent to the monthly maximum food stamp allotment in the food stamp program for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food stamp allotment in the food stamp program for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or member's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children.

(1) In determining profit from providing child care services in the applicant's or member's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the applicant or member requests to have actual expenses in excess of the 40 percent considered.

(2) When the applicant or member requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2)*"j."*

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

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

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

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Rescinded IAB 6/30/99, effective 9/1/99.

l. The applicant or member shall cooperate in supplying verification of all earned income and of any change in income, as defined at rule 441—75.50(249A). A self-employed applicant or member shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or member shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or member, exclusively for the applicant's or member's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent living in the family group who meet the age and school attendance requirements specified in subrule 75.54(1). Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8)*"b."*

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

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

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

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

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

b. The value of the coupon allotment in the food stamp program.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Subsidized guardianship program payments.

t. Any income restricted by law or regulation which is paid to a representative payee living outside the home, unless the income is actually made available to the applicant or member by the representative payee.

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

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

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

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

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

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

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

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

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. Deposits shall be deducted from nonexempt earned and unearned income beginning with the month following the month in which verification that deposits have begun is received. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Federal or state earned income tax credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective family investment program (FIP) payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Rescinded IAB 10/4/00, effective 10/1/00.

p. Rescinded IAB 10/4/00, effective 10/1/00.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. Rescinded IAB 10/4/00, effective 10/1/00.

s. Compensation in lieu of wages received by a child funded through an employment and training program of the U.S. Department of Labor.

t. Any amount for training expenses included in a payment funded through an employment and training program of the U.S. Department of Labor.

u. Earnings of a person aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Rescinded IAB 10/4/00, effective 10/1/00.

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

ag. Payments from property sold under an installment contract as specified in paragraphs 75.56(4)*"b"* and 75.57(1)*"d."*

ah. All census earnings received by temporary workers from the Bureau of the Census.

ai. Payments received through participation in the preparation for adult living program pursuant to 441—Chapter 187.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but who is not eligible for Medicaid is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 58 percent work incentive disregard described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group.

b. Treatment of income in stepparent cases. The income of a stepparent who is not included in the eligible group but who is living with the parent in the home of an eligible child shall be given the same consideration and treatment as that of a parent subject to the limitations of subparagraphs (1) through (10) below.

(1) The stepparent's monthly gross nonexempt earned income, earned as an employee or monthly net profit from self-employment, shall receive a 20 percent earned income deduction.

(2) The stepparent's monthly nonexempt earned income remaining after the 20 percent earned income deduction shall be allowed child care expenses for the stepparent's ineligible dependents in the home, subject to the restrictions described at subparagraphs 75.57(2)*"b"*(1) through (5).

(3) Any amounts actually paid by the stepparent to individuals not living in the home, who are claimed or could be claimed by the stepparent as dependents for federal income tax purposes, shall be deducted from nonexempt monthly earned and unearned income of the stepparent.

(4) The stepparent shall also be allowed a deduction from nonexempt monthly earned and unearned income for alimony and child support payments made to individuals not living in the home with the stepparent.

(5) Except as described at subrule 75.57(10), the nonexempt monthly earned and unearned income of the stepparent remaining after application of the deductions at subparagraphs 75.57(8)*"b"*(1) through (4) above shall be used to meet the needs of the stepparent and the stepparent's dependents living in the home, when the dependents' needs are not included in the eligible group and the stepparent claims or could claim the dependents for federal income tax purposes. These needs shall be determined in accordance with the schedule of needs for a family group of the same composition in accordance with subrule 75.58(2).

(6) The stepparent shall be allowed the 58 percent work incentive disregard from monthly earnings. The disregard shall be applied to earnings that remain after all other deductions at subparagraphs 75.57(8)*"b"*(1) through (5) have been subtracted from the earnings. However, the work incentive disregard is not allowed when determining initial eligibility as described at subparagraphs 75.57(9)*"a"*(2) and (3).

(7) The deductions described in subparagraphs (1) through (6) shall first be subtracted from earned income in the same order as they appear above.

When the stepparent has both nonexempt earned and unearned income and earnings are less than the allowable deductions, then any remaining portion of the deductions in subparagraphs (3) through (5) shall be subtracted from unearned income. Any remaining income shall be applied as unearned income to the needs of the eligible group.

If the stepparent has earned income remaining after allowable deductions, then any nonexempt unearned income shall be added to the earnings and the resulting total counted as unearned income to the needs of the eligible group.

(8) A nonexempt, nonrecurring lump sum received by a stepparent shall be considered as income and counted in computing eligibility in the same manner as it would be treated for a parent. Any portion of the nonrecurring lump sum retained by the stepparent in the month following the month of receipt shall be considered a resource to the stepparent if that portion is not exempted according to paragraph 75.56(1)*"f."*

(9) When the income of the stepparent, not in the eligible group, is insufficient to meet the needs of the stepparent and the stepparent's dependents living in the home who are not eligible for FMAP-related Medicaid, the income of the parent may be diverted to meet the unmet needs of the children of the current marriage except as described at subrule 75.57(10).

(10) When the needs of the stepparent, living in the home, are not included in the eligible group, the eligible group and any children of the parent living in the home who are not eligible for FMAP-related Medicaid shall be considered as one unit, and the stepparent and the stepparent's dependents, other than the spouse, shall be considered a separate unit.

(11) Rescinded IAB 6/30/99, effective 9/1/99.

c. Treatment of income in underage parent cases. In the case of a dependent child whose unmarried parent is under the age of 18 and living in the same home as the unmarried, underage parent's own self-supporting parents, the income of each self-supporting parent shall be considered available to the eligible group after appropriate deductions unless the provisions of rule 441—75.59(249A) apply. The deductions to be applied are the same as are applied to the income of a stepparent pursuant to subparagraphs 75.57(8)*"b"*(1) through (7). Child care expenses at subparagraph 75.57(8)*"b"*(2) shall

be allowed for the self-supporting parent's ineligible children. Nonrecurring lump sum income received by the self-supporting parent(s) shall be treated in accordance with subparagraph 75.57(8)*"b"*(8).

When the self-supporting spouse of a self-supporting parent is also living in the home, the income of that spouse shall be attributable to the self-supporting parent in the same manner as the income of a stepparent is determined pursuant to subparagraphs 75.57(8)*"b"*(1) through (7) unless the provisions of rule 441—75.59(249A) apply. Child care expenses at subparagraph 75.57(8)*"b"*(2) shall be allowed for the ineligible dependents of the self-supporting spouse who is a stepparent of the minor parent. Nonrecurring lump sum income received by the spouse of the self-supporting parent shall be treated in accordance with subparagraph 75.57(8)*"b"*(8). The self-supporting parent and any ineligible dependents of that person shall be considered as one unit. The self-supporting spouse and the spouse's ineligible dependents, other than the self-supporting parent, shall be considered a separate unit.

75.57(9) *Budgeting process.*

a. Initial and ongoing eligibility. Both initial and ongoing eligibility shall be based on a projection of income based on the best estimate of future income.

(1) Upon application, the department shall use all earned and unearned income received by the eligible group during the 30 days before the application date to project future income. EXCEPTION: If the applicant provides verification that the 30-day period specified above is not indicative of future income, income from a longer period or verification of anticipated income from the income source may be used to project future income. Allowable work expenses shall be deducted from earned income, except in determining eligibility under the 185 percent test defined at rule 441—75.57(249A). The determination of initial eligibility is a three-step process as described at rule 441—75.57(249A).

(2) Test 1. When countable gross nonexempt earned and unearned income exceeds 185 percent of the schedule of living costs (Test 1), as identified at subrule 75.58(2) for the eligible group, eligibility does not exist under any coverage group for which these income tests apply. Countable gross income means nonexempt gross income, as defined at rule 441—75.57(249A), without application of any disregards, deductions, or diversions.

(3) Test 2. When the countable gross nonexempt earned and unearned income equals or is less than 185 percent of the schedule of living costs for the eligible group, initial eligibility under the schedule of living costs (Test 2) shall then be determined. Initial eligibility under the schedule of living costs is determined without application of the 58 percent work incentive disregard as specified at paragraph 75.57(2)*"c."* All other appropriate exemptions, deductions and diversions are applied. Countable income is then compared to the schedule of living costs (Test 2) for the eligible group. When countable net earned and unearned income equals or exceeds the schedule of living costs for the eligible group, eligibility does not exist under any coverage group for which these income tests apply.

(4) Test 3. After application of Tests 1 and 2 for initial eligibility or of Test 1 for ongoing eligibility, the 58 percent work incentive disregard at paragraph 75.57(2)*"c"* shall be applied when there is eligibility for this disregard. When countable net earned and unearned income, after application of the work incentive disregard and all other appropriate exemptions, deductions, and diversions, equals or exceeds the schedule of basic needs (Test 3) for the eligible group, eligibility does not exist under any coverage group for which these tests apply. When the countable net income is less than the schedule of basic needs for the eligible group, the eligible group meets FMAP or CMAP income requirements.

(5) Rescinded IAB 10/4/00, effective 10/1/00.

(6) When income received weekly or biweekly (once every two weeks) is projected for future months, it shall be projected by adding all income received in the time period being used and dividing the result by the number of instances of income received in that time period. The result shall be multiplied by four if the income is received weekly, or by two if the income is received biweekly, regardless of the number of weekly or biweekly payments to be made in future months.

(7) Rescinded IAB 7/4/07, effective 8/1/07.

(8) When a change in circumstances that is required to be timely reported by the client pursuant to paragraphs 75.52(4)*"d"* and *"e"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change occurred. When a change in circumstances that is required to be reported by the client at annual review or upon the addition of an individual to the eligible

group pursuant to paragraph 75.52(4)*"c"* is not reported as required, eligibility shall be redetermined beginning with the month following the month in which the change was required to be reported. All other changes shall be acted upon when they are reported or otherwise become known to the department, allowing for a ten-day notice of adverse action, if required.

b. Recurring lump-sum income. Recurring lump-sum earned and unearned income, except for the income of the self-employed, shall be prorated over the number of months for which the income was received and applied to the eligibility determination for the same number of months.

(1) Income received by an individual employed under a contract shall be prorated over the period of the contract.

(2) Income received at periodic intervals or intermittently shall be prorated over the period covered by the income and applied to the eligibility determination for the same number of months. EXCEPTION: Periodic or intermittent income from self-employment shall be treated as described at paragraph 75.57(9)*"i."*

(3) When the lump-sum income is earned income, appropriate disregards, deductions and diversions shall be applied to the monthly prorated income. Income is prorated when a recurring lump sum is received at any time.

c. Nonrecurring lump-sum income. Moneys received as a nonrecurring lump sum, except as specified in subrules 75.56(4) and 75.56(7) and at paragraphs 75.57(8)*"b"* and *"c,"* shall be treated in accordance with this rule. Nonrecurring lump-sum income includes an inheritance, an insurance settlement or tort recovery, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits, such as social security, job insurance, or workers' compensation.

(1) Nonrecurring lump-sum income shall be considered as income in the month of receipt and counted in computing eligibility, unless the income is exempt.

(2) When countable income exclusive of any family investment program grant but including countable lump-sum income exceeds the needs of the eligible group under their current coverage group, the countable lump-sum income shall be prorated. The number of full months for which a monthly amount of the lump sum shall be counted as income in the eligibility determination is derived by dividing the total of the lump-sum income and any other countable income received in or projected to be received in the month the lump sum was received by the schedule of living costs, as identified at subrule 75.58(2), for the eligible group. This period is referred to as the period of proration. Any income remaining after this calculation shall be applied as income to the first month following the period of proration and disregarded as income thereafter.

(3) The period of proration shall begin with the month when the nonrecurring lump sum was received, whether or not the receipt of the lump sum was timely reported. If receipt of the lump sum was reported timely and the calculation was completed timely, no recoupment shall be made. If receipt of the lump sum was not reported timely or the calculation was not completed timely, recoupment shall begin with the month of receipt of the nonrecurring lump sum.

(4) The period of proration shall be shortened when:

1. The schedule of living costs as defined at subrule 75.58(2) increases; or

2. A portion of the lump sum is no longer available to the eligible group due to loss or theft or because the person controlling the lump sum no longer resides with the eligible group and the lump sum is no longer available to the eligible group; or

3. There is an expenditure of the lump sum made for the following circumstances unless there was insurance available to meet the expense: Payments made on medical services for the former eligible group or their dependents for services listed in 441—Chapters 78, 81, 82, and 85 at the time the expense is reported to the department; the cost of necessary repairs to maintain habitability of the homestead requiring the spending of over $25 per incident; cost of replacement of exempt resources as defined in subrule 75.56(1) due to fire, tornado, or other natural disaster; or funeral and burial expenses. The expenditure of these funds shall be verified.

(5) When countable income, including the lump-sum income, is less than the needs of the eligible group in accordance with the provisions of their current coverage group, the lump sum shall be counted as income for the month of receipt.

(6) For purposes of applying the lump-sum provision, the eligible group is defined as all eligible persons and any other individual whose lump-sum income is counted in determining the period of proration.

(7) During the period of proration, individuals not in the eligible group when the lump-sum income was received may be eligible as a separate eligible group. Income of this eligible group plus income of the parent or other legally responsible person in the home, excluding the lump-sum income already considered, shall be considered as available in determining eligibility.

d. The third digit to the right of the decimal point in any calculation of income, hours of employment and work expenses for care, as defined at paragraph 75.57(2)*"b,"* shall be dropped.

e. In any month for which an individual is determined eligible to be added to a currently active family medical assistance (FMAP) or FMAP-related Medicaid case, the individual's needs, income, and resources shall be included. An individual who is a member of the eligible group and who is determined to be ineligible for Medicaid shall be canceled prospectively effective the first of the following month if the timely notice of adverse action requirements as provided at 441—subrule 76.4(1) can be met.

f. Rescinded IAB 10/4/00, effective 10/1/00.

g. Rescinded IAB 2/11/98, effective 2/1/98.

h. Income from self-employment received on a regular weekly, biweekly, semimonthly or monthly basis shall be budgeted in the same manner as the earnings of an employee. The countable income shall be the net income.

i. Income from self-employment not received on a regular weekly, biweekly, semimonthly or monthly basis that represents an individual's annual income shall be averaged over a 12-month period of time, even if the income is received within a short period of time during that 12-month period. Any change in self-employment shall be handled in accordance with subparagraphs (3) through (5) below.

(1) When a self-employment enterprise which does not produce a regular weekly, biweekly, semimonthly or monthly income has been in existence for less than a year, income shall be averaged over the period of time the enterprise has been in existence and the monthly amount projected for the same period of time. If the enterprise has been in existence for such a short time that there is very little income information, the worker shall establish, with the cooperation of the client, a reasonable estimate which shall be considered accurate and projected for three months, after which the income shall be averaged and projected for the same period of time. Any changes in self-employment shall be considered in accordance with subparagraphs (3) through (5) below.

(2) These policies apply when the self-employment income is received before the month of decision and the income is expected to continue, in the month of decision, after assistance is approved.

(3) A change in the cost of producing self-employment income is defined as an established permanent ongoing change in the operating expenses of a self-employment enterprise. Change in self-employment income is defined as a change in the nature of business.

(4) When a change in operating expenses occurs, the department shall recalculate the expenses on the basis of the change.

(5) When a change occurs in the nature of the business, the income and expenses shall be computed on the basis of the change.

75.57(10) *Restriction on diversion of income.* Rescinded IAB 7/11/01, effective 9/1/01.

75.57(11) *Divesting of income.* Assistance shall not be approved when an investigation proves that income was divested and the action was deliberate and for the primary purpose of qualifying for assistance or increasing the amount of assistance paid.

441—75.58(249A) Need standards.

75.58(1) *Definition of eligible group.* The eligible group consists of all eligible persons specified below and living together, except when one or more of these persons have elected to receive supplemental security income under Title XVI of the Social Security Act or are voluntarily excluded in accordance with the provisions of rule 441—75.59(249A). There shall be at least one child, which may be an unborn child, in the eligible group except when the only eligible child is receiving supplemental security income.

a. The following persons shall be included (except as otherwise provided in these rules) without regard to the person's employment status, income or resources:

(1) All dependent children who are siblings of whole or half blood or adoptive.

(2) Any parent of such children, if the parent is living in the same home as the dependent children.

b. The following persons may be included:

(1) The needy specified relative who assumes the role of parent.

(2) The needy specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker.

(3) An incapacitated stepparent, upon request, when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent does not have a child in the eligible group.

1. A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

2. The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on Form 470-0447, Report on Incapacity.

3. When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on Form 470-0502, Authorization for Examination and Claim for Payment.

4. A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for the family medical assistance program (FMAP) and FMAP-related program purposes.

5. A stepparent who is considered incapacitated and is receiving Medicaid shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

(4) The stepparent who is not incapacitated when the stepparent is the legal spouse of the parent by ceremonial or common-law marriage and the stepparent is required in the home to care for the dependent children. These services must be required to the extent that if the stepparent were not available, it would be necessary to allow for care as a deduction from earned income of the parent.

75.58(2) *Schedule of needs.* The schedule of living costs represents 100 percent of the basic needs. The schedule of living costs is used to determine the needs of individuals when these needs must be determined in accordance with the schedule of needs defined at rule 441—75.50(249A). The 185 percent schedule is included for the determination of eligibility in accordance with rule 441—75.57(249A). The schedule of basic needs is used to determine the basic needs of those persons whose needs are included in the eligible group. The eligible group is considered a separate and distinct group without regard to the presence in the home of other persons, regardless of relationship to or whether they have a liability to support members of the eligible group. The schedule of basic needs is also used to determine the needs of persons not included in the eligible group. The percentage of basic needs paid to one or more persons as compared to the schedule of living costs is shown on the chart below:

SCHEDULE OF NEEDS

Number of Persons	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Test 1 185% of Living Costs	675.25	1330.15	1570.65	1824.10	2020.20	2249.60	2469.75	2695.45	2915.60	3189.40	320.05
Test 2 Schedule of Living Costs	365	719	849	986	1092	1216	1335	1457	1576	1724	173
Test 3 Schedule of Basic Needs	183	361	426	495	548	610	670	731	791	865	87
Ratio of Basic Needs to Living Costs	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18	50.18

CHART OF BASIC NEEDS COMPONENTS

(all figures are on a per person basis)

Number of Persons	1	2	3	4	5	6	7	8	9	10 or More
Shelter	77.14	65.81	47.10	35.20	31.74	26.28	25.69	22.52	20.91	20.58
Utilities	19.29	16.45	11.77	8.80	7.93	6.57	6.42	5.63	5.23	5.14
Household Supplies	4.27	5.33	4.01	3.75	3.36	3.26	3.10	3.08	2.97	2.92
Food	34.49	44.98	40.31	39.11	36.65	37.04	34.00	33.53	32.87	32.36
Clothing	11.17	11.49	8.70	8.75	6.82	6.84	6.54	6.39	6.20	6.10
Pers. Care & Supplies	3.29	3.64	2.68	2.38	2.02	1.91	1.82	1.72	1.67	1.64
Med. Chest Supplies	.99	1.40	1.34	1.13	1.15	1.11	1.08	1.06	1.09	1.08
Communications	7.23	6.17	3.85	3.25	2.50	2.07	1.82	1.66	1.51	1.49
Transportation	25.13	25.23	22.24	21.38	17.43	16.59	15.24	15.79	15.44	15.19

a. The definitions of the basic need components are as follows:

(1) Shelter: Rental, taxes, upkeep, insurance, amortization.

(2) Utilities: Fuel, water, lights, water heating, refrigeration, garbage.

(3) Household supplies and replacements: Essentials associated with housekeeping and meal preparation.

(4) Food: Including school lunches.

(5) Clothing: Including layette, laundry, dry cleaning.

(6) Personal care and supplies: Including regular school supplies.

(7) Medicine chest items.

(8) Communications: Telephone, newspapers, magazines.

(9) Transportation: Including bus fares.

b. Special situations in determining eligible group:

(1) The needs of a child or children in a nonparental home shall be considered a separate eligible group when the relative is receiving Medicaid for the relative's own children.

(2) When the unmarried specified relative under the age of 19 is living in the same home with a parent or parents who receive Medicaid, the needs of the specified relative, when eligible, shall be included in the same eligible group with the parents. When the specified relative is a parent, the needs of the eligible children for whom the unmarried parent is caretaker shall be included in the same eligible group. When the specified relative is a nonparental relative, the needs of the eligible children for whom the specified relative is caretaker shall be considered a separate eligible group.

When the unmarried specified relative under the age of 19 is living in the same home as a parent who receives Medicaid but the specified relative is not an eligible child, need of the specified relative shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative under the age of 19 is living with a nonparental relative or in an independent living arrangement, need shall be determined in the same manner as though the specified relative had attained majority.

When the unmarried specified relative is under the age of 18 and living in the same home with a parent who does not receive Medicaid, the needs of the specified relative, when eligible, shall be included in the eligible group with the children when the specified relative is a parent. When the specified relative is a nonparental relative as defined at subrule 75.55(1), only the needs of the eligible children shall be included in the eligible group. When the unmarried specified relative is aged 18, need shall be determined in the same manner as though the specified relative had attained majority.

(3) When a person who would ordinarily be in the eligible group has elected to receive supplemental security income benefits, the person, income and resources shall not be considered in determining eligibility for the rest of the family.

(4) When two individuals, married to each other, are living in a common household and the children of each of them are recipients of Medicaid, the eligibility shall be computed on the basis of their comprising one eligible group.

(5) When a child is ineligible for Medicaid, the income and resources of that child are not used in determining eligibility of the eligible group and the ineligible child is not a part of the household size. However, the income and resources of a parent who is ineligible for Medicaid are used in determining eligibility of the eligible group and the ineligible parent is counted when determining household size.

441—75.59(249A) Persons who may be voluntarily excluded from the eligible group when determining eligibility for the family medical assistance program (FMAP) and FMAP-related coverage groups.

75.59(1) *Exclusions from the eligible group.* In determining eligibility under the family medical assistance program (FMAP) or any FMAP-related Medicaid coverage group in this chapter, the following persons may be excluded from the eligible group when determining Medicaid eligibility of other household members.

a. Siblings (of whole or half blood, or adoptive) of eligible children.

b. Self-supporting parents of minor unmarried parents.

c. Stepparents of eligible children.

d. Children living with a specified relative, as listed at subrule 75.55(1).

75.59(2) *Needs, income, and resource exclusions.* The needs, income, and resources of persons who are voluntarily excluded shall also be excluded. If a self-supporting parent of a minor unmarried parent is voluntarily excluded, then the minor unmarried parent shall not be counted in the household size when determining eligibility for the minor unmarried parent's child. However, the income and resources of the minor unmarried parent shall be used in determining eligibility for the unmarried minor parent's child. If a stepparent is voluntarily excluded, the natural or adoptive parent shall not be counted in the household size when determining eligibility for the natural or adoptive parent's children. However, the income and resources of the natural or adoptive parent shall be used in determining eligibility for the natural or adoptive parent's children.

75.59(3) *Medicaid entitlement.* Persons whose needs are voluntarily excluded from the eligibility determination shall not be entitled to Medicaid under this or any other coverage group.

75.59(4) *Situations where parent's needs are excluded.* In situations where the parent's needs are excluded but the parent's income and resources are considered in the eligibility determination (e.g., minor unmarried parent living with self-supporting parents), the excluded parent shall be allowed the earned income deduction, child care expenses and the work incentive disregard as provided at paragraphs 75.57(2)*"a," "b,"* and *"c."*

75.59(5) *Situations where child's needs, income, and resources are excluded.* In situations where the child's needs, income, and resources are excluded from the eligibility determination pursuant to subrule 75.59(1), and the child's income is not sufficient to meet the child's needs, the parent shall be allowed to divert income to meet the unmet needs of the excluded child. The maximum amount to be diverted shall be the difference between the schedule of basic needs of the eligible group with the child included and the schedule of basic needs with the child excluded, in accordance with the provisions of subrule 75.58(2), minus any countable income of the child.

441—75.60(249A) Pending SSI approval. When a person who would ordinarily be in the eligible group has applied for supplemental security income benefits, the person's needs may be included in the eligible group pending approval of supplemental security income.

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CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Pharmacies are eligible to participate providing they are licensed in the state of Iowa or duly licensed in other states.

441—77.3(249A) Hospitals. All hospitals licensed in the state of Iowa and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program. Hospitals in other states are also eligible if duly licensed and certified for Medicare participation in that state.

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by

a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety's name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. Effective dates and submission dates.

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. Amount of bond. Bonds for any period shall be in the amount of $50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of $50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. Other requirements. Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Remedial services providers. A provider of remedial services is eligible to participate in the medical assistance program when:

1. The provider is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission pursuant to 441—Chapter 24; or
2. The provider was certified by the department as a provider of rehabilitative treatment services pursuant to 441—185.10(234) before September 1, 2006; or
3. The provider can demonstrate to the Iowa Medicaid enterprise that the provider has the skills and resources necessary to implement a member's treatment plan and remedial services implementation plan.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 7741B**, IAB 5/6/09, effective 7/1/09]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the standards of the National Register of Health Service Providers in Psychology.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

77.25(1) *Definitions.*

"Guardian" means a guardian appointed in probate or juvenile court.

"Major incident" means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

77.25(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

b. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The member's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) *Case management.* The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 441—Chapter 24.

77.25(6) *Day habilitation.* The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a," "d," "g,"* or *"h."*

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(7) *Home-based habilitation.* The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(8) *Prevocational habilitation.* The following providers may provide prevocational services:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. An agency that is certified by the department to provide prevocational services under:

(1) The home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

77.25(9) *Supported employment habilitation.* The following agencies may provide supported employment services:

a. An agency that is certified by the department to provide supported employment services under:

(1) The home- and community-based services mental retardation waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

f. An agency that is accredited by the International Center for Clubhouse Development.

77.25(10) *Provider enrollment.* A prospective provider that meets the criteria in this rule shall be enrolled as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. Payment for services will be made to a provider only upon department approval of the provider and of the service the provider is authorized to provide.

a. The Iowa Medicaid enterprise shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.

b. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:

(1) Current accreditations.

(2) Evaluations.

(3) Inspection reports.

(4) Reviews by regulatory and licensing agencies and associations.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) *Licensed independent social workers (LISW).* Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(3) *Licensed master social workers (LMSW).*

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

This rule is intended to implement Iowa Code chapter 249A as amended by 2008 Iowa Acts, Senate File 2425, section 123.

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) *Standards in 441—Chapter 24.* Providers shall meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) *Standards in 441—Chapter 186.* Rescinded IAB 10/12/05, effective 10/1/05.

441—77.30(249A) HCBS ill and handicapped waiver service providers. HCBS ill and handicapped waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled

HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS ill and handicapped waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules, 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

77.30(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.30(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the HCBS MR or BI waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 321—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137B.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a licensed dietitian:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the consumer's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the consumer.

d. The broker shall not work for an individual or entity that is providing services to the consumer.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the consumer.

f. The broker must complete an independent support brokerage certification approved by the department.

77.30(15) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age; and

(2) Be able to communicate successfully with the consumer.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

77.30(16) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age; and

(2) Be able to communicate successfully with the consumer.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

77.30(17) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age; and

(2) Be able to communicate successfully with the consumer.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timecards to the financial management service within 30 days from the date when the service was provided.

77.30(18) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS ill and handicapped waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135) or which are certified as a home health agency under Medicare.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the HCBS MR waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Area agencies on aging as designated in 321—4.4(231). Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide chore services may also provide chore services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers contracting with the department of public health shall be considered to have met these standards.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers certified under the HCBS MR waiver.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137B.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 321—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification provides under the ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 321—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a licensed dietitian:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Licensed dietitians approved by an area agency on aging.

77.33(13) *Assistive devices providers.* The following providers may provide assistive devices:

a. Medicaid-eligible medical equipment and supply dealers.

b. Area agencies on aging as designated according to department of elder affairs rules 321—4.3(249D) and 321—4.4(249D).

c. Assistive devices providers with a contract with an area agency on aging or with a letter of approval from an area agency on aging stating the organization is qualified to provide assistive devices.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards

and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider organization shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (The Council) to provide case management; or

(5) Is approved by the department of elder affairs as meeting the standards for case management services in 321—Chapter 21; or

(6) Is approved by the department of public health as meeting the standards for case management services in 641—Chapter 80.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1) Specific procedures to identify conflicts of interest.

(2) Procedures to eliminate any conflict of interest that is identified.

(3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

(1) That entity must also meet the provider qualifications in this subrule; and

(2) The contractor is responsible for verification of compliance.

77.33(22) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;

2. Results in bruising;

3. Results in seizure activity;

4. Results in injury to self, to others, or to property; or

5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

77.34(1) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) *Homemaker providers.* Homemaker providers shall be agencies which meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135) and 641—80.7(135), or which are certified as a home health agency under Medicare.

77.34(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the HCBS MR or BI waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137B.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 321—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.34(8) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements

of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) HCBS MR waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS mental retardation waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)*"a"*(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not

be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS MR providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS mental retardation waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS MR waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) *Review of providers.* Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)*"e"* and 77.37(13)*"f."*

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) *Supported community living providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.
2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. Living units designed to serve more than three supported community living consumers shall be approved as follows:

(1) The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.

(2) The department may approve conversion of a total of 40 living units for five persons or fewer formerly licensed as residential care facilities for persons with mental retardation to living units designed to serve supported community living consumers. Upon approval, the living unit shall surrender the facility license and continue to operate under the medical assistance home- and community-based services waiver for persons with mental retardation.

Approvals of living units for five persons or fewer formerly licensed as residential care facilities for persons with mental retardation granted before July 1, 2002, shall remain in effect.

Applications for approval to be granted under this subparagraph after July 1, 2003, shall be submitted to the Department of Human Services, Bureau of Long-Term Care, 1305 E. Walnut Street, Fifth Floor, Des Moines, Iowa 50319-0114. The application shall include a letter of support from the county in which the living unit is located. The letter shall verify that the county will request sufficient waiver slots for the consumers to be served and provide necessary county funding.

The bureau of long-term care shall approve the application based on the letter of support from the county and the requirement to maintain the geographical distribution of supported community living programs to avoid an overconcentration of programs in an area.

(3) Subject to federal approval, a residential program which serves not more than eight individuals and is licensed as an intermediate care facility for persons with mental retardation may surrender the facility license and continue to operate under the home- and community-based services waiver for persons with mental retardation if the department has approved the timelines submitted by the residential program pursuant to subparagraph 77.37(14)*"d"*(1).

(4) The department shall approve a living unit for five persons subject to all of the following conditions:

1. Approval will not result in an overconcentration of such living units in an area.
2. The county in which the living unit is located submits a letter of support for approval to the bureau of long-term care.
3. The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following:

- The quantity of services currently available in the county is insufficient to meet the need.
- The quantity of affordable rental housing in the county is insufficient.
- Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Home care agencies that meet the home care standards and requirements set forth in department of public health rules 641—80.5(135) through 641—80.7(135).

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

a. Providers responsible for the payroll of consumers shall have policies that include, but are not limited to:

(1) Consumer vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

(5) Department of labor requirements.

b. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.37(17) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the mental retardation or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues.Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.
3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.
4. Specific service activities to be provided to achieve the objectives.
5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.
6. Date of service initiation and date of individual service plan development.
7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.
2. Progress toward goals and objectives is not being made.
3. Changes have occurred in the identified service needs of the child, as listed on Form 470-3273, Mental Retardation Functional Assessment Tool.
4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.
2. What physical change will need to take place in the living units.
3. How children and their families will be involved in the transitioning process.
4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h"* and subparagraph 77.37(23)*"f"*(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 321—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.37(26) *Prevocational services providers.* Providers of prevocational services must be accredited by one of the following:

a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.

b. The Council on Quality and Leadership.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14) since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a"* or *"d."*

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.38(249A) Rehabilitative treatment service providers. Rescinded IAB 8/1/07, effective 9/5/07.

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject

to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

(3) The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties and the state to be served by the provider.

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a consumer will be severely jeopardized if the circumstances are not immediately corrected. The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department, the county of residence, and the central point of coordination shall be notified immediately to discontinue funding for that provider's service. If this action is appealed and the consumer, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the consumers deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)*"f."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. Living units designed to serve more than three supported community living consumers shall be approved as follows:

(1) The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of such programs in the area.

(2) The department may approve living units designed to serve more than four supported community living consumers under an exception to policy pursuant to rule 441—1.8(17A,217), subject to the following additional requirements:

1. The provider shall provide verification from the department of inspections and appeals that the program is not required to be licensed as a health care facility under Iowa Code chapter 135C.

2. The provider shall provide justification of the need for the service to be provided in a larger living unit instead of a living unit for four persons or less.

3. The geographic location of the program shall not result in an overconcentration of supported community living programs in the area.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS mental retardation waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(11) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

a. Providers responsible for the payroll of consumers shall have policies that include, but are not limited to:

(1) Consumer vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

(5) Both state and federal department of labor requirements.

b. The department shall certify only public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 321—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

77.39(19) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

77.39(21) *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) *Prevocational services providers.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) *Consumer-directed attendant care service providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the consumer or a parent or stepparent of a consumer aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on the behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers that meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and that have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to consumers shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the consumer or a parent or stepparent of the consumer if the consumer is aged 17 or under.

(3) Not be a usual caregiver of the consumer.

(4) Be qualified by training or experience, as determined by the usual caregivers and a licensed medical professional on the consumer's interdisciplinary team and documented in the service plan, to provide medical intervention or intervention in a medical emergency necessary to carry out the consumer's plan of care.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to consumers. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

c. The prospective provider's written agreement to work cooperatively with the state and central point of coordination in the counties to be served by the provider.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the consumer to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the consumer's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the consumer.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a consumer who receives home- and community-based services.

b. Home care providers that have a contract with the department of public health or have written certification from the department of public health stating that they meet the home care standards and

requirements set forth in department of public health rules 641—80.5(135), 641—80.6(135), and 641—80.7(135).

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are voluntarily accredited or certified by the department of elder affairs.

h. Adult day service providers which meet the conditions of participation for adult day care providers as specified at 441—subrule 77.30(3), 77.33(1), 77.34(7), or 77.39(20) and which have provided a point-in-time letter of notification from the department of elder affairs or an area agency on aging stating the adult day service provider also meets the requirements of department of elder affairs rules in 321—Chapter 25.

77.41(3) *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver or certified as home and vehicle modification providers under the mental retardation or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) *Transportation service providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 321—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

77.41(7) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09]

441—77.42(249A) Rehabilitation services to adults with chronic mental illness providers. Rescinded IAB 8/1/07, effective 9/5/07.

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

77.43(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards:

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION: The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS mental retardation or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. Qualified providers. The following agencies may provide family and community support services under the children's mental health waiver:

(1) Remedial services providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. Staff training. The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) *In-home family therapy providers.*

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) *Respite care providers.*

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Child care centers licensed in good standing by the department according to 441—Chapter 109 and child development homes registered according to 441—Chapter 110.

(4) Camps certified in good standing by the American Camping Association.

(5) Home health agencies that are certified in good standing to participate in the Medicare program.

(6) Home care agencies that meet the requirements set forth in department of public health rule 641—80.7(135).

(7) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321—Chapter 24.

(8) Assisted living programs certified in good standing by the department of inspections and appeals.

(9) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(10) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)*"c."*

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;
4. Identification and reporting of child abuse;
5. Incident reporting;
6. Documentation of service provision;
7. Appropriate behavioral interventions; and
8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 79]

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider's allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Payments to health care providers that are owned or operated by Iowa state or non-state government entities shall not exceed the provider's cost of providing services to Medicaid members. Providers of service must accept reimbursement based upon the department's methodology without making any additional charge to the member.

79.1(1) *Types of reimbursement.*

a. Prospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated prospectively for each participating provider based on reasonable and proper costs of operation. The rate is determined by establishing a base year per diem rate to which an annual index is applied.

b. Retrospective cost-related. Providers are reimbursed on the basis of a per diem rate calculated retrospectively for each participating provider based on reasonable and proper costs of operation with suitable retroactive adjustments based on submission of financial and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment (generally the Medicare principles of apportionment) to be the actual cost of service rendered medical assistance recipients.

c. Fee schedules. Fees for the various procedures involved are determined by the department with advice and consultation from the appropriate professional group. The fees are intended to reflect the amount of resources (time, training, experience) involved in each procedure. Individual adjustments will be made periodically to correct any inequity or to add new procedures or eliminate or modify others. If product cost is involved in addition to service, reimbursement is based either on a fixed fee, wholesale cost, or on actual acquisition cost of the product to the provider, or product cost is included as part of the fee schedule. Providers on fee schedules are reimbursed the lower of:

(1) The actual charge made by the provider of service.

(2) The maximum allowance under the fee schedule for the item of service in question.

Payment levels for fee schedule providers of service will be increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved to the extent data is available. Annual increases will be made beginning July 1, 1988.

There are some variations in this methodology which are applicable to certain providers. These are set forth below in subrules 79.1(3) to 79.1(9) and 79.1(15).

Fee schedules in effect for the providers covered by fee schedules can be obtained from the department's Web site at: http://www.ime.state.ia.us/Reports_Publications/FeeSchedules.html.

d. Monthly fee for service with cost settlement. Providers of MR/CMI/DD case management services are reimbursed on the basis of a payment for a month's provision of service for each client enrolled in an MR/CMI/DD case management program for any portion of the month based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

Providers are reimbursed throughout each fiscal year on the basis of a projected monthly rate for each participating provider, based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles) with annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider

on financial and statistical reports. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

The methodology for determining the reasonable and proper cost for service provision assumes the following:

(1) The indirect administrative costs shall be limited to 20 percent of other costs.

(2) Mileage shall be reimbursed at a rate no greater than the state employee rate.

(3) The rates a provider may charge are subject to limits established at 79.1(2).

(4) Costs of operation shall include only those costs which pertain to the provision of services which are authorized under rule 441—90.3(249A).

e. Retrospectively limited prospective rates. Providers are reimbursed on the basis of a rate for a unit of service calculated prospectively for each participating provider (and, for supported community living daily rates, for each consumer or site) based on projected or historical costs of operation, subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

The prospective rates for new providers who have not submitted six months of cost reports will be based on a projection of the provider's reasonable and proper costs of operation until the provider has submitted an annual cost report that includes a minimum of six months of actual costs. The prospective rates paid established providers who have submitted an annual report with a minimum of a six-month history are based on reasonable and proper costs in a base period and are adjusted annually for inflation. The prospective rates paid to both new and established providers are subject to the maximums listed in subrule 79.1(2) and to retrospective adjustment based on the provider's actual, current costs of operation as shown by financial and statistical reports submitted by the provider, so as not to exceed reasonable and proper costs actually incurred by more than 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital's fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5)*"aa"* and 79.1(16)*"h."*

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/08 plus 1%. Air ambulance: Fee schedule in effect 6/30/08 plus 1%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/08 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Behavioral health services	Fee schedule	Fee schedule.
Birth centers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/08 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Federally qualified health centers	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Veterans Administration contract rate or $22.12 per half-day, $44.03 per full day, or $66.03 per extended day if no Veterans Administration contract. For mental retardation waiver: County contract rate or, in the absence of a contract rate, $29.47 per half-day, $58.83 per full day, or $75.00 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $49.53. Ongoing monthly fee $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.81 per hour.
5. Nursing care	For elderly and mental retardation waivers: Fee schedule as determined by Medicare.	For elderly waiver: $82.92 per visit. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers: Cannot exceed $82.92 per visit.
6. Respite care when provided by:		
Home health agency:		
Specialized respite	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$13.12 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$13.12 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$13.12 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$13.12 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.71 per half hour.
8. Home-delivered meals	Fee schedule	$7.71 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1010 lifetime maximum. For mental retardation waiver: $5050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.25 per unit.
13. Assistive devices	Fee schedule	$110.05 per unit.
14. Senior companion	Fee schedule	$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$20.20 per hour not to exceed the daily rate of $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,117 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $36.71 per day.
Individual	Fee agreed upon by consumer and provider	$13.47 per hour not to exceed the daily rate of $78.56 per day.
16. Counseling		
Individual:	Fee schedule	$10.79 per unit.
Group:	Fee schedule	$43.14 per hour.
17. Case management	Fee schedule	For brain injury waiver: $598.68 per month. For elderly waiver: $70 per month.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR per diem.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour and 26 hours per 12 months.

Provider category	Basis of reimbursement	Upper limit
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.81 per hour for personal care. Maximum of $6.19 per hour for services in an enclave setting. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6060 per year.
21. Behavioral programming	Fee schedule	$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	$43.14 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $37.44 per day. For the mental retardation waiver: County contract rate or, in absence of a contract rate, $48.22 per day.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Child development home or center	Fee schedule	$13.12 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour.
29. In-home family therapy	Fee schedule	$93.63 per hour.
30. Financial management services	Fee schedule	$65.65 per enrolled consumer per month.
31. Independent support broker	Rate negotiated by consumer	$15.15 per hour.
32. Self-directed personal care	Rate negotiated by consumer	Determined by consumer's individual budget.
33. Self-directed community supports and employment	Rate negotiated by consumer	Determined by consumer's individual budget.
34. Individual-directed goods and services	Rate negotiated by consumer	Determined by consumer's individual budget.

Provider category	Basis of reimbursement	Upper limit
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule based on MR/CMI/DD case management rates as set under 79.1(1)*"d."*	$598.68 per month.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	$46.70 per hour or $105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	$13.21 per hour, $32.15 per half-day, or $64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	$9.91 per hour, $24.11 per half-day, or $48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	$6.19 per hour for services in an enclave setting; $19.81 per hour for personal care; and $34.98 per hour for all other services. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 6/30/08 plus 1%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.
Hospices	Fee schedule as determined by Medicare	Medicare cap. (See 79.1(14)*"d"*)
Hospitals (Critical access)	Retrospectively adjusted prospective rates. See 79.1(1)*"g"* and 79.1(5)	The reasonable cost of covered services provided to medical assistance recipients or the upper limits for other hospitals, whichever is greater.
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/08 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 7/01/08.

Provider category	Basis of reimbursement	Upper limit
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	Prospective reimbursement. See 441—82.5(249A)	Eightieth percentile of facility costs as calculated from annual cost reports.
Lead inspection agency	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/08 plus 1%.
MR/CMI/DD case management providers	Monthly fee for service with cost settlement. See 79.1(1)*"d"*	Retrospective cost-settled rate.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"* (1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"* (1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	
2. Hospital-based, Medicare-certified nursing care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(3)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance limit is 0%. The percentage of the median used to calculate the non-direct care excess payment allowance limit is 8% of the patient-day-weighted median.	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(3) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"*(3) is 110% of the patient-day-weighted median.
Occupational therapists	Fee schedule	Medicare fee schedule.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Physical therapists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/08 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Podiatrists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Prescribed drugs	See 79.1(8)	$4.57 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)

Provider category	Basis of reimbursement	Upper limit
Psychiatric medical institutions for children 1. Inpatient	Prospective reimbursement	Rate based on actual costs on 6/30/07, not to exceed a maximum of $167.19 per day.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost.
Rural health clinics	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 6/30/08 plus 1%.
State-operated institutions	Retrospective cost-related	

79.1(3) *Ambulatory surgical centers.* Payment is made for facility services on a fee schedule determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

Services of the physician or the dentist are reimbursed on the basis of a fee schedule (see paragraph 79.1(1)*"c"*). This payment is made directly to the physician or dentist.

79.1(4) *Durable medical equipment, prosthetic devices, medical supply dealers.* Fees for durable medical appliances, prosthetic devices and medical supplies are developed from several pricing sources and are based on pricing appropriate to the date of service; prices are developed using prior calendar year price information. The average wholesale price from all available sources is averaged to determine the fee for each item. Payment for used equipment will be no more than 80 percent of the purchase allowance. For supplies, equipment, and servicing of standard wheelchairs, standard hospital beds, enteral nutrients, and enteral and parenteral supplies and equipment, the fee for payment shall be the lowest price for which the devices are widely and consistently available in a locality.

79.1(5) *Reimbursement for hospitals.*

a. Definitions.

"Adolescent" shall mean a Medicaid patient 17 years or younger.

"Adult" shall mean a Medicaid patient 18 years or older.

"Average daily rate" shall mean the hospital's final payment rate multiplied by the DRG weight and divided by the statewide average length of stay for a DRG.

"Base year cost report," for rates effective October 1, 2005, shall mean the hospital's cost report with fiscal year end on or after January 1, 2004, and before January 1, 2005, except as noted in 79.1(5)*"x."* Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base amount" shall mean the case-mix-adjusted, hospital-specific operating cost per discharge associated with treating Medicaid patients, plus the statewide average case-mix-adjusted operating cost per Medicaid discharge, divided by two. This base amount is the value to which payments for inflation and capital costs are added to form a final payment rate. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide average case-mix-adjusted operating cost per Medicaid discharge.

For purposes of calculating the disproportionate share rate only, a separate blended base amount shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children. This separate amount shall be determined using only the case-mix-adjusted operating cost per discharge associated with treating Medicaid patients in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Blended capital costs" shall mean case-mix-adjusted hospital-specific capital costs, plus statewide average capital costs, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report shall not be used in determining the statewide average capital costs.

For purposes of calculating the disproportionate share rate only, separate blended capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the capital costs related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Capital costs" shall mean an add-on to the blended base amount, which shall compensate for Medicaid's portion of capital costs. Capital costs for buildings, fixtures and movable equipment are defined in the hospital's base year cost report, are case-mix adjusted, are adjusted to reflect 80 percent of allowable costs, and are adjusted to be no greater than one standard deviation off the mean Medicaid blended capital rate.

For purposes of calculating the disproportionate share rate only, separate capital costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only the base year cost report information related to the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix adjusted" shall mean the division of the hospital-specific base amount or other applicable components of the final payment rate by the hospital-specific case-mix index. For purposes of calculating the disproportionate share rate only, a separate case-mix adjustment shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the base amount or other applicable component for the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of cases treated in a hospital compared to the statewide average. For purposes of calculating the disproportionate share rate only, a separate case-mix index shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the average costliness of cases treated in the distinct area or areas of the hospital where services are provided predominantly to children under 18 years of age.

"Children's hospitals" shall mean hospitals with inpatients predominantly under 18 years of age. For purposes of qualifying for disproportionate share payments from the graduate medical education and disproportionate share fund, a children's hospital is defined as a duly licensed hospital that:

1. Either provides services predominantly to children under 18 years of age or includes a distinct area or areas that provide services predominantly to children under 18 years of age, and
2. Is a voting member of the National Association of Children's Hospitals and Related Institutions.

"Cost outlier" shall mean cases which have an extraordinarily high cost as established in 79.1(5)*"f,"* so as to be eligible for additional payments above and beyond the initial DRG payment.

"Critical access hospital" or *"CAH"* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

"Diagnosis-related group (DRG)" shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital's case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share payment" shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

"Disproportionate share percentage" shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5)*"y"*(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Disproportionate share rate" shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

"DRG weight" shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

"Final payment rate" shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider's reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

"Full DRG transfer" shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

"Indirect medical education rate" shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns' and residents' program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Inlier" shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

"Long stay outlier" shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5)*"f."*

"Low-income utilization rate" shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5)*"f."*

b. Determination of final payment rate amount. The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5)*"r."* Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5)*"r."* Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. Using all applicable claims for the period January 1, 2003, through December 31, 2004, and paid through March 31, 2005, the recalibration for rates effective October 1, 2005, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated from Medicaid charge data on discharge dates occurring from January 1, 2003, to December 31, 2004, and paid through March 31, 2005. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.

2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.

3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.

4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.

5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's 2004 fiscal year and paid through March 31, 2005, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital, using claims and associated DRG weights only for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and

2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs, direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average

case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus $16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient

remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5)*"r,"* and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)*"r,"* and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)*"r,"* which are paid per diem, as specified in paragraph 79.1(5)*"i."*

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)*"r"* and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)*"r"* is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital's base-year cost report pursuant to paragraph 79.1(5)*"a."* No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)*"j."*

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an

overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state's fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare's approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital's reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)*"y"*(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital's average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa's Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital's submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state's Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph *"y."*

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph *"y."*

n. Preadmission, preauthorization, or inappropriate services. Medicaid adopts most Medicare QIO regulations to control increased admissions or reduced services. Exceptions to the Medicare review practice are that the QIO reviews Medicaid short stay outliers and all Medicaid patients readmitted within 31 days. Payment can be denied if either admissions or discharges are performed without medical justification as determined by the QIO. Inpatient or outpatient services which require preadmission or preprocedure approval by the QIO are updated yearly by the department and are listed in the provider manual. Preauthorization for any of these services is transmitted directly from the QIO to the Iowa Medicaid enterprise and no additional information needs to be submitted as part of the claim filing for inpatient or outpatient services. To safeguard against these and other inappropriate practices, the department through the QIO will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

o. Hospital billing. Hospitals shall normally submit claims for DRG reimbursement to the Iowa Medicaid enterprise after a patient's discharge.

(1) Payment for outlier days or costs is determined when the claim is paid by the Iowa Medicaid enterprise, as described in paragraph *"f."*

(2) When a Medicaid patient requires acute care in the same facility for a period of no less than 120 days, a request for partial payment may be made. Written requests for this interim DRG payment shall be addressed to the Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315. A request for interim payment shall include:

1. The patient's name, state identification number, and date of admission;
2. A brief summary of the case;
3. A current listing of charges; and
4. A physician's attestation that the recipient has been an inpatient for 120 days and is expected to remain in the hospital for a period of no less than 60 additional days.

A departmental representative will then contact the facility to assist the facility in filing the interim claim.

p. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient.

(1) In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, but rather that the observation period was medically necessary for the physician to determine whether a patient should be released from the hospital or admitted to the hospital as an inpatient.

(2) Outpatient observation lasting greater than a 24-hour period will be subject to review by the Iowa Medicaid Enterprise (IME) Medical Services Unit to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established by the IME,

reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

q. Inpatient admission after outpatient services. A patient may be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient within three days of the day outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services.

r. Certification for reimbursement as a special unit or physical rehabilitation hospital. Certification for Medicaid reimbursement as a substance abuse unit under subparagraph 79.1(5)*"b"*(1), a neonatal intensive care unit under subparagraph 79.1(5)*"b"*(2), a psychiatric unit under paragraph 79.1(5)*"i,"* or a physical rehabilitation hospital or unit under paragraph 79.1(5)*"i"* shall be awarded as provided in this paragraph.

(1) Certification procedure. All hospital special units and physical rehabilitation hospitals must be certified by the Iowa Medicaid enterprise to qualify for Medicaid reimbursement as a special unit or physical rehabilitation hospital. Hospitals shall submit requests for certification to Iowa Medicaid Enterprise, Attention: Provider Services Unit, P.O. Box 36450, Des Moines, Iowa 50315, with documentation that the certification requirements are met. The provider services unit will notify the facility of any additional documentation needed after review of the submitted documentation.

Upon certification, reimbursement as a special unit or physical rehabilitation hospital shall be retroactive to the first day of the month during which the Iowa Medicaid enterprise received the request for certification. No additional retroactive payment adjustment shall be made when a hospital fails to make a timely request for certification.

(2) Certification criteria for substance abuse units. An in-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if the unit's program is licensed by the Iowa department of public health as a substance abuse treatment program in accordance with Iowa Code chapter 125 and 643—Chapter 3. In addition to documentation of the license, an in-state hospital must submit documentation of the specific substance abuse programs available at the facility with a description of their staffing, treatment standards, and population served.

An out-of-state substance abuse unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(1) if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27, as amended to September 1, 1994. An out-of-state hospital requesting reimbursement as a substance abuse unit must initially submit a copy of its current Medicare prospective payment system exemption notice, unless the facility had certification for reimbursement as a substance abuse unit before July 1, 1993. All out-of-state hospitals certified for reimbursement for substance abuse units must submit copies of new Medicare prospective payment system exemption notices as they are issued, at least annually.

(3) Certification criteria for neonatal intensive care units. A neonatal intensive care unit may be certified for Medicaid reimbursement under 79.1(5)*"b"*(2) if it is certified as a level II or level III neonatal unit and the hospital where it is located is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association. The Iowa Medicaid enterprise shall verify the unit's certification as a level II or level III neonatal unit in accordance with recommendations set forth by the American Academy of Pediatrics for newborn care. Neonatal units in Iowa shall be certified by the Iowa department of public health pursuant to 641—Chapter 150. Out-of-state units shall submit proof of level II or level III certification.

(4) Certification criteria for psychiatric units. A psychiatric unit may be certified for Medicaid reimbursement under paragraph 79.1(5)*"i"* if it is excluded from the Medicare prospective payment system as a psychiatric unit pursuant to 42 Code of Federal Regulations, Sections 412.25 and 412.27 as amended to August 1, 2002.

(5) Certification criteria for physical rehabilitation hospitals and units. A physical rehabilitation hospital or unit may be certified for Medicaid reimbursement under 79.1(5)*"i"* if it receives or qualifies to receive Medicare reimbursement as a rehabilitative hospital or unit pursuant to 42 Code of Federal Regulations, Sections 412.600 through 412.632 (Subpart P), as amended to January 1, 2002, and the

hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association.

s. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

t. Limitations and application of limitations on payment. Diagnosis related group payments are subject to the upper payment limits as stated in 42 CFR 447.271 and 42 CFR 447.272 as amended to September 5, 2001.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(1) The department may not pay a provider more for inpatient hospital services under Medicaid than the provider's customary charges to the general public for the services.

(2) Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs. The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report. The department shall determine the aggregate payments made to the hospital under the diagnosis-related group methodology and compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount. If the payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

(3) Aggregate payments to hospitals and state-operated hospitals may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. Rescinded IAB 5/30/01, effective 8/1/01.

w. Rate adjustments for hospital mergers. When one or more hospitals merge to form a distinctly different legal entity, the base rate plus applicable add-ons will be revised to reflect this new entity. Financial information from the original cost reports and original rate calculations will be added together and averaged to form the new rate for that entity.

x. For cost reporting periods beginning on or after July 1, 1993, reportable Medicaid administrative and general expenses are allowable only to the extent that they are defined as allowable using Medicare Reimbursement Principles or Health Insurance Reimbursement Manual 15 (HIM-15). Appropriate, reportable costs are those that meet the Medicare (or HIM-15) principles, are reasonable, and are directly related to patient care. In instances where costs are not directly related to patient care or are not in accord with Medicare Principles of Reimbursement, inclusion of those costs in the cost report would not be appropriate. Examples of administrative and general costs that must be related to patient care to be included as a reportable cost in the report are:

(1) Advertising.
(2) Promotional items.
(3) Feasibility studies.
(4) Administrative travel and entertainment.
(5) Dues, subscriptions, or membership costs.
(6) Contributions made to other organizations.
(7) Home office costs.
(8) Public relations items.
(9) Any patient convenience items.
(10) Management fees for administrative services.
(11) Luxury employee benefits (i.e., country club dues).
(12) Motor vehicles for other than patient care.
(13) Reorganization costs.

y. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education, indirect medical education, or disproportionate share payments directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amounts allocated to the fund, and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $8,642,112.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(4) Qualifying for indirect medical education. Hospitals qualify for indirect medical education payments from the fund when they receive a direct medical education payment from Iowa Medicaid and qualify for indirect medical education payments from Medicare. Qualification for indirect medical education payments is determined without regard to the individual components of the specific hospital's teaching program, state ownership, or bed size.

(5) Allocation to fund for indirect medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(6), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $15,174,101.

(6) Distribution to qualifying hospitals for indirect medical education. Distribution of the amount in the fund for indirect medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for indirect medical education, the following formula is used:

1. Multiply the total of all DRG weights for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's indirect medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for indirect medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for indirect medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(7) Qualifying for disproportionate share. For months beginning with July 2002, hospitals qualify for disproportionate share payments from the fund when the hospital's low-income utilization rate exceeds 25 percent, when the hospital's Medicaid inpatient utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate, or when the hospital qualifies as a children's hospital under subparagraph (10).

For those hospitals that qualify for disproportionate share under both the low-income utilization rate definition and the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

For those hospitals that qualify for disproportionate share under the low-income utilization rate definition, but do not qualify under the Medicaid inpatient utilization rate definition, the disproportionate share percentage shall be 2½ percent.

For those hospitals that qualify for disproportionate share under the Medicaid inpatient utilization rate definition, but do not qualify under the low-income utilization rate definition, the disproportionate share percentage shall be the product of 2½ percent multiplied by the number of standard deviations by which the hospital's own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals.

For those hospitals that qualify for disproportionate share as a children's hospital, the disproportionate share percentage shall be the greater of (1) the product of 2½ percent multiplied by the number of standard deviations by which the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all areas of the hospital where services are provided predominantly to children under 18 years of age exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent.

Information contained in the hospital's available 2004 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

Additionally, a qualifying hospital other than a children's hospital must also have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid-eligible persons who are in need of obstetric services. In the case of a hospital located in a rural area as defined in Section 1886 of the Social Security Act, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

Out-of-state hospitals serving Iowa Medicaid patients qualify for disproportionate share payments from the fund based on their state Medicaid agency's calculation of the Medicaid inpatient utilization rate. The disproportionate share percentage is calculated using the number of standard deviations by which the hospital's own state Medicaid inpatient utilization rate exceeds the hospital's own statewide mean Medicaid inpatient utilization rate.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

Hospitals receiving reimbursement as critical access hospitals shall not qualify for disproportionate share payments from the fund.

(8) Allocation to fund for disproportionate share. The total amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments for July 1, 2008, through June 30, 2009, is $7,253,641.

(9) Distribution to qualifying hospitals for disproportionate share. Distribution of the amount in the fund for disproportionate share shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for disproportionate share, the following formula is used:

1. Multiply the total of all DRG weights for claims paid July 1, 2005, through June 30, 2006, for each hospital that met the qualifications during the fiscal year used to determine the hospital's low-income utilization rate and Medicaid utilization rate (or for children's hospitals, during the preceding state fiscal year) by each hospital's disproportionate share rate to obtain a dollar value. For any hospital that qualifies for a disproportionate share payment only as a children's hospital, only the DRG weights for claims paid for services rendered to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age shall be used in this calculation.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for disproportionate share to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. In compliance with Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (Public Law 102-234) and 1992 Iowa Acts, chapter 1246, section 13, the total of disproportionate share payments from the fund and supplemental disproportionate share payments pursuant to paragraph 79.1(5)*"ab"* cannot exceed the amount of the federal cap under Public Law 102-234. If a hospital fails to qualify for disproportionate share payments from the fund due to closure or for any other reason, the amount of money that would have been paid to that hospital shall be removed from the fund.

(10) Qualifying for disproportionate share as a children's hospital. A licensed hospital qualifies for disproportionate share payments as a children's hospital if the hospital provides services predominantly to children under 18 years of age or includes a distinct area or areas providing services predominantly to children under 18 years of age, is a voting member of the National Association of Children's Hospitals and Related Institutions, and has Medicaid utilization and low-income utilization rates of 1 percent or greater for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

A hospital wishing to qualify for disproportionate share payments as a children's hospital for any state fiscal year beginning on or after July 1, 2002, must provide the following information to the Iowa Medicaid enterprise provider cost audits and rate-setting unit within 20 business days of a request by the department:

1. Base year cost reports.

2. Medicaid claims data for children under the age of 18 at the time of admission to the hospital in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

3. Other information needed to determine a disproportionate share rate encompassing the periods used to determine the disproportionate share rate and distribution amounts.

z. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/31/01, effective 1/1/02.

aa. Retrospective adjustment for critical access hospitals. Payments to critical access hospitals pursuant to paragraphs 79.1(5)*"a"* to *"z"* are subject to a retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care), based on the hospital's annual cost reports and Medicare cost principles, and the Medicaid fee-for-service reimbursement received pursuant to

paragraphs 79.1(5)*"a"* to *"z."* Amounts paid before adjustment that exceed reasonable costs shall be recovered by the department.

(1) The base rate upon which the DRG payment is built shall be changed after any retrospective adjustment to reflect, as accurately as is possible, the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year using the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the prospective DRG base rate is not subject to inflation factors, rebasing, or recalibration as provided in paragraph 79.1(5)*"k."*

ab. Enhanced disproportionate-share payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced disproportionate-share payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying criteria for enhanced disproportionate-share payments. A hospital qualifies for enhanced disproportionate-share payments if it qualifies for payments for disproportionate share from the graduate medical education and disproportionate-share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education.

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

3. Is an Iowa state-owned hospital for persons with mental illness.

(2) Amount of payment. The total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate share shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate-share payments shall not exceed the hospital-specific disproportionate-share caps under Public Law 103-666.

The amount available for enhanced disproportionate-share payments shall be the federal allotment less disproportionate-share payments from the graduate medical education and disproportionate share fund. In the event that the disproportionate-share allotment for enhanced payments is insufficient to pay 100 percent of the cost that is eligible for disproportionate-share payments, the allotment shall be allocated among qualifying hospitals using their eligible cost as an allocation basis.

(3) Final disproportionate-share adjustment. The department's total year-end disproportionate-share obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

ac. Enhanced graduate medical education payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced graduate medical education payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying for enhanced graduate medical education payments. A hospital shall qualify for enhanced graduate medical education payments if it qualifies to receive both direct and indirect medical education payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. Is an Iowa state-owned hospital with more than 500 beds and eight or more distinct residency specialty or subspecialty programs recognized by the American College of Graduate Medical Education; or

2. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

(2) Amount of payment. The total amount of graduate medical education payments from the graduate medical education and disproportionate share fund and enhanced graduate medical education shall not exceed each hospital's actual medical assistance program graduate medical education costs. The amount paid to each qualifying hospital for enhanced graduate medical education payments shall be the hospital's actual medical assistance program graduate medical education costs less the graduate medical education payments from the graduate medical education and disproportionate share fund.

(3) Final graduate medical education adjustment. The department's total year-end graduate medical education obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

79.1(6) *Independent laboratories.* The maximum payment for clinical diagnostic laboratory tests performed by an independent laboratory will be the areawide fee schedule established by the Centers for Medicare and Medicaid Services (CMS). The fee schedule is based on the definition of laboratory procedures from the Physician's Current Procedural Terminology (CPT) published by the American Medical Association. The fee schedules are adjusted annually by CMS to reflect changes in the Consumer Price Index for All Urban Consumers.

79.1(7) *Physicians.*

a. Fee schedule. The fee schedule is based on the definitions of medical and surgical procedures given in the most recent edition of Physician's Current Procedural Terminology (CPT). Refer to 441—paragraph 78.1(2)*"e"* for the guidelines for immunization replacement.

b. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

79.1(8) *Drugs.* The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

a. Effective June 25, 2005, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph *"g."*

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a drug and all equivalent products (the average price pharmacies pay to obtain drugs as evidenced by purchase records) adjusted by a multiplier of 1.4, plus the professional dispensing fee specified in paragraph *"g."*

(4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Effective June 25, 2005, reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g."*

(2) The submitted charge, representing the provider's usual and customary charge for the drug.

c. No payment shall be made for sales tax.

d. All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.

e. The basis of payment for nonprescription drugs shall be the same as specified in paragraph *"a"* except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.

f. An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.

g. For services rendered after June 30, 2008, the professional dispensing fee is $4.57 or the pharmacy's usual and customary fee, whichever is lower.

h. For purposes of this subrule, "equivalent products" shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, "Approved Prescription Drug Products With Therapeutic Equivalence Evaluations."

i. Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)*"a"*(3) and 79.1(8)*"c"* and for the efficient operation of the pharmacy benefit.

(1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

(2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.

j. Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.

79.1(9) *HCBS consumer choices financial management.*

a. Monthly allocation. A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer's individual budget amount as determined under 441—paragraph 78.34(13)*"b,"* 78.37(16)*"b,"* 78.38(9)*"b,"* 78.41(15)*"b,"* 78.43(15)*"b,"* or 78.46(6)*"b."*

b. Cost settlement. The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.

c. Start-up grants. A qualifying financial management service provider may be reimbursed up to $10,000 for the costs associated for starting the service.

(1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.

(2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) *Prohibition against reassignment of claims.* No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to

a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) *Prohibition against factoring.* Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) *Reasonable charges for services, supplies, and equipment.* For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) *Copayment by member.* A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than $25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay $1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay $2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay $3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay $1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

79.1(14) *Reimbursement for hospice services.*

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

(1) Routine home care.

(2) Continuous home care.

(3) Inpatient respite care.

(4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of

the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.
2. Multiplying excess inpatient care days by the routine home care rate.
3. Adding together the amounts calculated in "1" and "2."
4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

79.1(15) *HCBS retrospectively limited prospective rates.* This methodology applies to reimbursement for HCBS supported community living; HCBS family and community support services; HCBS supported employment enhanced job search activities; HCBS interim medical monitoring and treatment when provided by an HCBS-certified supported community agency; HCBS respite when

provided by nonfacility providers, camps, home care agencies, or providers of residential-based supported community living; and HCBS group respite provided by home health agencies.

a. Reporting requirements.

(1) Providers shall submit cost reports for each waiver service provided using Form 470-0664, Financial and Statistical Report for Purchase of Service, and Form 470-3449, Supplemental Schedule. The cost reporting period is from July 1 to June 30. The completed cost reports shall be submitted to the IME Provider Cost Audits and Rate-Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, or by electronic mail to costaudit@dhs.state.ia.us, by September 30 of each year.

(2) If a provider chooses to leave the HCBS program or terminates a service, a final cost report shall be submitted within 60 days of termination for retrospective adjustment.

(3) Costs reported under the waiver shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under the waiver.

(4) Financial information shall be based on the agency's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Providers which are multiple program agencies shall submit a cost allocation schedule, prepared in accordance with generally accepted accounting principles.

(5) Failure to maintain records to support the cost reports may result in termination of the provider's HCBS certification.

(6) The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate noncompliance with reporting instructions.

(7) A 30-day extension for submitting the cost reports due by September 30 may be obtained by submitting a letter to the bureau of long-term care by September 30. No extensions will be granted beyond 30 days.

(8) Failure to submit a report that meets the requirements of this paragraph by September 30 or an extended deadline granted per subparagraph (7) shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

b. Home- and community-based general rate criteria.

(1) To receive reimbursement for services, a certified provider shall enter into an agreement with the department on Form 470-2918, HCBS Waiver Agreement, and have an approved service plan for the consumer.

(2) The rates a provider may charge are subject to limits established in subrule 79.1(2).

(3) Indirect administrative costs shall be limited to 20 percent of other costs.

(4) Mileage costs shall be reimbursed according to state employee rate.

(5) Consumer transportation, consumer consulting, consumer instruction, consumer environmental modification and repairs and consumer environmental furnishings shall not exceed $1,570 per consumer per year for supported community living services.

(6) For respite care provided in the consumer's home, only the cost of care is reimbursed.

(7) For respite care provided outside the consumer's home, charges may include room and board.

(8) Transportation and therapeutic resources reimbursement shall not exceed $1,500 per child per year for family and community support services.

c. Prospective rates for new providers other than respite.

(1) Providers who have not submitted an annual report including at least 6 months of actual, historical costs shall be paid prospective rates based on projected reasonable and proper costs of operation for a 12-month period reported in Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule.

(2) Prospective rates shall be subject to retrospective adjustment as provided in paragraph *"e."*

(3) After a provider has submitted an annual report including at least six months of actual, historical costs, prospective rates shall be determined as provided in paragraph *"d."*

d. Prospective rates for established providers other than respite.

(1) Providers who have submitted an annual report including at least six months of actual, historical costs shall be paid prospective rates based on reasonable and proper costs in a base period, as adjusted for inflation.

(2) The base period shall be the period covered by the first Form SS-1703-0, Financial and Statistical Report, and Form 470-3449, Supplemental Schedule, submitted to the department after 1997 that includes at least six months of actual, historical costs.

(3) Reasonable and proper costs in the base period shall be inflated by a percentage of the increase in the consumer price index for all urban consumers for the preceding 12-month period ending June 30, based on the months included in the base period, to establish the initial prospective rate for an established provider.

(4) After establishment of the initial prospective rate for an established provider, the rate will be adjusted annually, effective for the third month after the month during which the annual cost report is submitted to the department. The provider's new rate shall be the actual reconciled rate or the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, whichever is less.

(5) Prospective rates for services other than respite shall be subject to retrospective adjustment as provided in paragraph *"f."*

e. Prospective rates for respite. Prospective rates for respite shall be agreed upon between the consumer, interdisciplinary team and the provider up to the maximum, subject to retrospective adjustment as provided in paragraph *"f."*

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) *Outpatient reimbursement for hospitals.*

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base-year cost report," for rates effective July 1, 2008, shall mean the hospital's cost report with fiscal year end on or after January 1, 2006, and before January 1, 2007. Cost reports shall be reviewed using Medicare's cost-reporting and cost reimbursement principles for those cost-reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph *"g"* and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

"Discount factor" means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

"Graduate medical education and disproportionate share fund" shall mean a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

"Healthcare common procedures coding system" or *"HCPCS"* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

"Hospital-based clinic" means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

"International classifications of diseases—fourth edition, ninth revision (ICD-9)" is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person's injury or illness.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.

(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. For dates of services beginning on or after July 1, 2008, the department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients.	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).

	• Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. • May be paid when submitted on a bill type other than outpatient hospital. • An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: • That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or • For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.

H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Blood and blood products Brachytherapy sources Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q	Packaged services subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria. If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital's base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, to calculate the Medicaid cost per service. The hospital's total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital's total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital's base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n."*

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs *"g"* to *"n,"* for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus $2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital's cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)*"a"* shall be the hospital's line-item charge multiplied by the hospital's Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital's annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)*"j."*

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

(2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

(3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

(1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

(2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

(3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

(4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16)*"v"*(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

(2) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

(1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

(2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Hospital billing. Rescinded IAB 07/02/08, effective 07/01/08.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the

determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—78.31(4)*"d"*(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs.

(1) The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report.

(2) The department shall determine the aggregate payments made to the hospital under the APC methodology and shall compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, aggregate payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount.

(3) If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to all hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(16)*"v"*(3), the total amount of funding that is allocated to the graduate medical education and

disproportionate share fund for direct medical education related to outpatient services for July 1, 2008, through June 30, 2009, is $2,922,460.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from July 1, 2005, through June 30, 2006, for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/29/03, effective 1/1/04.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service.

79.1(20) *Dentists.* The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) *Rehabilitation agencies.* Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) *Medicare crossover claims for inpatient and outpatient hospital services.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

"Crossover claim" means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicaid reimbursement" means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

"Medicare payment amount" means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant to paragraph *"b"* and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph *"b."* The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

79.1(23) *Reimbursement for remedial services.* Reimbursement for remedial services shall be made on the basis of a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation. The unit rate shall not exceed the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1). The unit of service may be a quarter-hour, a half-hour, an hour, a half-day, or a day, depending on the service provided.

a. Interim rate. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. On an interim basis, pending determination of remedial services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's

obligation to reimburse that provider's reasonable costs. The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to subparagraph 79.1(23)*"c"*(1).

b. Cost reports. Reasonable and proper costs of operation shall be determined based on cost reports submitted by the provider.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) The provider shall complete Form 470-4414, Financial and Statistical Report for Remedial Services, and submit it to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year.

(3) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(4) Providers of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under remedial services.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(1) A reasonable cost for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services to members who have similar diagnoses and live in similar settings.

(2) When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(24) *Reimbursement for home- and community-based habilitation services.* Reimbursement for case management, job development, and employer development is based on a fee schedule developed using the methodology described in paragraph 79.1(1)*"d."* Reimbursement for home-based habilitation, day habilitation, prevocational habilitation, enhanced job search and supports to maintain employment is based on a retrospective cost-related rate calculated using the methodology in this subrule. All rates are subject to the upper limits established in subrule 79.1(2).

a. Units of service.

(1) A unit of case management is one month.

(2) A unit of home-based habilitation is one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(5) A unit of supported employment habilitation for activities to obtain a job is:

1. One job placement for job development and employer development.
2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. The department shall determine reasonable and proper costs of operation for home-based habilitation, day habilitation, prevocational habilitation, and supported employment based on cost reports submitted by the provider on Form 470-4425, Financial and Statistical Report for HCBS Habilitation Services.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's Medicaid enrollment.

(2) For home-based habilitation, the provider's cost report shall reflect all staff-to-member ratios and costs associated with members' specific support needs for travel and transportation, consulting, and instruction, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the member's comprehensive service plan. The total costs shall not exceed $1570 per consumer per year. The provider must maintain records to support all expenditures.

(3) The provider shall submit the complete cost report to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315, within three months of the end of the provider's fiscal year. The submission must include a working trial balance. Cost reports submitted without a working trial balance will be considered incomplete.

(4) A provider may obtain a 30-day extension for submitting the cost report by sending a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(5) A provider of services under multiple programs shall submit a cost allocation schedule, prepared in accordance with the generally accepted accounting principles and requirements specified in OMB Circular A-87. Costs reported under habilitation services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under habilitation services.

(6) If a provider fails to submit a cost report that meets the requirement of paragraph 79.1(24)*"b,"* the department shall reduce payment to 76 percent of the current rate. The reduced rate shall be paid for not longer than three months, after which time no further payments will be made.

(7) A projected cost report shall be submitted when a new habilitation services provider enters the program or an existing habilitation services provider adds a new service code. A prospective interim rate shall be established using the projected cost report. The effective date of the rate shall be the day the provider becomes certified as a Medicaid provider or the day the new service is added.

c. Rate determination based on cost reports. Reimbursement shall be made using a unit rate that is calculated retrospectively for each provider, considering reasonable and proper costs of operation.

(1) Interim rates. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate. Pending determination of habilitation services provider costs, the provider may bill for and shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

(2) Audit of cost reports. Cost reports as filed shall be subject to review and audit by the Iowa Medicaid enterprise to determine the actual cost of services rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

(3) Retroactive adjustment. When the reasonable and proper costs of operation are determined, a retroactive adjustment shall be made. The retroactive adjustment represents the difference between the

amount that the provider received during the year for covered services through an interim rate and the reasonable and proper costs of operation determined in accordance with this subrule.

79.1(25) *Reimbursement for community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3).*

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled int he Medicaid program before October 1, 2006, submits a cost report in order to develop a provider-specific interim rate, the Iowa Medicaid enterprise shall make interim payments to the provider based upon 105 percent of the greater of:

1. The statewide fee schedule for community mental health centers effective July 1, 2006, or
2. The average Medicaid managed care contracted fee amounts for community mental health centers effective July 1, 2006.

(2) For a provider that enrolls in the Medicaid program on or after October 1, 2006, until a provider-specific interim rate is developed, the Iowa Medicaid enterprise shall make interim payments based upon the average statewide interim rates for community mental health centers at the time services are rendered. A new provider may submit a projected cost report that the Iowa Medicaid enterprise will use to develop a provider-specific interim rate.

(3) Cost reports as filed are subject to review and audit by the Iowa Medicaid enterprise. The Iowa Medicaid enterprise shall determine each provider's actual, allowable costs in accordance with generally accepted accounting principles and in accordance with Medicare cost principles, subject to the exceptions and limitations in the department's administrative rules.

(4) The Iowa Medicaid enterprise shall make retroactive adjustment of the interim rate after the submission of annual cost reports. The adjustment represents the difference between the amount the provider received during the year through interim payments for covered services and the amount determined to be the actual, allowable cost of service rendered to Medicaid members.

(5) The Iowa Medicaid enterprise shall use each annual cost report to develop a provider-specific interim fee schedule to be paid prospectively. The effective date of the fee schedule change is the first day of the month following completion of the cost settlement.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(1) Financial information shall be based on the provider's financial records. When the records are not kept on an accrual basis of accounting, the provider shall make the adjustments necessary to convert the information to an accrual basis for reporting. Failure to maintain records to support the cost report may result in termination of the provider's enrollment with the Iowa Medicaid program.

(2) Providers that offer multiple programs shall submit a cost allocation schedule prepared in accordance with generally accepted accounting principles and requirements as specified in OMB Circular A-87 adopted in federal regulations at 2 CFR Part 225 as amended to August 31, 2005.

(3) Costs reported for community mental health clinic services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs under community mental health clinic services.

(4) Providers shall submit completed cost reports to the IME Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, Iowa 50315. A provider that is not hospital-based shall submit Form 470-4419 on or before the last day of the third month after the end of the provider's fiscal year. A hospital-based provider shall submit both Form 470-4419 and CMS Form 2552-96 on or before the last day of the fifth month after the end of the provider's fiscal year.

(5) A provider may obtain a 30-day extension for submitting the cost report by submitting a letter to the IME provider cost audit and rate setting unit before the cost report due date. No extensions will be granted beyond 30 days.

(6) If a provider fails to submit a cost report that meets the requirements of this paragraph, the Iowa Medicaid enterprise shall reduce the provider's interim payments to 76 percent of the current interim rate. The reduced interim rate shall be paid for not longer than three months, after which time no further payments will be made.

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

[**ARC 7835B**, IAB 6/3/09, effective 7/8/09; **ARC 7937B**, IAB 7/1/09, effective 7/1/09]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) *Definitions.*

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider's peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider's patients.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

d. Suspension or withholding of payments to provider.

e. Referral to peer review.

f. Prior authorization of services.

g. One hundred percent review of the provider's claims prior to payment.

h. Referral to the state licensing board for investigation.

i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

j. Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) *Imposition and extent of sanction.*

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

(1) Seriousness of the offense.

(2) Extent of violations.

(3) History of prior violations.

(4) Prior imposition of sanctions.
(5) Prior provision of provider education.
(6) Provider willingness to obey program rules.
(7) Whether a lesser sanction will be sufficient to remedy the problem.
(8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5)*"c"* are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations,
b. The known dollar value of the discrepancies or violations,
c. The method of computing the dollar value,
d. Notification of further actions to be taken or sanctions to be imposed by the department, and
e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

441—79.3(249A) Maintenance of records by providers of service. A provider of a service that is charged to the medical assistance program shall maintain complete and legible records as required in this rule. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1) *Financial (fiscal) records.*

a. A provider of service shall maintain records as necessary to:

(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and

(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.

b. A financial record does not constitute a medical record.

79.3(2) *Medical (clinical) records.* A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. Required records shall include any records required to maintain the provider's license in good standing.

a. Definition. "Medical record" (also called "clinical record") means a tangible history that provides evidence of:

(1) The provision of each service and each activity billed to the program; and

(2) First and last name of the member receiving the service.

b. Purpose. The medical record shall provide evidence that the service provided is:

(1) Medically necessary;

(2) Consistent with the diagnosis of the member's condition; and

(3) Consistent with professionally recognized standards of care.

c. Components.

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. The medical record shall include the items specified below unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

(3) Service documentation. The record for each service provided shall include information necessary to substantiate that the service was provided and shall include the following:

1. The specific procedures or treatments performed.
2. The complete date of the service, including the beginning and ending date if the service is rendered over more than one day.
3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis.

4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)*"c"* or *"d,"* 441—paragraph 77.33(6)*"d,"* 441—paragraph 77.34(5)*"d,"* 441—paragraph 77.37(15)*"d,"* 441—paragraph 77.39(13)*"e,"* 441—paragraph 77.39(14)*"d,"* or 441—paragraph 77.46(5)*"i,"* or 441—subparagraph 78.9(10)*"a"*(1).

5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

6. Any supplies dispensed as part of the service.

7. The first and last name and professional credentials, if any, of the person providing the service.

8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's identity.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the person who provided the services.

(4) Outcome of service. The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.
2. Nursing facility physician order.
3. Telephone order.
4. Pharmacy notes.
5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.
2. Anesthesia notes and records.
3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.
2. Certifying physician statement.
3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.
2. Preanesthesia physical examination report.
3. Operative report.
4. Anesthesia record.
5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.
2. Original prescription or updated prescriptions for corrective lenses or contact lenses.
3. Prior authorization documentation.

(8) Psychologist services:
1. Service or office psychotherapy notes or narratives.
2. Psychological examination report and notes.
(9) Clinic services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Prescriptions.
5. Medication administration records.
(10) Services provided by rural health clinics or federally qualified health centers:
1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
3. Procedure, laboratory, or test orders and results.
4. Immunization records.
(11) Services provided by community mental health centers:
1. Service referral documentation.
2. Initial evaluation.
3. Individual treatment plan.
4. Service or office notes or narratives.
5. Narratives related to the peer review process and peer review activities related to a member's treatment.
6. Written plan for accessing emergency services.
(12) Screening center services:
1. Service or office notes or narratives.
2. Immunization records.
3. Laboratory reports.
4. Results of health, vision, or hearing screenings.
(13) Family planning services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Nurses' notes.
4. Immunization records.
5. Consent forms.
6. Prescriptions.
7. Medication administration records.
(14) Maternal health center services:
1. Service or office notes or narratives.
2. Procedure, laboratory, or test orders and results.
3. Form 470-2942, Prenatal Risk Assessment.
(15) Birthing center services:
1. Service or office notes or narratives.
2. Form 470-2942, Prenatal Risk Assessment.
(16) Ambulatory surgical center services:
1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
2. Physician orders.
3. Consent forms.
4. Anesthesia records.
5. Pathology reports.
6. Laboratory and X-ray reports.
(17) Hospital services:
1. Physician orders.

2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).
3. Progress or status notes.
4. Diagnostic procedures, including laboratory and X-ray reports.
5. Pathology reports.
6. Anesthesia records.
7. Medication administration records.

(18) State mental hospital services:
1. Service referral documentation.
2. Resident assessment and initial evaluation.
3. Individual comprehensive treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:
1. Physician orders.
2. Progress or status notes.
3. Service notes or narratives.
4. Procedure, laboratory, or test orders and results.
5. Nurses' notes.
6. Physical therapy, occupational therapy, and speech therapy notes.
7. Medication administration records.
8. Form 470-0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:
1. Physician orders.
2. Progress or status notes.
3. Preliminary evaluation.
4. Comprehensive functional assessment.
5. Individual program plan.
6. Form 470-0374, Resident Care Agreement.
7. Program documentation.
8. Medication administration records.
9. Nurses' notes.
10. Form 470-0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:
1. Physician orders or court orders.
2. Independent assessment.
3. Individual treatment plan.
4. Service notes or narratives (history and physical, therapy records, discharge summary).
5. Form 470-0042, Case Activity Report.
6. Medication administration records.

(22) Hospice services:
1. Physician certifications for hospice care.
2. Form 470-2618, Election of Medicaid Hospice Benefit.
3. Form 470-2619, Revocation of Medicaid Hospice Benefit.
4. Plan of care.
5. Physician orders.
6. Progress or status notes.
7. Service notes or narratives.
8. Medication administration records.
9. Prescriptions.

(23) Services provided by rehabilitation agencies:
1. Physician orders.
2. Initial certification, recertifications, and treatment plans.
3. Narratives from treatment sessions.
4. Treatment and daily progress or status notes and forms.
(24) Home- and community-based habilitation services:
1. Notice of decision for service authorization.
2. Service plan (initial and subsequent).
3. Service notes or narratives.
(25) Remedial services and rehabilitation services for adults with a chronic mental illness:
1. Order for services.
2. Comprehensive treatment or service plan (initial and subsequent).
3. Service notes or narratives.
(26) Services provided by area education agencies and local education agencies:
1. Service notes or narratives.
2. Individualized education program (IEP).
3. Individual health plan (IHP).
4. Behavioral intervention plan.
(27) Home health agency services:
1. Plan of care or plan of treatment.
2. Certifications and recertifications.
3. Service notes or narratives.
4. Physician orders or medical orders.
(28) Services provided by independent laboratories:
1. Laboratory reports.
2. Physician order for each laboratory test.
(29) Ambulance services:
1. Documentation on the claim or run report supporting medical necessity of the transport.
2. Documentation supporting mileage billed.
(30) Services of lead investigation agencies:
1. Service notes or narratives.
2. Child's lead level logs (including laboratory results).
3. Written investigation reports to family, owner of building, child's medical provider, and local childhood lead poisoning prevention program.
4. Health education notes, including follow-up notes.
(31) Medical supplies:
1. Prescriptions.
2. Certificate of medical necessity.
3. Prior authorization documentation.
4. Medical equipment invoice or receipt.
(32) Orthopedic shoe dealer services:
1. Service notes or narratives.
2. Prescriptions.
3. Certifying physician's statement.
(33) Case management services, including HCBS case management services:
1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. Individual treatment plan.
6. Reassessment of member needs.

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).
2. Service notes or narratives.

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Forms 470-3372, HCBS Consumer-Directed Attendant Care Agreement, and 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.

(36) Physical therapist services:

1. Physician order for physical therapy.
2. Initial physical therapy certification, recertifications, and treatment plans.
3. Treatment notes and forms.
4. Progress or status notes.

(37) Chiropractor services:

1. Service or office notes or narratives.
2. X-ray results.

(38) Hearing aid dealer and audiologist services:

1. Physician examinations and audiological testing (Form 470-0361, Sections A, B, and C).
2. Documentation of hearing aid evaluation and selection (Form 470-0828).
3. Waiver of informed consent.
4. Prior authorization documentation.
5. Service or office notes or narratives.

(39) Behavioral health services:

1. Assessment.
2. Individual treatment plan.
3. Service or office notes or narratives.

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first-hand knowledge of the service.

(2) A correction to a medical record must not be written over or otherwise obliterate the original entry. A single line may be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making the change and any other person authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:

a. During the time the member is receiving services from the provider.

b. For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment.

c. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

79.3(4) *Availability.* Rescinded IAB 1/30/08, effective 4/1/08.

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

441—79.4(249A) Reviews and audits.

79.4(1) *Definitions.*

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard-copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services
Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
Reviewer Name & Phone Number: _____
Provider Name: _____
Provider Number: _____
Provider Type: _____

Please sign this form and return it with the information requested.
Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.
Please send copies. Do not send original records.
If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number

470-4479 (4/08)

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.

(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on-site reviews and audits.

(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third-party payment records.

(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.* Officers shall be a chairperson, and a vice-chairperson.

a. Elections will be held the first meeting after the beginning of the calendar year.

b. The term of office shall be two years. Officers shall serve no more than two terms for each office.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a nominating committee of not less than three members and shall appoint other committees approved by the council.

79.7(2) *Alternates.* Each organization represented may select one alternate as representative when the primary appointee is unable to be present. Alternates may attend any and all meetings of the council, but only one representative of each organization shall be allowed to vote.

79.7(3) *Expenses.* The travel expenses of the public representatives and other expenses, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations.

79.7(4) *Meetings.* The council shall meet at least four times each year. At least two of these meetings shall be with the department of human services. Additional meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of such meetings. Each notice shall include an agenda for the meeting.

79.7(5) *Procedures.*

a. A quorum shall consist of 50 percent of the voting members.

b. Where a quorum is present, a position is carried by two-thirds of the council members present.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and alternate and to the executive office of each organization or body represented.

d. Notice shall be made to the representing organization when the member, or alternate, has been absent from three consecutive meetings.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) *Duties.* The medical assistance advisory council shall:

a. Make recommendations on the reimbursement for medical services rendered by providers of services.

b. Assist in identifying unmet medical needs and maintenance needs which affect health.

c. Make recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

d. Reserved.

e. Reserved.

f. Recommend ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

g. Advise on such administrative and fiscal matters as the commissioner of the department of human services may request.

h. Advise professional groups and act as liaison between them and the department.

i. Report at least annually to the appointing authority.

j. Perform other functions as may be provided by state or federal law or regulation.

k. Communicate information considered by the council to the member organizations and bodies.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the member organizations and bodies. The department will consider all advice and counsel of the council.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, regulations, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members and alternates on the council.

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) *Making the request.*

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.

b. Be in accordance with standards of good medical practice.

c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.

d. Be the least costly type of service which would reasonably meet the medical need of the patient.

e. Be eligible for federal financial participation unless specifically covered by state law or rule.

f. Be within the scope of the licensure of the provider.

g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.

h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88.

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

441—79.12(249A) Advance directives. "Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by

the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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

441—79.15(249A) Education about false claims recovery. The provisions in this rule apply to any entity that has received medical assistance payments totaling at least $5 million during a federal fiscal year (ending on September 30). For entities whose payments reach this threshold, compliance with this rule is a condition of receiving payments under the medical assistance program during the following calendar year.

79.15(1) *Policy requirements.* Any entity whose medical assistance payments meet the threshold shall:

a. Establish written policies for all employees of the entity and for all employees of any contractor or agent of the entity, including management, which provide detailed information about:

(1) The False Claims Act established under Title 31, United States Code, Sections 3729 through 3733;

(2) Administrative remedies for false claims and statements established under Title 31, United States Code, Chapter 38;

(3) Any state laws pertaining to civil or criminal penalties for false claims and statements;

(4) Whistle blower protections under the laws described in subparagraphs (1) to (3) with respect to the role of these laws in preventing and detecting fraud, waste, and abuse in federal health care programs, as defined in Title 42, United States Code, Section 1320a-7b(f); and

(5) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

b. Include in any employee handbook a specific discussion of:

(1) The laws described in paragraph 79.15(1)*"a"*;

(2) The rights of employees to be protected as whistle blowers; and

(3) The entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

79.15(2) *Reporting requirements.*

a. Any entity whose medical assistance payments meet the specified threshold during a federal fiscal year shall provide the following information to the Iowa Medicaid enterprise by the following December 31:

(1) The name, address, and national provider identification numbers under which the entity receives payment;

(2) Copies of written or electronic policies that meet the requirements of subrule 79.15(1); and

(3) A written description of how the policies are made available and disseminated to all employees of the entity and to all employees of any contractor or agent of the entity.

b. The information may be provided by:

(1) Mailing the information to the IME Surveillance and Utilization Review Services Unit, P.O. Box 36390, Des Moines, Iowa 50315; or

(2) Faxing the information to (515)725-1354.

79.15(3) *Enforcement.* Any entity that fails to comply with the requirements of this rule shall be subject to sanction under rule 441—79.2(249A), including probation, suspension or withholding of payments, and suspension or termination from participation in the medical assistance program.

This rule is intended to implement Iowa Code section 249A.4 and Public Law 109-171, Section 6032.

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◊ Two or more ARCs

[1] Effective date of 79.1(2) and 79.1(5)*"t"* delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

[2] Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

[3] Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

[4] Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

[5] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

[6] Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program. The purpose of this program is to provide transitional health care coverage to uninsured children who are ineligible for Title XIX (Medicaid) assistance. The program is implemented and administered in compliance with Title XXI of the federal Social Security Act. The rules establish requirements for the third-party administrator responsible for the program administration and for the participating health plans that will be delivering services to the enrollees.

441—86.1(514I) Definitions.

"Applicant" shall mean all parents, spouses, and children under the age of 19 who are counted in the HAWK-I family size and who are listed on the application or renewal form.

"Benchmark benefit package" shall mean any of the following:

1. The standard Blue Cross Blue Shield preferred provider option service benefit plan, described in and offered under 5 U.S.C. Section 8903(1).
2. A health benefits coverage plan that is offered and generally available to state employees in this state.
3. The plan of a health maintenance organization, as defined in 42 U.S.C. Section 300e, with the largest insured commercial, nonmedical assistance enrollment of covered lives in the state.

"Capitation rate" shall mean the fee the department pays monthly to a participating health plan for each enrollee for the provision of covered medical services whether or not the enrollee received services during the month for which the fee is intended.

"Contract" shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health plan for the provision of medical services to HAWK-I enrollees for whom the participating health plans assume risk.

"Cost sharing" shall mean the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act and Iowa Code section 514I.10.

"Covered services" shall mean all or a part of those medical and health services set forth in rule 441—86.14(514I).

"Department" shall mean the Iowa department of human services.

"Director" shall mean the director of the Iowa department of human services.

"Earned income" means the earned income of all parents, spouses, and children under the age of 19 who are not students who are living together in accordance with subrule 86.2(3). Income shall be countable earned income when a person produces it as a result of the performance of services. "Earned income" includes:

1. All income in the form of a salary, wages, tips, bonuses, and commissions earned as an employee, and
2. The net profit from self-employment determined by comparing gross income produced from self-employment with the allowable costs of producing the income. The allowable costs of producing self-employment income shall be determined by the costs allowed for income tax purposes. Additionally, the cost of depreciation of capital assets identified for income tax purposes shall be allowed as a cost of doing business for self-employed persons. Losses from a self-employment enterprise may not be used to offset income from any other source.

"Eligible child" shall mean an individual who meets the criteria for participation in the HAWK-I program as set forth in rule 441—86.2(514I).

"Emergency medical condition" shall mean 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" shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical condition.

"Enrollee" shall mean a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

"Family" shall mean all parents, spouses, and children under the age of 19 who are counted in the HAWK-I family size.

"Federal poverty level" shall mean the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

"Good cause" shall mean 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 third-party administrator's request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

"Gross countable income" means gross income minus exemptions permitted by paragraph 86.2(2)*"b."*

"Gross income" means a combination of the following:

1. Earned income,
2. Unearned income, and
3. Recurring lump-sum income prorated over the time the income is intended to cover.

"HAWK-I board" or *"board"* shall mean the entity that adopts rules, establishes policy, and directs the department regarding the HAWK-I program.

"HAWK-I program" or *"program"* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health care coverage to eligible children.

"Health insurance coverage" shall mean health insurance coverage as defined in 42 U.S.C. Section 300gg(c).

"Institution for mental diseases" shall mean a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services as defined at 42 CFR Section 435.1009 as amended November 10, l994.

"Nonmedical public institution" shall mean an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control as defined in 42 CFR Section 435.1009 as amended November 10, l994.

"Participating health plan" shall mean any entity licensed by the division of insurance of the department of commerce to provide health insurance in Iowa or an organized delivery system licensed by the director of public health that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

"Physician" shall be defined as provided in Iowa Code subsection 135.1(4).

"Provider" shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical care or services to an enrollee pursuant to the HAWK-I program.

"Recurring lump-sum income" means earned and unearned lump-sum income that is received on a regular basis. These payments may include, but are not limited to:

1. Annual bonuses.
2. Lottery winnings that are paid out annually.

"Regions" shall mean the six regions of the state as follows:

- Region 1: Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Plymouth, Cherokee, Buena Vista, Woodbury, Ida, Sac, Monona, Crawford, and Carroll.
- Region 2: Kossuth, Winnebago, Worth, Mitchell, Howard, Hancock, Cerro Gordo, Floyd, Pocahontas, Humboldt, Wright, Franklin, Calhoun, Webster, Hamilton, Hardin, Greene, Boone, Story, Marshall, and Tama.
- Region 3: Winneshiek, Allamakee, Chickasaw, Fayette, Clayton, Butler, Bremer, Grundy, Black Hawk, Buchanan, Delaware, Dubuque, Jones, Jackson, Cedar, Clinton, and Scott.
- Region 4: Harrison, Shelby, Audubon, Pottawattamie, Cass, Mills, Montgomery, Fremont, and Page.
- Region 5: Guthrie, Dallas, Polk, Jasper, Adair, Madison, Warren, Marion, Adams, Union, Clarke, Lucas, Taylor, Ringgold, Decatur, and Wayne.
- Region 6: Benton, Linn, Poweshiek, Iowa, Johnson, Muscatine, Mahaska, Keokuk, Washington, Louisa, Monroe, Wapello, Jefferson, Henry, Des Moines, Appanoose, Davis, Van Buren, and Lee.

"Self-employed" means that a person satisfies any of the following conditions:

1. The person is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions; or
2. The person establishes the person's own working hours, territory, and methods of work; or
3. The person files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

"Third-party administrator" shall mean the person or entity with which the department contracts to provide administrative services for the HAWK-I program.

"Unearned income" means cash income of all parents, spouses, and children under the age of 19 who are living together in accordance with subrule 86.2(3) that is not gained by labor or service. The available unearned income shall be the amount remaining after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Examples of unearned income include, but are not limited to:

1. Social security benefits, meaning the amount of the entitlement before withholding of a Medicare premium.
2. Child support and alimony payments received for a member of the family.
3. Unemployment compensation.
4. Veterans benefits.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09]

441—86.2(514I) Eligibility factors. The decision with respect to eligibility shall be based primarily on 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 HAWK-I 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. Gross countable income. In determining initial and ongoing eligibility for the HAWK-I program, gross countable income shall not exceed 300 percent of the federal poverty level for a family of the same size.

b. Exempt income. The following shall not be counted toward the income limit when establishing eligibility for the HAWK-I program.

(1) Nonrecurring lump sum income. Nonrecurring lump sum income is income that is not expected to be received more than once. These payments may include, but are not limited to:

1. An inheritance.
2. A one-time bonus.
3. Lump sum lottery winnings.
4. Other one-time payments.

(2) Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

(3) The value of benefits issued in the Food Assistance Program.

(4) The value of the United States Department of Agriculture donated foods (surplus commodities).

(5) 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.

(6) Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

(7) Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

(8) 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.

(9) Interest and dividend income.

(10) Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe.

(11) Payments to volunteers participating in the Volunteers in Service to America (VISTA) program.

(12) 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.

(13) Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

(14) Experimental housing allowance program payments.

(15) The income of a Supplemental Security Income (SSI) recipient.

(16) Income of an ineligible child if the family chooses not to include the child in the eligibility determination in accordance with the provisions of paragraph 86.2(3)*"c."*

(17) Income in kind.

(18) Family support subsidy program payments.

(19) All earned and unearned educational funds of an undergraduate or graduate student or a person in training. However, any additional amount of educational funds received for the person's dependents that are in the eligible group shall be considered as nonexempt income.

(20) Bona fide loans.

(21) 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.).

(22) Payment 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.

(23) Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383 entitled Wartime Relocation of Civilians.

(24) Payments received from the Radiation Exposure Compensation Act.

(25) Reimbursements from a third party or from an employer for job-related expenses.

(26) Payments received for providing foster care when the family is operating a licensed foster home.

(27) Any payments received as a result of an urban renewal or low-cost housing project from any governmental agency.

(28) Retroactive corrective payments.

(29) The training allowance issued by the division of vocational rehabilitation, department of education.

(30) Payments from the PROMISE JOBS program.

(31) The training allowance issued by the department for the blind.

(32) Payments from passengers in a car pool.

(33) Compensation in lieu of wages received by a child under the Job Training Partnership Act of 1982.

(34) Any amount for training expenses included in a payment issued under the Job Training Partnership Act of 1982.

(35) Earnings of a child under the age of 19 who is a full-time student as defined at 441—75.54(1)*"b"*(1) and (2).

(36) Incentive payments received from participation in the adolescent pregnancy prevention programs.

(37) Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complementary assistance by federal regulations.

(38) Incentive allowance payments received from the work force investment project, provided the payments are considered complementary assistance by federal regulation.

(39) Honorarium income and all moneys paid to an eligible family in connection with the welfare reform longitudinal study.

(40) Family investment program (FIP) benefits.

(41) Moneys received through pilot self-sufficiency grants or diversion programs.

(42) Income that has ended as of the date of application.

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

(44) A federal or state earned income tax credit, regardless of whether the payment is received with the regular paycheck or as a lump sum with the federal or state income tax refund.

(45) All earnings received by temporary workers from the U.S. Bureau of the Census.

c. Verification of income. Income shall be verified using the best information available. For example, earnings from the 30 days before the date of application may be used to verify earned income if it is representative of the income expected in future months.

(1) Pay stubs, tip records, tax records and employers' statements are acceptable forms of verification of earned income.

(2) Unearned income shall be verified through data matches when possible, award letters, warrant copies, or other acceptable means of verification.

(3) Self-employment income shall be verified using business records or income tax returns from the previous year if they are representative of anticipated earnings.

(4) When a child who has been determined ineligible for Medicaid is referred to the HAWK-I program, the third-party administrator shall use the income amount used by the Medicaid program unless rules in this chapter require the income to be treated differently.

d. 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 HAWK-I 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 HAWK-I program, the family size shall consist of all persons living together who are children under the age of 19 or who are parents of those children as defined below.

EXCEPTION: Persons who are receiving Supplemental Security Income (SSI) under Title XVI of the Social Security Act or who are voluntarily excluded in accordance with the provisions of paragraph *"c"* below are not considered in determining family size.

a. Children. A child under the age of 19 and any siblings under the age of 19 of whole or half blood or adoptive shall be considered together unless the child is emancipated due to marriage, in which case, the emancipated child is not included in the family size unless the marriage has been annulled. Emancipated children, their spouses, and children who live with parents or siblings of the emancipated child shall be considered as a separate family when establishing eligibility for the HAWK-I program.

b. Parents. Any parent living with the child under the age of 19 shall be included in the family size. This includes the biological parent, stepparent, or adoptive parent of the child and is not dependent upon whether the parents are married to each other. In situations where the parents do not live together

but share joint physical custody of the children, the family size shall be based on the household in which the child spends the majority of time. If both parents share physical custody equally, either parent may apply on behalf of the child and the family size shall be based on the household of the applying parent.

c. Persons who may be excluded when determining family size. If including a child in the family size causes siblings to be ineligible, the family may choose not to count the child in the family size. However, this rule shall not apply when the child is receiving Supplemental Security Income (SSI) benefits because SSI recipients are not counted in determining family size for the purposes of HAWK-I eligibility.

d. Temporary absence from the home. The following policies shall be applied to any person who would be counted in the family size in accordance with paragraphs *"a"* and *"b"* who is temporarily absent from the home.

(1) When a person is absent from the home to secure education or training (e.g., the person is attending college), the person shall be included when establishing the size of the family at home and, if otherwise eligible, shall be covered under the program.

(2) When a person is absent from the home to secure medical care, the person shall be included when establishing the size of the family at home and, if otherwise eligible, shall be covered under the program when the reason for the absence is expected to last less than 12 months.

(3) When a person is absent from the home because the person is an inmate in a nonmedical public institution (e.g., a penal institution) in accordance with the provisions of subrule 86.2(9), the person shall be included when establishing the size of the family at home if the absence is expected to be less than three months. However, when the person is a child under the age of 19, coverage under the program shall not be provided pursuant to subrule 86.2(10) until the child returns to the home.

(4) When a child is absent from the home because the child is in foster care, the child shall not be included when establishing the size of the family at home.

(5) When a child is absent from the home for a vacation or a visit to an absent parent, for example, the child shall be included in establishing the size of the family at home and, if otherwise eligible, shall be covered under the program if the absence is expected to be less than three months.

86.2(4) *Uninsured status.* The child must be uninsured.

a. A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program. However, a child who is enrolled in a plan shall not be considered insured for purposes of the HAWK-I program if:

(1) The plan provides coverage only for a specific disease or service (such as a vision, dental, or cancer policy), or

(2) The child does not have reasonable geographic access to care under that plan. "Reasonable geographic access" means that the plan or an option available under the plan does not have service area limitations or, if the plan has service area limitations, the child lives within 30 miles or 30 minutes of a network primary care provider.

b. Rescinded IAB 7/9/03, effective 7/1/03.

c. American Indian and Alaska Native. American Indian and Alaska Native children are eligible for the HAWK-I program on the same basis as other children in the state, regardless of whether or not they may be eligible for or served by Indian Health Services-funded care.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid if application were made 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).

a. A child who would be eligible for Medicaid except for the parent's failure or refusal to cooperate in establishing initial or ongoing eligibility shall not be eligible for coverage under the HAWK-I program.

b. Children who are excluded from the Medicaid household due to the income or resources of the child may participate in the HAWK-I program if otherwise eligible.

86.2(6) *Iowa residency.* The child shall be a resident of the state of Iowa. A resident of Iowa is a person:

a. Who is living in Iowa voluntarily with the intention of making that person's home in Iowa and not for a temporary purpose; or

b. Who, at the time of application, is not receiving assistance from another state and entered Iowa with a job commitment or to seek employment or who is living with parents or guardians who entered Iowa with a job commitment or to seek employment.

86.2(7) *Citizenship and alien status.* The child shall be a citizen or lawfully admitted alien. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted alien child is eligible to participate in the HAWK-I program. The citizenship or alien status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the HAWK-I 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" shall mean $10 or less per month.

86.2(9) *Inmates of nonmedical public institutions.* The child shall not be an inmate of a nonmedical public institution as defined at 42 CFR Section 435.1009 as amended November 10, l994.

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 435.1009 as amended November 10, l994.

86.2(11) *Preexisting medical conditions.* The child shall not be denied eligibility based on the presence of a preexisting medical condition.

86.2(12) *Furnishing a social security number.* Rescinded IAB 10/20/99, effective 12/1/99.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09; **ARC 7881B**, IAB 7/1/09, effective 7/1/09]

441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply without delay. When the request is made in person, the requester shall immediately be given an application form. When a request is made that the application form be mailed, it shall be sent in the next outgoing mail.

a. Child lives with parents. When the child lives with the child's parents, including stepparents and adoptive parents, the parent shall file the application on behalf of the child unless the parent is unable to do so.

If the parent is unable to act on the child's behalf because the parent is incompetent or physically disabled, another person may file the application on behalf of the child. The responsible person shall be a family member, friend or other person who has knowledge of the family's financial affairs and circumstances and a personal interest in the child's welfare or a legal representative such as a conservator, guardian, executor or someone with power of attorney. The responsible person shall sign the application form and assume the responsibilities of the incompetent or disabled parent in regard to the application process and ongoing eligibility determinations.

b. Child lives with someone other than a parent. When the child lives with someone other than a parent (e.g., another relative, friend, guardian), the person who has assumed responsibility for the care of the child may apply on the child's behalf. This person shall sign the application form and assume responsibility for providing all information necessary to establish initial and ongoing eligibility for the child.

c. Child lives independently or is married. When a child under the age of 19 lives in an independent living situation or is married, the child may apply on the child's own behalf, in which case, the child shall be responsible for providing all information necessary to establish initial and ongoing eligibility. If the child is married, both the child and the spouse shall sign the application form.

86.3(2) *Application form.* An application for the HAWK-I program shall be submitted on Comm. 156, HAWK-I Application, or on Form 470-4016, HAWK-I Electronic Application Summary and Signature, unless the family applies for the Medicaid program first.

a. When an application has been filed for the Medicaid program in accordance with the provisions of rule 441—76.1(249A) and Medicaid eligibility does not exist in accordance with the provisions of rule 441—75.1(249A), or the family must meet a spenddown in accordance with the provisions of 441—subrule 75.1(35) before the child can attain eligibility, the Medicaid application shall be used to

establish eligibility for the HAWK-I program in lieu of the HAWK-I Application, Comm. 156, or Form 470-4016, HAWK-I Electronic Application Summary and Signature.

b. Applications may be obtained by telephoning the toll-free telephone number of the third-party administrator or by accessing the Web site at www.hawk-i.org.

86.3(3) *Place of filing.* An application for the HAWK-I program shall be filed with the third-party administrator responsible for making the eligibility determination. Any local or area office of the department of human services, disproportionate share hospital, federally qualified health center, other facilities in which outstationing activities are provided, school nurse, Head Start, maternal and child health center, WIC office, or other entity may accept the application. However, all applications shall be forwarded to the third-party administrator.

86.3(4) *Date and method of filing.* The application is considered filed on the date an identifiable application is received by the third-party administrator or the department. An identifiable application is an application containing a legible name, address, and signature.

a. Medicaid applications referred to the HAWK-I program. When the family has applied for Medicaid first and the department makes a referral to the third-party administrator, the date the Medicaid application was originally filed with the department shall be the filing date.

b. Electronic applications. When an application is submitted electronically to the third-party administrator, the application is considered filed on the date the third-party administrator receives Form 470-4016, HAWK-I Electronic Application Summary and Signature, containing a legible signature.

86.3(5) *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 shall be documented, and the applicant shall be sent a notice of decision confirming the request.

86.3(6) *Application not required.*

a. An application shall not be required when a child becomes ineligible for Medicaid and the local office of the department makes a referral to the HAWK-I program.

(1) A referral to the HAWK-I program pursuant to subrule 86.4(3) or 86.4(4) shall be accepted in lieu of an application.

(2) The original Medicaid application or the last review form that is on file in the local office of the department, whichever is more current, shall suffice to meet the signature requirements.

b. A new application shall not be required when an eligible child is added to an existing HAWK-I eligible group.

86.3(7) *Information and verification procedure.* The decision with respect to eligibility shall be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee.

a. The third-party administrator shall notify the applicant, enrollee, or person acting on behalf of the applicant or enrollee in writing of additional information or verification that is required to establish eligibility. The third-party administrator shall provide this notice personally, by mail, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the third-party administrator to secure the information shall serve as a basis for rejection of the application or cancellation of coverage.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee shall have ten working days to supply the information or verification requested by the third-party administrator. The third-party administrator may extend the deadline 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(8) *Time limit for decision.* The third-party administrator shall make a decision regarding the applicant's eligibility to participate in the HAWK-I program within ten working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed within the period for a reason that is beyond the control of the third-party administrator.

a. EXCEPTION: When the application is referred for a Medicaid eligibility determination and Medicaid eligibility is denied, the third-party administrator shall determine HAWK-I eligibility no later than ten working days from the date the administrator receives the notice of Medicaid denial unless additional verification is needed.

b. "Day one" of the ten-day period shall mean the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(9) *Applicant cooperation.* An applicant must cooperate with the third-party administrator 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(10) *Waiting lists.* When the department has established that all of the funds appropriated for this program are obligated, the third-party administrator shall deny all subsequent applications for HAWK-I coverage unless Medicaid eligibility exists.

a. The third-party administrator shall mail a notice of decision. The notice shall state that:

(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 person does not meet eligibility requirements. In which case, the applicant shall not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, the third-party administrator shall refer the application to the Medicaid program for an eligibility determination. If Medicaid eligibility exists, the department shall approve the child for Medicaid coverage in accordance with 441—86.4(514I).

c. The third-party administrator shall enter applicants on the waiting list on the basis of the date an identifiable application form specified in subrule 86.3(2) is date-stamped by the third-party administrator. An identifiable application is an application containing a legible name, address, and signature.

(1) In the event that more than one application is received on the same day, the third-party administrator shall enter applicants 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) The third-party administrator shall decide any subsequent ties by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, the third-party administrator shall select applicants from the waiting list based on the order in which their names appear on the list and shall notify them 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 third-party administrator shall delete the applicant's name from the waiting list and shall contact the next applicant on the waiting list.

86.3(11) *Falsification of information.* Rescinded IAB 11/19/08, effective 1/1/09.

86.3(12) *Applications pended due to unavailability of a plan.* When there is no participating health plan in the applicant's county of residence, the application shall be held until a plan is available. The application shall be processed when a plan becomes available and coverage shall be effective the first day of the month the plan becomes available.

441—86.4(514I) Coordination with Medicaid.

86.4(1) *HAWK-I applicant appears eligible for Medicaid.* At the time of initial application, if it appears the child may be 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), a referral shall be made by the third-party administrator to the department for a determination of Medicaid eligibility as follows:

a. The original Healthy and Well Kids in Iowa (HAWK-I) Application, Form 470-3526, or Form 470-4016, HAWK-I Electronic Application Summary and Signature Page, and copies of any accompanying information and verification shall be forwarded to the department within 24 hours, or

the next working day, whichever is sooner. The third-party administrator shall maintain a copy of all documentation sent to the department and a log to track the disposition of all referrals.

b. The third-party administrator shall notify the family that the referral has been made. The third-party administrator shall return to the family any original verification and information that was submitted with the application and retain a copy in the file record.

c. The referral shall be considered an application for Medicaid in accordance with the provisions of rule 441—76.1(249A). The time limit for processing the referred application begins with the date the Healthy and Well Kids in Iowa (HAWK-I) Application, Form 470-3526, or Form 470-4016, HAWK-I Electronic Application Summary and Signature Page, is date-stamped as being received by the third-party administrator.

86.4(2) *HAWK-I enrollee appears eligible for Medicaid.* At the time of the annual review, if it appears the child may be 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 third-party administrator shall make a referral to the department for a determination of Medicaid eligibility as stated in subrule 86.4(1) above. However, the child shall remain eligible for the HAWK-I program pending the Medicaid eligibility determination unless the 12-month certification period expires first.

86.4(3) *Medicaid applicant not eligible.* If a child is not eligible for Medicaid under 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), or is voluntarily excluded from the Medicaid eligible group under the provisions of 441—75.59(249A) and meets the criteria specified at 86.2(5), the department shall make a referral to the third-party administrator for an eligibility determination under the HAWK-I program as follows:

a. The department worker shall submit an electronic referral to the HAWK-I program or complete Form 470-3563, Referral to HAWK-I, and send the form and a copy of the Medicaid notice of decision to the third-party administrator.

b. The third-party administrator shall date-stamp Form 470-3563 with the date the completed form is received.

c. The third-party administrator shall notify the family of the referral and proceed with an eligibility determination under the HAWK-I program.

d. The period for processing the referral begins with the day on which:

(1) Form 470-3563, Referral to HAWK-I, is date-stamped as received by the third-party administrator; or

(2) The third-party administrator receives the electronic referral file.

86.4(4) *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 spenddown under the medically needy program at 441—subrule 75.1(35), or is voluntarily excluded from the Medicaid eligible group under the provisions of rule 441—75.59(249A) and meets the criteria specified at subrule 86.2(5), the department shall make a referral to the third-party administrator for an eligibility determination under the HAWK-I program as follows:

a. The department worker shall submit an electronic referral to the HAWK-I program or complete Form 470-3563, Referral to HAWK-I, and send the form and a copy of the Medicaid notice of decision to the third-party administrator.

b. The third-party administrator shall:

(1) Date-stamp Form 470-3563 with the date the completed form is received;

(2) Notify the family of the referral; and

(3) Proceed with an eligibility determination under the HAWK-I program.

c. The period for processing the referral begins with the day on which:

(1) Form 470-3563, Referral to HAWK-I, is date-stamped as received by the third-party administrator; or

(2) The third-party administrator receives the electronic referral file.

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for children who are determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall 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, or when a plan becomes available in the applicant's county of residence.

86.5(2) *Referrals from Medicaid.*

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the HAWK-I program on the basis of a referral from Medicaid due to cancellation of Medicaid benefits shall be effective the first day of the month after Medicaid eligibility is lost, regardless of the date of the referral, in order to ensure that there is no break in coverage. However, when such a child does not meet the provisions of subrule 86.2(4), coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

b. Denial of Medicaid. Coverage for children who are determined eligible for the HAWK-I program on the basis of a referral from Medicaid due to denial of Medicaid benefits shall be effective no earlier than the first day of the month following the month in which the Medicaid application was received in accordance with 441—subrule 76.1(2). However, when such a child does not meet the provisions of subrule 86.2(4), coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

441—86.6(514I) Selection of a plan. At the time of initial application, if there is more than one participating plan available in the child's county of residence, the applicant shall select the plan in which the applicant wishes to enroll as part of the eligibility process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2)*"a"* apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.

86.6(1) *Coverage in another county's plan.* If a child traditionally travels to another county to receive medical care, the applicant may choose to participate in the plan available in the county in which the child receives medical care.

86.6(2) *Period of enrollment.* Once enrolled in a plan, the child shall remain enrolled in the selected plan for a period of 12 months unless:

a. There is a substantial change in the provider panel of the health plan originally chosen, as determined by the board. A substantial change means, but is not limited to, loss of a contracted hospital or provider group. When there is another participating health plan available in the child's county of residence, the child may disenroll from the current plan and enroll in the other health plan.

b. The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the plan from which the child was originally disenrolled unless the provisions of subrule 86.7(1) apply.

c. The child is added to an existing enrollment. When a family requests to add an eligible child, the child shall be enrolled for the months remaining in the current enrollment period.

86.6(3) *Failure to select a plan.* When more than one plan is available, if the applicant fails to select a plan within ten working days of the written request to make a selection, the third-party administrator shall select the plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating plans.

If the third-party administrator has assigned a child a plan, the family has 30 days to request enrollment into another participating plan. All changes shall be made prospectively and shall be effective on the first day of the month following the month of the request. If the family has not requested a change of enrollment into another available plan within 30 days, the provisions of 86.6(2) shall apply.

441—86.7(514I) Disenrollment. The child shall be disenrolled from the selected plan prior to the end of the 12-month enrollment period for any of the following:

86.7(1) *Child moves from the service area.* The child may be disenrolled from the plan when the child moves to an area of the state in which the plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

86.7(2) *Age.* The child shall be disenrolled from the plan and canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

86.7(3) *Nonpayment of premiums.* The child shall be disenrolled from the plan and canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3) and 86.8(5).

86.7(4) *Iowa residence abandoned.* The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which the child relocated to another state. A child shall not be disenrolled when the child is temporarily absent from the state in accordance with the provisions of subrule 86.2(6).

86.7(5) *Eligible for Medicaid.* The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which the third-party administrator is notified of Medicaid eligibility. If there are months during which the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(6) *Enrolled in other health insurance coverage.* The child shall be disenrolled from the plan as of the first day of the month following the month in which the third-party administrator 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 HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

86.7(7) *Admission to a nonmedical public institution.* The child shall be disenrolled from the plan and canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3)*"d"* apply.

86.7(8) *Admission to an institution for mental disease.* The child shall be disenrolled from the plan and canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(9) *Employment with the state of Iowa.* The child shall be disenrolled from the plan and canceled from the HAWK-I program as of the first day of the month in which the child's parent became eligible to participate in a health plan available to state of Iowa employees.

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The countable income considered in determining the premium amount shall be the family's gross countable income minus 20 percent of the family's earned income.

86.8(2) *Premium amount.* Premiums under the HAWK-I program shall be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaskan Native; or

(2) The family's countable income is less than 150 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 150 percent of the federal poverty level for a family of the same size but does not exceed 200 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 200 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. "Initial application" means the first program application or a subsequent application that is not a renewal. 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 tenth day of the second month following the month of decision.

b. Payment upon renewal. "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.

(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 tenth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the third-party administrator shall notify the plan of the enrollment.

c. Subsequent payments. All subsequent premiums are due by the tenth day of each month for the next month's coverage and must be postmarked no later than the last day of the month before the month of coverage. Failure to pay the premium by the last day of the month before the month of coverage shall result in disenrollment from the plan. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

86.8(4) *Reinstatement.* A child may be reinstated once per enrollment period when the family fails to pay the premium by the last day of the month for the next month's coverage. If the premium is subsequently received, coverage will be reinstated if the premium was postmarked or otherwise paid in the calendar month immediately following disenrollment.

86.8(5) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, automatic bank account withdrawals, or other methods established by the third-party administrator.

86.8(6) *Failure to pay premium.* Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in disenrollment from the plan and cancellation from the program unless the reinstatement provisions of subrule 86.8(4) apply. Once a child is disenrolled and canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

86.8(7) *Copayment.* There shall be a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition.

EXCEPTION: A copayment shall not be imposed when family income is less than 150 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaskan Native.

[**ARC 7770B**, IAB 5/20/09, effective 7/1/09]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" shall be the first month in which coverage is provided.

86.9(1) *Review form.* The third-party administrator shall send the family Form 470-3526, Healthy and Well Kids in Iowa (HAWK-I) Application, 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. The family shall be required to provide verification of current income and 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.

86.9(3) *Change in plan.* At the time of the annual review of eligibility, if more than one plan is available, the child may be enrolled in another plan. The plan choice may be designated verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current plan if the family does not notify the third-party administrator, either verbally or in writing, of a new plan choice by the end of the current 12-month enrollment period.

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the third-party administrator. "Timely" shall mean no later than ten working days after the change occurred. "Day one" of the ten-day period shall mean the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change. If the child is emancipated, married, or otherwise in an independent living situation, the child shall be responsible for reporting the change.

86.10(1) *Pregnancy.* The pregnancy of a child shall be reported when the pregnancy is diagnosed.

86.10(2) *Entry to a nonmedical public institution.* The entry of a child into a nonmedical public institution, such as a penal institution, shall be reported following entry to the institution.

86.10(3) *Iowa residence is abandoned.* The abandonment of Iowa residence shall be reported following the move from the state.

86.10(4) *Other insurance coverage.* Enrollment of the child in other health insurance coverage shall be reported.

86.10(5) *Employment with the state of Iowa.* The employment of the child's parent with the state of Iowa shall be reported.

86.10(6) *Decrease in income.* If the family reports a decrease in income, the third-party administrator shall 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(7) *Failure to report changes.* Rescinded IAB 11/19/08, effective 1/1/09.

86.10(8) *Information reported by a third party.* Information reported by a third party shall not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(9) *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(10) *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 shall be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).

441—86.11(514I) Notice requirements. The applicant shall be provided an adequate written notice of the decision of the third-party administrator regarding the applicant's eligibility for the HAWK-I program. The enrollee shall be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice shall be timely and adequate as provided in 441—subrule 7.7(1).

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision by the third-party administrator to reduce, cancel or deny participation in the HAWK-I program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.

441—86.13(514I) Third-party administrator. The third-party administrator shall have the following responsibilities:

86.13(1) *Determination of eligibility.* The third-party administrator shall determine eligibility in accordance with the provisions of rule 441—86.2(514I).

86.13(2) *Dissemination of application forms and information.* The third-party administrator shall disseminate the following:

a. Rescinded IAB 10/17/01, effective 12/1/01.

b. Outreach materials, application forms, or other materials developed and produced by the department to any organization or individual making a request for the materials. If the request is for quantities exceeding ten, the third-party administrator shall forward the request to Iowa prison industries for dissemination.

c. Participating health plan information.

d. Other materials as specified by the department.

86.13(3) *Toll-free dedicated customer services line.* The third-party administrator shall maintain a toll-free multilingual dedicated customer service line in accordance with the requirements of the department.

86.13(4) *HAWK-I program web site.* The third-party administrator shall work in cooperation with the department to maintain a web site providing information about the HAWK-I program.

86.13(5) *Application process.* The third-party administrator shall process applications in accordance with the provisions of rule 441—86.3(514I).

a. Processing applications and mailing of approvals and denials shall be completed within ten working days of receipt of the application and all necessary information and verification unless the application cannot be processed within this period for a reason beyond the control of the third-party administrator.

b. Original verification information shall be returned to the applicant or enrollee upon completion of review.

86.13(6) *Tracking of applications.* The third-party administrator shall track and maintain applications. This includes, but is not limited to, the following procedures:

a. Date-stamping all applications with the date of receipt.

b. Screening applications for completeness and requesting in writing any additional information or verification necessary to establish eligibility. All information or verification of information attained shall be logged.

c. Entering all applications received into the data system with an identifier status of pending, approved, or denied.

d. Referring applications to the county office of the department, when appropriate, and receiving application referrals from the department.

e. Rescinded IAB 7/9/03, effective 7/1/03.

f. Notifying the plans when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the plan.

86.13(7) *Effective date of coverage.* The third-party administrator shall establish effective date of coverage in accordance with the provisions of rule 441—86.5(514I).

86.13(8) *Selection of plan.* The third-party administrator shall provide participating health plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a plan in accordance with the provisions of rule 441—86.6(514I).

86.13(9) *Enrollment.* The third-party administrator shall notify participating health plans of enrollments.

86.13(10) *Disenrollments.* The third-party administrator shall disenroll an enrollee in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health plan when an enrollee is disenrolled.

86.13(11) *Annual reviews of eligibility.* The third-party administrator shall annually review eligibility in accordance with the provisions of rules 441—86.2(514I) and 441—86.9(514I).

86.13(12) *Acting on reported changes.* The third-party administrator shall ensure that all changes reported by the HAWK-I enrollee in accordance with rule 441—86.10(514I) are acted upon no later than ten working days from the date the change is reported.

86.13(13) *Premiums.* The third-party administrator shall:

a. Calculate premiums in accordance with the provisions of rule 441—86.8(514I).

b. Collect HAWK-I premium payments. The funds shall be deposited into an interest-bearing account maintained by the department for periodic transmission of the funds and any accrued interest to the HAWK-I trust fund in accordance with state accounting procedures.

c. Track the status of the enrollee premium payments and provide the data to the department.

d. Mail a reminder notice to the family if the premium is not received by the due date.

86.13(14) *Notices to families.* The third-party administrator shall develop and provide timely and adequate approval, denial, and cancellation notices to families that clearly explain the action being taken in regard to an application or an existing enrollment. Denial and cancellation notices shall clearly explain the appeal rights of the applicant or enrollee. All notices shall be available in English and Spanish.

86.13(15) *Records.* The third-party administrator shall at a minimum maintain the following records:

a. All records required by the department and the department of inspections and appeals.

b. Records which identify transactions with or on behalf of each enrollee by social security number or other unique identifier.

c. Application, case and financial records.

d. All other records as required 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.

86.13(16) *Confidentiality.* The third-party administrator shall protect and maintain the confidentiality of HAWK-I applicants and enrollees in accordance with 441—Chapter 9.

86.13(17) *Reports to the department.* The third-party administrator shall submit reports as required by the department.

86.13(18) *Systems.* The third-party administrator shall maintain data files that are compatible with the department's and the health plans' data files and shall make the system accessible to department staff.

441—86.14(514I) Covered services. The benefits provided under the HAWK-I program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act.

86.14(1) *Required 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. Dental services (including restorative and preventative services).

m. Hearing services.

n. Vision services (including corrective lenses).

86.14(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.

441—86.15(514I) Participating health plans.

86.15(1) *Licensure.* The participating health plan must be licensed by the division of insurance of the department of commerce to provide health care coverage in Iowa or be an organized delivery system licensed by the director of public health to provide health care coverage.

86.15(2) *Services.* The participating health plan shall provide health care coverage for the services specified in rule 441—86.14(514I) to all children determined eligible by the third-party administrator.

a. The participating health plan shall make services it provides to HAWK-I 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 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 plan does not provide statewide coverage, the plan shall participate in every county within the region in which the plan has contracted to provide services in which it is licensed and in which a provider network has been established. Regions are specified in rule 441—86.1(514I).

86.15(3) *Premium tax.* Premiums paid to participating health plans by the third-party administrator are exempt from premium tax.

86.15(4) *Provider network.* The participating health plan shall establish a network of providers. Providers contracting with the participating health plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

86.15(5) *Medical cards.* Medical identification cards shall be issued by the participating health plan to the enrollees for use in securing covered services.

86.15(6) *Marketing.*

a. Participating health plans may not distribute directly or through an agent or independent contractor any marketing materials.

b. All marketing materials require prior approval from the department.

c. At a minimum, participating health 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 HAWK-I 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 plan literature and brochures shall be available in English and any other language when enrollment in the plan by enrollees who speak the same non-English language equals or exceeds 10 percent of all enrollees in the plan and shall be made available to the third-party administrator for distribution.

d. All health plan literature and brochures shall be approved by the department.

e. The participating health plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health plan may make marketing presentations at the discretion of the department.

86.15(7) *Appeal process.* The participating health plan shall have a written procedure by which enrollees may appeal issues concerning the health care services provided through providers contracted with the 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 which ensure that appeals be resolved within 60 days, except for appeals which 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 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 which is made available to the department at its request.

i. Ensures that the participating health plan's written appeal procedures be provided to each newly covered enrollee.

j. Requires that the participating health plan make quarterly reports to the department summarizing appeals and resolutions.

86.15(8) *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

86.15(9) *Records and reports.* The participating health plan shall maintain records and reports as follows:

a. The 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 plan or subcontractor of the plan, as appropriate, must maintain a medical records system that:

(1) Identifies each medical record by HAWK-I enrollee identification number.

(2) Maintains a complete medical record for each enrollee.

(3) Provides a specific medical record on demand.

(4) Meets state and federal reporting requirements applicable to the HAWK-I program.

(5) Maintains the confidentiality of medical records information and releases the information only in accordance with established policy below:

1. All medical 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 records information to physicians, other practitioners, or facilities that are providing services to enrollees under a subcontract with the plan. This provision also applies to specialty providers who are retained by the plan to provide services which are infrequently used, which provide a support system service to the operation of the plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator 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 plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical records information to physicians or facilities providing emergency care pursuant to paragraph 86.15(2)*"b."*

4. Written consent is required for the transmission of the medical records information of a former enrollee to any physician not connected with the plan.

5. The extent of medical records information to be released in each instance shall be based upon a test of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: 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 plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

(1) A list of providers of medical services under the plan.
(2) Rescinded IAB 10/17/01, effective 12/1/01.
(3) Rescinded IAB 10/17/01, effective 12/1/01.
(4) Rescinded IAB 10/17/01, effective 12/1/01.
(5) Encounter data on a monthly basis as required by the department.
(6) Rescinded IAB 10/17/01, effective 12/1/01.
(7) Other information as directed by the department.

c. Each plan shall at a minimum provide reports and 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 which define activity for child health care, appeals and other designated activities which 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.

86.15(10) *Systems.* The participating health plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

86.15(11) *Payment to the participating health plan.*

a. In consideration for all services rendered by a plan, the 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 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 plan for risks assumed under the current or any previous contract. The plan accepts the rate as payment in full for the contracted services. Any savings realized by the plan due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the plan.

d. If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical expenses, it is the right and responsibility of the plan to investigate these third-party resources and attempt to obtain payment. The 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.

86.15(12) *Quality assurance.* The plan shall have in effect an internal quality assurance system.

441—86.16(514I) Clinical advisory committee. Members of the clinical advisory committee established in accordance with the provisions of 441—paragraph 1.10(2)*"c"* shall be appointed to three-year terms. Members may be appointed for more than one term. No more than one-third of the membership of the committee shall rotate off the committee in any given calendar year.

441—86.17(514I) Use of donations to the HAWK-I program. If an individual or other entity makes a monetary donation to the HAWK-I program, the department shall deposit the donation into the HAWK-I trust fund. The department shall track all donations separately and shall not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to the HAWK-I board.

86.17(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.

86.17(2) If the donation is less than $5,000 and the donor does not specifically identify how it is to be used, the department shall 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 the HAWK-I board.

86.17(3) If the donation is more than $5,000 and the donor does not specify how the funds are to be used, the HAWK-I board shall determine how the funds are to be used.

441—86.18(505) Health insurance data match program. All carriers, as defined in Iowa Code section 514C.13, shall enter into an agreement with the department to provide data necessary to allow the department to comply with the mandate of Iowa Code section 505.25. Each carrier shall either:

1. Enter into and maintain an agreement with the department on Form 470-4435, HAWK-I Data Use Agreement; or
2. Provide proof of an existing agreement with the department or the department's designee.

441—86.19(514I) Recovery.

86.19(1) *Definitions.*

"Administrative error" means an action attributed to the department or to the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health 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 HAWK-I third-party administrator.
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.
9. Failure of the department to provide correct information to the HAWK-I third-party administrator regarding a child's Medicaid eligibility.

"Client error" means an intentional or negligent action attributed to the enrollee that results in incorrect payment of benefits, including premiums paid to a health plan, because the enrollee or the enrollee's representative:

1. Failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. Failed to timely report a change as defined in rule 441—86.10(514I).

86.19(2) *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 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 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 plan to a provider of medical services are not subject to recovery from the enrollee regardless of the cause of the error.

86.19(3) *Notification.* The enrollee shall 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.

86.19(4) *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.

86.19(5) *Appeals.* The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

These rules are intended to implement Iowa Code chapter 514I.

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CHAPTER 4
EMPLOYERS
[Prior to 6/9/04, see 581—Ch 21]

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. *"Political subdivision"* means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. *"Instrumentality of the state or a political subdivision"* means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. *"Public agency"* means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

a. Former name;
b. Former address;
c. IPERS account number;
d. New name, address, and telephone number of the employer;
e. Reason for the change if other than a change of reporting official; and
f. Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

a. Complete name and address of the dissolved entity;
b. Assigned IPERS account number;
c. Last date on which wages were paid;
d. Date on which the entity dissolved;
e. Reason for the dissolution;
f. Whether or not the entity expects to pay wages in the future;
g. Whether the entity is being absorbed by another covered employer;
h. Name and address of absorbing employer if applicable; and
i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Records shall show with respect to each employee:
a. Employee's name, address and social security account number;
b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
c. Total amount of wages paid on each date including noncash wage equivalents;
d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.
a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.
b. Effective July 1, 1991, employers must report all terminating employees to IPERS within seven working days following the employee's termination date. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.
c. Effective December 31, 2004, and annually thereafter, employers whose job classes include correctional officers, correctional supervisors, and others whose primary purpose is, through ongoing direct inmate contact, to enforce and maintain discipline, safety and security within a correctional facility shall submit to IPERS each calendar year a list of jobs that qualify for protection occupation class coverage. This report shall also contain any changes in the designation of jobs as qualifying or not qualifying for protection occupation class coverage and effective dates of changes. IPERS' sole responsibility with respect to protection occupation status determinations is to ascertain whether IPERS' records correctly reflect service credit and contributions that are in accordance with the employer's designation of a position as being within a protection occupation class.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) *Payment of contributions.* For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS covered employer, the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) *Wage reports.* For wages paid on or after July 1, 2008, all IPERS covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via the IPERS' employer self service Web application, on compact discs, or as a paper report. However, for those employers submitting reports on compact discs or on paper, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) *Deadlines for payment of contributions.*

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) *Request for time extension.* A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or holiday, the contribution or report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the report or timely pay because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self service Web application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of $20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self service Web application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee

is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code section 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

495—4.4(97B) Accrual of interest and application of employer payments. Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of $20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) Credit memos voided. Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) Contribution rates. The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) Contribution rates for regular class members.

a. Effective July 1, 2007, except as otherwise provided by law, the following contribution rates shall be effective for all covered members except those identified in subrules 4.6(2) and 4.6(3):

	Ended June 30, 2007	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010
Combined rate	9.45%	9.95%	10.45%	10.95%	11.45%
Employer	5.75%	6.05%	6.35%	6.65%	6.95%
Employee	3.70%	3.90%	4.10%	4.30%	4.50%

b. Effective July 1, 2011, and every year thereafter, the contribution rates shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective no later than July 1 of the next fiscal year.

4.6(2) Contribution rates for sheriffs and deputy sheriffs.

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009
Combined rate	15.40%	15.04%	15.24%
Employer	7.70%	7.52%	7.62%
Employee	7.70%	7.52%	7.62%

4.6(3) Contribution rates for protection occupation.

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009
Combined rate	14.11%	14.08%	15.34%
Employer	8.47%	8.45%	9.20%
Employee	5.64%	5.63%	6.14%

4.6(4) Members employed in a "protection occupation" shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a "correctional officer" position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another "correctional officer" position that meets this definition. Movement to a position that does not meet this definition shall cancel "protection occupation" coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a "peace officer" by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff's or deputy sheriff's eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[**ARC 7591B**, IAB 2/25/09, effective 7/1/09; **ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, termination date and last check date, when appropriate, and employer identification number.

For new employee enrollments submitted on or after August 1, 2008, employers shall submit the required information using IPERS' employer self service Web application, on compact discs, or on paper. However, those employers submitting information on compact discs or on paper will be charged a fee as described in subrule 4.3(6).

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours. This rule applies only to the restoration of covered wages reduced by an employer-mandated reduction in hours (EMRH). It does not apply to reductions in base wages, reduced overtime wages, reduced wages due to position changes, permanent layoffs or other termination of employment situations.

4.8(1) A member may restore the member's three-year average covered wage to the amount that it would have been but for an EMRH by completing the IPERS EMRH application form and related payroll deduction authorization and by filing the application and payroll deduction authorization forms with the employer. By so doing, the member agrees to pay the employee and employer contributions for all EMRH wages retroactive to January 1, 2009, and all future EMRH wages through June 30, 2010.

4.8(2) A member cannot pay the EMRH contributions described under this rule in any manner except through payroll deductions.

4.8(3) The payroll deduction authorization described under this rule shall be irrevocable, except upon death, retirement or termination of employment. If revoked by the member's death, retirement, or termination of employment, all amounts held by an employer in the member's name shall be forwarded to the member along with the member's final wages.

4.8(4) A member may obtain a refund of EMRH contributions collected under this rule as part of a refund of the member's entire account balance or an actuarial equivalent (AE) payment, but a member who commences a monthly retirement allowance shall not receive a refund of any amounts contributed, even if the covered wages being restored are not used in the member's three-year average covered wage.

4.8(5) A covered employer must cooperate with an eligible member's request for payroll deductions using the applicable IPERS forms. Employers shall be required to complete and submit wage certifications showing the covered wages that would have been reported but for the EMRH.

4.8(6) After IPERS has received and processed wage certification forms, the employer will be billed for the applicable EMRH contributions on the next employer monthly statement. If contributions are not paid by the employer statement's due date, the employer will be assessed late fees and interest in accordance with rule 495—4.3(97B).

4.8(7) In completing the federal and state wage reporting forms to be filed with the federal and state tax authorities, an employer shall treat the EMRH contributions collected and forwarded to IPERS the same as pretax IPERS employee contributions.

4.8(8) Upon receipt of the contributions pursuant to this rule, IPERS shall apply them to the member's account as pretax employee contributions.

4.8(9) This rule applies to reductions in wages caused by an EMRH through June 30, 2010. An employer's collection of contributions from such wages shall terminate as of midnight, July 31, 2010. All completed EMRH forms and contributions collected under this rule must be forwarded to IPERS by a covered employer no later than August 15, 2010.

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, House File 414, section 51.

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CHAPTER 6
COVERED WAGES
[Prior to 6/9/04, see 581—Ch 21]

495—6.1(97B) IRS requirements. Wages as discussed in this chapter shall not exceed the amount permitted for a given year under Section 401(a)(17) of the Internal Revenue Code.

495—6.2(97B) Definition of wages. "Wages" means all compensation earned by employees including, except as otherwise provided under this chapter, vacation pay; sick pay; back pay; amounts deducted from the employee's pay at the employee's discretion for tax-sheltered annuities, dependent care and cafeteria plans; and the cash value of wage equivalents. This definition applies to these rules, regulations, interpretations, forms and other IPERS publications unless the context otherwise requires.

495—6.3(97B) IPERS coverage for various forms of compensation. The following is a list of various types of compensation and the corresponding IPERS coverage treatment:

6.3(1) *Vacation pay or annual leave pay.* Vacation pay or annual leave pay means the amount paid to an employee during a period of vacation.

6.3(2) *Sick pay.* Sick pay means payments made for sick leave which are a continuation of salary payments.

6.3(3) *Workers' compensation payments and other third-party payments.* Workers' compensation payments, unemployment payments, or short-term and long-term disability payments made by an insurance company or third-party payer, such as a trust, are not included as wages. Payments for sick leave which are a continuation of salary payments if paid from the employer's general assets, regardless of whether the employer labels the payments as sick leave, short-term disability, or long-term disability, are covered wages.

6.3(4) *Compensatory time.* Wages include amounts paid for compensatory time taken in lieu of regular work hours or when paid as a lump sum. However, compensatory time paid in a lump sum shall not exceed 240 hours per employee per year or any lesser number of hours set by the employer. Each employer shall determine whether to use the calendar year or a fiscal year other than the calendar year when setting its compensatory time policy.

6.3(5) *Banked holiday pay.* If an employer codes banked holiday time as holiday or additional accrued vacation time, the banked holiday pay will be vacation pay under subrule 6.3(1). If an employer codes banked holiday time as compensatory time, the banked holiday pay will be combined with compensatory pay and subject to the limits set forth in subrule 6.3(4).

6.3(6) *Special lump sum payments.* Wages do not include special lump sum payments made during or at the end of service as a payoff of unused accrued sick leave or of unused accrued vacation. Wages do not include special lump sum payments made during or at the end of service as an incentive to retire early or as payments made upon dismissal, severance, or a special bonus payment intended as an early retirement incentive. Wages do not include: catastrophic leave paid in a lump sum, bonuses, tips or honoraria. Exclusion of payments as described in this subrule applies whether the payment is in a lump sum or in installments.

6.3(7) *Covered wage treatment for supplemental payments.*

a. Payments excluded from covered wages as bonuses include the following:

(1) Recruitment payments.

(2) Retention payments.

(3) Payments to members who achieve improvements in their employer's financial status or performance ratings.

(4) Employee performance incentive payments.

(5) Extraordinary job performance payments.

(6) Payments for the possession, attainment, or maintenance of special skills or professional certifications (does not apply to advancements in a member's placement in wage or salary schedule, or placement in a higher tier wage or salary schedule).

(7) Payments to members made in lieu of merit increases because the members' wage or salary scales are capped.

(8) Payments similar in substance to those enumerated above without regard to the payments' titles, tag lines, labels or classifications by employers.

b. Payments included in covered wages that are not to be treated as bonuses include the following:

(1) Payments authorized by statute and used to increase the general level of teacher pay, except as otherwise provided in this subrule (for example, when such moneys are used to pay retention bonuses).

(2) Payments for which additional, or new and different, job duties are required in order to receive the payment.

(3) Payments for employment longevity.

c. Payments that are otherwise to be treated as covered wages under paragraph *"b"* shall not be covered if IPERS determines that the payments are made for paragraph *"a,"* subparagraphs (1) to (8), of this subrule or other subrules, including, but not limited to, recruitment or retention bonuses, retirement incentive and severance payments, reimbursements of business expenses, and payment of allowances.

d. IPERS shall have the final authority to determine if supplemental payments not described in paragraphs *"a,""b"* and *"c"* of this subrule should be treated as excluded bonus payments or covered wages. In making its determination, IPERS may consider, but is not limited to, such factors as the supplemental payments' similarity to payments described in paragraphs *"a,""b"* and *"c"* of this subrule, whether such payments are discretionary with the employer, and whether, on the one hand, the payments are regular and periodic over the working careers of a broad group of individuals or, on the other hand, are short-term, irregular, or ad hoc payments whose primary effect is to spike certain members' final average salaries.

6.3(8) *Other special payment arrangements.* Wages do not include amounts paid pursuant to special arrangements between an emplyoer and employee whereby the employer pays increased wages and the employee reimburses the employer or a third-party obligor for all or part of the wage increase. This limitation includes, but is not limited to, the practice of increasing an employee's wages by the employer's share of health care costs and having the employee reimburse the employer or a third-party provider for such health care costs. Wages do not include amounts paid pursuant to a special arrangement between an employer and employee whereby wages in excess of the covered wage ceiling for a particular year are deferred to one or more subsequent years. Wages do not include employer contributions to a plan, program, or arrangement that are not included in the employee's federal taxable income. However, certain employer contributions under IRC Section 125 plans are permitted to be treated as covered wages under rule 495—6.5(97B) subject to the terms of that rule.

Employers and employees that knowingly and willfully enter into the types of arrangements described in this subrule, causing an impermissible increase in the payments authorized under Iowa Code chapter 97B, may be prosecuted under Iowa Code section 97B.40 for engaging in a fraudulent practice. If IPERS determines that its calculation of a member's monthly benefit includes amounts paid under an arrangement described in this subrule, IPERS shall recalculate the member's monthly benefit, after making the appropriate wage adjustments. IPERS may recover the amount of overpayments caused by the inclusion of the payments described in this subrule from the monthly amounts plus interest payable to the member or amounts payable to the member's successor(s) in interest, regardless of whether or not IPERS chooses to prosecute the employers and employees under Iowa Code section 97B.40.

6.3(9) *Wage equivalents.* Items such as food, lodging and transportation are includable as employee income, if they are paid as compensation for employment. The basic test is whether or not such wage equivalent was given for the convenience of the employee or employing unit. Wage equivalents are not reportable under IPERS if given for the convenience of the employing unit or are not reasonably quantifiable. Wage equivalents that are not included in the member's federal taxable income shall be deemed to be for the convenience of the employer. A wage equivalent is not reportable if the employer certifies that there was a substantial business reason for providing the wage equivalent, even if the wage equivalent is included in the employee's federal taxable income. Wages paid in any other form than money are measured by the fair market value of the meals, lodging, travel or other wage equivalents.

6.3(10) *Members of the general assembly.* Wages for a member of the general assembly means the total compensation received by a member of the general assembly, whether paid in the form of per diem or annual salary. Wages include per diem payments paid to members of the general assembly during interim periods between sessions of the general assembly. Wages do not include expense payments except that, effective July 1, 1990, wages include daily allowances to members of the general assembly for nontravel expenses of office during a session of the general assembly. Such nontravel expenses of office during a session of the general assembly shall not exceed the maximum established by law for members from Polk County. A member of the general assembly who has elected to participate in IPERS shall receive four quarters of service credit for each calendar year during the member's term of office, even if no wages are reported in one or more quarters during a calendar year.

6.3(11) *Wages restored following an employer-mandated reduction in hours.* Notwithstanding rule 495—6.4(97B), wages restored following the receipt of contributions forwarded pursuant to 495—4.8(97B) shall be credited to quarters in which the wages would have been received but for the employer-mandated reduction in hours (EMRH).

6.3(12) *Wages paid as a back pay settlement.* IPERS contributions must be calculated on the gross amount of a back pay settlement before the settlement is reduced for taxes, interim wages, unemployment compensation, and similar mitigation of damages adjustments. IPERS contributions must be calculated by reducing the gross amount of a back pay settlement by any amounts not considered covered wages such as, but not limited to, lump sum payments for medical expenses.

Notwithstanding the foregoing, a back pay settlement that does not require the reinstatement of a terminated employee and payment of the amount of wages that would have been paid during the period of severance (before adjustments) shall be treated by IPERS as a "special lump sum payment" under subrule 6.3(6) and shall not be covered.

6.3(13) *Limitations on benefits and contributions.*

a. Section 415(b) limitations on benefits. A member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Internal Revenue Code Sections 415(b) and 415(d). For purposes of applying the limits under Internal Revenue Code Section 415(b) (Limit), the following will apply:

(1) With respect to a member who does not receive a portion of the member's annual benefit in a lump sum:

1. The member's Limit will be applied to the member's annual benefit in the first limitation year without regard to any automatic cost-of-living increases;

2. To the extent the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases under the IPERS trust fund until such time as the benefit plus the accumulated increases are less than the applicable Limit; and

3. Thereafter, in any subsequent limitation year, the member's annual benefit including any automatic cost-of-living increase shall be tested under the then applicable benefit Limit, including any adjustment to the Internal Revenue Code Section 415(b)(1)(A) dollar limit under Internal Revenue Code Section 415(d) (cost-of-living adjustments) and the regulations thereunder; and

(2) With respect to a member who receives a portion of the member's annual benefit in a lump sum:

1. The member's applicable Limit shall be applied taking into consideration automatic cost of living increases as required by Internal Revenue Code Section 415(b) and applicable Treasury Regulations; and

2. In no event shall a member's annual benefit payable under the system in any limitation year be greater than the Limit applicable at the annuity starting date, as increased in subsequent years pursuant to Internal Revenue Code Section 415(d) and the regulations thereunder. If the form of benefit without regard to the automatic benefit increase feature is not a straight life or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent straight life annuity benefit determined using the assumptions required by Treasury Regulations, including the mortality table specified in Revenue Ruling 2001-62 or Revenue Ruling 2007-67, as applicable.

b. Section 415(c) limitations on contributions and other member additions. Member contributions and other additions paid to the system may not exceed the annual limits on contributions and other additions allowed by Internal Revenue Code Section 415(c). For purposes of applying these limits, the definition of "compensation," where applicable, will be compensation as defined in Treasury Regulation Section 1.415(c)-2(d)(3), or successor regulation. The foregoing definition of compensation will exclude member contributions picked up under Internal Revenue Code Section 414(h)(2) and, for plan years beginning after December 31, 1997, compensation will include the amount of any elective deferrals, as defined in Internal Revenue Code Section 402(g)(3), and any amount contributed or deferred by the employer at the election of the member and which is not includible in the gross income of the member by reason of Internal Revenue Code Section 125 or 457 and, for plan years beginning on and after January 1, 2001, pursuant to Internal Revenue Code Section 132(f)(4).

c. Limitation year. The limitation year is the calendar year.

6.3(14) *Employer payments treated as remuneration counted against the reemployment earnings limit.* All taxable or nontaxable compensation, regardless of the title, tag line, label, or classification attributed to that compensation paid by IPERS-covered employers to retired reemployed IPERS members, shall be considered remuneration when determining reemployment earnings limits and reductions as set forth under Iowa Code section 97B.48A and rule 495—12.8(97B). This rule shall apply whether the compensation is paid pursuant to individual contracts or otherwise, and regardless of whether it is considered covered or noncovered compensation under Iowa Code section 97B.1A(26) and the administrative rules thereunder, except for:

a. Contributions to health insurance plans and programs, and

b. Reimbursements of actual work-related expenses required by the retired reemployed members' jobs.

6.3(15) *Employer contributions as remuneration counted against the reemployment earnings limit.* Employer contributions made on behalf of retired reemployed members to tax qualified and nonqualified retirement and deferred compensation plans and to other fringe benefit arrangements, excluding health insurance plans and programs, shall constitute remuneration from employment which shall be applied to the reemployment earnings limits and reductions set forth under rule 495—12.8(97B). Such contributions, even if counted as remuneration hereunder, shall not be counted as covered wages, unless the facts in the particular case indicate that, under the circumstances, the arrangement should be treated as covered wages under rules 495—6.1(97B) through 495—6.5(97B). Nonelective employer contributions to the following shall constitute remuneration when determining reemployment earnings limits: tax qualified retirement and deferred compensation plans; all nonqualified retirement plans and deferred compensation arrangements; IRAs; rabbi, secular, and other trust arrangements; split dollar and other life insurance arrangements; and long-term care insurance.

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—6.4(97B) Month for which wages are to be reported. Wages are reportable for the month in which they are actually paid to the employee, except when employees are awarded lump sum payments of back wages, whether as a result of litigation or otherwise, receive lump sum payments of extra duty pay, or request wage restorations following EMRH, and similar situations involving regular and periodic lump sum payments which IPERS in its sole discretion determines should be treated as covered wages. The employer shall file wage adjustment reporting forms with IPERS allocating the wages to the periods of service for which such payments are awarded. Employers shall forward the required employer and employee contributions and interest to IPERS.

6.4(1) Actual and constructive receipt. An employer cannot report wages as having been paid to employees as of a monthly reporting date if the employee has not actually or constructively received the payments in question. For example, wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on June 30 would be reported as June wages, but wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on July 3 would be reported as July wages.

6.4(2) One quarter of service will be credited for each quarter in which a member is paid IPERS covered wages.

a. "Covered wages" means wages of a member during periods of service that do not exceed the annual covered wage maximum as permitted for a given year under Section 401(a)(17) of the Internal Revenue Code.

b. Effective January 1, 1988, covered wages shall include wages paid a member regardless of age. (From July 1, 1978, until January 1, 1988, covered wages did not include wages paid a member on or after the first day of the month in which the member reached the age of 70.)

c. If a member is employed by more than one employer during the calendar year, the total amount of wages paid by all covered employers shall be included in determining the annual covered wage limit established under Section 401(a)(17) of the Internal Revenue Code. If the amount of wages paid to a member by several employers during any given month exceeds the covered wage limit as determined for that calendar year, the amount of the excess shall not be subject to contributions required by Iowa Code section 97B.11. IPERS shall not accept excess wages and applicable contributions from employers and shall return excess contributions as provided in 495—subrule 4.3(8).

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—6.5(97B) Covered wage treatment for employer contributions to IRC Section 125 plans. If certain conditions are met, employer contributions to fringe benefit programs that qualify under IRC Section 125 may be treated as covered wages. The following subrules set forth IPERS' regulations for determining covered wage treatment and for making wage adjustments when employer-paid contributions have been covered or excluded in violation of the standards set forth below.

6.5(1) *Section 125 plans.* For purposes of this rule, a Section 125 plan means an employer-sponsored fringe benefit plan that is subject to Section 125 of the federal Internal Revenue Code. Some of the common names for this type of plan are cafeteria plan, flexible benefits plan, flex plan, and flexible spending arrangement.

6.5(2) *Elective employer contributions.* For purposes of this rule, "elective employer contributions" means employer contributions made to a Section 125 plan that can be received in cash or used to purchase benefits under the Section 125 plan. Generally, elective employer contributions that are not subject to special eligibility requirements qualify as covered wages.

6.5(3) *Mandatory minimum coverage requirements.* The term "elective employer contributions" does not include employer contributions that must be used to purchase benefits under a Section 125 plan. For example, if an employer provides $2,500 to its employees to purchase benefits in a Section 125 plan, but requires that all employees must use $1,000 of that amount to purchase single health coverage, the cost of the single coverage is deducted. In this example, $1,000 would be subtracted from the $2,500 provided, resulting in $1,500 of covered wages.

6.5(4) *Uniformity determined coverage group by coverage group.* Iowa Code section 97B.1A(26)*"a"*(1)*"b"* states that elective employer contributions shall be treated as covered wages only if made uniformly available and not limited to highly compensated employees. The application of the uniformity concept may be illustrated as follows: Employer Z has two major groupings of employees covered under its cafeteria plan: teaching staff and support staff. Every member of the teaching staff is provided $3,000 to purchase benefits under the Section 125 plan. Every member of the teaching staff must take single coverage costing $1,500. Every member of the support staff is provided $2,500 and must also take the single coverage costing $1,500. Each member of the teaching staff would have $1,500 treated as covered wages, and each member of the support staff would have $1,000 treated as covered wages. This would be considered uniform treatment.

Uniformity is not destroyed by the fact that the amount available to members of a coverage group varies because the actual cost of mandatory minimum coverage varies depending on actuarial factors that apply to each individual. For example, assume Employer Z above also requires each employee to have long-term disability coverage. In Employer Z's case, the actual cost of disability coverage will vary from individual to individual. In that case, Employer Z would also deduct the actual cost of the required disability coverage, individual by individual, when determining IPERS covered wages.

Uniformity is not destroyed if an employer has two groups of employees who, as a result of collective bargaining, have differing entitlements to employer contributions. For example, Employer Y has a contract that provides $3,500 to each employee to purchase benefits under the Section 125 plan. Every employee may take all the cash by waiving participation in the plan, or may use all or part of the employer contributions to the Section 125 plan. In the collective bargaining process, a new contract is adopted which states that the employer will still provide $3,500 to each employee to purchase benefits under the Section 125 plan. However, under the new contract, persons who waived participation before April 15 may still waive participation in the plan and take all the cash, but persons who did not waive participation and those hired after April 15 must have single coverage costing $1,700. Employer Y would be treated as having two groups of employees with different elective employer contribution amounts. The grandfathered group (employees who waived participation before April 15) would have covered wages of $3,500, and the group consisting of those who did not waive participation before April 15 and new employees would have covered wages of $1,800.

6.5(5) *Highly compensated employee test.* Iowa Code chapter 97B provides that, in addition to being uniformly available, employer contributions must not discriminate in favor of highly compensated employees (HCEs). For purposes of this subrule, an HCE is an employee who has reported wages and tips subject to Medicare tax in excess of the IRC Section 414(q) limit then in effect. IPERS shall apply the HCE limitation as follows. If elective employer contributions are made available to HCEs, the total elective employer contributions made available to the HCE group must not exceed 25 percent of the total elective employer contributions made available under the Section 125 plan to all employees, including the HCEs. If the elective employer contributions available to the HCE group exceed the 25 percent limit (or if it is determined that the Section 125 plan discriminates in favor of HCEs under other IRS rules), elective employer contributions for HCEs shall not exceed the highest amount available to a nonexecutive coverage group of employees covered under such plan. The general application of these principles is illustrated below, using the 2002 IRC Section 414(q) dollar limit of $90,000.

Employer W has a Section 125 plan that provides elective employer contributions totaling $7,000 to executive staff, $4,500 to teaching staff, and $3,500 to support staff. There are no other limits or exclusions that apply. These amounts are treated as covered wages for each member of each group, provided that the total amount of contributions made available to HCEs does not exceed 25 percent of the total elective employer contributions for all employees covered under the plan. If elective employer contributions for the executive staff totaled $70,000, and total elective employer contributions for the remainder of the staff totaled $500,000, the HCE percentage of total elective employer contributions would be 12 percent ($70,000 divided by $570,000), and all elective employer contributions would be treated as covered wages for all groups. However, if elective employer contributions for the executive staff totaled $70,000, and elective employer contributions for the remainder of the staff totaled $200,000, the HCE percentage would be 26 percent ($70,000 divided by $270,000), and HCEs' elective employer contributions would be limited to $4,500 per HCE for covered wage purposes.

6.5(6) *Elective employer contributions limited to dual coverage employees.* In some cases, a Section 125 plan provides for what appear to be mandatory employer contributions for health plan coverage, but the terms of the Section 125 plan permit dual coverage employees to waive coverage and receive the employer contributions in cash, if the employee can prove coverage under another health care plan. IPERS shall continue to treat the full amount of employer contributions in such cases as not being IPERS covered wages, even though individual employees with the described dual coverage may actually receive the employer contribution in cash.

6.5(7) *Corrections for overpayments and underpayments of contributions and benefits caused by Section 125 plan covered wage errors.* IPERS shall use the following guidelines in requiring corrections for overpayments and underpayments of contributions and benefits caused by the erroneous inclusion or exclusion of employer contributions to a Section 125 plan. Corrections must be made for all active, terminated and retired members, subject to the following limitations:

a. If elective employer contributions that should have been covered were not covered, wage adjustments shall be filed, and employers shall be billed for all shortages plus interest. Employers shall be entitled to collect reimbursement for the employee share of contributions as provided in Iowa Code

section 97B.9. If retirement benefits, death benefits or refunds have been underpaid as a result of the error, IPERS shall, upon receipt of the contribution shortage, make the appropriate adjustments and pay all back benefits.

b. If employer contributions that should not have been covered were covered, wage adjustments shall be filed, and the appropriate contribution amounts shall be repaid to employers for distribution to the respective employee and employer contributors. If the reporting error caused an overpayment of retirement benefits, death benefits, or refunds, IPERS shall offset excess contributions received against overpayments and shall request a repayment of the remainder of the overpayment, if any, from the recipient.

Wage adjustments, overpayments, and underpayments and unintentional reporting errors shall be determined as of the onset of the error, but shall be limited to three years before the beginning of the current contract year for school employers, or current fiscal year for all other covered employers. IPERS may go back to the onset of the error, even if the period exceeds three years, if the error is caused by intentional misconduct or gross neglect. Notwithstanding the foregoing adjustment and collection standards, IPERS reserves the right to negotiate adjustments with individual employers in special situations, and no negotiated settlement with an employer shall be deemed to constitute a waiver of this rule or a binding precedent for other employers.

6.5(8) *Bounties.* In some cases, an employer has a Section 125 plan with employer contributions, and what IPERS refers to as a bounty option. A bounty is an amount that may be elected by all employees, or by a subset of that group, such as employees with coverage under another health care plan, either in lieu of any coverage under the employer's health care plan, or in lieu of family coverage. A bounty is generally set at an amount that is less than the amount that would otherwise be available to purchase benefits under the Section 125 plan. IPERS does not treat bounties as covered wages. The uniformity and nondiscrimination principles described in subrule 6.5(4) do not apply to such benefits.

These rules are intended to implement Iowa Code sections 97B.1A(26), 97B.9, 97B.11, 97B.14 and 97B.14A.

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CHAPTER 15
DIVIDENDS
[Prior to 11/24/04, see 581—Ch 21]

495—15.1(97B) Dividend payments for beneficiaries of members retiring prior to July 1, 1990, who chose joint and survivor annuity options.

15.1(1) *November dividend adjustment.* Effective July 1, 2008, in order to determine whether the adjustment to dividend payments is payable under Iowa Code section 97B.49F(1)*"b,"* an IPERS actuary shall compare the actuarially required contribution rate for the fiscal year of the dividend adjustment to the statutory contribution rate for that same fiscal year and certify the results to IPERS. If the actuarially required contribution rate exceeds the statutory contribution rate for that same fiscal year, the applicable percentage used to calculate dividend adjustments shall be zero.

15.1(2) *General.* The dividend payable to the beneficiary of a pre-July 1, 1990, retired member who selected a joint and survivor annuity option, except for the year of the member's death and the next year, is calculated in the same manner as for retired members.

For a member who lives into November of the year in which the member dies, the dividend will be payable to the member's account.

15.1(3) *Dividend for the years in which member's death occurs.* For a member who does not live into November of the year in which the member dies, the dividend payable for the year in which the member dies is calculated the same as it would have been calculated for the deceased retired member. The dividend amount that would have been payable to the deceased retired member is then multiplied by the survivor annuity percentage selected for the contingent annuitant (CA) in the member's retirement application.

15.1(4) *Dividend for the year following the year of the retired member's death.* For a member who does not live into November of the year in which the member dies, the dividend payable in the year following the year of the member's death is calculated as follows. The sum of the survivor's monthly benefit payments received for the year in which the member's death occurs is divided by the number of survivor benefit payments for that year, and that amount is multiplied by 12. That amount plus the member's survivor's prior dividend is then multiplied by the dividend rate for the year following the year of the member's death, which equals the dividend adjustment for the year following the year of the member's death. This dividend adjustment plus the prior year's dividend produces the dividend amount for the year following the year of the member's death.

15.1(5) *Examples.*

a. Dividend for the year of the member's death. The following assumptions are made. The member retired in 1989 and selected a joint and 50 percent to survivor annuity. The retired member received a monthly payment of $1,000, and died in June 2002. The member received $12,000 in monthly benefits for January through December 2001. The member received a dividend of $500 in 2001, and the dividend rate is 3 percent for 2002.

2001 total monthly benefits		2001 dividend amount		2002 dividend rate		2002 dividend adjustment		2001 dividend amount		Dividend payable amount		CA%		CA 2002 dividend
$12,000.00	+	$500.00	×	3%	=	$375.00	+	$500.00	=	$875.00	×	50%	=	$437.50

b. Dividend for the year following the year of the member's death. The following assumptions are made. The member retired in 1989 and selected a joint and 50 percent to survivor annuity. The retired member received a monthly payment of $1,000, and died in June 2002. The survivor received $500 each month for July through December of 2002 for a total of $3,000. The survivor received a dividend of $437.50 in 2002, and the dividend rate is 3 percent for 2003.

2002 total monthly benefits for CA		Total of payments for CA 2002		Twelve months for 2002		2002 dividend amount		2003 dividend rate		2003 dividend adjustment		2002 dividend amount		Dividend payable to CA for 2003
$3,000.00	÷	6 months	×	12 months	+	$437.50	×	3%	=	$193.13	+	$437.50	=	$630.63

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—15.2(97B) Favorable experience dividend (FED) under Iowa Code section 97B.49F(2). For members retiring on and after July 1, 1990, dividends are payable as follows.

15.2(1) *Allocation of favorable experience.* The system shall, following the first annual actuarial evaluation in which IPERS is found to be fully funded, determine by rule the allocation of the system's favorable actuarial experience, if any, between the reserve account created under Iowa Code section 97B.49F(2) and the remainder of the retirement fund.

Effective July 1, 2006, IPERS shall in no event credit amounts attributable to favorable experience to the FED reserve account, unless IPERS is fully funded and will remain fully funded after such amounts are credited to the FED reserve account. "Fully funded" means that the funded ratio as determined under Iowa Code section 97B.1A(11A) remains at least 100 percent following the allocation of favorable experience to the FED reserve account.

15.2(2) *Determination of applicable percentage.* The system shall have sole discretion to determine the applicable percentages that will be used in calculating favorable experience dividends payable under this rule, if any, subject to the actuary's certification that the resulting favorable experience dividends meet the requirements of Iowa Code section 97B.49F(2) and this rule.

a. The system's annual applicable percentage target for calculating dividends under Iowa Code section 97B.49F(2) shall be equal to the applicable percentage used in calculating dividends payable to retired members under Iowa Code section 97B.49F(1). Notwithstanding the foregoing, the system may set a greater or lesser applicable percentage for calculating dividends under this rule depending on the funding adequacy of the reserve account. In no event shall the applicable percentage exceed 3 percent.

b. In determining the annual applicable percentage, the system shall consider, but not be limited to, the value of the reserve account, distributions made from the reserve account in previous years, and the likelihood of future credits to and distributions from the reserve account. The system shall make its annual applicable percentage decisions using at least a rolling five-year period.

c. If for any year the system cannot afford an applicable percentage equal to that payable to retired members under Iowa Code section 97B.49F(1), the system may use applicable percentages in succeeding years that are higher than those used in calculating dividends for retired members under Iowa Code section 97B.49F(1) (but not in excess of 3 percent).

d. An applicable percentage in excess of the applicable percentage declared under Iowa Code section 97B.49F(1) made for catch-up purposes shall not reduce the funding of the reserve account below the amount the system's actuary determines is necessary to pay the maximum favorable experience dividend for each of the next five years, based on reasonable actuarial assumptions.

15.2(3) *Calculation of FED for individual members and beneficiaries.* A member must be retired for one full year to qualify for a favorable experience dividend. In determining whether a member has been retired one full year, the system shall count the member's first month of entitlement as the first month of the one-year period. The month in which the favorable experience dividend is payable shall be included in determining whether a member meets the eligibility requirements.

An eligible member's favorable experience dividend shall be calculated by multiplying the retirement allowance payable to the retired member, beneficiary, or contingent annuitant for the previous December, or such other month as determined by the system, by 12, and then multiplying that amount by the number of complete years the member has been retired or would have been retired if living on the date the dividend is payable, and by the applicable percentage set by the system. The number of complete years the member has been retired shall be determined by rounding down to the nearest whole year.

For otherwise eligible retired reemployed members who chose to suspend their monthly allowance under 495—paragraph 12.8(2)*"c,"* the suspension shall have no effect on the calculation of FED.

15.2(4) *FED for eligible members and beneficiaries who die before the January distribution date.* If a member or beneficiary receiving monthly payments would have been eligible for a FED distribution in the following January but dies prior to the January distribution date, IPERS will pay a FED to the member's or beneficiary's account for the calendar year in which the death occurred. The FED shall be calculated using the monthly payments received in the calendar year the death occurred. A lump sum death benefit shall not constitute a monthly payment for purposes of determining FED eligibility or in making FED calculations.

The FED percentage applied to the monthly payments received in the calendar year of death shall be the most recently declared FED percentage in effect at the time of the FED payment to the member or beneficiary. This subrule shall not be construed to permit a FED distribution to a member where the total monthly benefits received by the member, counting the month of death, is less than 12, even if a period of 12 months has elapsed between the first payment of monthly benefits to the member and the January distribution date.

Notwithstanding the foregoing, if IPERS determines in January of a given year that, based on reasonable actuarial assumptions, there is a reasonable likelihood that a FED will not be declared for the next following January, IPERS may defer paying FED distributions under this subrule until the determination is made. If IPERS subsequently determines that no FED will be declared for a given year, no FED will be payable to a person whose death occurs during the applicable calendar year.

Effective July 1, 2000, a retired member or beneficiary eligible for a FED payment must, in addition to all other applicable requirements, be living on January 1 in order to receive a FED payment otherwise payable in that January.

15.2(5) *Limit on transfers of favorable experience.* Rescinded IAB 11/22/06, effective 12/27/06.

These rules are intended to implement Iowa Code sections 97B.1A(11A), 97B.49F and 97B.70.

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TITLE V
MANAGEMENT AREAS AND PRACTICES

CHAPTER 51
GAME MANAGEMENT AREAS

[Prior to 12/31/86, Conservation Commission[290] Chs 1,2,4,8,9,24]

571—51.1(481A) Definitions.

"Blind" means a constructed place of ambush or concealment for the purpose of hunting, observing, or photographing any species of wildlife.

"Commission" means the natural resource commission.

"Decoy" means a bird, or animal, or a likeness of one, used to lure game within shooting range.

"Department" means the department of natural resources.

"Director" means the director of the department of natural resources or a designee.

"Handicapped person" means an individual commonly termed a paraplegic or quadriplegic, with paralysis or a physical condition of the lower half of the body with the involvement of both legs, usually due to disease or injury to the spinal cord; a person who is a simple or double amputee of the legs; or a person with any other physical affliction which makes it impossible to ambulate successfully without the use of a motor vehicle.

"Horse" means any equine animal, including horses, mules, burros, donkeys, and all llamas or alpacalike animals.

571—51.2(481A) Jurisdiction. All lands and waters under the jurisdiction of the department are established as game management areas under the provisions of Iowa Code section 481A.6.

571—51.3(481A) Use of firearms.

51.3(1) *Restrictions.* The use or possession of firearms on certain game management areas is restricted.

a. Target shooting, for the purposes of this rule, is defined as the discharge of a firearm for any reason other than the taking of, or attempting to take, any game birds, game animals, or furbearers. Target shooting with shotguns shooting shot is not restricted to a specific range, except as otherwise provided. Target shooters using shotguns with lead shot cannot discharge the shot over water.

b. Target shooting shall occur only on the designated and posted shooting range.

c. Any person target shooting with any type of handgun or any type of rifle, or shooting shotgun slugs through a shotgun, must fire through one of the firing tubes, if provided, or at the firing points on the rifle or pistol range.

d. It is a violation of these rules to place any target on the top of the earthen backstop or to fire at any target placed on top of the backstop.

e. The shotgun range, if provided, is restricted to the use of shotguns and the shooting of shotshells only.

f. Target shooting shall occur only between the hours of sunrise and sunset.

g. No alcoholic beverages are allowed on the shooting range or adjacent parking area.

h. Target shooting is restricted to legal firearms and shall not be done with any fully automatic pistol, rifle, or shotgun of any kind. No armor-piercing ammunition is permitted.

i. Targets are restricted to paper or cardboard targets or metal silhouette-type targets. No glass, plastic containers, appliances, or other materials may be used. Targets must be removed from the area after use or must be disposed of in trash receptacles if provided.

j. All requirements listed in this subrule shall apply to the following shooting ranges:

(1) Banner Mine Area – Warren County.
(2) Bays Branch Area – Guthrie County.
(3) Brushy Creek Area – Webster County.
(4) Hawkeye Wildlife Area – Johnson County.
(5) Hull Wildlife Area – Mahaska County.
(6) Mines of Spain – Dubuque County.

(7) Ocheyedan Wildlife Area – Clay County.
(8) Princeton Wildlife Area – Scott County.
(9) Spring Run Wildlife Area – Dickinson County.

k. In addition to the requirements listed, the following shooting range has specific restrictions.

Oyens Shooting Range – Plymouth County. The range is closed to the public except between 9 a.m. and sunset. Law enforcement firearms training and qualification of local, county, state or federal officers shall have priority over general public use of the range. Shotguns shooting birdshot may be fired outside the firing tubes, but within the designated range area. General shooting by the public shall take place on a first-come, first-served basis.

l. McIntosh Wildlife Area - Cerro Gordo County. The use or possession of firearms, except shotguns shooting shot only, is prohibited.

51.3(2) *Use of paintball guns.* The use of any item generally referred to as a paintball gun is prohibited on all game management areas.

571—51.4(481A) Use of horses on game management areas.

51.4(1) *Prohibition.* Horses are prohibited on all game management areas unless allowed by exception. This rule does not apply to state forests or state recreation areas.

51.4(2) *Exception for hunting and field trials.* Horses may be used on all game management areas for training raccoon hunting dogs from October 1 to February 1 and for hunting raccoons during open hunting seasons. Horses may be used for participating in authorized field trials, unless this activity is posted as prohibited.

51.4(3) *Exception for horseback riding.* Horseback riding is allowed on the following game management areas from May 25 to September 30 and is confined to existing roads or trails as posted:

a. Elk Grove Wildlife Area – Guthrie County.
b. Lennon Mills Wildlife Area – Guthrie County.
c. Marlow Ray Wildlife Area – Guthrie County.
d. Middle Raccoon River Wildlife Area – Guthrie County.
e. Sand Creek Wildlife Area – Decatur and Ringgold Counties.
f. Cardinal Marsh – Winneshiek County.
g. Hawkeye Wildlife Area – Johnson County.
h. Black Hawk Wildlife Area – Sac County.
i. Turkey River Wildlife Area – Howard County.

571—51.5(481A) Dogs prohibited—exception. Dogs shall be prohibited on all state-owned game management areas, as established under authority of Iowa Code section 481A.6, between the dates of March 15 and July 15 each year; except that, training of dogs shall be permitted on designated training areas. Field and retriever meets shall be conducted at designated sites. A permit as provided in Iowa Code section 481A.22 must be secured for field and retriever meets.

The permit shall show the exact designated site of said meet and all dogs shall be confined to that site.

571—51.6(481A) Use of blinds and decoys on game management areas.

51.6(1) *Stationary blinds.* The construction and use of stationary blinds on all game management areas, except on Pool 14 downstream of the Upper Mississippi River National Wildlife and Fish Refuge (River Mile 502) near Princeton, Iowa, and on Pools 15, 16, 17, and 18 of the Mississippi River, are restricted as follows:

a. Construction. Any person may construct a stationary blind using only the natural vegetation found on the area. No trees or parts of trees other than willows may be cut for use in constructing a blind. No other man-made materials of any type may be used for building or providing access to a stationary blind.

b. Use of blinds. The use of any stationary blind which is constructed in violation of 51.6(1)*"a"* is prohibited.

c. Ownership of blinds. Any person who constructs or uses a stationary blind shall not have any proprietary right-of-ownership to the blind.

51.6(2) *Portable blinds.* The construction and use of portable blinds on game management areas shall be restricted as follows:

a. Construction. A portable blind may be constructed of any natural or man-made material, as long as it is a self-contained unit capable of being readily moved from one site to another.

b. Prohibited use. Portable blinds shall be prohibited from one hour after sunset until midnight each day. Portable blinds which are built on, or are part of, a boat shall be considered as removed from an area when the boat and blind are tied up or moored at an approved access site. No boat shall be anchored away from shore and left unattended unless it is attached to a legal buoy.

c. Exception—tree blinds. Portable blinds placed in trees and used for purposes other than hunting waterfowl may be left on an area for a continuous period of time beginning seven days prior to the open season for hunting deer or turkey and ending seven days after the final day of that open season. Portable blinds left on game management areas do not guarantee the owner exclusive use of the blind when unattended, or exclusive use of the site.

d. Protection of trees. The use of any spike, nail, pin, or other object which is driven or screwed into a tree is prohibited.

51.6(3) *Use of waterfowl decoys.* The use of waterfowl decoys on any game management area, except on Pool 14 downstream of the Upper Mississippi River National Wildlife and Fish Refuge (River Mile 502) near Princeton, Iowa, and on Pools 15, 16, 17, and 18 of the Mississippi River, is restricted as follows:

Decoys are prohibited from one hour after sunset until midnight each day, and decoys cannot be left unattended for over 30 minutes between midnight and one hour after sunset. Decoys shall be considered as removed from an area when they are picked up and placed in a boat, vehicle or other container at an approved access site.

51.6(4) *Use of stationary blinds and waterfowl decoys on Pool 14 downstream of the Upper Mississippi River National Wildlife and Fish Refuge (River Mile 502) near Princeton, Iowa, and on Pools 15, 16, 17, and 18 of the Mississippi River.* The use of permanent blinds for waterfowl hunting on Pool 14 downstream of the Upper Mississippi River National Wildlife and Fish Refuge (River Mile 502) near Princeton, Iowa, and on Pools 15, 16, 17, and 18 of the Mississippi River is restricted as follows:

a. Registration. Hunters must register their blind site with the department of natural resources by completing a registration card and designating the blind's location on a map. Registration will be held in August at a site to be publicly announced by the department. Registration is for a five-year period and requires payment of a fee of $100. The blind registration number must be visibly posted at the blind's entrance.

b. Construction. Blinds must have minimum dimensions of 4 feet by 8 feet and not greater than 500 square feet of floor space, not including a boat hide. The blind must be constructed of biodegradable materials, including nontreated dimensional lumber and nontreated plywood, unless the blind will be removed at the end of the waterfowl season. The use of metal or nylon fasteners, including but not limited to nails, screws, lag bolts, staples and ties, is allowed. Treated lumber, treated plywood, woven wire, chicken wire, cattle panels, tin and sheet metal, vinyl and plastic, and other nonbiodegradable materials are not allowed unless those materials or the entire blind is removed within three days after the close of the waterfowl season.

c. Tree and brush removal. No person shall remove brush or trees around any blind, except willows. Willows and annual vegetation from the blind site may be used to cover the blind.

d. Occupation of blinds. Registrants must occupy their blind site by the opening of shooting time each day to claim the blind site for that day. After that time, unoccupied blind sites will be available to any other hunters. No person shall claim or attempt to claim a blind that is legally occupied. No person shall harass, in any manner, the occupants of a blind that is legally occupied.

e. Locking blinds. No person shall lock a blind.

f. *Decoys.* Decoys may be left out for the entire waterfowl season but must be picked up and removed from the area within three days after the close of the waterfowl season. All jugs and other floating devices used to attract waterfowl shall be considered decoys.
[**ARC 7917B**, IAB 7/1/09, effective 8/5/09]

571—51.7(481A) Trapping on game management areas.

51.7(1) *Marking trap sites.* No one shall place on any game management area any trap, stake, flag, marker, or any other item or device to be used for trapping furbearers, or to mark or otherwise claim any site for trapping furbearers, except during the open season for taking furbearers other than coyote.

51.7(2) Reserved.

571—51.8(481A) Motor vehicle restrictions. The use of motor vehicles on all game management areas is restricted.

51.8(1) *Roads and parking lots.* Except as otherwise provided in these rules, motor vehicles are prohibited on a game management area except on constructed and designated roads and parking lots.

51.8(2) *Handicapped persons.* Handicapped persons may use certain motor vehicles on game management areas, according to the restrictions set out in this rule, in order that they might enjoy such uses as are available to others.

a. *Definitions.* For purposes of this subrule, 51.8(2), the following definition shall apply: "Motor vehicle" means any self-propelled vehicle having at least three wheels and registered as a motor vehicle under Iowa Code chapter 321, 321G, or 321I.

b. *Permits.* Each handicapped person must have a permit issued by the director in order to use motor vehicles on game management areas. Such permits will be issued without charge. Applicants must submit certificates from their doctors stating that the applicants meet the criteria describing handicapped persons. Nonhandicapped companions of permit holders are not covered under the conditions of the permit.

c. *Approved areas.* A permit holder must contact the technician or wildlife biologist of the specific area(s) that the permit holder wishes to use annually. The technician or wildlife biologist will determine which areas or portions of areas will not be open to use by permittees, in order to protect the permittee from hazards or to protect certain natural resources of the area. The technician or wildlife biologist will assist by arranging access to the area and by designated specific sites on the area where the motor vehicle may be used, and where it may not be used. The technician or wildlife biologist will provide a map of the area showing the sites where use is permitted and bearing the signature of the technician or wildlife biologist and the date.

d. *Exclusive use.* The issuance of a permit does not imply that the permittee has exclusive use of an area. Permittees shall take reasonable care so as not to unduly interfere with the use of the area by others.

e. *Prohibited acts.* Except as provided in subrule 51.8(1), the use of a motor vehicle on any game management area by a person without a valid permit, or at any site not approved on a signed map, is prohibited. Permits and maps must be carried by the permittee at any time the permittee is using a motor vehicle on a game management area, and must be exhibited to any department employee or law enforcement official upon request.

f. *Shooting from motor vehicle.* Except where prohibited by law, a handicapped person meeting the conditions of this rule may shoot from a stationary motor vehicle.

571—51.9(481A) Employees exempt. Restrictions in rules 51.3(481A) to 51.8(481A) shall not apply to department personnel, law enforcement officials, or other authorized persons engaged in research, management, or enforcement when in performance of their duties.

571—51.10(481A) Use of nontoxic shot on wildlife areas. It shall be unlawful to hunt any migratory game bird or resident game or furbearers, except deer and turkeys, or target shoot with a shotgun while having in one's possession any shot other than nontoxic shot approved by the U.S. Fish and Wildlife Service on the following wildlife areas:

County	Wildlife Area
Benton	Iowa River Corridor
Boone	Harrier Marsh
Buena Vista	All state and federal areas
Calhoun	South Twin Lake
Cerro Gordo	All state and federal areas
Clay	All state and federal areas except the Ocheyedan wildlife area target shooting range
Dickinson	All state and federal areas except the Spring Run target shooting range
Emmet	All state and federal areas
Franklin	All state and federal areas
Greene	All state and federal areas except Rippey Access and McMahon Access
Guthrie	McCord Pond, Lakin Slough and Bays Branch, except the target shooting range at Bays Branch
Hamilton	Little Wall Lake, Gordon Marsh and Bauer Slough
Hancock	All state and federal areas
Humboldt	All state and federal areas
Iowa	Iowa River Corridor
Jasper	Chichaqua
Kossuth	All state and federal areas
Osceola	All state and federal areas
Palo Alto	All state and federal areas
Pocahontas	All state and federal areas except Kalsow Prairie
Polk	Paul Errington Marsh and Chichaqua
Sac	All state and federal areas except White Horse Access and Sac City Access
Story	Hendrickson Marsh and Colo Bog
Tama	Iowa River Corridor
Winnebago	All state and federal areas
Worth	All state and federal areas
Wright	All state and federal areas

571—51.11(481A) Rock climbing and rappelling. Rock climbing and rappelling are prohibited at all game management areas except at Indian Bluffs and Pictured Rocks wildlife management areas, Boone Forks wildlife management area only on the abandoned railroad bridge piers, and those authorized by 571—subrule 61.5(13). No one shall place bolts, pitons, or similar anchoring devices at Indian Bluffs or Pictured Rocks unless authorized to do so by the wildlife biologist in charge of the area.

571—51.12(481A) Camping restrictions. Primitive camping is allowed on all game management areas for a period not to exceed 14 days of consecutive use, unless specific restrictions are posted on site. The department may prohibit or restrict camping at any game management area by the posting of signs stating the applicable restrictions. Where posted, camping shall be prohibited within 100 yards of public parking lots, boat ramps, fishing jetties and other public use facilities.

These rules are intended to implement Iowa Code sections 456A.24(2)*"a"* and 481A.6.

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CHAPTER 52
WILDLIFE REFUGES

[Prior to 12/31/86, Conservation Commission[290] Chs 3,7,46]

571—52.1(481A) Established. The following state-owned lands and water under the jurisdiction of the department of natural resources are established as wildlife refuges or sanctuaries for the purpose of preserving the biological balance pursuant to the provisions of Iowa Code section 481A.39, and for the protection of public parks, public health safety and welfare, and to effect sound wildlife management.

52.1(1) *State parks, recreation areas and preserves.*

Park or Preserve	County
A.A. Call	Kossuth
Abbie Gardner Sharp	Dickinson
Arnolds Park Pier	Dickinson
Backbone	Delaware
Barkley Memorial	Boone
Beeds Lake	Franklin
Bellevue	Jackson
Big Creek	Polk
Bixby	Clayton
Black Hawk Lake	Sac
Bob White	Wayne
Browns Lake	Woodbury
Brush Creek Canyon	Fayette
Cameron Woods	Scott
Clear Lake	Cerro Gordo
Cold Springs	Cass
Dolliver Memorial	Webster
Eagle Lake	Hancock
E.B. Lyons Prairie-Woodland Preserve and Nature Interpretive Center	Dubuque
Echo Valley	Fayette
Elinor Bedell	Dickinson
1. Except that area along the shoreline signed as a public hunting area.	
Elk Rock	Marion
Fish Farm Mounds	Allamakee
Fort Atkinson	Winneshiek
Fort Defiance	Emmet
Frank A. Gotch	Humboldt
Frank Pellett Memorial Woods	Cass
Galland School	Lee
Geode	Des Moines-Henry
George Wyth	Black Hawk
Green Valley	Union
Gull Point (Okoboji Areas)	Dickinson
Heery Woods	Butler
Honey Creek	Appanoose
Indian Village	O'Brien
Inn Area (Okoboji Areas)	Dickinson
Kearny	Palo Alto
Kish-Ke-Kosh Prairie	Jasper
Lacey-Keosauqua	Van Buren
Lake Ahquabi	Warren
Lake Anita	Cass

Lake Darling . . . . . Washington

1. That portion of the recreation area south and west of the main entrance road from Highway 1 and 78 to the south end of the modern campground.

2. That portion south of the east recreation area road from its intersection with the main entrance road to Honey Creek.

3. That area between the main entrance road and the south shore of Lake Darling starting at 7/8 mile from the intersection with Highway 1 and 78 and ending at the south end of the modern campground.

Lake Keomah . . . . . Mahaska
Lake Macbride . . . . . Johnson
Lake Manawa . . . . . Pottawattamie
Lake of Three Fires . . . . . Taylor
Lake Wapello . . . . . Davis
Ledges . . . . . Boone
Lennon Mills . . . . . Guthrie
Lewis and Clark . . . . . Monona
Little Maquoketa Mounds . . . . . Dubuque
McGregor Heights . . . . . Clayton
McIntosh Woods . . . . . Cerro Gordo
Malchow Mounds . . . . . Des Moines
Maquoketa Caves . . . . . Jackson
Margo Frankel Woods . . . . . Polk
Mericle Woods . . . . . Tama
Merritt Forest . . . . . Clayton
Mill Creek . . . . . O'Brien
Mines of Spain . . . . . Dubuque

1. That portion within the city limits of the city of Dubuque located west of U.S. Highway 61 and north of Mar Jo Hills Road.

2. The tract leased by the department of natural resources from the city of Dubuque upon which the E.B. Lyons Interpretive Center is located.

3. That portion located south of the north line of Section 8, Township 88 North, Range 3 East of the 5th P.M. between the west property boundary and the east line of said Section 8.

4. That portion located north of Catfish Creek, east of the Mines of Spain Road, south of the railroad tracks. This portion includes the Julien Dubuque Monument.

Mini-Wakan . . . . . Dickinson
Nestor Stiles Prairie . . . . . Cherokee
Nine Eagles . . . . . Decatur
Oak Grove . . . . . Sioux
Oakland Mills . . . . . Henry
Okamanpedan . . . . . Emmet
Orleans Beach . . . . . Dickinson
Palisades-Kepler . . . . . Linn
Pammel . . . . . Madison
Pecan Grove . . . . . Muscatine
Pikes Peak (McGregor Area) . . . . . Clayton
Pikes Point . . . . . Dickinson
Pillsbury Point . . . . . Dickinson
Pilot Grove . . . . . Iowa
Pilot Knob . . . . . Hancock
Pine Lake . . . . . Hardin
Pioneer . . . . . Mitchell
Plum Grove . . . . . Johnson
Point Ann . . . . . Clayton

Prairie Rose . . . . . Shelby
Preparation Canyon . . . . . Monona
Red Haw Hill . . . . . Lucas
Rice Lake . . . . . Worth-Winnebago
Rock Creek. . . . . Jasper
Sharon Bluffs . . . . . Appanoose
Silver Lake . . . . . Delaware
Spring Lake . . . . . Greene
Springbrook . . . . . Guthrie

1. That portion of the recreation area enclosed within the following described boundary: beginning at the southeasternmost corner of the property boundary and following that boundary west to the Raccoon River; then northwesterly along the river to the mouth of Springbrook Creek; then northeasterly along the east bank of Springbrook Creek to a point directly north of the water tower; then southeast to the trail east of the water tower; then along the northern and easternmost portion of that trail system to a point near the pond dam located in the southeasternmost corner of the park; then southeast to the point of beginning.

2. That portion of the recreation area enclosed within the following described boundary: beginning at the easterly southeast boundary corner and proceeding both north and west along County Highway F25 for a distance of 200 yards; then on a straight northeast/southwest line between the two points described above.

3. That portion of the recreation area bounded on the north by the property boundary, on the east by the dirt road known as Oak Avenue intersecting with State Highway 384 and on the southwest by State Highway 384.

4. That portion of the recreation area located on and west of a line approximately 100 yards east of the west property boundary which is east of the dirt road known as Oak Avenue from State Highway 384 north to the north property boundary.

All above areas are posted with "closed to hunting" boundary signs.

Starr's Cave . . . . . Des Moines
Steamboat Rock. . . . . Hardin
Stone Park . . . . . Woodbury
Strasser Woods. . . . . Polk
Trappers Bay . . . . . Dickinson
Turkey River Mounds . . . . . Clayton
Twin Lakes. . . . . Calhoun
Union Grove . . . . . Tama
Viking Lake . . . . . Montgomery

1. That portion of the recreation area enclosed within the following described boundary: on the north, the boundary of the refuge is described as the main entrance road to its "T" intersection with the road to the north boat ramp; thence northeasterly along the boat ramp road to the northwest corner of the boat ramp area to the lake water line.

2. On the south, the boundary is described as a line beginning at the north/south-east/west boundary corner south of the entrance road east to the road leading to the south picnic area parking lot and along that road to the easterly corner of that parking area; thence east to the lake water line.

3. All of the above area is posted with "closed to hunting" boundary signs.

Walnut Woods . . . . . Polk
Wanata . . . . . Clay
Wapsipinicon . . . . . Jones

1. All of the property within the state ownership boundary lines except the portion locally known as the "Oler Property" located in the southeast portion of the property line the boundary of which is marked with wildlife refuge signs.

2. Within the above described area, a circular shaped parcel approximately 400 yards in diameter centered on the enclosed rental shelter.

Waubonsie	Fremont
Wildcat Den	Muscatine
Woodman Hollow	Webster

52.1(2) *Wildlife refuges.*

a. Restrictions. The following areas under the jurisdiction of the department of natural resources are established as game refuges where posted. It shall be unlawful to hunt, pursue, kill, trap, or take any wild animal, bird, or game on these areas at any time, and no one shall carry firearms thereon, except where and when specifically authorized by the department of natural resources. It shall also be unlawful to trespass in any manner on the following areas, where posted, between the dates of September 1 and January 31 of each year, both dates inclusive, except that department personnel and law enforcement officials may enter the area at any time in performance of their duties, and hunters, under the supervision of department staff, may enter when specifically authorized by the department of natural resources.

Area	County
Lake Icaria	Adams
Pool Slough Wildlife Area	Allamakee
Rathbun Area	Appanoose, Lucas, Wayne
Sedan Bottoms	Appanoose
Wildlife Exhibit Area	Boone
Sweet Marsh	Bremer
Big Marsh	Butler
South Twin Lake	Calhoun
Ventura Marsh	Cerro Gordo
Round Lake	Clay
Allen Green Refuge	Des Moines
Henderson	Dickinson
Jemmerson Slough Complex	Dickinson
Spring Run	Dickinson
Ingham Lake	Emmet
Forney Lake	Fremont
Riverton Area	Fremont
Dunbar Slough	Greene
Bays Branch	Guthrie
Crystal Hills	Hancock
Eagle Flats	Hancock
Eagle Lake	Hancock
Green Island Area	Jackson
Hawkeye Wildlife Area	Johnson
Muskrat Slough	Jones
Colyn Area	Lucas
Red Rock Area	Marion, Polk, Warren
Badger Lake	Monona
Tieville/Decatur Bend	Monona
Five Island Lake	Palo Alto
Big Creek-Saylorville Complex	Polk
Chichaqua Area	Polk
Smith Area	Pottawattamie
McCausland	Scott
Princeton Area	Scott
Prairie Rose Lake	Shelby
Otter Creek Marsh	Tama
Green Valley Lake	Union
Three Mile Lake	Union

Lake Sugema . . . . . Van Buren
Rice Lake Area . . . . . Winnebago
Snyder Lake . . . . . Woodbury
Elk Creek Marsh . . . . . Worth
Lake Cornelia. . . . . Wright

b. It shall be unlawful to trespass in any manner on the following areas, where posted, anytime year around, except that department personnel and law enforcement officials may enter the area at any time in performance of their duties, and hunters under the supervision of department staff may enter when specifically authorized by the department of natural resources.

Area	County
Middle River Wildlife Area (formerly Banner Pits).	Warren
Black Hawk Bottoms Wildlife Area	Des Moines

c. It shall be unlawful to trespass in any manner on the following areas or portion of the areas during the time of the year they are posted as refuges. Department personnel and law enforcement officials may enter the area at any time in performance of their duties, and hunters under the supervision of department staff may enter to retrieve dead or wounded game animals when specifically authorized by the department.

Area	County
Gladys Black Eagle Refuge	Marion

52.1(3) *Open water refuges.* Rescinded 6/17/98, effective 7/22/98.

[**ARC 7918B**, IAB 7/1/09, effective 8/5/09]

This rule is intended to implement Iowa Code sections 481A.5, 481A.6, 481A.9 and 481A.39.

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CHAPTER 95
GAME HARVEST REPORTING AND LANDOWNER-TENANT REGISTRATION

571—95.1(481A) Harvest reporting system. Deer and turkey hunters must report each deer and wild turkey harvested to the department of natural resources (DNR) harvest reporting system. The hunter whose name is on the transportation tag is responsible for making the report. Hunters who do not bag a deer or wild turkey do not report.

95.1(1) *Reporting deadlines for deer and turkey.* A harvest report must be made by midnight on the day after the animal is tagged or before the animal is taken to a locker or taxidermist, is processed for consumption, or is transported out of state, whichever occurs first.

95.1(2) *Method of reporting.* Hunters may report the harvest in one of three ways:

a. By calling the DNR toll-free harvest reporting telephone number. The telephone number will be in operation from 6 a.m. to midnight each day during hunting seasons and for the legal reporting period after the season.

b. By reporting through the Internet using the DNR online harvest reporting system. The system will function 24 hours a day, seven days a week during hunting seasons and for the legal reporting period after the season.

c. By visiting an electronic licensing system for Iowa (ELSI) license agent during the license agent's normal business hours. Reports may be made through ELSI whenever hunting seasons are open and for the legal reporting period after the seasons.

95.1(3) *Report confirmation.* After the report is made, the hunter will be given a confirmation number to write on the harvest report tag to verify that the hunter has reported the kill. The harvest report tag and confirmation number must remain attached to the deer or wild turkey until the deer or turkey is processed for consumption.

571—95.2(481A) Verifying eligibility for free landowner or tenant licenses. Eligibility for free and reduced-fee deer and wild turkey hunting licenses, which are hereafter referred to as free licenses, is defined in Iowa Code section 483A.24, rule 571—98.5(483A) and rule 571—106.12(481A). The electronic licensing system for Iowa (ELSI) will not issue free licenses to persons who have not registered their eligibility with ELSI.

95.2(1) *Farm unit.* As provided in 571—subrule 106.12(6), all the land under the lawful control of the landowner or tenant is considered one farm unit no matter how it is subdivided for business purposes. No one may be registered as eligible for free licenses on more than one farm unit. Registering on one parcel of land within the farm unit will allow the landowner, tenant or family member to hunt on all land in the farm unit.

95.2(2) *Who may obtain free licenses.* One member of the landowner family (the landowner or an eligible family member) may obtain a free any-deer license. Members of the landowner family may divide the free antlerless-deer-only licenses for which the family is eligible among themselves in any way they choose. If there is a tenant on the same property, one member of the tenant family (the tenant or an eligible family member) may also obtain a free any-deer license. Members of the tenant family may divide the free antlerless-deer-only licenses for which they may be eligible among themselves in any way they choose. One member of the landowner family and one member of the tenant family may each obtain one free spring turkey hunting license and one free fall turkey hunting license.

95.2(3) *Method of registration.* A landowner or tenant may register in one of the following ways:

a. Landowners. Persons who own at least one parcel of qualifying land may register on the Internet through ELSI or by mailing or faxing an affidavit obtained from DNR. The online system is available 24 hours a day, seven days a week. An online registrant may immediately obtain a free license once the registration process is complete. A person who registers through the mail or by fax may have to wait up to ten business days after the form is received by DNR to obtain a free license.

b. Tenants. A person who qualifies as a tenant but does not own any qualifying land may register on the Internet through ELSI or by mailing or faxing an affidavit obtained from DNR. A tenant may have to wait up to ten business days after the affidavit is received by DNR before obtaining a free license.

95.2(4) *Information verifying eligibility.* In order to register, a landowner, tenant or qualifying family member must have a customer record in ELSI, i.e., have already purchased a license through ELSI. A person without an ELSI customer record must call the ELSI telephone ordering system to establish a customer record before registering. When registering, landowners, tenants and family members will be required to provide their ELSI customer number or their Iowa driver's license number or social security number and their date of birth to identify their ELSI customer record.

a. Landowners. A landowner shall provide the parcel identification number (PIN) from the landowner's current property tax statement for one parcel of qualifying land owned by the landowner and the number of the county where the land is located. Qualifying family members shall be registered to the same parcel of qualifying land as the landowner.

b. Partnerships, corporations or other forms of joint land ownership. Each owner of a jointly owned farm unit and the owner's qualifying family members who wish to receive free licenses for that farm unit shall register with the same county number and PIN. Only one joint owner or family member may obtain the one any-deer license available for the farm unit. The other joint owner(s) and family members may divide any other free licenses to which they are entitled among themselves in any way they choose.

c. Tenants. A tenant shall provide an affidavit that contains the name, address, and telephone number of the owner of the qualifying land rented by the tenant; the county number where the land is located; and the landowner's PIN from one parcel of that qualifying land. If a tenant rents land from more than one landowner, the tenant shall provide the required information about only one landowner. The tenant's qualifying family members shall be registered to the same parcel of qualifying land as the tenant.

d. Signature required. Pursuant to Iowa Code section 483A.24(2)*"f,"* all affidavits submitted to register eligibility for free licenses shall bear the signature of the landowner, tenant, or family member attesting that the information contained therein is true.

95.2(5) *Forms.* Instructions and affidavits may be obtained online at www.iowadnr.com, at DNR offices, or by calling (515)281-5918.

95.2(6) *Registration expiration and renewal.* A registered landowner, tenant, or eligible family member may obtain free licenses as allowed in subrule 95.2(2) provided the registration information and eligibility status remain valid. If the registration information or eligibility status of a registered landowner, tenant, or eligible family member changes, that individual must send by U.S. mail or by fax a DNR affidavit form or contact the DNR by telephone. The DNR will periodically review registration information to verify eligibility status and will inactivate registrations when the registration information fails to indicate eligibility.

95.2(7) *Penalties.* Free licenses will not be issued to an applicant until a legible and complete affidavit is received by DNR. An illegible or incomplete affidavit will be returned to the applicant for correction. A person who has made a false attestation in obtaining a license in violation of Iowa Code Supplement section 483A.24(2)*"f"* shall be guilty of a simple misdemeanor and subject to license revocation, as provided in Iowa Code section 483A.21, Iowa Code supplement section 483A.24(2)*"f"* and 571—subrule 106.8(3).

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CHAPTER 99
WILD TURKEY FALL HUNTING BY RESIDENTS

571—99.1(481A) General. When hunting wild turkey, all hunters must have in possession a fall wild turkey hunting license valid for the current year, the unused transportation tag issued with that license, a hunting license, and evidence of having paid the habitat fee (if normally required to have a hunting license and to pay the habitat fee to hunt). No person shall carry or have in possession a fall wild turkey hunting license or transportation tag issued to another person while hunting wild turkey. No one who is issued a wild turkey hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while turkey hunting or tagging a turkey.

571—99.2(481A) Licenses.

99.2(1) *Paid combination shotgun-or-archery licenses.* Paid combination shotgun-or-archery licenses shall be valid for taking turkeys of either sex in the zone designated on the license.

99.2(2) *Paid archery-only licenses.* Paid archery-only licenses shall be valid statewide for taking turkeys of either sex.

99.2(3) *Number of licenses.* No one may apply for or obtain more than two wild turkey fall hunting licenses, whether free or paid. A hunter may obtain no more than two combination shotgun-or-archery licenses, or two archery-only licenses, or one of each. One license of either type may be free to eligible landowners or tenants.

[**ARC 7920B**, IAB 7/1/09, effective 8/5/09]

571—99.3(481A) Seasons. Wild turkey may be taken only during specified periods as follows:

99.3(1) *Combination shotgun-or-archery season.* The dates for the combination shotgun-or-archery season shall be from the Monday following the second Saturday in October through the Friday before the first Saturday in December of the same year.

99.3(2) *Archery-only season.* The dates for the fall archery-only wild turkey hunting season shall be the same as the dates for the bow season for deer as defined in 571—Chapter 106.

571—99.4(481A) Zones. Wild turkey may be taken with a combination shotgun-or-archery license only in the following zones:

99.4(1) *Zone 4.* Zone 4 is that portion of Iowa bounded on the north by Interstate Highway 80 and on the west by U.S. Highway 59.

99.4(2) *Zone 5.* Zone 5 is that portion of Iowa bounded on the east by U.S. Highway 59 and on the north by U.S. Highway 20.

99.4(3) *Zone 6.* Zone 6 is that portion of Iowa bounded on the south by Interstate Highway 80 and on the west by U.S. Highway 63.

99.4(4) *Zone 7.* Zone 7 is that portion of Iowa bounded on the north by U.S. Highway 20, on the west by U.S. Highway 59, on the south by Interstate Highway 80, and on the east by U.S. Highway 63.

99.4(5) *Zone 8.* Zone 8 is that portion of Iowa bounded on the south by U.S. Highway 20, on the east by U.S. Highway 63, and on the west by U.S. Highway 69.

99.4(6) *Zone 9.* Zone 9 is that portion of Iowa bounded on the south by U.S. Highway 20 and on the east by U.S. Highway 69.

571—99.5(481A) Quotas.

99.5(1) *Combination shotgun-or-archery licenses.* A limited number of paid combination shotgun-or-archery licenses will be issued by zone as follows:

a. Zone 4. 1,500
b. Zone 5. 650
c. Zone 6. 1,400
d. Zone 7. 250
e. Zone 8. 150
f. Zone 9. 200

99.5(2) *Archery-only licenses.* The number of archery-only licenses shall not be limited.

99.5(3) *Free landowner-tenant licenses.* The number of free licenses shall not be limited.

99.5(4) *Additional licenses.* Additional combination shotgun-or-archery licenses may be added to zone quotas if turkey surveys indicate that annual brood production and turkey populations are high enough to warrant additional hunting opportunity. The licenses will be added at the discretion of the natural resource commission upon advice from the wildlife bureau.
[**ARC 7920B**, IAB 7/1/09, effective 8/5/09]

571—99.6(481A) Daily, season, and possession bag limits. The daily, season, and possession bag limit is one wild turkey per license.

571—99.7(481A) Shooting hours.

99.7(1) *Combination shotgun-or-archery season.* Shooting hours shall be from one-half hour before sunrise to sunset each day.

99.7(2) *Archery-only season.* Shooting hours shall be from one-half hour before sunrise to one-half hour after sunset each day.

571—99.8(481A) Means and method of take.

99.8(1) *Permitted weapons.* In accordance with the type of license issued, wild turkey may be taken by shotgun and muzzleloading shotgun not smaller than 20-gauge and shooting only shot sizes 2 or 3 nontoxic shot or 4, 5, 6, 7½, or 8 lead or nontoxic shot; and by longbow, recurve or compound bow shooting broadhead or blunthead (minimum diameter 9/16 inch) arrows only. No person may carry or have in possession shotshells containing shot of any size other than 2 or 3 nontoxic shot or 4, 5, 6, 7½, or 8 lead or nontoxic shot while hunting wild turkey. Arrows with chemical or explosive pods are not permitted.

99.8(2) *Prohibited devices.* The use of live decoys, horses, motorized vehicles, aircraft, bait and the use or aid of recorded or electronically amplified bird calls or sounds, or recorded or electronically amplified imitations of bird calls or sounds are prohibited. Paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Paraplegic" means an individual afflicted with paralysis of the lower half of the body with the involvement of both legs, usually due to disease of or injury to the spinal cord. "Bait" means grain, fruit, vegetables, nuts or any other natural food materials; commercial products containing natural food materials; or by-products of such materials transported to or placed in an area for the intent of attracting wildlife.

571—99.9(481A) Procedures to obtain licenses. All paid and free resident fall turkey hunting licenses must be obtained using the electronic licensing system for Iowa (ELSI). Licenses may be purchased from ELSI license agents or by calling the ELSI telephone ordering system.

99.9(1) *Licenses with quotas.* All paid turkey hunting licenses for which a quota is established may be obtained from ELSI agents on a first-come, first-served basis beginning August 15 until the quota fills, or through the last day of the hunting period for which the license is valid.

99.9(2) *Licenses without quotas.* All paid and free turkey hunting licenses that have no quota may be obtained from ELSI agents beginning August 15 through the last day of the hunting period for which a license is valid.

99.9(3) *Providing false information.* If anyone provides false information when obtaining any fall turkey hunting license, that license and transportation tag and any other fall turkey hunting license and transportation tag obtained during the same year shall be invalid.

571—99.10(481A) Transportation tag. Immediately upon the killing of a wild turkey, the transportation tag issued with the license and bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to one leg of the turkey. The hunter who shot the turkey must use the transportation tag issued to that hunter to tag the turkey. No one may tag a turkey with a transportation tag issued to another hunter. The tag must be attached in such a manner that it cannot be removed without mutilating or destroying the tag. The tag must be attached before the

carcass can be moved in any manner from the place of kill. The transportation tag shall remain affixed to the leg of the turkey until the turkey is processed for consumption. The leg that bears the tag must be attached to the carcass of any wild turkey being transported within the state during any wild turkey hunting season. The tag shall be proof of possession of the carcass by the above-mentioned licensee.

571—99.11(481A) Eligibility for free landowner/tenant turkey licenses.

99.11(1) *Who qualifies for free turkey hunting license.*

a. Owners and tenants of a farm unit and the spouse or domestic partner as defined by the Iowa department of administrative services and juvenile child of an owner or tenant who reside with the owner or tenant are eligible for free turkey licenses. The owner or tenant does not have to reside on the farm unit but must be actively engaged in farming it. Nonresident landowners do not qualify.

b. "Juvenile child" means a person less than 18 years of age or a person who is 18 or 19 years of age and is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma or a high school equivalency diploma. A person 18 years of age or older who has received a high school diploma or high school equivalency diploma does not qualify.

99.11(2) *Who qualifies as a tenant.* A "tenant" is a person other than the landowner who is actively engaged in the operation of the farm. The tenant may be a member of the landowner's family, including in some circumstances the landowner's spouse or child, or a third party who is not a family member. The tenant does not have to reside on the farm unit.

99.11(3) *What "actively engaged in farming" means.* Landowners and tenants are "actively engaged in farming" if they personally participate in decisions about farm operations and those decisions, along with external factors such as weather and market prices, determine their profit or loss for the products they produce. Tenants qualify if they farm land owned by another and pay rent in cash or in kind. A farm manager or other third party who operates a farm for a fee or a laborer who works on the farm for a wage and is not a family member does not qualify as a tenant.

99.11(4) *Landowners who qualify as active farmers.* These landowners:

a. Are the sole operator of a farm unit (along with immediate family members), or

b. Make all decisions about farm operations, but contract for custom farming or hire labor to do some or all of the work, or

c. Participate annually in decisions about farm operations such as negotiations with federal farm agencies or negotiations about cropping practices on specific fields that are rented to a tenant, or

d. Raise specialty crops from operations such as orchards, nurseries, or tree farms that do not necessarily produce annual income but require annual operating decisions about maintenance or improvements, or

e. May have portions of the farm enrolled in a long-term land retirement program such as the Conservation Reserve Program (CRP) as long as other farm operations occur annually, or

f. Place their entire cropland in the CRP or other long-term land retirement program with no other active farming operation occurring on the farm.

99.11(5) *Landowners who do not qualify.* These landowners:

a. Use a farm manager or other third party to operate the farm, or

b. Cash rent the entire farm to a tenant who is responsible for all farm operations including following preapproved operations plans.

99.11(6) *Where free licenses are valid.* A free license is valid only on the farm unit of the landowner or tenant. "Farm unit" means all parcels of land that are at least two contiguous acres in size, that are operated as a unit for agricultural purposes, and that are under lawful control of the landowner or tenant regardless of how that land is subdivided for business purposes. Individual parcels of land do not need to be adjacent to one another to be included in the farm unit. "Agricultural purposes" includes but is not limited to field crops, livestock, horticultural crops (e.g., nurseries, orchards, truck farms, or Christmas tree plantations), and land managed for timber production.

99.11(7) *How many free licenses may be obtained.* The maximum number of free licenses for the fall turkey season is two per farm unit, one for the landowner (or family member) and one for the tenant (or family member). If there is no tenant, the landowner's family may obtain only one license. A tenant

or the tenant's family is entitled to only one free license even if the tenant farms land for more than one landowner.

99.11(8) *Registration of landowners and tenants.* Landowners and tenants and their eligible family members who want to obtain free fall wild turkey hunting licenses must register with DNR before the free licenses will be issued. Procedures for registering are described in 571—95.2(481A).

571—99.12(481A) Harvest reporting. Each hunter who bags a turkey must report that kill according to procedures described in 571—95.1(481A).

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48 and 483A.7.

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CHAPTER 106
DEER HUNTING BY RESIDENTS

[Prior to 12/31/86, Conservation Commission[290] Ch 106]

571—106.1(481A) Licenses. When hunting deer, all hunters must have in their possession a valid deer hunting license and a valid resident hunting license and must have paid the habitat fee (if normally required to have a hunting license and to pay the habitat fee to hunt). No person while hunting deer shall carry or have in possession any license or transportation tag issued to another person. No one who is issued a deer hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while that person is deer hunting or tagging a deer.

106.1(1) *Type of license.*

a. Any-deer licenses. Any-deer licenses shall be valid for taking deer of either sex in one season selected at the time the license is purchased. Paid any-deer licenses shall be valid statewide except where prohibited in deer population management zones established under 571—Chapter 105. Free any-deer licenses shall be valid only on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

b. Antlerless-deer-only licenses. Antlerless-deer-only licenses shall be valid for taking deer that have no forked antler. Paid antlerless-deer-only licenses shall be valid in one county or in one deer population management zone and in one season as selected at the time the license is purchased. Free and reduced-fee antlerless-deer-only licenses shall be valid on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

106.1(2) *Bow season licenses.* Any-deer and antlerless-deer-only licenses, paid or free, shall be valid in both segments of the bow season.

106.1(3) *Regular gun season licenses.* Paid any-deer and antlerless-deer-only licenses shall be valid in either the first or the second regular gun season, as designated on the license. Free any-deer licenses and antlerless-deer-only licenses shall be valid in both the first and second regular gun seasons.

106.1(4) *Muzzleloader season licenses.* Any-deer and antlerless-deer-only licenses, paid or free, shall be valid in either the early or the late muzzleloader season, as designated on the license.

106.1(5) *November antlerless-deer-only licenses.* Only antlerless-deer-only licenses, paid or free, will be issued for the November antlerless-deer-only season.

106.1(6) *January antlerless-deer-only licenses.* Only antlerless-deer-only licenses, paid or free, will be issued for the January antlerless-deer-only season. Free antlerless-deer-only licenses shall be available only in the portion of the farm unit located in a county where paid antlerless-deer-only licenses are available during that season.

106.1(7) *Free and reduced-fee deer licenses for landowners and tenants.* A maximum of one free any-deer license, two free antlerless-deer-only licenses, and two reduced-fee antlerless-deer-only licenses may be issued to a qualifying landowner or eligible family member and a qualifying tenant or eligible family member. Eligibility for licenses is described in 571—106.12(481A). The free any-deer license shall be available for one of the following seasons: the youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season or first and second regular gun seasons. One free antlerless-deer-only license shall be available for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, or November antlerless-deer-only season. The second free antlerless-deer-only license shall be valid only for the January antlerless-deer-only season and will be available only if a portion of the farm unit lies within a county where paid antlerless-deer-only licenses are available during that season. Each reduced-fee antlerless-deer-only license shall be valid for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, November antlerless-deer-only season or January antlerless-deer-only season. January antlerless-deer-only licenses will be available only if a portion of the farm unit is located in a county where paid antlerless-deer-only licenses are available in that season.

106.1(8) *Antlerless-deer-only crossbow licenses for senior citizens.* Persons 70 years old or older may obtain one paid antlerless-deer-only license valid statewide for taking antlerless deer with a crossbow. The license will be valid only during the bow season.
[**ARC 7921B**, IAB 7/1/09, effective 8/5/09]

571—106.2(481A) Season dates. Deer may be taken only during the following seasons:

106.2(1) *Bow season.* Deer may be taken in accordance with the type of license issued from October 1 through the Friday before the first Saturday in December and from the Monday following the third Saturday in December through January 10 of the following year.

106.2(2) *Regular gun seasons.* Deer may be taken in accordance with the type, season and zone designated on the license from the first Saturday in December and continuing for five consecutive days (first regular gun season) or from the second Saturday in December and continuing for nine consecutive days (second regular gun season).

106.2(3) *Muzzleloader seasons.* Deer may be taken in accordance with the type, season and zone designated on the license from the Saturday closest to October 14 and continuing for nine consecutive days (early muzzleloader season) or from the Monday following the third Saturday in December through January 10 of the following year (late muzzleloader season).

106.2(4) *November antlerless-deer-only season.* Antlerless deer may be taken for three days beginning the Friday after Thanksgiving.

106.2(5) *January antlerless-deer-only season.* Antlerless deer may be taken from January 11 through the third following Sunday.

571—106.3(481A) Shooting hours. Legal shooting hours shall be from one-half hour before sunrise to one-half hour after sunset in all seasons.

571—106.4(481A) Limits.

106.4(1) *Bow season.* The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(2) *Muzzleloader seasons.* The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(3) *Regular gun seasons.* The bag limit is one deer for each hunter in the party who has a valid deer transportation tag. The possession limit is one deer per license. "Possession" shall mean that the deer is in the possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

106.4(4) *November antlerless-deer-only season.* The bag and possession limits and the tagging requirements are the same as for the regular gun seasons.

106.4(5) *January antlerless-deer-only season.* The daily bag and possession limit and the tagging requirements are the same as for the regular gun seasons.

106.4(6) *Maximum annual possession limit.* The maximum annual possession limit for a resident deer hunter is one deer for each legal license and transportation tag obtained.

571—106.5(481A) Areas closed to hunting. There shall be no open seasons for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth County, where posted accordingly. There shall be no open seasons for hunting deer on all portions of rights-of-way on Interstate Highways 29, 35, 80 and 380.

571—106.6(481A) Paid deer license quotas and restrictions. Paid deer licenses, including antlerless-deer-only licenses, will be restricted in the type and number that may be purchased.

106.6(1) *Paid any-deer licenses.* Residents may purchase no more than two paid any-deer licenses, one for the bow season and one for one of the following seasons: early muzzleloader season, late muzzleloader season, first regular gun season, or second regular gun season. No more than 7,500

paid statewide any-deer licenses will be sold for the early muzzleloader season. Fifty additional paid early muzzleloader season licenses will be sold through and will be valid only for the Iowa Army Ammunition Plant. There will be no quota on the number of paid any-deer licenses issued in the bow season, late muzzleloader season, first regular gun season, or second regular gun season.

106.6(2) *Paid antlerless-deer-only licenses.* Paid antlerless-deer-only licenses have quotas for each county and will be sold for each county until quotas are reached.

a. Paid antlerless-deer-only licenses may be purchased for any season in counties where licenses are available, except as outlined in 106.6(2)*"b."* A license must be used in the season, county or deer population management area selected at the time the license is purchased.

b. No one may obtain paid licenses for both the first regular gun season and second regular gun season regardless of whether the licenses are valid for any deer or antlerless deer only. Paid antlerless-deer-only licenses for the early muzzleloader season may only be purchased by hunters who have already purchased one of the 7,500 paid statewide any-deer licenses.

c. Prior to September 15, a hunter may purchase one antlerless-deer-only license for any season for which the hunter is eligible. Beginning September 15, a hunter may purchase an unlimited number of antlerless-deer-only licenses for any season for which the hunter is eligible, as set forth in 106.6(2)*"b,"* until the county or population management area quotas are filled. Licenses purchased for deer population management areas will not count in the county quota.

106.6(3) *November antlerless-deer-only season.* Antlerless-deer-only licenses for the November antlerless-deer-only season shall be available in the following counties: Adair, Adams, Allamakee, Appanoose, Cass, Clarke, Clayton, Dallas, Davis, Decatur, Des Moines, Fayette, Fremont, Guthrie, Harrison, Henry, Jasper, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Polk, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Winneshiek, and Woodbury. Beginning the second Saturday prior to the opening of the November antlerless-deer-only season, an unlimited number of paid antlerless-deer-only licenses may be purchased for the November antlerless-deer-only season. These licenses may be obtained regardless of any other paid any-deer or paid antlerless-deer-only licenses that may have been obtained. Licenses will be sold until county quotas are filled. Licenses issued for this season are valid only on private property.

106.6(4) *January antlerless-deer-only licenses.* Antlerless-deer-only licenses for the January antlerless-deer-only season shall be available in the following counties: Adair, Adams, Allamakee, Appanoose, Cass, Clarke, Clayton, Dallas, Davis, Decatur, Des Moines, Fayette, Fremont, Guthrie, Harrison, Henry, Jasper, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Polk, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Winneshiek, and Woodbury. Beginning December 15, an unlimited number of paid antlerless-deer-only licenses may be purchased for the January antlerless-deer-only season. These licenses may be obtained regardless of any other paid any-deer or paid antlerless-deer-only licenses that may have been obtained.

106.6(5) *Free landowner/tenant licenses.* A person obtaining a free landowner/tenant license may purchase any combination of paid bow and paid gun licenses available to persons who are not eligible for landowner/tenant licenses as described in 571—106.12(481A).

106.6(6) *Antlerless-deer-only licenses.* Paid antlerless-deer-only licenses will be available by county as follows:

County	Quota	County	Quota	County	Quota
Adair	2400	Floyd	150	Monona	1900
Adams	1950	Franklin	100	Monroe	3000
Allamakee	4500	Fremont	1500	Montgomery	1300
Appanoose	3300	Greene	150	Muscatine	1700
Audubon	100	Grundy	0	O'Brien	0
Benton	1000	Guthrie	3300	Osceola	0

County	Quota	County	Quota	County	Quota
Black Hawk	0	Hamilton	100	Page	1800
Boone	650	Hancock	0	Palo Alto	0
Bremer	700	Hardin	400	Plymouth	100
Buchanan	400	Harrison	1900	Pocahontas	0
Buena Vista	0	Henry	2000	Polk	1500
Butler	150	Howard	800	Pottawattamie	2100
Calhoun	0	Humboldt	0	Poweshiek	750
Carroll	100	Ida	0	Ringgold	2600
Cass	1300	Iowa	1200	Sac	0
Cedar	1300	Jackson	1800	Scott	800
Cerro Gordo	0	Jasper	1700	Shelby	300
Cherokee	0	Jefferson	2150	Sioux	0
Chickasaw	600	Johnson	2000	Story	500
Clarke	2200	Jones	1500	Tama	800
Clay	0	Keokuk	1900	Taylor	2650
Clayton	5800	Kossuth	0	Union	2100
Clinton	1200	Lee	2500	Van Buren	5400
Crawford	200	Linn	1900	Wapello	2150
Dallas	2700	Louisa	1500	Warren	3200
Davis	3600	Lucas	2200	Washington	2250
Decatur	2800	Lyon	0	Wayne	3000
Delaware	1700	Madison	4000	Webster	100
Des Moines	2000	Mahaska	1350	Winnebago	0
Dickinson	0	Marion	2250	Winneshiek	3500
Dubuque	2000	Marshall	650	Woodbury	1900
Emmet	0	Mills	1350	Worth	50
Fayette	3000	Mitchell	150	Wright	0

[**ARC 7921B**, IAB 7/1/09, effective 8/5/09]

571—106.7(481A) Method of take. Permitted weapons and devices vary according to the type of season.

106.7(1) *Bow season.* Only longbow, compound or recurve bows shooting broadhead arrows are permitted during the bow season. Arrows must be at least 18 inches long.

a. Crossbows may be used during the bow season in the following two situations:

(1) By persons with certain afflictions of the upper body as provided in 571—15.5(481A); and

(2) By persons over the age of 70 with an antlerless-deer-only license as provided in Iowa Code section 483A.8A.

b. No explosive or chemical devices may be attached to the arrow, broadhead or bolt (if used with a crossbow).

106.7(2) *Regular gun seasons.* Only 10-, 12-, 16- and 20-gauge shotguns shooting single slugs and muzzleloaders and handguns as described in 106.7(3) will be permitted for taking deer during the regular gun seasons.

106.7(3) *Muzzleloader seasons.* Only muzzleloading rifles and muzzleloading pistols will be permitted for taking deer during the early muzzleloader season. During the late muzzleloader season, deer may be taken with a muzzleloader, centerfire handgun, or bow as described in 106.7(1). Muzzleloading rifles are defined as flintlock or percussion cap lock muzzleloaded rifles and muskets of

not less than .44 and not larger than .775 caliber, shooting single projectiles only. Centerfire handguns must be .357 caliber or larger shooting straight-walled cartridges propelling an expanding-type bullet (no full-metal jacket) and complying with all other requirements provided in Iowa Code section 481A.48. Legal handgun calibers are listed on the department of natural resources list of Acceptable Handgun Calibers for Hunting Deer in Iowa. Revolvers, pistols and black powder handguns must have a 4-inch minimum barrel length. There can be no shoulder stock or long-barrel modifications to handguns. Muzzleloading handguns must be .44 caliber or larger, shooting single projectiles only.

106.7(4) *November antlerless-deer-only season.* Bows, shotguns, muzzleloaders and handguns as described in this rule may be used.

106.7(5) *January antlerless-deer-only season.* Bows, shotguns, muzzleloaders and handguns as described in this rule may be used during the January antlerless-deer-only season. Centerfire rifles .24 caliber or larger may be used in the southern two tiers of counties.

106.7(6) *Prohibited weapons and devices.* The use of dogs, domestic animals, bait, rifles other than muzzleloaded or as provided in 106.7(5), handguns except as provided in 106.7(3), crossbows except as provided in 106.7(1), automobiles, aircraft, or any mechanical conveyance or device, including electronic calls, is prohibited, except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Bait" means grain, fruit, vegetables, nuts, hay, salt, mineral blocks, or any other natural food materials; commercial products containing natural food materials; or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. "Paraplegic" means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease of or injury to the spinal cord. It shall be unlawful for a person, while hunting deer, to carry or have in possession a rifle except as provided in 106.7(3) and 106.7(5). It shall be unlawful for a person hunting with a bow license to carry a handgun unless that person also has a valid deer hunting license and an unfilled transportation tag that permits a handgun to be used to take deer.

106.7(7) *Discharge of firearms from roadway.* No person shall discharge a rifle, including a muzzleloading rifle or musket, or a handgun from a highway while deer hunting. In addition, no person shall discharge a shotgun shooting slugs from a highway north of U.S. Highway 30. A "highway" means the way between property lines open to the public for vehicle traffic, including the road ditch, as defined in Iowa Code section 321.1(78).

106.7(8) *Hunting from blinds.* No person shall use a blind for hunting deer during the regular gun deer seasons as defined in 106.2(3), unless such blind exhibits a solid blaze orange marking visible in all directions with a minimum height of 12 inches and a minimum width of 12 inches. Such blaze orange shall be affixed directly on or directly on top of the blind. For the purposes of this subrule, the term "blind" is defined as a place of concealment constructed, either wholly or partially from man-made materials, and used by a person who is hunting for the purpose of hiding from sight. A blind is not a naturally occurring landscape feature or an arrangement of natural or agricultural plant material that a hunter uses for concealment. In addition to the requirements in this subrule, hunters using blinds must also satisfy the requirements of wearing blaze orange as prescribed in Iowa Code section 481A.122.

571—106.8(481A) Procedures to obtain licenses. All resident deer hunting licenses must be obtained using the electronic licensing system for Iowa (ELSI). Licenses may be purchased from ELSI license agents, or online at www.iowadnr.com, or by calling the ELSI telephone ordering system.

106.8(1) *Licenses with quotas.* All paid deer hunting licenses for which a quota is established may be obtained from the ELSI system on a first-come, first-served basis beginning August 15 until the quota fills, or through the last day of the hunting period for which the license is valid.

106.8(2) *Licenses without quotas.* All deer hunting licenses that have no quota may be obtained from the ELSI system beginning August 15 through the last day of the hunting period for which a license is valid.

106.8(3) *Providing false information.*

a. Any person who provides false information about the person's identity or eligibility for any paid or free landowner/tenant deer license and tag and who attests that the information is correct by accepting

and signing the license or tag shall have the person's hunting license revoked as a part of the sentencing for such criminal conviction, and the person shall not be issued a hunting license for one year pursuant to the authority of Iowa Code Supplement section 483A.24(2)*"f"* and rule 571—15.6(483A).

b. In addition to any legal penalties that may be imposed, the obtaining of a license in violation of this rule shall invalidate that deer license and transportation tag and any other deer hunting license and transportation tag obtained during the same year.

571—106.9(481A) Transportation tag. A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to the carcass of each deer in such a manner that the tag cannot be removed without mutilating or destroying the tag. This tag shall be attached to the carcass of the deer within 15 minutes of the time the deer is killed or before the carcass is moved in any manner, whichever occurs first. No person shall tag a deer with a transportation tag issued to another person. During the youth/disabled hunter season, bow season, early muzzleloader season and late muzzleloader season, the hunter who killed the deer must tag the deer by using the transportation tag issued in that person's name. During the first and second regular gun seasons and the November and January antlerless-deer-only seasons, anyone present in the hunting party may tag a deer with a tag issued in that person's name. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to the deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility or until the deer has been processed for consumption.

571—106.10(481A) Youth deer and severely disabled hunts.

106.10(1) *Licenses.*

a. Youth deer hunt. A youth deer license may be issued to any Iowa resident who is not over 15 years old on the day the youth obtains the license. The youth license may be paid or free to persons eligible for free licenses. If the youth obtains a free landowner/tenant license, it will count as the one free any-deer license for which the youth's family is eligible.

Each participating youth must be accompanied by an adult who possesses a regular hunting license and has paid the habitat fee (if the adult is normally required to have a hunting license and to pay the habitat fee to hunt). Only one adult may participate for each youth hunter. The accompanying adult must not possess a firearm or bow and must be in the direct company of the youth at all times.

A person may obtain only one youth any-deer license but may also obtain any other paid or free any-deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner with which other hunters obtain them, as described in 106.6(2).

b. Severely disabled hunt. Any severely disabled Iowa resident meeting the requirements of Iowa Code section 321L.1(8) may be issued one any-deer license to hunt deer during the youth season. A person applying for this license must either possess a disability parking permit or provide a completed form from the department of natural resources. The form must be signed by a physician verifying that the person's disability meets the criteria defined in Iowa Code section 321L.1(8). Forms are available online at www.iowadnr.com, by visiting the DNR central office or any district office, or by calling (515)281-5918. A person between 16 and 65 years of age must also possess a regular hunting license and have paid the habitat fee to obtain a license (if normally required to have a hunting license and to pay the habitat fee to hunt). A severely disabled person obtaining this license may obtain any other paid and free any-deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner by which other hunters obtain them, as described in 106.6(2).

106.10(2) *Season dates.* Deer of either sex may be taken statewide for 16 consecutive days beginning on the third Saturday in September. A person who is issued a youth deer hunting license and does not take a deer during the youth deer hunting season may use the deer hunting license and unused tag during the early muzzleloader, late muzzleloader, and one of the shotgun seasons. The license will be valid for the type of deer and in the area specified on the original license. The youth must follow

all other rules specified in this chapter for each season. A youth hunting in one of the other seasons must obtain a hunting license and habitat stamp or hunt with a licensed adult if required by Iowa Code section 483A.24. If the tag is filled during one of the seasons, the license will not be valid in subsequent seasons.

106.10(3) *Shooting hours.* Legal shooting hours will be one-half hour before sunrise to one-half hour after sunset each day regardless of weapon used.

106.10(4) *Limits and license quotas.* An unlimited number of licenses may be issued. The daily and season bag and possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.10(5) *Method of take and other regulations.* Deer may be taken with shotgun, bow or muzzleloaded rifles as permitted in 571—106.7(481A). All participants must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122. All other regulations for obtaining licenses or hunting deer shall apply.

106.10(6) *Procedures for obtaining licenses.* Paid and free youth season licenses and licenses for severely disabled hunters may be obtained through ELSI beginning August 15 through the last day of the youth season.

571—106.11(481A) Deer depredation management. The deer depredation management program provides assistance to producers through technical advice and additional deer licenses and permits where the localized reduction of female deer is needed to reduce damage. Upon signing a depredation management agreement with the department, producers of agricultural or high-value horticultural crops may be issued deer depredation permits to shoot deer causing excessive crop damage. If immediate action is necessary to forestall serious damage, depredation permits may be issued before an agreement is signed. Further permits will not be authorized until an agreement is signed.

106.11(1) *Method of take and other regulations.* Legal weapons and restrictions will be governed by 571—106.7(481A). For deer shooting permits only, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93. The producer or designee must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122.

106.11(2) *Eligibility.* Producers growing typical agricultural crops (such as corn, soybeans, hay and oats and tree farms and other forestlands under a timber management program) and producers of high-value horticultural crops (such as Christmas trees, fruit or vegetable crops, nursery stock, and commercially grown nuts) shall be eligible to enter into depredation management agreements if these crops sustain excessive damage.

a. The producer may be the landowner or a tenant, whoever has cropping rights to the land.

b. Excessive damage is defined as crop losses exceeding $1,000 in a single growing season, or the likelihood that damage will exceed $1,000 if preventive action is not taken, or a documented history of at least $1,000 of damage annually in previous years.

c. Producers who lease their deer hunting rights are not eligible for the deer depredation management program.

106.11(3) *Depredation management plans.* Upon request from a producer, field employees of the wildlife bureau will inspect and identify the type and amount of crop damage sustained from deer. If damage is not excessive, technical advice will be given to the producer on methods to reduce or prevent future damage. If damage is excessive and the producer agrees to participate, a written depredation management plan will be developed by depredation biologists in consultation with the producer.

a. The goal of the management plan will be to reduce damage to below excessive levels within a specified time period through a combination of producer-initiated preventive measures and the issuance of deer depredation permits.

(1) Depredation plans written for producers of typical agricultural crops may require preventive measures such as harassment of deer with pyrotechnics and cannons, guard dogs, and temporary fencing, as well as allowing more hunters, increasing the take of antlerless deer, and other measures that may prove effective.

(2) Depredation plans written for producers of high-value horticultural crops may include all of the measures in (1) above, plus permanent fencing where necessary. Fencing will not be required if the cost of a fence exceeds $1,000.

(3) Depredation permits to shoot deer may be issued to Iowa residents to reduce deer numbers until long-term preventive measures become effective. Depredation permits will not be used as a long-term solution to deer damage problems.

b. Depredation management plans will normally be written for a three-year period with progress reviewed annually by the department and the producer.

(1) The plan will become effective when signed by the depredation biologist and the producer.

(2) Plans may be modified or extended if mutually agreed upon by the department and the producer.

(3) Depredation permits will not be issued after the initial term of the management plan if the producer fails to implement preventive measures outlined in the plan.

106.11(4) *Depredation permits.* Two types of permits may be issued under a depredation management plan.

a. Deer depredation licenses. Deer depredation licenses may be sold to resident hunters only for the regular deer license fee for use during one or more legal hunting seasons. Depredation licenses will be available to producers of agricultural and horticultural crops.

(1) Depredation licenses will be issued up to the number specified in the management plan.

(2) The landowner or an eligible family member, which shall include the landowner's spouse or domestic partner and juvenile children, may obtain one depredation license for each season established by the commission. No other individual may initially obtain more than three depredation licenses per management plan. When a deer is reported harvested on one of these licenses, then another license may be obtained.

(3) Depredation licenses will be valid only for hunting antlerless deer, regardless of restrictions that may be imposed on regular deer hunting licenses in that county.

(4) Hunters may keep any deer legally tagged with a depredation license.

(5) All other regulations for the hunting season specified on the license will apply.

(6) Depredation licenses will be valid only on the land where damage is occurring and the immediately adjacent property unless the land is within a designated block hunt area as described in subparagraph (7). Other parcels of land in the farm unit not adjacent to the parcels receiving damage will not qualify.

(7) Block hunt areas are areas designated and delineated by wildlife biologists of the wildlife bureau to facilitate herd reduction in a given area where all producers may not qualify for the depredation program or in areas of persistent deer depredation. Depredation licenses issued to producers within the block hunt area are valid on all properties within the delineated boundaries. Individual landowner permission is required for hunters utilizing depredation licenses within the block hunt area boundaries. Creation of a given block hunt area does not authorize trespass.

b. Deer shooting permits. Permits for shooting deer outside an established hunting season may be issued to producers of high-value horticultural crops when damage cannot be controlled in a timely manner during the hunting seasons (such as late summer buck rubs in an orchard and winter browsing in a Christmas tree plantation) and to other agricultural producers who have an approved DNR deer depredation plan, and on areas such as airports where public safety may be an issue.

(1) Deer shooting permits will be issued at no cost to the applicant.

(2) The applicant or one or more designees approved by the department may take all the deer specified on the permit.

(3) Permits available to producers of high-value horticultural crops or agricultural crops may be valid for taking deer outside of a hunting season depending on the nature of the damage. The number and type of deer to be killed will be determined by a department depredation biologist and will be part of the deer depredation management plan.

(4) Permits issued due to public safety concerns may be used for taking any deer, as necessary, to address unpredictable intrusion which could jeopardize public safety. Permits may be issued for an entire year (January 1 through December 31) if the facility involved signs an agreement with the department.

(5) All deer killed must be recovered and processed for human consumption.

(6) The times, dates, place and other restrictions on the shooting of deer will be specified on the permit.

(7) Antlers from all deer recovered must be turned over to the conservation officer within 48 hours. Antlers will be disposed of according to department rules.

(8) For out-of-season shooting permits, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93.

c. Depredation licenses and shooting permits will be issued in addition to any other licenses for which the hunters may be eligible.

d. Depredation licenses and shooting permits will not be issued if the producer restricts the legal take of deer from the property sustaining damage by limiting hunter numbers below levels required to control the deer herd. This restriction does not apply in situations where shooting permits are issued for public safety concerns.

e. A person who receives a depredation permit pursuant to this paragraph shall pay a $1 fee for each license that shall be used and is appropriated for the purpose of deer herd population management, including assisting with the cost of processing deer donated to the help us stop hunger (HUSH) program administered by the commission and a $1 writing fee for each license to the license agent.

106.11(5) *Disposal.* Rescinded IAB 7/16/08, effective 8/20/08.

[**ARC 7921B**, IAB 7/1/09, effective 8/5/09]

571—106.12(481A) Eligibility for free landowner/tenant deer licenses.

106.12(1) *Who qualifies for free deer hunting licenses.*

a. Owners and tenants of a farm unit and the spouse and juvenile child of an owner or tenant who reside with the owner or tenant are eligible for free deer licenses. The owner or tenant does not have to reside on the farm unit but must be actively engaged in farming it. Nonresident landowners do not qualify.

b. Juvenile child defined. "Juvenile child" means a person less than 18 years of age or a person who is 18 or 19 years of age and is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma or a high school equivalency diploma. A person 18 years of age or older who has received a high school diploma or high school equivalency diploma does not qualify.

106.12(2) *Who qualifies as a tenant.* A "tenant" is a person other than the landowner who is actively engaged in the operation of the farm. The tenant may be a member of the landowner's family, including in some circumstances the landowner's spouse or child, or a third party who is not a family member. The tenant does not have to reside on the farm unit.

106.12(3) *What "actively engaged in farming" means.* Landowners and tenants are "actively engaged in farming" if they personally participate in decisions about farm operations and those decisions, along with external factors such as weather and market prices, determine their profit or loss for the products they produce. Tenants qualify if they farm land owned by another and pay rent in cash or in kind. A farm manager or other third party who operates a farm for a fee or a laborer who works on the farm for a wage and is not a family member does not qualify as a tenant.

106.12(4) *Landowners who qualify as active farmers.* These landowners:

a. Are the sole operator of a farm unit (along with immediate family members), or

b. Make all decisions about farm operations, but contract for custom farming or hire labor to do some or all of the work, or

c. Participate annually in decisions about farm operations such as negotiations with federal farm agencies or negotiations about cropping practices on specific fields that are rented to a tenant, or

d. Raise specialty crops from operations such as orchards, nurseries, or tree farms that do not necessarily produce annual income but require annual operating decisions about maintenance or improvements, or

e. May have portions of the farm enrolled in a long-term land retirement program such as the Conservation Reserve Program (CRP) as long as other farm operations occur annually, or

f. Place their entire cropland in the CRP or other long-term land retirement program with no other active farming operation occurring on the farm.

106.12(5) *Landowners who do not qualify.* These landowners:

a. Use a farm manager or other third party to operate the farm, or

b. Cash rent the entire farm to a tenant who is responsible for all farm operations including following preapproved operations plans.

106.12(6) *Where free licenses are valid.* A free license is valid only on that portion of the farm unit that is in a zone open to deer hunting. "Farm unit" means all parcels of land in tracts of two or more contiguous acres that are operated as a unit for agricultural purposes and are under lawful control of the landowner or tenant regardless of how that land is subdivided for business purposes. Individual parcels of land do not need to be adjacent to one another to be included in the farm unit. "Agricultural purposes" includes but is not limited to field crops, livestock, horticultural crops (e.g., from nurseries, orchards, truck farms, or Christmas tree plantations), and land managed for timber production.

106.12(7) *Registration of landowners and tenants.* Landowners and tenants and their eligible family members who want to obtain free deer hunting licenses must register with the department before the free licenses will be issued. Procedures for registering are described in 571—95.2(481A).

571—106.13(481A) Harvest reporting. Each hunter who bags a deer must report that kill according to procedures described in 571—95.1(481A).

571—106.14(481A) Extension to the regular gun seasons. Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.24, 483A.24B, and 483A.24C.

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CHAPTER 108
MINK, MUSKRAT, RACCOON, BADGER, OPOSSUM, WEASEL, STRIPED SKUNK, FOX (RED AND GRAY), BEAVER, COYOTE, RIVER OTTER, BOBCAT, GRAY (TIMBER) WOLF AND SPOTTED SKUNK SEASONS

[Prior to 12/31/86, Conservation Commission[290] Ch 104]

571—108.1(481A) Mink, muskrat and weasel. Open season for the taking of mink, muskrat and weasel shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

108.1(1) *Molesting or disturbing muskrat houses.* Any department of natural resources officer, natural resource biologist, or county conservation board director may permit trappers to molest or disturb muskrat houses on specific state or county game management areas as provided in Iowa Code section 481A.90, after finding that muskrats are causing excessive damage by destroying the vegetation essential to the welfare of a marsh and after so posting the area.

108.1(2) *Game management areas.* Open season for taking muskrats on certain state game management areas, certain federal national wildlife refuges, and certain county conservation board areas, only where approved by the wildlife bureau and posted accordingly, shall be from 8 a.m. the day after the regular muskrat trapping season ends until April 1. The use of leg-hold traps during this season is prohibited unless each trap is placed completely inside a muskrat house. No bag or possession limit.

[**ARC 7933B**, IAB 7/1/09, effective 8/5/09]

571—108.2(481A) Raccoon, badger, opossum and striped skunk. Open season for the taking of raccoon, badger, opossum, and striped skunk shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

571—108.3(481A) Red and gray fox. Open season for the taking of red and gray fox shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

571—108.4(481A) Beaver. Open season for the taking of beaver shall be from 8 a.m. on the first Saturday in November through April 1 of succeeding year. No bag or possession limit.

571—108.5(481A) Coyote.

108.5(1) *Hunting.* Continuous open season. Entire state open. No bag or possession limit.

108.5(2) *Trapping.* Open season for trapping coyote shall be 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit. Any conservation officer or wildlife biologist may authorize a landowner, tenant or designee to trap coyotes causing damage outside the established trapping season dates.

571—108.6(481A) Gray (timber) wolf and spotted skunk. Continuous closed season.

571—108.7(481A) River otter and bobcat.

108.7(1) *License requirements.* Each person who takes river otters or bobcats shall have a valid fur harvester license and pay the habitat fee if normally required to have a license to hunt or trap.

108.7(2) *Open area.* River otters may be taken statewide. Bobcats may be taken in the following counties: Adams, Appanoose, Clarke, Davis, Decatur, Des Moines, Fremont, Harrison, Henry, Jefferson, Lee, Lucas, Mills, Monona, Monroe, Montgomery, Page, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Wayne, and Woodbury.

108.7(3) *Quotas and seasonal bag limit.*

a. Seasonal bag limit. The seasonal bag limit is 2 river otters and 1 bobcat per person.

b. Quotas. The quota for the number of river otters that may be taken is 500 statewide. The quota for the number of bobcats that may be taken is 200 in the open area. The season shall end for river otters when the number of river otters trapped, as determined by the harvest reporting system, reaches 500. The

season shall end for bobcats when the number of bobcats taken, as determined by the harvest reporting system, reaches 200. Trappers shall be allowed a 48-hour grace period after the quota is reached to clear their traps of river otters or bobcats. River otters or bobcats found in traps during the grace period may be kept even though the quota is exceeded provided that the trapper has not reached the trapper's personal bag limit. River otters or bobcats trapped after the grace period or in excess of the seasonal bag limit must be turned over to the department; the trapper shall not be penalized.

108.7(4) *Season dates.* The season for taking river otters and bobcats opens on the first Saturday in November and closes when the quota has been reached, as explained in this rule, or on January 31 of the following year, whichever occurs first.

108.7(5) *Reporting requirements.*

a. Anyone, including a landowner or tenant not required to have a fur harvester license, who takes a river otter or bobcat must report the harvest to a DNR conservation officer or designated DNR employee within 24 hours. The fur harvester must arrange to receive a CITES tag from the officer or designated DNR employee within 48 hours of the time the harvest is reported or before the river otter or bobcat is skinned, whichever occurs first.

b. Upon receiving a telephone report that a river otter or bobcat has been legally taken, the conservation officer or DNR employee will call the department's harvest reporting system. The number of river otters and bobcats taken will be updated daily, and a message will be recorded on the department's telephone system. The number taken will be available 24 hours a day. Fur harvesters may check the message daily to determine when the season closes and when the grace period begins and ends. The department will use all practical means to publicize these dates.

108.7(6) *Tagging requirements.* Every river otter or bobcat that may legally be kept must have a CITES tag attached. Tags will be supplied by the conservation officer or designated DNR employee. The tag must remain with the pelt until the pelt is sold or used for other purposes that render it no longer available for sale. Persons displaying river otters or bobcats as taxidermy mounts or as other decorative items must keep the tags in their possession as proof of legal harvest.

[**ARC 7933B**, IAB 7/1/09, effective 8/5/09]

571—108.8(481A) Accidental capture of a river otter or bobcat during a closed season. A person who accidentally captures a river otter or bobcat during a closed season or in a closed area or after the person's individual bag limit has been reached shall not be penalized provided that:

1. The river otter or bobcat is captured during a legal trapping season or as part of a legal depredation control process; and
2. A conservation officer is contacted within 24 hours and the river otter or bobcat and all parts thereof are turned over to a conservation officer as soon as practical.

571—108.9(481A) Trapping restrictions. Trapping for all furbearers will be restricted as follows:

108.9(1) *Exposed bait.* No person shall set or maintain any leghold, body-clasping trap, or snare within 20 feet of exposed bait on land anywhere in the state or over water in the following areas:

a. Mississippi River corridor—Allamakee, Clayton, Dubuque, Jackson, Clinton, Scott, Muscatine, Louisa, Des Moines and Lee Counties.

b. Missouri River corridor—Those portions of Woodbury, Monona, Harrison, Pottawattamie, Mills and Fremont Counties west of Interstate 29.

c. Des Moines River corridor—Boone, Dallas, Polk, Marion, Mahaska, Wapello and Van Buren Counties.

Exposed bait means meat or viscera or any animal, bird, fish, amphibian, or reptile with or without skin, hide, or feathers visible to soaring birds.

108.9(2) *Trapping near beaver lodges and dens.* Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.6, 481A.38, 481A.39, 481A.87, and 481A.90.

These rules are based on the best biological data available as determined by research conducted by the department of natural resources.

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CHAPTER 110
TRAPPING LIMITATIONS

[Prior to 12/31/86, Conservation Commission[290] Ch 114]

571—110.1(481A) Public roadside limitations—snares, body-gripping, and conibear type traps. No person shall set or maintain any snare, body-gripping, or conibear type trap within any public road right-of-way within 200 yards of buildings inhabited by human beings unless a resident of the dwelling adjacent to the public road right-of-way has given permission or unless the body-gripping or conibear type trap is completely underwater or at least one-half of the loop of a snare is underwater. Nothing in this rule shall be construed as limiting the use of foothold traps or box-type live traps in public road rights-of-way. No person shall place or leave any trap, stake, or nonindigenous set making material upon any public road right-of-way except during a period of time that begins two weeks before the trapping season opens and ends on the last day of the season.

[**ARC 7922B**, IAB 7/1/09, effective 8/5/09]

571—110.2(481A) Snares.

110.2(1) *Placement.* No person shall set or maintain any snare in any public road right-of-way so that the snare when fully extended can touch any fence. Snares may not be attached to a drag.

110.2(2) *Loop size.* No snare when set will have a loop larger than 8 inches in horizontal measurement except for snares set with at least one-half of the loop underwater or snares set on private land other than roadsides within 30 yards of a pond, lake, drainage ditch, creek, stream or river shall not have a loop larger than 11 inches in horizontal measurement.

110.2(3) *Deer locks.* All snares must have a functional deer lock that will not allow the snare loop to close smaller than 2½ inches in diameter.

110.2(4) *Mechanical snares.* It shall be illegal to set any mechanically powered snare designed to capture an animal by the neck or body unless such snares are placed completely underwater.

571—110.3(481A) Body-gripping and conibear type traps. No person shall set or maintain any body-gripping or conibear type trap on any public road right-of-way within 5 feet of any fence.

571—110.4(481A) Foothold and leghold traps. No person shall set or maintain on land any foothold or leghold trap with metal-serrated jaws, metal-toothed jaws or a spread inside the set jaws of greater than 7 inches.

571—110.5(481A) Removal of animals from traps and snares. All animals or animal carcasses caught in any type of trap or snare, except those which are placed entirely underwater and designed to drown the animal immediately, must be removed from the trap or snare by the trap or snare user immediately upon discovery and within 24 hours of the time the animal is caught.

571—110.6(481A) Trap tag requirements. All traps and snares, whether set or not, possessed by a person who can reasonably be presumed to be trapping shall have a metal tag attached plainly labeled with the user's name and address.

571—110.7(481A) Colony traps. All colony traps must be set entirely under water.

These rules are intended to implement Iowa Code sections 481A.38 and 481A.92.

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CHAPTER 7
ADVANCED REGISTERED NURSE PRACTITIONERS
[Prior to 8/26/87, Nursing Board[590] Ch 7]

655—7.1(152) Definitions.

"Advanced registered nurse practitioner (ARNP)" means a nurse with current licensure as a registered nurse in Iowa or who is licensed in another state and recognized for licensure in this state pursuant to the nurse licensure compact contained in 2000 Iowa Acts, House File 2105, section 8, and is also registered in Iowa to practice in an advanced role. The ARNP is prepared for an advanced role by virtue of additional knowledge and skills gained through a formal advanced practice education program of nursing in a specialty area approved by the board. In the advanced role, the nurse practices nursing assessment, intervention, and management within the boundaries of the nurse-client relationship. Advanced nursing practice occurs in a variety of settings, within an interdisciplinary health care team, which provide for consultation, collaborative management, or referral. The ARNP may perform selected medically delegated functions when a collaborative practice agreement exists.

"Basic nursing education" as used in this chapter is a nursing program that prepares a person for initial licensure to practice nursing as a registered nurse.

"Board" as used in this chapter means Iowa board of nursing.

"Certified clinical nurse specialist" is an ARNP prepared at the master's level who possesses evidence of current advanced level certification as a clinical specialist in an area of nursing practice by a national professional nursing certifying body as approved by the board.

"Certified nurse-midwife" is an ARNP educated in the disciplines of nursing and midwifery who possesses evidence of current advanced level certification by a national professional nursing certifying body approved by the board. The certified nurse-midwife is authorized to manage the care of normal newborns and women, antepartally, intrapartally, postpartally or gynecologically.

"Certified nurse practitioner" is an ARNP educated in the disciplines of nursing who has advanced knowledge of nursing, physical and psychosocial assessment, appropriate interventions, and management of health care, and who possesses evidence of current certification by a national professional nursing certifying body approved by the board.

"Certified registered nurse anesthetist" is an ARNP educated in the disciplines of nursing and anesthesia who possesses evidence of current advanced level certification or recertification, as applicable, by a national professional nursing certifying body approved by the board.

"Collaboration" is the process whereby an ARNP and physician jointly manage the care of a client.

"Collaborative practice agreement" means an ARNP and physician practicing together within the framework of their respective professional scopes of practice. This collaborative agreement reflects both independent and cooperative decision making and is based on the preparation and ability of each practitioner.

"Consultation" is the process whereby an ARNP seeks the advice or opinion of a physician, pharmacist, or another member of the health care team. ARNPs practicing in a noninstitutional setting as sole practitioners, or in small clinical practice groups, shall regularly consult with a licensed physician or pharmacist regarding the distribution, storage, and appropriate use of controlled substances.

"Controlled substance" is a drug, substance, or immediate precursor in Schedules I through V of division II, Iowa Code chapter 124.

"National professional nursing certifying body" is a professional nursing certifying body approved by the board. Agencies approved by the board include the American Nurses Credentialing Center, the American Academy of Nurse Practitioners, the American College of Nurse-Midwives Certification Council, the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, the National Certification Board of Pediatric Nurse Practitioners and Nurses, the National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties, the Oncology Nursing Certification Organization, and the American Association of Critical Care Nurses Certification Corporation.

"Physician" means a medical doctor licensed under Iowa Code chapter 148 or osteopathic physician and surgeon licensed under Iowa Code chapter 150A.

"Prescriptive authority" is the authority granted to an ARNP registered in Iowa in a recognized nursing specialty to prescribe, deliver, distribute, or dispense prescription drugs, devices, and medical gases when the nurse is engaged in the practice of that nursing specialty. Registration as a practitioner with the Federal Drug Enforcement Administration and the Iowa board of pharmacy examiners extends this authority to controlled substances. ARNPs shall access the Iowa board of pharmacy examiners Web site for Iowa pharmacy law and administrative rules and the Iowa Board of Pharmacy Examiners Newsletter.

"Referral" is the process whereby the ARNP directs the client to a physician or another health care professional for management of a particular problem or aspect of the client's care.

655—7.2(152) General requirements for the advanced registered nurse practitioner.

7.2(1) *Specialty areas of nursing practice for the advanced registered nurse practitioner.* The board derives its authority to define the educational and clinical experience that is necessary to practice at an advanced registered nurse practitioner level under the provisions of Iowa Code section 152.1(6)*"d."* The specialty areas of nursing practice for the advanced registered nurse practitioner which shall be considered as legally authorized by the board are as follows:

a. Certified clinical nurse specialist.

b. Certified nurse-midwife.

c. Certified nurse practitioner.

d. Certified registered nurse anesthetist.

7.2(2) *Supervision of fluoroscopy.* An advanced registered nurse practitioner (ARNP) shall be permitted to provide direct supervision in the use of fluoroscopic X-ray equipment, pursuant to 641—subrule 42.1(2), definition of "supervision."

a. The ARNP shall provide direct supervision of fluoroscopy pursuant to the following provisions:

(1) Completion of an educational course including content in radiation physics, radiobiology, radiological safety and radiation management applicable to the use of fluoroscopy, and maintenance of documentation verifying successful completion.

(2) Collaboration, as needed, as defined in rule 655—7.1(152).

(3) Compliance with facility policies and procedures.

b. The ARNP shall complete an annual radiological safety course whose content includes, but is not limited to, time, dose, distance, shielding and the effects of radiation.

c. The ARNP shall maintain documentation of the initial educational course and all annual radiological safety updates.

d. The initial and annual education requirements are subject to audit by the board pursuant to 655—subrule 5.2(5).

7.2(3) *Titles and abbreviations.* A registered nurse who has completed all requirements to practice as an advanced registered nurse practitioner and who is registered with the board to practice shall use the title advanced registered nurse practitioner (ARNP). Utilization of the title which denotes the specialty area is at the discretion of the advanced registered nurse practitioner.

a. No person shall practice or advertise as or use the title of advanced registered nurse practitioner for any of the defined specialty areas unless the name, title and specialty area appear on the official record of the board and on the current license.

b. No person shall use the abbreviation ARNP for any of the defined specialty areas or any other words, letters, signs or figures to indicate that the person is an advanced registered nurse practitioner unless the name, title and specialty area appears on the official record of the board and on the current license.

c. Any person found to be practicing under the title of advanced registered nurse practitioner or using the abbreviation ARNP without being registered as defined in this subrule shall be subject to disciplinary action.

7.2(4) *General education and clinical requirements.*

a. The general educational and clinical requirements necessary for recognition by the board as a specialty area of nursing practice are as follows:

(1) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills as approved by the board; or

(2) Satisfactory completion of a formal advanced practice educational program of study in a nursing specialty area approved by the board and appropriate clinical experience as approved by the board.

b. Additional requirements. Nothing in this rule shall be construed to mean that additional general educational or clinical requirements cannot be defined in a specialty area.

7.2(5) *Application process.* A registered nurse who wishes to practice as an advanced registered nurse practitioner shall submit the following to the office of the board:

a. An advanced registered nurse practitioner application form which may be obtained from the office of the board.

b. A registration fee as established by the board.

c. A copy of the time-dated, advanced level certification by appropriate national certifying body evidencing that the applicant holds current certification in good standing; copy of official transcript directly from the formal advanced practice educational program maintaining the records necessary to document that all requirements have been met in one of the specialty areas of nursing practice as listed in subrule 7.2(1). The transcript shall verify the date of completion of the program/graduation and the degree conferred. A registered nurse may make application to practice in more than one specialty area of nursing practice.

7.2(6) *Initial registration.* The executive director or a designee shall have the authority to determine if all requirements have been met for registration as an advanced registered nurse practitioner. If it has been determined that all requirements have been met:

a. Official licensure records of the registered nurse shall denote registration as an advanced registered nurse practitioner as well as the specialty area(s) of nursing practice.

b. The registered nurse shall be issued a registration card and a certificate to practice as an ARNP which clearly denotes the name, title, specialty area(s) of nursing practice, and expiration date of registration. The expiration date shall be based on the same period of licensure to practice as a registered nurse.

7.2(7) *Registration completion.* The registered nurse shall complete the registration process within 12 months of receipt of the application materials. The board reserves the right to destroy the documents after 12 months.

7.2(8) *Denial of registration.* If it has been determined that all requirements have not been met, the registered nurse shall be notified in writing of the reason(s) for the decision. The applicant shall have the right of appeal to the Iowa board of nursing within 30 days of denial by the executive director or designee.

7.2(9) *Application process for renewal of registration.* Renewal of registration for the advanced registered nurse practitioner shall be for the same period of licensure to practice as a registered nurse. The executive director or a designee shall have the authority to determine if all requirements have been met for renewal as an advanced registered nurse practitioner. A registered nurse who wishes to continue practice as an advanced registered nurse practitioner shall submit the following at least 30 days prior to the license expiration to the office of the Iowa board of nursing:

a. Completed renewal application form.

b. Renewal fee as outlined in rule 655—3.1(17A,147,152,272C), definition of "fees."

c. Documentation of current time-dated, advanced level certification by appropriate national certifying body.

7.2(10) *Continuing education requirements.* Continuing education shall be met as required for certification by the relevant national certifying body, as outlined in 655—subrule 5.2(3), paragraph *"e."*

7.2(11) *Denial of renewal registration.* If it has been determined that all requirements have not been met, the applicant shall be notified in writing of the reason(s) for the decision. Failure to obtain the renewal will result in termination of registration and of the right to practice in the advanced registered

nurse practitioner specialty area(s). The applicant shall have the right of appeal to the Iowa board of nursing within 30 days of denial of the executive director or designee.

7.2(12) *Registration to practice as an advanced registered nurse practitioner restricted, revoked, or suspended.* Rescinded IAB 12/29/99, effective 2/2/00.
[**ARC 7888B**, IAB 7/1/09, effective 8/5/09]

These rules are intended to implement Iowa Code sections 17A.3, 147.10, 147.53, 147.76, 147.107(6), 152.1, 152E.1 and 152E.2.

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PHARMACY BOARD[657]

[Prior to 2/10/88, see Pharmacy Examiners, Board of [620], renamed Pharmacy Examiners Board[657] under the "umbrella" of Public Health Department by 1986 Iowa Acts, ch 1245; renamed by 2007 Iowa Acts, Senate File 74]

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[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 8]

657—10.1(124) Who shall register. Any person or business located in Iowa that manufactures, distributes, dispenses, prescribes, imports or exports, conducts research or instructional activities, or conducts chemical analysis with controlled substances in the state of Iowa, or that proposes to engage in such activities with controlled substances in the state, shall obtain and maintain a registration issued by the board unless exempt from registration pursuant to rule 10.6(124). A person or business required to be registered shall not engage in any activity for which registration is required until the application for registration is granted and the board has issued a certificate of registration to such person or business.

Manufacturers, distributors, reverse distributors, importers and exporters, individual practitioners (M.D., D.O., D.D.S., D.V.M., D.P.M., O.D., P.A., resident physician, advanced registered nurse practitioner), pharmacies, hospitals and animal shelters, care facilities, researchers and dog trainers, analytical laboratories, and teaching institutions shall register on forms provided by the board office. To be eligible to register, individual practitioners must hold a current, active license in good standing, issued by the appropriate Iowa professional licensing board, to practice their profession in Iowa.

657—10.2(124) Application forms. Application forms may be obtained from the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Forms are also available on the board's Web site, www.state.ia.us/ibpe. Registration renewal forms will be mailed to each registrant approximately 60 days before the expiration date of the registration. A registrant who has not received a renewal form 45 days before the expiration date of the registration is responsible for contacting the board to request an application.

10.2(1) *Signature requirements.* Each application, attachment, or other document filed as part of an application shall be signed by the applicant as follows:

a. If the applicant is an individual practitioner, the practitioner shall sign the application and supporting documents.

b. If the applicant is a business, the application and supporting documents shall be signed by the person ultimately responsible for the security and maintenance of controlled substances at the registered location.

10.2(2) *Submission of multiple applications.* Any person or business required to obtain more than one registration may submit all applications in one package. Each application shall be complete and shall not refer to any accompanying application or any attachment to an accompanying application for required information.

657—10.3(124) Registration and renewal. For each registration or timely renewal of a registration to manufacture, distribute, dispense, prescribe, import or export, conduct research or instructional activities, or conduct chemical analysis with controlled substances listed in Schedules I through V of Iowa Code chapter 124, registrants shall pay a biennial fee of $100.

10.3(1) *Time and method of payment.* Registration and renewal fees shall be paid at the time the application for registration or renewal is submitted. Payment should be made in the form of a personal, certified, or cashier's check or a money order made payable to the Iowa Board of Pharmacy. Payments made in the form of foreign currency or third-party endorsed checks will not be accepted.

10.3(2) *Late renewal.* Any registered person or business may apply, on forms provided by the board office, for registration renewal not more than 60 days prior to the expiration of the registration. Failure to renew a registration prior to the first day of the month following expiration shall require payment of the renewal fee and a penalty fee of $100. Payment shall be made as specified in subrule 10.3(1).

657—10.4(124) Exemptions—registration fee. The registration fee is waived for federal, state, and local law enforcement agencies and for the following federal and state institutions: hospitals, health care or teaching institutions, and analytical laboratories authorized to possess, manufacture, distribute, and dispense controlled substances in the course of official duties.

10.4(1) *Law enforcement officials.* In order to enable law enforcement agency laboratories to obtain and transfer controlled substances for use as standards in chemical analysis, such laboratories shall maintain a registration to conduct chemical analysis. Such laboratories shall be exempt from payment of a fee for registration.

10.4(2) *Registration and duties not exempt.* Exemption from payment of a registration or registration renewal fee as provided in this rule does not relieve the agency or institution of registration or of any other requirements or duties prescribed by law.

657—10.5(124) Separate registration for independent activities; coincident activities. The following activities are deemed to be independent of each other and shall require separate registration. Any person or business engaged in more than one of these activities shall be required to separately register for each independent activity, provided, however, that registration in an independent activity shall authorize the registrant to engage in activities identified coincident with that independent activity.

10.5(1) *Manufacturing controlled substances.* A person or business registered to manufacture controlled substances in Schedules I through V may distribute any substances for which registration to manufacture was issued. A person or business registered to manufacture controlled substances in Schedules II through V may conduct chemical analysis and preclinical research, including quality control analysis, with any substances listed in those schedules for which the person or business is registered to manufacture.

10.5(2) *Distributing controlled substances.* This independent activity includes the delivery, other than by administering or dispensing, of controlled substances listed in Schedules I through V. No coincident activities are authorized.

10.5(3) *Dispensing or instructing with controlled substances.* This independent activity includes, but is not limited to, prescribing by individual practitioners, dispensing by pharmacies and hospitals, and conducting instructional activities with controlled substances listed in Schedules II through V. A person or business registered for this independent activity may conduct research and instructional activities with those substances for which the person or business is registered to the extent authorized under state law.

10.5(4) *Conducting research with controlled substances listed in Schedule I.* A researcher may manufacture or import the substances for which registration was issued provided that such manufacture or import is permitted under the federal Drug Enforcement Administration (DEA) registration. A researcher may distribute the substances for which registration was issued to persons or businesses registered or authorized to conduct research with that class of substances or registered or authorized to conduct chemical analysis with controlled substances.

10.5(5) *Conducting research with controlled substances listed in Schedules II through V.* A researcher may conduct chemical analysis with controlled substances in those schedules for which registration was issued, may manufacture such substances if and to the extent such manufacture is permitted under the federal DEA registration, and may import such substances for research purposes. A researcher may distribute controlled substances in those schedules for which registration was issued to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances, and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3), and may conduct instructional activities with controlled substances.

10.5(6) *Conducting chemical analysis with controlled substances.* A person or business registered to conduct chemical analysis with controlled substances listed in Schedules I through V may manufacture and import controlled substances for analytical or instructional activities; may distribute such substances to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3); may export such substances to persons in other countries performing chemical analysis or enforcing laws relating to controlled substances or drugs in those countries; and may conduct instructional activities with controlled substances.

10.5(7) *Importing or exporting controlled substances.* A person or business registered to import controlled substances listed in Schedules I through V may distribute any substances for which such registration was issued.

657—10.6(124) Separate registrations for separate locations; exemption from registration. A separate registration is required for each principal place of business or professional practice location where controlled substances are manufactured, distributed, imported, exported, or dispensed unless the person or business is exempt from registration pursuant to Iowa Code subsection 124.302(3) or this rule.

10.6(1) *Warehouse.* A warehouse where controlled substances are stored by or on behalf of a registered person or business shall be exempt from registration except as follows:

a. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to registered locations other than the registered location from which the substances were delivered to the warehouse.

b. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to persons exempt from registration pursuant to Iowa Code subsection 124.302(3).

10.6(2) *Sales office.* An office used by agents of a registrant where sales of controlled substances are solicited, made, or supervised shall be exempt from registration. Such office shall not contain controlled substances, except substances used for display purposes or for lawful distribution as samples, and shall not serve as a distribution point for filling sales orders.

10.6(3) *Prescriber's office.* An office used by a prescriber who is registered at another location and where controlled substances are prescribed but where no supplies of controlled substances are maintained shall be exempt from registration. However, a prescriber who practices at more than one office location where controlled substances are administered or otherwise dispensed as a regular part of the prescriber's practice shall register at each location wherein the prescriber maintains supplies of controlled substances.

10.6(4) *Prescriber in hospital.* A prescriber who is registered at another location and who treats patients and may order the administration of controlled substances in a hospital other than the prescriber's registered practice location shall not be required to obtain a separate registration for the hospital.

10.6(5) *Affiliated interns, residents, or foreign physicians.* An individual practitioner who is an intern, resident, or foreign physician may dispense and prescribe controlled substances under the registration of the hospital or other institution which is registered and by whom the registrant is employed provided that:

a. The hospital or other institution by which the individual practitioner is employed has determined that the practitioner is permitted to dispense or prescribe drugs by the appropriate licensing board;

b. Such individual practitioner is acting only in the scope of employment in the hospital or institution;

c. The hospital or other institution authorizes the intern, resident, or foreign physician to dispense or prescribe under the hospital registration and designates a specific internal code number, letters, or combination thereof which shall be appended to the institution's DEA registration number, preceded by a hyphen (e.g., AP1234567-10 or AP1234567-12); and

d. The hospital or institution maintains a current list of internal code numbers identifying the corresponding individual practitioner, available for the purpose of verifying the authority of the prescribing individual practitioner.

657—10.7 to **10.9** Reserved.

657—10.10(124,147,155A) Inspection. The board may inspect, or cause to be inspected, the establishment of an applicant or registrant. The board shall review the application for registration and other information regarding an applicant or registrant in order to determine whether the applicant or registrant has met the applicable standards of Iowa Code chapter 124 and these rules.

657—10.11(124) Modification or termination of registration. A registered individual or business may apply to modify a current registration as provided by this rule.

10.11(1) *Change of substances authorized.* Any registrant may apply to modify the substances authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, registration number, and the substances or schedules to be

added to or removed from the registration and shall be signed by the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

10.11(2) *Change of address of registered location.*

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the address of the registered location by submitting a written request to the board. The request shall include the registrant's name, current address, new address, telephone number, effective date of the address change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the address of the registered location by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

10.11(3) *Change of registrant's name.*

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the registrant's name by submitting a written request to the board. The request shall include the registrant's current name, the new name, address, telephone number, effective date of the name change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification. Change of name, as used in this paragraph, refers to a change of the legal name of the registrant and does not authorize the transfer of a registration issued to an individual practitioner or researcher to another individual practitioner or researcher.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the registrant name by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

10.11(4) *Change of ownership of registered business entity.* A change of immediate ownership of a pharmacy, hospital, care facility, manufacturer, distributor, analytical laboratory, teaching institution, importer, or exporter shall require the completion of an application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

10.11(5) *Change of responsible individual.* Any registrant, except an individual practitioner, a researcher, a hospital, or a pharmacy, may apply to change the responsible individual authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, the name and title of the current responsible individual and of the new responsible individual, the effective date of the change, and the registration number, and shall be signed by the new responsible individual. No fee shall be required for the modification.

a. Individual practitioners and researchers. Responsibility under a registration issued to an individual practitioner or researcher shall remain with the named individual practitioner or researcher. The responsible individual under such registration may not be changed.

b. Pharmacies and hospitals. The responsible pharmacist may execute a power of attorney for DEA order forms to change responsibility under the registration issued to the pharmacy or hospital. The power of attorney shall include the name, address, DEA registration number, and Iowa uniform controlled substances Act (CSA) registration number of the registrant. The power of attorney shall identify the current and new responsible individuals and shall authorize the new responsible individual to execute applications and official DEA order forms to requisition Schedule II controlled substances. The power of attorney shall be signed by both individuals, shall be witnessed by two adults, and shall be maintained by the registrant and available for inspection or copying by representatives of the board or other state or federal authorities.

10.11(6) *Termination of registration.* A registration issued to an individual shall terminate upon the death of the individual. A registration issued to an individual or business shall terminate when the registered individual or business ceases legal existence, discontinues business, or discontinues professional practice.

657—10.12(124) Denial, modification, suspension, or revocation of registration.

10.12(1) *Grounds for suspension or revocation.* The board may suspend or revoke any registration upon a finding that the registrant:

a. Has furnished false or fraudulent material information in any application filed under this chapter;

b. Has had the registrant's federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked;

c. Has been convicted of a public offense under any state or federal law relating to any controlled substance. For the purpose of this rule only, a conviction shall include a plea of guilty, a forfeiture of bail or collateral deposited to secure a defendant's appearance in court which forfeiture has not been vacated, or a finding of guilt in a criminal action even though entry of the judgment or sentence has been withheld and the individual has been placed on probation;

d. Has committed such acts as would render the registrant's registration under Iowa Code section 124.303 inconsistent with the public interest as determined by that section; or

e. Has been subject to discipline by the registrant's respective professional licensing board and the discipline revokes, suspends, or modifies the registrant's authority regarding controlled substances (including, but not limited to, limiting or prohibiting the registrant from prescribing or handling controlled substances). A certified copy of the record of licensee discipline or a copy of the licensee's surrender of the professional license shall be conclusive evidence.

10.12(2) *Limited suspension or revocation.* If the board finds grounds to suspend or revoke a registration, the board may limit revocation or suspension of the registration to the particular controlled substance with respect to which the grounds for revocation or suspension exist. If the revocation or suspension is limited to a particular controlled substance or substances, the registrant shall be given a new certificate of registration for all substances not affected by revocation or suspension; no fee shall be required for the new certificate of registration. The registrant shall deliver the old certificate of registration to the board.

10.12(3) *Denial of registration or registration renewal.* If upon examination of an application for registration or registration renewal, including any other information the board has or receives regarding the applicant, the board determines that the issuance of the registration would be inconsistent with the public interest, the board shall serve upon the applicant an order to show cause why the registration should not be denied.

10.12(4) *Considerations in denial of registration.* In determining the public interest, the board shall consider all of the following factors:

a. Maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels.

b. Compliance with applicable state and local law.

c. Any convictions of the applicant under any federal and state laws relating to any controlled substance.

d. Past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion.

e. Furnishing by the applicant of false or fraudulent material in any application filed under this chapter.

f. Suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law.

g. Any other factors relevant to and consistent with the public health and safety.

10.12(5) *Order to show cause.* Before denying, modifying, suspending, or revoking a registration, the board shall serve upon the applicant or registrant an order to show cause why the registration should

not be denied, modified, revoked, or suspended. The order to show cause shall contain a statement of the basis therefor and shall call upon the applicant or registrant to appear before an administrative law judge or the board at a time and place not less than 30 days after the date of service of the order. The order to show cause shall also contain a statement of the legal basis for such hearing and for the denial, revocation, or suspension of registration and a summary of the matters of fact and law asserted. If the order to show cause involves the possible denial of registration renewal, the order shall be served not later than 30 days before the expiration of the registration. Proceedings to refuse renewal of registration shall not abate the existing registration, which shall remain in effect pending the outcome of the administrative hearing unless the board issues an order of immediate suspension pursuant to subrule 10.12(9).

10.12(6) *Hearing requested.* If an applicant or registrant who has received an order to show cause desires a hearing on the matter, the applicant or registrant shall file a request for a hearing within 30 days after the date of service of the order to show cause. If a hearing is requested, the board shall hold a hearing pursuant to 657—Chapter 35 at the time and place stated in the order and without regard to any criminal prosecution or other proceeding. Unless otherwise ordered by the board, an administrative law judge employed by the department of inspections and appeals shall be assigned to preside over the case and to render a proposed decision for the board's consideration.

10.12(7) *Waiver of hearing.* If an applicant or registrant entitled to a hearing on an order to show cause fails to file a request for hearing, or if the applicant or registrant requests a hearing but fails to appear at the hearing, the applicant or registrant shall be deemed to have waived the opportunity for a hearing unless the applicant or registrant shows good cause for such failure.

10.12(8) *Final board order when hearing waived.* If an applicant or registrant entitled to a hearing waives or is deemed to have waived the opportunity for a hearing, the executive director of the board may cancel the hearing and issue, on behalf of the board, the board's final order on the order to show cause.

10.12(9) *Order of immediate suspension.* The board may suspend any registration simultaneously with the service upon the registrant of an order to show cause why such registration should not be revoked or suspended if it finds there is an imminent danger to the public health or safety that warrants such action. If the board suspends a registration simultaneously with the service of the order to show cause upon the registrant, it shall serve an order of immediate suspension containing a statement of its findings regarding the danger to public health or safety upon the registrant with the order to show cause. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review thereof, under the provisions of the Iowa administrative procedure Act, unless sooner withdrawn by the board or dissolved by the order of the district court or an appellate court.

10.12(10) *Disposition of controlled substances.* If the board suspends or revokes a registration, the registrant shall promptly return the certificate of registration to the board. Also, upon service of the order of the board suspending or revoking the registration, the registrant shall deliver all affected controlled substances in the registrant's possession to the board or authorized agent of the board. Upon receiving the affected controlled substances from the registrant, the board or its authorized agent shall place all such substances under seal and retain the sealed controlled substances pending final resolution of any appeals or until a court of competent jurisdiction directs otherwise. No disposition may be made of the substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of proceeds of the sale with the court. Upon a revocation order's becoming final, all such controlled substances may be forfeited to the state.

10.12(11) *Notifications.* The board shall promptly notify the DEA and the Iowa department of public safety of all orders suspending or revoking registration and all forfeitures of controlled substances.

657—10.13 and **10.14** Reserved.

657—10.15(124,155A) Security requirements. All applicants and registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances. In order to determine whether a person has provided effective controls against diversion, the board shall use

the security requirements set forth in these rules as standards for the physical security controls and operating procedures necessary to prevent diversion.

10.15(1) *Physical security.* Physical security controls shall be commensurate with the schedules and quantity of controlled substances in the possession of the registrant in normal business operation. A registrant shall periodically review and adjust security measures based on rescheduling of substances or changes in the quantity of substances in the possession of the registrant.

a. Controlled substances listed in Schedule I shall be stored in a securely locked, substantially constructed cabinet.

b. Controlled substances listed in Schedules II through V may be stored in a securely locked, substantially constructed cabinet. However, pharmacies and hospitals may disperse these substances throughout the stock of noncontrolled substances in a manner so as to obstruct the theft or diversion of the controlled substances.

10.15(2) *Factors in evaluating physical security systems.* In evaluating the overall security system of a registrant or applicant necessary to maintain effective controls against theft or diversion of controlled substances, the board may consider any of the following factors it deems relevant to the need for strict compliance with the requirements of this rule:

a. The type of activity conducted;

b. The type, form, and quantity of controlled substances handled;

c. The location of the premises and the relationship such location bears to security needs;

d. The type of building construction comprising the facility and the general characteristics of the building or buildings;

e. The type of vault, safe, and secure enclosures available;

f. The type of closures on vaults, safes, and secure enclosures;

g. The adequacy of key control systems or combination lock control systems;

h. The adequacy of electric detection and alarm systems, if any;

i. The adequacy of supervision over employees having access to controlled substances, to storage areas, or to manufacturing areas;

j. The extent of unsupervised public access to the facility, including the presence and characteristics of perimeter fencing, if any;

k. The procedures for handling business guests, visitors, maintenance personnel, and nonemployee service personnel;

l. The availability of local police protection or of the registrant's or applicant's security personnel; and

m. The adequacy of the registrant's or applicant's system for monitoring the receipt, manufacture, distribution, and disposition of controlled substances.

10.15(3) *Manufacturing and compounding storage areas.* Raw materials, bulk materials awaiting further processing, and finished products which are controlled substances listed in any schedule shall be stored pursuant to federal laws and regulations.

657—10.16(124) Report of theft or loss. A registrant shall report in writing, on forms provided by the board, any theft or significant loss of any controlled substance when the loss is attributable to other than inadvertent error. The report shall be submitted to the board office within two weeks of the discovery of the theft or loss. Thefts shall be reported whether or not the controlled substances are subsequently recovered or the responsible parties are identified and action is taken against them. A copy of the report shall be maintained in the files of the registrant, and the board will provide a copy of the report to the DEA. In addition to this required report, DEA requires the registrant to deliver notice, immediately upon discovery of a theft or significant loss of controlled substances, to the nearest DEA field office via telephone, facsimile, or a brief written message explaining the circumstances.

657—10.17(124) Accountability of stock supply. An individual who administers a controlled substance from a non-patient-specific, stock supply in an institutional setting shall personally document on a separate readily retrievable record system each dose administered, wasted, or returned to the

pharmacy. Such documentation shall not be delegated to another individual. Wastage documentation shall include the signature of a witnessing licensed health care practitioner.

Distribution records for non-patient-specific, floor-stocked controlled substances shall bear the following information:

1. Patient's name;
2. Prescriber who ordered drug;
3. Name of drug, dosage form, and strength;
4. Time and date of administration to patient and quantity administered;
5. Signature or unique electronic signature of individual administering controlled substance;
6. Returns to the pharmacy;
7. Waste, which is required to be witnessed and cosigned by another licensed health care practitioner.

657—10.18(124) Disposal. Any persons legally authorized to possess controlled substances in the course of their professional practice or the conduct of their business shall dispose of such drugs pursuant to the procedures and requirements of this rule. Disposal records shall be maintained in the files of the registrant.

10.18(1) *Registrant stock supply.* Pharmacy personnel, registrants, and registrant staff shall remove from current inventory and dispose of controlled substances by one of the following procedures.

a. The responsible individual shall utilize the services of a DEA-registered and Iowa-licensed disposal firm.

b. The board may authorize and instruct the registrant to dispose of the controlled substances in one of the following manners:

(1) By delivery to an agent of the board or to the board office;

(2) By destruction of the drugs in the presence of a board officer, agent, inspector, or other authorized individual; or

(3) By such other means as the board may determine to ensure that drugs do not become available to unauthorized persons.

10.18(2) *Waste.* Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient from a registrant's stock or emergency supply or resulting from drug compounding operations may be destroyed or otherwise disposed of by the registrant or a pharmacist in witness of one other licensed health care provider or a registered pharmacy technician 18 years of age or older pursuant to this subrule. A written record of the wastage shall be made and maintained by the registrant for a minimum of two years following the destruction or other disposal. The record shall include the signatures of the individual destroying or otherwise disposing of the waste controlled substance and of the witnessing licensed health care provider or registered pharmacy technician and shall identify the following:

a. The controlled substance wasted;

b. The date of destruction or other disposition;

c. The quantity or estimated quantity of the wasted controlled substance;

d. The source of the controlled substance, including identification of the patient to whom the substance was administered or the drug compounding process utilizing the controlled substance; and

e. The reason for the waste.

10.18(3) *Previously dispensed controlled substances.* Controlled substances dispensed to or for a patient and subsequently requiring destruction due to discontinuance of the drug, death of the patient, or other reasons necessitating destruction may be destroyed or otherwise disposed of by a pharmacist in witness of one other responsible adult pursuant to this subrule. All licenses and registrations issued to the pharmacy, the pharmacist, and any individual witnessing the destruction or other disposition shall not be subject to sanctions relating to controlled substances at the time of the destruction or disposition. The individuals involved in the destruction or other disposition shall not have been subject to any criminal, civil, or administrative action relating to violations of controlled substances laws, rules, or regulations within the past five years. The pharmacist in charge shall be responsible for designating pharmacists

authorized to participate in the destruction or other disposition pursuant to this subrule. The authorized pharmacist shall prepare and maintain in the pharmacy a readily retrievable record of the destruction or other disposition, which shall be clearly marked to indicate the destruction or other disposition of noninventory or patient drugs. The record shall include, at a minimum, the following:

a. Source of the controlled substance (patient identifier or administering practitioner, if applicable, and date of return);

b. The name, strength, and dosage form of the substance;

c. The quantity returned and destroyed or otherwise disposed;

d. The date the substance is destroyed or otherwise disposed;

e. The signatures or other unique identification of the pharmacist and the witness.

657—10.19 and **10.20** Reserved.

657—10.21(124,126,155A) Prescription requirements. All prescriptions for controlled substances shall be dated as of, and manually signed on, the day issued. Controlled substances prescriptions shall be valid for six months following date of issue.

10.21(1) *Form of prescription.* All prescriptions shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and DEA registration number of the prescriber. All prescriptions issued by individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber's signature. When an oral order is not permitted, prescriptions shall be written with ink, indelible pencil, or typed print and shall be manually signed by the prescriber. A secretary or agent may prepare a prescription for the signature of the prescriber but the prescribing practitioner is responsible for the accuracy, completeness, and validity of the prescription. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by this rule.

10.21(2) *Verification by pharmacist.* The pharmacist shall verify the authenticity of the prescription with the individual prescriber in each case when a prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient's agent is known to the pharmacist. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist's name or unique identifier.

10.21(3) *Intern, resident, foreign physician.* An intern, resident, or foreign physician exempt from registration pursuant to subrule 10.6(5) shall include on all prescriptions issued the hospital's registration number and the special internal code number assigned by the hospital in lieu of the prescriber's registration number required by this rule. Each prescription shall include the stamped or printed name of the intern, resident, or foreign physician as well as the prescriber's signature.

10.21(4) *Valid prescriber/patient relationship.* Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or to oversee the patient's use of the controlled substance, a prescription shall lose its validity. A prescriber/patient relationship shall be deemed broken when the prescriber dies, retires, or moves out of the local service area or when the prescriber's authority to prescribe is suspended, revoked, or otherwise modified to exclude authority for the schedule in which the prescribed substance is listed. The pharmacist, upon becoming aware of the situation, shall cancel the prescription and any remaining refills. However, the pharmacist shall exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new prescription can be issued.

10.21(5) *Schedule II prescriptions.* With appropriate verification, a pharmacist may add information provided by the patient or patient's agent, such as the patient's address, to a Schedule II controlled substance prescription. A pharmacist shall never change the patient's name, the controlled substance prescribed except for generic substitution, or the name or signature of the prescriber. After consultation with the prescribing practitioner and documentation of such consultation, a pharmacist may change or add the following information on a Schedule II controlled substance prescription:

a. The drug strength;

b. The dosage form;
c. The drug quantity;
d. The directions for use; and
e. The date the prescription was issued.

657—10.22(124) Schedule II emergency prescriptions.

10.22(1) *Emergency situation defined.* For the purposes of authorizing an oral or electronically transmitted prescription for a Schedule II controlled substance listed in Iowa Code section 124.206, the term "emergency situation" means those situations in which the prescribing practitioner determines that all of the following apply:

a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.

b. No appropriate alternative treatment is available, including administration of a drug that is not a Schedule II controlled substance.

c. It is not reasonably possible for the prescribing practitioner to provide a written prescription to be presented to the person dispensing the substance prior to the dispensing.

10.22(2) *Requirements of emergency prescription.* In the case of an emergency situation as defined herein, a pharmacist may dispense a controlled substance listed in Schedule II pursuant to an electronic transmission or upon receiving oral authorization of a prescribing individual practitioner provided that:

a. The quantity prescribed and dispensed is limited to the smallest available quantity to meet the needs of the patient during the emergency period. Dispensing beyond the emergency period requires a written prescription manually signed by the prescribing individual practitioner.

b. If the pharmacist does not know the prescribing individual practitioner, the pharmacist shall make a reasonable effort to determine that the authorization came from an authorized prescriber. The pharmacist shall record the manner by which the authorization was verified and include the pharmacist's name or unique identification.

c. The pharmacist shall prepare a temporary written record of the emergency prescription. The temporary written record shall consist of a hard copy of the electronic transmission or a written record of the oral transmission authorizing the emergency dispensing. If the emergency prescription is transmitted by the practitioner's agent, the record shall include the name and title of the individual who transmitted the prescription.

d. If the emergency prescription is transmitted via electronic transmission, the means of transmission shall not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the written prescription, and the hard-copy record of the electronic transmission shall not be obscured or rendered illegible due to such security features.

e. Within seven days after authorizing an emergency prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of 657—10.21(124,126,155A), the prescription shall have written on its face "Authorization for Emergency Dispensing" and the date of the emergency order. The written prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the seven-day period. The written prescription shall be attached to and maintained with the temporary written record prepared pursuant to paragraph *"c."*

f. The pharmacist shall notify the board if the prescribing individual fails to deliver a written prescription. Failure of the pharmacist to so notify the board, or failure of the prescribing individual to deliver the required written prescription as herein required, shall void the authority conferred by this subrule.

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657—10.23(124) Schedule II prescriptions—partial filling. The partial filling of a prescription for a controlled substance listed in Schedule II is permitted as provided in this rule.

10.23(1) *Insufficient supply on hand.* If the pharmacist is unable to supply the full quantity called for in a prescription and makes a notation of the quantity supplied on the prescription record, a partial fill of the prescription is permitted. The remaining portion of the prescription must be filled within 72 hours of the first partial filling. If the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall so notify the prescriber. No further quantity may be supplied beyond 72 hours without a new prescription.

10.23(2) *Long-term care or terminally ill patient.* A prescription for a Schedule II controlled substance written for a patient in a long-term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units as provided by this subrule.

a. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner prior to partially filling the prescription. Both the pharmacist and the practitioner have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient.

b. The pharmacist shall record on the prescription whether the patient is "terminally ill" or an "LTCF patient." For each partial filling, the dispensing pharmacist shall record on the back of the prescription, or on another appropriate uniformly maintained and readily retrievable record, the date of the partial filling, the quantity dispensed, the remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

c. The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed. Schedule II prescriptions for patients in a LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

d. Information pertaining to current Schedule II prescriptions for patients in a LTCF or for patients with a medical diagnosis documenting a terminal illness may be maintained in a computerized system pursuant to rule 657—21.4(124,155A).

657—10.24(124) Schedule II medication order. Schedule II controlled substances may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.18(124,155A), as applicable.

657—10.25 and **10.26** Reserved.

657—10.27(124,155A) Facsimile transmission of a controlled substance prescription.

10.27(1) *Schedule II prescription.* A prescription for a Schedule II controlled substance may be transmitted via facsimile to the pharmacy only as provided in rules 657—21.12(124,155A) to 657—21.16(124,155A).

10.27(2) *Schedule III, IV, or V prescription.* A prescription for a Schedule III, IV, or V controlled substance may be transmitted via facsimile to the pharmacy only as provided in rule 657—21.9(124,155A).

657—10.28(124,155A) Schedule III, IV, or V refills. No prescription for a controlled substance listed in Schedule III, IV, or V shall be filled or refilled more than six months after the date on which it was issued nor be refilled more than five times.

10.28(1) *Record.* Each filling and refilling of a prescription shall be entered on the prescription or on another uniformly maintained and readily retrievable record.

a. The following information shall be retrievable by the prescription number: the name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, the unique identification of the dispensing pharmacist for each refill, and the total number of refills authorized for that prescription.

b. If the pharmacist merely initials or affixes the pharmacist's unique identifier and dates the back of the prescription, it shall be deemed that the full face amount of the prescription has been dispensed.

10.28(2) *Oral refill authorization.* The prescribing practitioner may authorize additional refills of Schedule III, IV, or V controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

a. The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issuance of the original prescription.

b. The pharmacist who obtains the oral authorization records from the prescriber who issued the original prescription records on or with the original prescription the date, the quantity of each refill, the number of additional refills authorized, and the pharmacist's unique identification.

c. The quantity of each additional refill is equal to or less than the quantity authorized for the initial filling of the original prescription.

d. The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

10.28(3) *Automated data processing record system.* An automated data processing record system may be used for the storage and retrieval of Schedule III, IV, and V controlled substance prescription fill and refill information subject to the conditions and requirements of rules 657—21.4(124,155A) and 657—21.5(124,155A).

657—10.29(124,155A) Schedule III, IV, or V partial fills. The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible provided that each partial fill is recorded in the same manner as a refill. The total quantity dispensed in all partial fills shall not exceed the total quantity prescribed. No dispensing shall occur later than six months after the date on which the prescription was issued.

657—10.30(124,155A) Schedule III, IV, and V medication order. A Schedule III, IV, or V controlled substance may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124,155A), as applicable.

657—10.31(124,155A) Dispensing Schedule V controlled substances without a prescription. A controlled substance listed in Schedule V, which substance is not a prescription drug as determined under the federal Food, Drug and Cosmetic Act, and excepting products containing ephedrine, pseudoephedrine, or phenylpropanolamine, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.31(1) *Who may dispense.* Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.31(2) *Frequency and quantity.* Dispensing at retail to the same purchaser in any 48-hour period shall be limited to no more than one of the following quantities of a Schedule V controlled substance:

a. 240 cc (8 ounces) of any controlled substance containing opium.

b. 120 cc (4 ounces) of any other controlled substance.

c. 48 dosage units of any controlled substance containing opium.

d. 24 dosage units of any other controlled substance.

10.31(3) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.31(4) *Identification.* The pharmacist shall require every purchaser under this rule not known by the pharmacist to present a government-issued photo identification, including proof of age when appropriate.

10.31(5) *Record.* A bound record book (i.e., with pages sewn or glued to the spine) for dispensing of Schedule V controlled substances pursuant to this rule shall be maintained by the pharmacist. The book shall contain the name and address of each purchaser, the name and quantity of controlled substance purchased, the date of each purchase, and the name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the substance to the purchaser.

10.31(6) *Prescription not required under other laws.* No other federal or state law or regulation requires a prescription prior to distributing or dispensing a Schedule V controlled substance.

657—10.32(124,155A) Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine. A product containing ephedrine, pseudoephedrine, or phenylpropanolamine, which substance is a Schedule V controlled substance and is not listed in another controlled substance schedule, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.32(1) *Who may dispense.* Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.32(2) *Packaging of nonliquid forms.* A nonliquid form of a product containing ephedrine, pseudoephedrine, or phenylpropanolamine includes gel caps. Nonliquid forms of these products to be sold pursuant to this rule shall be packaged either in blister packaging with each blister containing no more than two dosage units or, if blister packs are technically infeasible, in unit dose packets or pouches.

10.32(3) *Frequency and quantity.* Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

10.32(4) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.32(5) *Identification.* The pharmacist shall require every purchaser under this rule to present a government-issued photo identification, including proof of age when appropriate. The pharmacist shall be responsible for verifying that the name on the identification matches the name provided by the purchaser and that the photo image depicts the purchaser.

10.32(6) *Record.* A legible dispensing record shall be created and maintained for the dispensing of ephedrine, pseudoephedrine, and phenylpropanolamine products pursuant to this rule.

a. Record contents. The record shall contain the following:

(1) The name, address, and signature of the purchaser.

(2) The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.

(3) The date and time of the purchase.

(4) The name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the product.

b. Record format. The record shall be maintained using one of the following options:

(1) A hard-copy record maintained in a bound logbook (i.e., with pages sewn or glued to the spine).

(2) A record in the pharmacy's electronic prescription dispensing record-keeping system.

(3) A record in an electronic data collection system that captures each of the data elements required by this subrule. The electronic data collection system shall be capable of producing a hard-copy printout of a record upon request by the board or its representative or to such other persons or governmental agencies authorized by law to receive such information.

10.32(7) *Notice required.* The following notice shall be included in the logbook required pursuant to subrule 10.32(6) or shall be displayed in the dispensing area and be visible to the public:

"WARNING: Section 1001 of Title 18, United States Code, states that whoever, with respect to the logbook, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, shall be fined not more than $250,000 if an individual or $500,000 if an organization, imprisoned not more than five years, or both."

657—10.33(124,155A) Schedule II perpetual inventory in pharmacy. Each pharmacy located in Iowa that dispenses Schedule II controlled substances shall maintain a perpetual inventory system for all Schedule II controlled substances pursuant to the requirements of this rule. All records relating to the perpetual inventory shall be maintained by the pharmacy and shall be available for inspection and copying by the board or its representative for a period of two years from the date of the record.

10.33(1) *Record format.* The perpetual inventory record may be maintained in a manual or an electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed.

10.33(2) *Information included.* The perpetual inventory record shall identify all receipts for and disbursements of Schedule II controlled substances by drug or by national drug code (NDC) number. The record shall be updated to identify each prescription filled and each shipment received. The record shall also include incident reports and reconciliation records pursuant to subrules 10.33(3) and 10.33(4).

10.33(3) *Changes to a record.* If a perpetual inventory record is able to be changed, the individual making a change to the record shall complete an incident report documenting the change. The incident report shall identify the specific information that was changed including the information before and after the change, shall identify the individual making the change, and shall include the date and the reason the record was changed. If the electronic record system documents within the perpetual inventory record all of the information that must be included in an incident report, a separate report is not required.

10.33(4) *Reconciliation.* The pharmacist in charge shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance on a periodic basis but no less frequently than annually. In case of any discrepancies between the physical inventory and the perpetual inventory, the pharmacist in charge shall determine the need for further investigation, and significant discrepancies shall be reported to the board pursuant to rule 10.16(124) and to the DEA pursuant to federal DEA regulations. Periodic reconciliation records shall be maintained and available for review and copying by the board or agents of the board for a period of two years from the date of the record. The reconciliation process may be completed using either of the following procedures or a combination thereof:

a. The dispensing pharmacist verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. If controlled substances are maintained on the patient care unit, the nurse or other responsible licensed health care provider verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. All discrepancies shall be reported to the pharmacist in charge. If any Schedule II controlled substances in the pharmacy's current inventory have been dispensed and verified in this manner within the year, and there are no discrepancies noted, no additional reconciliation action is required. A drug that has had no activity within the year shall be reconciled pursuant to paragraph *"b"* of this subrule.

b. A physical count of each Schedule II controlled substance stocked by the pharmacy shall be completed at least once each year, and that count shall be reconciled with the perpetual inventory record balance. The physical count and reconciliation may be completed over a period of time not to exceed one year in a manner that ensures that the perpetual inventory and the physical inventory of Schedule II controlled substances are annually reconciled. The individual performing the reconciliation shall record the date, the time, the individual's initials or unique identification, and any discrepancies between the physical inventory and the perpetual inventory. Any discrepancies between the physical inventory and the perpetual inventory shall be reported to the pharmacist in charge.

657—10.34(124,155A) Records. Every inventory or other record required to be kept under this chapter or under Iowa Code chapter 124 shall be kept by the registrant and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record except as otherwise required in these rules. Controlled substances records shall be maintained in a readily retrievable manner that establishes the receipt and distribution of all controlled substances.

10.34(1) *Schedule I and II records.* Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the registrant.

10.34(2) *Schedule III, IV, and V records.* Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the required information is readily retrievable from the ordinary business records of the registrant.

10.34(3) *Date of record.* The date on which a controlled substance is actually received, imported, distributed, exported, or otherwise transferred shall be used as the date of receipt or distribution.

10.34(4) *Receipt and disbursement records.* Each record of receipt or disbursement of controlled substances, unless otherwise provided in these rules or pursuant to federal law, shall include the following:

a. The name of the substance;

b. The strength and dosage form of the substance;

c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from whom the substances were acquired;

d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to whom the substances were distributed; and

e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to whom the substances were distributed for disposal, if appropriate.

10.34(5) *Dispensing records.* Each record of dispensing of controlled substances to a patient or research subject shall include the following information:

a. The name and address of the person to whom dispensed;

b. The date of dispensing;

c. The name of the substance;

d. The quantity of the substance dispensed; and

e. The name or unique identification of the individual who dispensed or administered the substance.

10.34(6) *Ordering or distributing Schedule I or II controlled substances - DEA Form 222.* Except as otherwise provided by subrule 10.34(7) and under federal law, a DEA Form 222 is required for each distribution of a Schedule I or II controlled substance. An order form may be executed only on behalf of the registrant named on the order form and only if the registrant's DEA and Iowa registrations for the substances being purchased have not expired or been revoked or suspended by the issuing agency.

a. Order forms shall be obtained, executed, and filled pursuant to DEA requirements. Each form shall be complete, legible, and properly prepared, executed, and endorsed and shall contain no alteration, erasure, or change of any kind.

b. The purchaser shall submit Copy 1 and Copy 2 of the order form to the supplier.

c. The purchaser shall maintain Copy 3 of the order form in the files of the registrant. Upon receipt of the substances from the supplier, the purchaser shall record on Copy 3 of the order form the quantity of each substance received, and the date of receipt, and shall initial each line identifying a substance received.

d. The supplier shall record on Copy 1 and Copy 2 of the order form the quantity of each substance distributed to the purchaser and the date on which the shipment is made. The supplier shall maintain Copy 1 of the order form in the files of the supplier and shall forward Copy 2 of the order form to the DEA district office.

e. Order forms shall be maintained separately from all other records of the registrant.

f. Each unaccepted, defective, or otherwise "void" order form and any attached statement or other documents relating to any order form shall be maintained in the files of the registrant.

g. If the registration of any purchaser of Schedule I or II controlled substances is terminated for any reason, or if the name or address of the registrant as shown on the registration is changed, the registrant shall return all unused order forms to the DEA district office.

10.34(7) *Ordering or distributing Schedule I or II controlled substances - electronic ordering system.* A registrant authorized to order or distribute Schedule I or II controlled substances via the DEA Controlled Substances Ordering System (CSOS) shall comply with the requirements of the DEA relating to that system, including the maintenance and security of digital certificates, signatures, and passwords and all record-keeping and reporting requirements.

a. For an electronic order to be valid, the purchaser shall sign the electronic order with a digital signature issued to the purchaser or the purchaser's agent by the DEA.

b. An electronic order may include controlled substances that are not in Schedules I and II and may also include noncontrolled substances.

c. A purchaser shall submit an order to a specific wholesale distributor appropriately licensed to distribute in Iowa.

d. Prior to filling an order, a supplier shall verify the integrity of the signature and the order, verify that the digital certificate has not expired, check the validity of the certificate, and verify the registrant's authority to order the controlled substances.

e. The supplier shall retain an electronic record of every order, including a record of the number of commercial or bulk containers furnished for each item and the date on which the supplier shipped the containers to the purchaser. The shipping record shall be linked to the electronic record of the order. Unless otherwise provided under federal law, a supplier shall ship the controlled substances to the registered location associated with the digital certificate used to sign the order.

f. If an order cannot be filled for any reason, the supplier shall notify the purchaser and provide a statement as to the reason the order cannot be filled. When a purchaser receives such a statement from a supplier, the purchaser shall electronically link the statement of nonacceptance to the original electronic order. Neither a purchaser nor a supplier may correct a defective order; the purchaser must issue a new order for the order to be filled.

g. When a purchaser receives a shipment, the purchaser shall create a record of the quantity of each item received and the date received. The record shall be electronically linked to the original order and shall identify the individual reconciling the order. A purchaser shall, for each order filled, retain the original signed order and all linked records for that order for two years. The purchaser shall also retain all copies of each unfilled or defective order and each linked statement.

h. A supplier shall retain each original order filled and all linked records for two years. A supplier shall, for each electronic order filled, forward to the DEA within two business days either a copy of the electronic order or an electronic report of the order in a format specified by the DEA.

i. Records of CSOS electronic orders and all linked records shall be maintained by a supplier and a purchaser for two years following the date of shipment or receipt, respectively. Records may be maintained electronically or in hard-copy format. Records that are maintained electronically shall be readily retrievable from all other records, shall be easily readable or easily rendered into a readable format, shall be readily retrievable at the registered location, and shall be made available to the board, to the board's agents, or to the DEA upon request. Records maintained in hard-copy format shall be maintained in the same manner as DEA Form 222.

657—10.35(124,155A) Physical count and record of inventory. Responsibility for ensuring that a required inventory is timely completed shall rest with the registrant or, in the case of a registered business, shall rest with the owner of the business. A registrant or owner of a registered business may delegate the actual taking of any inventory. The person or persons responsible for taking the inventory shall sign the completed inventory record.

10.35(1) *Record and procedure.* Each inventory record, except the periodic count and reconciliation required pursuant to subrule 10.33(4), shall comply with the requirements of this subrule and shall be maintained for a minimum of two years from the date of the inventory.

a. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date and at the time the inventory is taken.

b. Each inventory shall be maintained in a handwritten, typewritten, or electronically printed form at the registered location. An inventory of Schedule II controlled substances shall be maintained separately from an inventory of all other controlled substances.

c. Controlled substances shall be deemed to be on hand if they are in the possession of or under the control of the registrant. These shall include prescriptions prepared for dispensing to a patient but not yet delivered to the patient, substances maintained in emergency medical services programs or care facility emergency supplies, outdated or adulterated substances pending destruction, and substances stored in a warehouse on behalf of the registrant.

d. A separate inventory shall be made for each registered location and for each independent activity registered except as otherwise provided under federal law.

e. The inventory shall be taken either prior to opening or following the close of business on the inventory date, and the inventory record shall identify either opening or close of business.

f. The inventory record, unless otherwise provided under federal law, shall include the following information:

(1) The name of the substance;

(2) The strength and dosage form of the substance; and

(3) The quantity of the substance.

g. For all substances listed in Schedule I or II, and for all solid oral and injectable hydrocodone-containing products, the quantity shall be an exact count or measure of the substance.

h. For all substances listed in Schedule III, IV, or V, except for hydrocodone-containing products identified in paragraph *"g"* herein, the quantity may be an estimated count or measure of the substance unless the container has been opened and originally held more than 100 dosage units. If the opened commercial container originally held more than 100 dosage units, an exact count of the contents shall be made. Liquid oral hydrocodone-containing products packaged in incremented containers shall be measured to the nearest increment; products packaged in nonincremented containers may be estimated to the nearest one-fourth container.

10.35(2) *Initial inventory.* A new registrant shall take an inventory of all stocks of controlled substances on hand on the date the new registrant first engages in the manufacture, distribution, or dispensing of controlled substances. If the registrant commences business or the registered activity with no controlled substances on hand, the initial inventory shall record that fact.

10.35(3) *Annual inventory.* After the initial inventory is taken, a registrant shall take a new inventory of all stocks of controlled substances on hand at least annually. The annual inventory may be taken on any date that is within one year of the previous inventory date.

10.35(4) *Change of ownership.* Both the current owner and the prospective owner shall be responsible for ensuring that an inventory of all controlled substances is timely completed whenever there is a change of ownership of any pharmacy or drug wholesaler licensed pursuant to Iowa Code section 155A.13 or 155A.17, respectively.

10.35(5) *Change of pharmacist in charge (PIC).* An inventory of all controlled substances shall be completed whenever there is a change of PIC. The inventory shall be taken following the close of business the last day of the terminating PIC's employment and prior to opening for business the first day of the new PIC's employment. A single inventory shall be sufficient if there is no lapse between employment of the terminating PIC and the new PIC.

10.35(6) *Change of registered location.* A registrant shall take an inventory of all controlled substances whenever there is a change of registered location. The inventory shall be taken following the close of business the last day at the location being vacated. This inventory shall serve as the ending inventory for the location being vacated as well as a record of beginning inventory for the new location.

10.35(7) *Discontinuing registered activity.* A registrant shall take an inventory of controlled substances at the close of business the last day the registrant is engaged in registered activities. If the registrant is selling or transferring the remaining controlled substances to another registrant, this

inventory shall serve as the ending inventory for the registrant discontinuing business as well as a record of additional or starting inventory for the registrant to whom the substances are transferred.

10.35(8) *Newly controlled substances.* On the effective date of the addition of a previously noncontrolled substance to any schedule of controlled substances, any registrant who possesses the newly controlled substance shall take an inventory of all stocks of the substance on hand. That initial inventory record shall be maintained with the most recent controlled substances inventory record. Thereafter, the newly controlled substance shall be included in each inventory made by the registrant.

657—10.36(124) Samples and other complimentary packages—records. Complimentary packages and samples of controlled substances may be distributed to practitioners pursuant to federal and state law only if the person distributing the items leaves with the practitioner a specific written list of the items delivered.

10.36(1) *Distribution record.* The record form for the distribution of complimentary packages of controlled substances shall contain the following information:

a. The name, address, and DEA registration number of the supplier;

b. The name, address, and DEA registration number of the practitioner;

c. The name, strength, and quantity of the specific controlled substances delivered; and

d. The date of delivery.

10.36(2) *Reports to the board.* Any person who distributes controlled substances pursuant to this rule shall report all such distributions to the board. Reports shall:

a. Include the information identified in subrule 10.36(1). Reports may consist of copies of those distribution records or may be computer-generated listings identifying those distributions.

b. Be submitted as soon as practicable after distribution to the practitioner but no less often than once each calendar quarter.

10.36(3) *Practitioner records.* A practitioner who regularly administers or dispenses controlled substances shall keep records of the receipt and disbursement of such drugs, including complimentary packages and samples. Records shall be filed in a readily retrievable manner in accordance with federal requirements and shall be made available for inspection and copying by agents of the board or other authorized individuals for at least two years from the date of the record.

657—10.37(124,126) Revision of controlled substances schedules.

10.37(1) *Application for exception.* Any person seeking to have any compound, mixture, or preparation containing any depressant or stimulant substance listed in any of the schedules in Iowa Code chapter 124 excepted from the application of all or any part of that chapter may apply to the board for such exception.

a. An application for an exception under this rule shall provide evidence that an exception has been granted under the federal Controlled Substances Act.

b. The board shall permit any interested person to file written comments on or objections to the proposal for exception and shall designate the time during which such filings may be made. After consideration of the application and any comments on or objections to the proposal for exception, the board shall issue its findings on the application.

10.37(2) *Designation of new controlled substance.* The board may designate any new substance as a controlled substance to be included in any of the schedules in Iowa Code chapter 124 no sooner than 30 days following publication in the Federal Register of a final order so designating the substance under federal law. Designation of a new controlled substance under this subrule shall be temporary as provided in Iowa Code section 124.201, subsection 4.

10.37(3) *Objection to designation of a new controlled substance.* The board may object to the designation of any new substance as a controlled substance within 30 days following publication in the Federal Register of a final order so designating the substance under federal law. The board shall file objection to the designation of a substance as controlled, shall afford all interested parties an opportunity to be heard, and shall issue the board's decision on the new designation as provided in Iowa Code section 124.201, subsection 4.

657—10.38(124) Temporary designation of controlled substances.

10.38(1) Amend Iowa Code section 124.206, subsection 3, by adding the following new paragraph:

ab. Tapentadol.

10.38(2) Amend Iowa Code section 124.212, subsection 5, as follows:

5. Depressants. Unless specifically exempted or excluded or unless listed in another schedule, any material, compound, mixture, or preparation that contains any quantity of the following substance having a depressant effect on the central nervous system, including its salts: ~~pregabalin~~

a. Lacosamide [(R)-2-acetoamido-N-benzyl-3-methoxy-propionamide].

b. Pregabalin [(S)-3-(aminomethyl)-5-methylhexanoic acid].

[**ARC 7906B**, IAB 7/1/09, effective 6/22/09]

657—10.39(124,126) Excluded substances. The Iowa board of pharmacy hereby excludes from all schedules the current list of "Excluded Nonnarcotic Products" identified in Title 21, CFR Part 1308, Section 22. Copies of the list of excluded products may be obtained by written request to the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

657—10.40(124,126) Anabolic steroid defined. Anabolic steroid, as defined in Iowa Code section 126.2, paragraph 2, includes any substance identified as such in Iowa Code section 124.208, paragraph 6, or in Iowa Code section 126.2, paragraph 2.

These rules are intended to implement Iowa Code sections 124.201, 124.301 to 124.308, 124.402, 124.403, 124.501, 126.2, 126.11, 147.88, 147.95, 147.99, 155A.13, 155A.17, 155A.26, 155A.37, and 205.3.

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CHAPTER 37
IOWA PRESCRIPTION MONITORING PROGRAM

657—37.1(124) Purpose. These rules establish a prescription monitoring program that compiles a central database of reportable prescriptions dispensed to patients in Iowa. An authorized health care practitioner may, but is not required to, access prescription monitoring program (PMP) information regarding the practitioner's patient to assist in determining appropriate treatment options and to improve the quality of patient care. The PMP is intended to provide a health care practitioner with a resource for information regarding a patient's use of controlled substances. This database will assist the practitioner in identifying any potential diversion, misuse, or abuse of controlled substances without impeding the appropriate medical use of controlled substances.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.2(124) Definitions. As used in this chapter:

"Board" means the Iowa board of pharmacy.

"Controlled substance" means a drug, substance, or immediate precursor in Schedules I through V set forth in Iowa Code chapter 124, division II.

"Council" means the PMP advisory council established pursuant to Iowa Code section 124.555 to provide oversight and to co-manage PMP activities with the board.

"Database information" or *"PMP information"* means information submitted to and maintained by the PMP database.

"DEA number" means the registration number issued to an individual or pharmacy by the U.S. Department of Justice, Drug Enforcement Administration authorizing the individual or pharmacy to engage in the prescribing, dispensing, distributing, or procuring of a controlled substance.

"Dispenser" means a person who delivers to the ultimate user a substance required to be reported to the PMP database. "Dispenser" does not include a person exempt from reporting pursuant to subrule 37.3(1).

"National drug code" or *"NDC number"* means the universal product identifier used in the United States to identify a specific human drug product.

"Patient" means the person or animal that is the ultimate user of a drug for whom a prescription is issued or for whom a drug is dispensed.

"Patient's agent" means a person legally authorized to make health care decisions or gain access to health care records on behalf of the patient for purposes of directing the patient's care.

"Patients rights committee" or *"committee"* means the physician and pharmacist members of the council responsible for monitoring and ensuring protection and preservation of patients' rights as provided in Iowa Code section 124.555(3)*"e."*

"PMP administrator" means the board staff person or persons designated to manage the PMP under the direction and oversight of the board and the council.

"Practitioner" means a prescriber or a pharmacist.

"Prescriber" means a licensed health care professional with the authority to prescribe prescription drugs including controlled substances.

"Prescription monitoring program" or *"PMP"* means the program established pursuant to these rules for the collection and maintenance of PMP information and for the provision of PMP information to authorized individuals, including health care providers, for use in treatment of their patients.

"Prescription monitoring program database" or *"PMP database"* means a centralized database of reportable controlled substance prescriptions dispensed to patients and includes data access logs, security tracking information, and records of each individual who requests PMP information.

"Reportable prescription" means the record of a Schedule II, III, or IV controlled substance dispensed by a pharmacy to a patient pursuant to a prescriber-authorized prescription. "Reportable prescription" does not include those records excluded in subrule 37.3(1).

"Schedule II, III, and IV controlled substances" means those substances that are identified and listed as Schedule II, III, or IV substances in Iowa Code sections 124.205 through 124.210 or in the federal Controlled Substances Act (21 U.S.C. Section 812).
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.3(124) Requirements for the PMP. Each dispenser, unless identified as exempt from reporting pursuant to subrule 37.3(1), shall submit to the PMP administrator a record of each reportable prescription dispensed during a reporting period.

37.3(1) *Exemptions.* The dispensing of a controlled substance as described in this subrule shall not be considered a reportable prescription. A dispenser engaged in the distribution of controlled substances solely pursuant to one or more of the practices identified in paragraphs *"a"* or *"b"* of this subrule shall so notify the PMP administrator and shall be exempt from reporting to the PMP.

a. A licensed hospital pharmacy shall not be required to report the dispensing of a controlled substance for the purposes of inpatient hospital care, the dispensing of a prescription for a starter supply of a controlled substance at the time of a patient's discharge from such a facility, or the dispensing of a prescription for a controlled substance in a quantity adequate to treat the patient for a maximum of 72 hours.

b. A licensed pharmacy shall not be required to report the dispensing of a controlled substance for a patient residing in a long-term care facility or for a patient residing in an inpatient hospice facility.

c. A prescriber or other authorized person who administers or dispenses a controlled substance, including samples of a controlled substance, for the purposes of outpatient care shall not be required to report such administration or dispensing. This exception shall not apply to a pharmacist who administers a controlled substance, as directed by the prescriber, pursuant to a prescription.

d. A wholesale distributor of a controlled substance shall not be required to report the wholesale distribution of such a substance.

37.3(2) *Data elements.* The information submitted for each prescription shall include, at a minimum, the following items:

a. Dispenser DEA number.
b. Date the prescription is filled.
c. Prescription number.
d. Indication as to whether the prescription is new or a refill.
e. NDC number for the drug dispensed.
f. Quantity of the drug dispensed.
g. Number of days of drug therapy provided by the drug as dispensed.
h. Patient name.
i. Patient address including street address, city, state, and ZIP code.
j. Patient date of birth.
k. Patient gender.
l. Prescriber DEA number.
m. Date the prescription was issued by the prescriber.
n. Method of payment as either third-party payer or patient cash payment.

37.3(3) *Reporting periods.* A record of each reportable prescription dispensed shall be submitted by each dispenser pursuant to the following schedule. Records may be submitted with greater frequency than required by this schedule. This schedule defines minimum report frequency.

a. Records of reportable prescriptions dispensed between the first and the fifteenth day of a month shall be submitted no later than the twenty-fifth day of the month.

b. Records of reportable prescriptions dispensed between the sixteenth and the last day of a month shall be submitted no later than the tenth day of the following month.

37.3(4) *Transmission methods.* Prescription information shall be transmitted using one of the following methods:

a. Data upload to a reporting Web site via a secure Internet connection. The PMP administrator will provide dispensers with initial secure login and password information. Dispensers will be required to register on the reporting Web site prior to initial data upload.

b. Electronic media including CD-ROM, DVD, or diskette, accompanied by a transmittal form identifying the dispenser submitting the electronic media, the number of prescription records included on the media, and the individual submitting the media.

c. If a dispenser does not have an automated record-keeping system capable of producing an electronic report as provided in this rule, the dispenser may submit prescription information on the industry standard universal claim form. The dispenser may complete and submit the claim form on the reporting Web site or, if the dispenser does not have Internet access, the completed paper claim form may be submitted.

d. Chain pharmacies and pharmacies under shared ownership may submit combined data transmissions on behalf of all facilities by utilizing the secure FTP procedure.

37.3(5) *Zero reports.* If a dispenser has not been identified as exempt from reporting to the PMP and the dispenser did not dispense any reportable prescriptions during a reporting period, the dispenser shall submit a zero report via the established reporting Web site. If such a dispenser does not have Internet access, the dispenser shall notify the PMP administrator via mail or facsimile transmission that the dispenser did not dispense any reportable prescriptions during the reporting period. The schedule identified in subrule 37.3(3) shall determine timely submission of zero reports.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.4(124) Access to database information. Prescription information submitted to the board for inclusion in the PMP database shall be privileged and strictly confidential and not subject to public or open records laws. All information contained in the PMP database, including records of requests for PMP information, shall be privileged and strictly confidential and not subject to public or open records laws. The board, council, and PMP administrator shall maintain procedures to ensure the privacy and confidentiality of patients, prescribers, dispensers, practitioners, and patient information collected, recorded, transmitted, and maintained in the PMP database and to ensure that program information is not disclosed to persons except as provided in this rule.

37.4(1) *Prescribers and pharmacists.* A health care practitioner authorized to prescribe or dispense controlled substances may obtain PMP information regarding the practitioner's patient, or a patient seeking treatment from the practitioner, for the purpose of providing patient health care.

a. Prior to being granted access to PMP information, a practitioner shall submit a request for registration and program access. A practitioner with Internet access may register via a secure Web site established by the board for that purpose. A practitioner without Internet access shall submit a written registration request on a form provided by the PMP administrator. The PMP administrator shall take reasonable steps to verify the identity of a practitioner and to verify a practitioner's credentials prior to providing a practitioner with a secure login and initial password. Except in an emergency when the patient would be placed in greater jeopardy by restricting PMP information access to the practitioner, a registered practitioner shall not share the practitioner's secure login and password information and shall not delegate PMP information access to another health care practitioner or to the practitioner's agent.

b. A practitioner with Internet access may submit a request for PMP information via a secure Web site established by the board for that purpose. The requested information shall be provided to the requesting practitioner in a format established by the board and shall be delivered via the secure Web site.

c. A practitioner without Internet access may submit to the PMP administrator a written request for PMP information via mail or facsimile transmission. The written request shall be in a format established by the board and shall be signed by the requesting practitioner. Prior to processing a written request for PMP information, the PMP administrator shall take reasonable steps to verify the request, which may include but not be limited to a telephone call to the practitioner at a telephone number known to be the number for the practitioner's practice.

d. A practitioner who requests and receives PMP information consistent with the requirements and intent of these rules may provide that information to another practitioner who is involved in the care of the patient who is the subject of the information. Information from the PMP database remains privileged and strictly confidential. Such disclosures among practitioners shall be consistent with these rules and federal and state laws regarding the confidentiality of patient information. The information shall be used for medical or pharmaceutical care purposes.

37.4(2) *Regulatory agencies and boards.* Professional licensing boards and regulatory agencies that supervise or regulate a health care practitioner or that provide payment for health care services shall be able to access information from the PMP database only pursuant to an order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause.

a. A director of a licensing board with jurisdiction over a practitioner, or the director's designee, who seeks access to PMP information for an investigation shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

b. A director of a regulatory agency with jurisdiction over a practitioner or with jurisdiction over a person receiving health care services pursuant to one or more programs provided by the agency, or the director's designee, who seeks access to PMP information for an investigation shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, or personal delivery. The request shall be signed by the director or the director's designee and shall be accompanied by an order, subpoena, or other form of legal compulsion establishing that the request is supported by a determination of probable cause.

37.4(3) *Law enforcement agencies.* Local, state, and federal law enforcement or prosecutorial officials engaged in the administration, investigation, or enforcement of any state or federal law relating to controlled substances shall be able to access information from the PMP database by order, subpoena, or other means of legal compulsion relating to a specific investigation of a specific individual and supported by a determination of probable cause. A law enforcement officer shall submit to the PMP administrator in a format established by the board a written request via mail, facsimile, or personal delivery. The request shall be signed by the requesting officer or the officer's superior. The request shall be accompanied by an order, subpoena, or warrant issued by a court or legal authority that requires a determination of probable cause and shall be processed by the PMP administrator. A report identifying PMP information relating to the specific individual identified by the order, subpoena, or warrant may be delivered to the law enforcement officer via mail or alternate secure delivery.

37.4(4) *Patients.* A patient or the patient's agent may request and receive PMP information regarding prescriptions reported to have been dispensed to the patient.

a. A patient may submit a signed, written request for records of the patient's prescriptions dispensed during a specified period of time. The request shall identify the patient by name, including any aliases used by the patient, and shall include the patient's date of birth and gender. The request shall also include any address where the patient resided during the time period of the request and the patient's current address and daytime telephone number. A patient may personally deliver the request to the PMP administrator or authorized staff member at the offices of the board located at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. The patient will be required to present current government-issued photo identification at the time of delivery of the request. A copy of the patient's identification shall be maintained in the records of the PMP.

b. A patient who is unable to personally deliver the request to the board offices may submit a request via mail or commercial delivery service. The request shall comply with all provisions of paragraph *"a"* above, and the signature of the requesting patient shall be witnessed and the patient's identity shall be attested to by a currently registered notary public. In addition to the notary's signature and assurance of the patient's identity, the notary shall certify a copy of the patient's government-issued

photo identification and that certified copy shall be submitted with the written request. The request shall be submitted to the Iowa Board of Pharmacy at the address identified in paragraph *"a."*

c. In the case of a patient whose health care decisions have been legally transferred to the patient's agent, the patient's agent may submit a request on behalf of the patient pursuant to the appropriate procedure in paragraph *"a"* or *"b."* In addition to the patient's information, the patient's agent shall be identified by name, current address, and telephone number. In lieu of the patient's signature and identification, the patient's agent shall sign the request and the government-issued photo identification shall identify the patient's agent. The patient's agent shall include a certified copy of the legal document that transferred control over decisions regarding the patient's health care to the patient's agent.

37.4(5) *Court orders and subpoenas.* The PMP administrator shall provide PMP information in response to court orders and county attorney or other subpoenas issued by a court upon a determination of probable cause.

37.4(6) *Statistical data.* The PMP administrator, following review and approval by the patients rights committee, may provide summary, statistical, or aggregate data to public or private entities for statistical, research, or educational purposes. Prior to the release of any such data, the PMP administrator shall remove any information that could be used to identify an individual patient, prescriber, dispenser, practitioner, or other person who is the subject of the PMP information or data.

37.4(7) *PMP administrator access.* Other than technical, error, and administrative function reports needed by PMP support staff to determine that records are received and maintained in good order, any other reports concerning the information received from dispensers shall only be prepared at the direction of the board, the council, or the PMP administrator. The board and the council may compile statistical reports from PMP information for use in determining the advisability of continuing the PMP and for use in preparing required reports to the governor and the legislature. The reports shall not include information that would identify any patient, prescriber, dispenser, practitioner, or other person who is the subject of the PMP information or data.

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.5(124) Fees. The board may charge a fee and recover costs incurred for the provision of PMP information, including statistical data, except that no fees or costs shall be assessed to a dispenser for reporting to the PMP or to a practitioner for querying the PMP regarding a practitioner's patient. Any fees or costs assessed by the board shall be considered repayment receipts as defined in Iowa Code section 8.2.

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.6(124) PMP information retained. All dispenser records of prescriptions reported to the PMP shall be retained by the PMP for a period of four years following the date of the record. All records of access to or query of PMP information shall be retained by the PMP for a period of four years following the date of the record. At least semiannually, all PMP information identified as exceeding that four-year period shall be deleted from the PMP and discarded in a manner to maintain the confidentiality of the PMP information and data. Statistical data and reports from which all personally identifiable information has been removed or which do not contain personally identifiable information as provided in subrules 37.4(6) and 37.4(7) may be retained by the PMP for historical purposes.

[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.7(124) Information errors. Any person who believes that PMP information about that person is false or in error shall submit a written statement to the PMP administrator. The statement shall identify the information the person believes to be false or in error and the reason the individual believes the information to be false or in error. The PMP administrator may examine the information identified in the statement and may request the assistance of the board's compliance staff to determine whether or not the PMP information is accurate. Prior to initiating any action to correct, delete, or amend any PMP information, the PMP administrator shall submit the statement and the resulting report to the patients rights committee for review and approval of the recommended action. If correction, deletion, or amendment of any PMP information is authorized, that action shall be accomplished by the PMP

administrator within 72 hours of the committee's decision. The PMP administrator shall respond, in writing, to the person who submitted the statement charging that the PMP information was false or in error. The response shall identify the action approved by the committee.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.8(124) Dispenser and practitioner records. Nothing in these rules shall apply to records created or maintained in the regular course of business of a pharmacy or health care practitioner. All information, documents, or records otherwise available from pharmacies or health care practitioners shall not be construed as immune from discovery or use in any civil proceedings merely because the information contained in those records was reported to the PMP in accordance with these rules.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

657—37.9(124) Prohibited acts. The PMP administrator shall report to a dispenser's or a practitioner's professional licensing board any known violation of the confidentiality provisions or the reporting requirements of the law and these rules for which the dispenser or practitioner is subject to disciplinary action.

37.9(1) *Confidentiality.* A pharmacy or a practitioner who knowingly fails to comply with the confidentiality provisions of the law or these rules or who delegates PMP information access to another individual, except in an emergency situation as provided in paragraph 37.4(1)*"a,"* is subject to disciplinary action by the appropriate professional licensing board. The PMP administrator or a member of the program staff who knowingly fails to comply with the confidentiality provisions of the law or these rules is subject to disciplinary action by the board.

37.9(2) *Dispenser reporting.* A dispenser or a pharmacist who fails to comply with the reporting requirements of the law or these rules may be subject to disciplinary action by the board.
[**ARC 7903B**, IAB 7/1/09, effective 8/5/09]

These rules are intended to implement Iowa Code sections 124.551 to 124.558 as amended by 2009 Iowa Acts, House file 122.

[Filed ARC 7903B (Notice ARC 7676B, IAB 4/8/09), IAB 7/1/09, effective 8/5/09]

PUBLIC SAFETY DEPARTMENT[661]

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CHAPTER 7
IGNITION INTERLOCK DEVICES

[Ch 7 as appeared prior to 6/27/79 rescinded]
[Rules 7.1 to 7.5 appeared as rule 3.13 prior to 6/27/79]
[Prior to 4/20/88, see Public Safety Department[680] Ch 7]

Rescinded IAB 7/1/09, effective 10/1/09

CHAPTER 158
IGNITION INTERLOCK DEVICES

661—158.1(321J) Scope and authority.

158.1(1) The rules in this chapter establish standards and requirements that apply to ignition interlock devices installed in motor vehicles pursuant to court orders or administrative orders issued by the department of transportation pursuant to Iowa Code chapter 321J.

158.1(2) Various sections of Iowa Code chapter 321J require drivers who have been convicted of violating or administratively adjudged to have violated certain provisions of Iowa Code chapter 321J to have ignition interlock devices "of a type approved by the commissioner of public safety" installed on their vehicles in order to continue to drive legally. The rules in this chapter provide the standards for such approval.

[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.2(321J) Definitions. The following definitions apply to rules 661—158.1(321J) through 661—158.9(321J):

"Alcohol" means any member of the class of organic compounds known as alcohols and, specifically, ethyl alcohol.

"Authorized service provider" or *"ASP"* means a person or company meeting all qualifications outlined in this chapter and approved and trained by the manufacturer to service, install, monitor or calibrate IIDs approved pursuant to this chapter.

"Breath alcohol concentration" or *"BrAC"* means the amount of alcohol determined by chemical analysis of the individual's breath measured in grams of alcohol per 210 liters of breath.

"Bypassing" or *"tampering"* means the attempted or successful circumvention of the proper functioning of an IID including, but not limited to, the push start of a vehicle equipped with an IID, disabling, disconnecting or altering an IID, or introduction of a breath sample into an IID other than a nonfiltered direct breath sample from the driver of the vehicle in order to defeat the intended purpose of the IID.

"DCI" means the Iowa division of criminal investigation.

"DOT" means Iowa department of transportation, office of driver services.

"Fail level" means a BrAC equal to or greater than 0.025 grams per 210 liters of breath, at which level the IID will prevent the vehicle from starting or will indicate a violation once the vehicle is running.

"Ignition interlock device" or *"IID"* means an electronic device that is installed in a vehicle and that requires the completion of a breath sample test prior to starting the vehicle and at periodic intervals after the vehicle has been started. If the IID detects an alcohol concentration of 0.025 grams or greater per 210 liters of breath, the vehicle shall be prevented from starting.

"Laboratory" means the division of criminal investigation criminalistics laboratory.

"Lessee" means a person who has entered into an agreement with a manufacturer or an ASP to lease an IID and whose driving privileges are contingent on the use of an IID.

"Lockout condition" means a situation in which a proper breath sample was not provided to an IID when required, or when a random retest results in an alcohol concentration equal to or greater than 0.025 BrAC. Once a lockout condition occurs, the IID shall be reset by the manufacturer or the ASP within five days, or the IID shall render the vehicle ignition incapable of starting the vehicle.

"Manufacturer" means the person, company, or corporation that produced the IID.

"Random retest" means a breath sample that is collected in a nonscheduled, random manner after the vehicle has been started.

"User" means a person operating a vehicle equipped with an IID.

"Violation" means a condition caused by either (1) failure to provide a proper breath sample to the IID during a random retest, (2) the IID indicating a concentration exceeding the maximum allowable concentration of 0.025 BrAC during a random retest, or (3) the IID indicating that bypassing the device or tampering with the device occurred or was attempted.

[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.3(321J) Approval. To be approved, an IID shall meet or exceed performance standards contained in the Model Specifications for Breath Alcohol Ignition Interlock Devices, as published in the Federal Register, April 7, 1992, pages 11772-11787. Only a notarized statement from a laboratory capable of performing the tests specified will be accepted as proof of meeting or exceeding the standards.

158.3(1) In addition to the federal standards, the DCI criminalistics laboratory shall apply scientific tests or methods to a particular IID to determine whether it meets an acceptable standard for accuracy.

158.3(2) At the discretion of the laboratory administrator, the laboratory may accept test results from other public laboratories or authorities.

158.3(3) The laboratory shall maintain a list of IIDs approved by the commissioner of public safety. The list is available without cost by writing to the Iowa Department of Public Safety, Division of Criminal Investigation, Criminalistics Laboratory, 2240 South Ankeny Blvd., Ankeny, Iowa 50023; by telephoning (515)725-1500; or by accessing the list on the laboratory's Web site.

NOTE: As of October 1, 2009, the Web site of the laboratory is http://www.dps.state.ia.us/DCI/Crime_Lab/index.shtml.

158.3(4) On or after January 1, 2010, any IID installed in a vehicle in Iowa pursuant to this chapter, including a replacement for a device previously installed, shall utilize fuel cell technology. Any device installed prior to January 1, 2010, may continue to be used until the expiration of the order that resulted in its use or until it is replaced, whichever occurs earlier.

[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.4(321J) Revocation of approval. The approval of an IID shall remain valid until either voluntarily surrendered by the manufacturer or until the approval of the IID has been revoked by the commissioner of public safety for cause. Reasons for revocation include but are not limited to the following.

158.4(1) Evidence of repeated IID failures due to defects in design, materials, or workmanship during manufacture, installation, monitoring, or calibration of the IID such that the accuracy of the IID or the reliability of the IID as approved is not being met as determined by the laboratory.

158.4(2) A pattern of evidence that the mandatory operational features of the IID as described in rule 661—158.6(321J) are not functioning properly.

158.4(3) A pattern of evidence indicating that the IID may be easily tampered with or bypassed.

158.4(4) Any violation on the part of the manufacturer of the IID of any laws or regulations related to the installation, servicing, monitoring, and calibration of IIDs, or failure of a manufacturer to address repeated violations by an ASP.

158.4(5) Cancellation of the manufacturer's required liability insurance coverage.

158.4(6) Cessation of business operations by the manufacturer.

158.4(7) Failure to notify the laboratory in writing of any material modifications or alterations to the components or the design of the approved IID.

158.4(8) Failure of the manufacturer or an ASP to notify the DOT and the county attorney of the county of residence of the lessee within 30 days of the discovery of evidence of tampering with or attempting to bypass an IID.

158.4(9) Evidence that the manufacturer or ASP(s), or its owners, employees, or agents, has committed any act of theft or fraud, deception or material omission of fact related to the distribution, installation, or operation of any IID subject to this chapter.

158.4(10) Revocation of approval in another state for any of the reasons for revocation listed in subrules 158.4(1) through 158.4(9).

158.4(11) A revocation shall be effective 30 days from the date of the letter sent to the manufacturer via certified mail, return receipt requested, unless otherwise specified by the commissioner. A copy of each notice of revocation shall be provided to the director of the Iowa department of transportation.

158.4(12) Upon voluntary surrender or revocation, all IIDs subject to the surrender or revocation shall be removed and replaced by an approved IID within 60 days of the effective date of such surrender or revocation. The manufacturer or the ASP must notify all affected lessees of the surrender or revocation

and the requirement that a new IID must be installed by an existing ASP within the time frame specified in this subrule.

158.4(13) A revocation of a previously approved IID may be appealed to the department of public safety by the filing of an appeal in accordance with the procedures specified in rule 661—10.101(17A) within ten days of the issuance of the notice of revocation.
[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.5(321J) Modifications to an approved IID. The manufacturer shall inform the laboratory in writing of any modifications that will affect the accuracy, reliability, ease of use, or general function of the approved IID. The notification shall include, but not be limited to, a listing of those modifications that were made, those components that were redesigned or replaced, and any additional alterations. Each of these changes should also include a narrative explaining how the modifications or alterations will affect the accuracy, reliability, ease of use, or general function of the IID. The laboratory reserves the right to test the IID to determine if the IID meets or exceeds the requirements established in this chapter.
[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.6(321J) Mandatory operational features. In addition to any requirements established elsewhere in this chapter, an approved IID shall comply with the following.

158.6(1) The IID shall be designed and constructed to measure a person's breath alcohol concentration by utilizing a sample of the person's breath delivered directly into the IID.

158.6(2) The IID shall be designed and constructed so that the ignition system of the vehicle in which it is installed will not be activated if the breath alcohol concentration of the person using the IID exceeds 0.025 BrAC.

158.6(3) The IID shall prevent engine ignition if the IID has not been calibrated within 67 days subsequent to the last calibration. Calibration may be required more frequently at the discretion of the manufacturer or the ASP.

EXCEPTION: The laboratory administrator may approve a device using fuel cell technology to be recalibrated within 187 days of the previous calibration provided that the device passes specific precision and functionality testing approved by the laboratory administrator and carried out by the laboratory or an independent laboratory acceptable to the laboratory administrator.

158.6(4) The IID shall record every instance when the vehicle is started, the results of the breath sample test, how long the vehicle was operated, and any indications that the IID may have been tampered with or bypassed.

158.6(5) The IID shall require the operator to submit to a random retest within 10 minutes of starting the vehicle. A minimum of two additional random retests shall occur within 60 minutes of starting the vehicle, and a minimum of two random retests shall occur within every 60 minutes thereafter. Random retests may be achieved during operation of the vehicle. The IID shall enter a lockout condition within five days if two or more violations are recorded in a single monitoring period. An IID may, at the discretion of the manufacturer or the ASP, enter a lockout condition on the basis of a single violation.

158.6(6) The IID shall permit a sample-free restart for a maximum period of two minutes unless the IID has initiated a random retest, in which case the operator must successfully perform a breath sample test before the vehicle may be restarted.

158.6(7) The IID shall automatically and completely purge residual alcohol before allowing subsequent tests.

158.6(8) The IID shall be installed in such a manner that it will not interfere with the normal operation of the vehicle after the vehicle has been started.

158.6(9) The IID shall be equipped with a method of immediately notifying peace officers if the retest required by subrule 158.6(5) is not performed or if the result of a random retest exceeds the alcohol concentration of 0.025 BrAC. Examples of acceptable forms of notification are repeated honking of the vehicle's horn and repeated flashing of the vehicle's headlights. Such notification may be disabled only by switching the engine off or by achievement of a retest at a level below 0.025 BrAC.

158.6(10) Each IID shall be uniquely identified by a serial number. Along with any other information required by the DOT or by an originating court, all reports to the DOT or to an originating

court concerning a particular IID shall include the name, address, and driver's license number of the lessee and the unique serial number of the IID. The name, address, telephone number, and contact person of the manufacturer or the ASP furnishing the report shall also be included as part of the report.
[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.7(321J) IID security. The manufacturer and its ASPs shall take all reasonable steps necessary to prevent tampering with or physical circumvention of the IID. These steps shall include the following.

158.7(1) ASPs shall use special locks, seals, installation procedures, or design characteristics that prevent or record evidence of tampering or circumvention attempts.

158.7(2) The manufacturer or the ASP shall affix a label to the IID indicating that attempts to tamper with or circumvent the IID may subject a person to criminal prosecution or administrative sanctions.

158.7(3) No owner or employee of a manufacturer or an ASP may authorize or assist with the disconnection of an IID or enable the use of any emergency bypass mechanism or any other bypass procedure that allows a person restricted to the use of a vehicle equipped with a functioning IID to start or operate a vehicle without providing all required breath samples. Authorizing or assisting with the disconnection of an IID may subject the owner or employee of a manufacturer or an ASP to criminal prosecution or administrative sanctions.
[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.8(321J) IID maintenance and reports.

158.8(1) An IID utilized in accordance with the provisions of this chapter shall have the calibration checked and shall be recalibrated at least once every 60 days using either a wet bath simulator or dry gas standard. Calibration shall be completed by the manufacturer or the ASP. In lieu of calibration of an installed IID, an installed IID may be exchanged for another calibrated IID. The laboratory administrator may approve a device that employs fuel cell technology to be used for up to 180 days from the date of the previous calibration, provided that the device passes specific precision and functionality testing approved by the laboratory administrator and carried out by the laboratory or an independent laboratory acceptable to the laboratory administrator. An IID shall automatically enter a lockout condition if the IID has not been calibrated within 7 days after the deadlines established in this subrule.

158.8(2) The calibration record for the IID currently installed in a vehicle pursuant to Iowa Code section 321J.4 and this chapter and for any other IID installed in the same vehicle shall be maintained by the manufacturer or the ASP. The record shall include the following:

a. Name of the person performing the calibration;
b. Date;
c. Value and type of standard used;
d. Batch or lot number of standard;
e. Unit type and identification number of the IID; and
f. Description of the vehicle in which the IID is installed, including:
(1) Registration plate number and state;
(2) Make;
(3) Model;
(4) Vehicle identification number;
(5) Year; and
(6) Color.

158.8(3) The IID must be calibrated for accuracy according to the manufacturer's procedures. All data contained in the IID's memory must be downloaded, and the manufacturer or the ASP shall make a hard copy or the electronic equivalent of a hard copy of client data and results of each examination.

158.8(4) All information obtained as a result of each inspection shall be retained by the manufacturer or the ASP for five years from the date the IID is removed from the vehicle.

158.8(5) Any manufacturer or ASP who discovers evidence of tampering with or attempting to bypass an IID shall, within 30 days of the discovery, notify the DOT and the county attorney of the county of residence of the lessee of that evidence.

158.8(6) The manufacturer or the ASP must provide, upon request, additional reports in a format acceptable to, and at no cost to, the DOT and the DCI.

158.8(7) The manufacturer or the ASP shall notify the DOT within 10 days if an IID is not calibrated within the time period specified in subrule 158.6(3).

[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

661—158.9(321J) Other provisions. In addition to any other applicable provisions of this chapter, each manufacturer of an approved IID, either on its own or through its ASPs, shall comply with the following provisions.

158.9(1) Each manufacturer and ASP of IIDs approved for use in Iowa pursuant to this chapter shall maintain general liability insurance coverage that is effective in Iowa and that has been issued by an insurance carrier authorized to operate in Iowa by the Iowa division of insurance in an amount of not less than $1 million per occurrence and $3 million in the aggregate. Each manufacturer and ASP shall furnish the DCI with proof of this insurance coverage in the form of a certificate of insurance from the insurance company issuing the policy. All insurance policies required by this subrule shall carry an endorsement requiring that the DCI be provided with written notice of cancellation of insurance coverage required by this subrule at least ten days prior to the effective date of cancellation.

158.9(2) Each manufacturer and ASP of IIDs approved for use in Iowa shall maintain an E-mail address and a telephone number that are available 24 hours a day, 365 days a year, for lessees or users to contact the manufacturer or the ASP if lessees or users have problems with the IID leased from the manufacturer or the ASP.

158.9(3) Each manufacturer and ASP of IIDs approved for use in Iowa shall provide the lessee with instructions on how to properly use the IID. The instructions shall include recommending a 15-minute waiting period between the last drink of an alcoholic beverage and the time of breath sample delivery into the IID.

158.9(4) An IID utilized under these rules shall be installed and removed by the manufacturer or the ASP in conformance with the prescribed procedures of the manufacturer.

158.9(5) The department of public safety reserves the right to inspect any IID, manufacturer, or ASP at any time at the department's discretion. All records of IIDs installed, results of calibrations, violations, data logs, and results of known alcohol standards shall be made available for inspection upon request to any representatives of the department of public safety, the department of transportation, or any peace officer.

[**ARC 7887B**, IAB 7/1/09, effective 10/1/09]

These rules are intended to implement Iowa Code chapter 321J.

[Filed ARC 7887B (Notice ARC 7566B, IAB 2/11/09), IAB 7/1/09, effective 10/1/09]

CHAPTERS 159 to 173
Reserved

CHAPTER 1
ADMISSION RULES COMMON TO THE THREE STATE UNIVERSITIES

[Prior to 4/20/88, Regents, Board of[720]]

Preamble: The state board of regents has adopted the following requirements governing admission of students to the three state universities.

Each university is expected to describe in its catalog the requirements and other information necessary to make the admission process operate within the framework of these requirements.

Amendments and changes in these requirements normally are proposed by the universities to the regent committee on educational relations which examines the proposals and makes specific recommendations through the interinstitutional committee on educational coordination to the state board of regents which is empowered by law to establish the admission requirements.

681—1.1(262) Admission of undergraduate students directly from high school. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

1.1(1) Application. Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(18) and detailed in rule 681—1.7(262), and have their secondary school provide a transcript of their academic record, including credits and grades, rank in class, and certification of graduation. Applicants must also submit SAT Reasoning Test or ACT scores. Applicants whose primary language is not English must also meet the English language proficiency requirement specified by each university. Applicants may be required to submit additional information or data to support their applications.

1.1(2) Admission criteria.

a. Effective for students who seek admission prior to fall 2009. Graduates of approved Iowa high schools who have the subject matter background required by each university and who rank in the upper one-half of their graduating class will be admitted to any regent university. Applicants who are not in the upper one-half of their graduating class may, after an individual review of their academic and test records, and at the discretion of the admissions officers:

(1) Be admitted unconditionally,

(2) Be admitted conditionally,

(3) Be required to enroll for a tryout period during a preceding summer session, or

(4) Be denied admission.

b. Effective for students who seek admission in fall 2009 and thereafter.

(1) Decisions on admission to a regent university are based on the following four factors: performance on standardized tests (SAT Reasoning Test or ACT); high school grade point average (GPA); high school percentile rank in class; and number of high school courses completed in the core subject areas. These factors are used in the following equation to calculate a regent admission index (RAI):

RAI = (2 × ACT composite score) + (1 × high school rank expressed as a percentile) + (20 × high school grade point average) + (5 × number of high school courses completed in the core subject areas)

NOTE: For purposes of calculating the regent admission index, the ACT composite score has a top value of 36 (SAT scores will be converted to ACT composite equivalents); high school rank is expressed as a percentile with 99 percent as the top value; high school GPA is expressed in a four-point scale; and number of high school courses completed in the core subject areas is expressed in terms of years or fractions of years of study.

(2) Graduates of approved Iowa high schools who have the subject matter background required by each university and who meet the regent admission index of 245 required for automatic admission will be admitted to any regent university. Applicants who do not meet the regent admission index of 245 for automatic admission or for whom a regent admission index cannot be calculated may, after an individual review of their academic and test records, and at the discretion of the admissions officers:

1. Be admitted unconditionally,
2. Be admitted conditionally,
3. Be required to enroll for a tryout period during a preceding summer session, or
4. Be denied admission.

1.1(3) Graduates of approved high schools in other states may be held to higher academic standards, but must meet at least the same requirements as graduates of Iowa high schools. The options for conditional admission or summer tryout enrollment may not necessarily be offered to these students.

1.1(4) Applicants who are graduates of nonapproved high schools will be considered for admission in a manner similar to applicants from approved high schools, but additional emphasis will be given to scores obtained on standardized examinations.

1.1(5) Applicants who are not high school graduates, but whose classes have graduated, may be considered for admission. These applicants will be required to submit all academic data to the extent that it exists and achieve scores on standardized examinations which will demonstrate that they are adequately prepared for academic study.

1.1(6) Early admission.

a. Students with superior academic records may be admitted, on an individual basis, for part-time university study while enrolled in high school or during the summers prior to high school graduation.

b. In rare situations, exceptional students may be admitted as full-time students to a regent university before completing high school. Early admission to a regent university is provided to serve persons whose academic achievement and personal and intellectual maturity clearly suggest readiness for collegiate level study. Each university will specify requirements and conditions for early admission.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.2(262) Admission of undergraduate students by transfer from other colleges. Students desiring admission to the University of Iowa, Iowa State University, or the University of Northern Iowa must meet the requirements in this rule and also any special requirements for the curriculum, school, or college of their choice.

Applicants must submit a formal application for admission, together with the appropriate application fee as approved by the state board of regents pursuant to Iowa Code subsection 262.9(18) and detailed in rule 681—1.7(262), and request that each college they have attended send an official transcript of record to the admissions office. High school academic records and standardized test results may also be required. The Test of English as a Foreign Language (TOEFL) is required of foreign students whose first language is not English.

1.2(1) Transfer applicants with a minimum of 24 semester hours of graded credit from regionally accredited colleges or universities, who have achieved for all college work previously attempted the grade point required by each university for specific programs, will be admitted. Higher academic standards may be required of students who are not residents of Iowa.

Applicants who have not maintained the grade point required by each university for specific programs or who are under academic suspension from the last college attended may, after a review of their academic and test records, and at the discretion of the admissions officers:

a. Be admitted unconditionally,
b. Be admitted conditionally,
c. Be required to enroll for a tryout period during a preceding summer session, or
d. Be denied admission.

1.2(2) Admission of students with fewer than 24 semester hours of college credit will be based on high school academic and standardized test records in addition to review of the college record.

1.2(3) Transfer applicants under disciplinary suspension will not be considered for admission until information concerning the reason for the suspension has been received from the college assigning the suspension. Applicants granted admission under these circumstances will be admitted on probation.

1.2(4) Transfer applicants from colleges and universities not regionally accredited will be considered for admission on an individual basis taking into account all available academic information.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.3(262) Transfer credit practices. The regent universities endorse the Joint Statement on Transfer and Award of Academic Credit approved in 1978 by the American Council on Education (ACE), the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and the Council on Postsecondary Accreditation (COPA). The current issue of Transfer Credit Practices of Selected Educational Institutions, published by the American Association of Collegiate Registrars and Admissions Officers (AACRAO), and publications of the Council on Postsecondary Accreditation (COPA) are examples of references used by the universities in determining transfer credit. The acceptance and use of transfer credit is subject to limitations in accordance with the educational policies operative at each university.

1.3(1) *Students from regionally accredited colleges and universities.* Credit earned at regionally accredited colleges and universities is acceptable for transfer except that credit in courses determined by the receiving university to be of a remedial, vocational, or technical nature, or credit in courses or programs in which the institution granting the credit is not directly involved, may not be accepted, or may be accepted to a limited extent.

Of the coursework earned at a two-year college, students may apply up to one-half but no more than 65 hours of the credits required for a bachelor's degree toward that degree at a regent university. This policy becomes effective September 29, 1993.

1.3(2) *Students from colleges and universities which have candidate status.* Credit earned at colleges and universities which have become candidates for accreditation by a regional association is acceptable for transfer in a manner similar to that from regionally accredited colleges and universities if the credit is applicable to the bachelor's degree at the receiving university.

Credit earned at the junior and senior classification from an accredited two-year college which has received approval by a regional accrediting association for change to a four-year college may be accepted by a regent university.

1.3(3) *Students from colleges and universities not regionally accredited.* When students are admitted from colleges and universities not regionally accredited, they may validate portions or all of their transfer credit by satisfactory academic study in residence, or by examination. Each university will specify the amount of the transfer credit and the terms of the validation process at the time of admission.

In determining the acceptability of transfer credit from private colleges in Iowa which do not have regional accreditation, the regent committee on educational relations, upon request from the institutions, evaluates the nature and standards of the academic program, faculty, student records, library, and laboratories.

In determining the acceptability of transfer credit from colleges in states other than Iowa which are not regionally accredited, acceptance practices indicated in the current issue of Transfer Credit Practices of Selected Educational Institutions will be used as a guide. For institutions not listed in the publication, guidance is requested from the designated reporting institution of the appropriate state.

1.3(4) *Students from foreign colleges and universities.* Transfer credit from foreign educational institutions may be granted after a determination of the type of institution involved and after an evaluation of the content, level, and comparability of the study to courses and programs at the receiving university. Credit may be granted in specific courses, but is frequently assigned to general areas of study. Extensive use is made of professional journals and references which describe the education systems and programs of individual countries.

This rule is intended to implement Iowa Code section 262.9(3).

681—1.4(262) Classification of residents and nonresidents for admission, tuition, and fee purposes.

1.4(1) *General.*

a. A person enrolling at one of the three state universities shall be classified as a resident or nonresident for admission, tuition, and fee purposes by the registrar or someone designated by the registrar. The decision shall be based upon information furnished by the student and other relevant information.

b. In determining resident or nonresident classification, the issue is essentially one of why the person is in the state of Iowa. If the person is in the state primarily for educational purposes, that person

will be considered a nonresident. For example, it may be possible that an individual could qualify as a resident of Iowa for such purposes as voting, or holding an Iowa driver's license, and not meet the residency requirements as established by the board of regents for admission, tuition, and fee purposes.

c. The registrar, or designated person, is authorized to require written documents, affidavits, verifications, or other evidence deemed necessary to determine why a student is in Iowa. The burden of establishing that a student is in Iowa for other than educational purposes is upon the student.

A student may be required to file any or all of the following:

(1) A statement from the student describing employment and expected sources of support;

(2) A statement from the student's employer;

(3) A statement from the student's parents verifying nonsupport and the fact that the student was not listed as a dependent on tax returns for the past year and will not be so listed in future years;

(4) A statement from the student's spouse related to sources of family support, length of residence in Iowa, and reasons for being in the state of Iowa;

(5) Supporting statements from persons who might be familiar with the family situation;

(6) Iowa state income tax return.

d. Applications for resident classification for a given semester or session are due no later than the fifteenth class day of that semester or session. Applications received after the fifteenth class day of that semester or session will be considered for the next semester or session. Appeals of any nonresident classification decision resulting from applications for resident classifications are due no later than midterm of that semester or session. Change of classification from nonresident to resident will not be made retroactive beyond the term in which application for resident classification is made.

e. A student who gives incorrect or misleading information to evade payment of nonresident fees shall be subject to serious disciplinary action and must also pay the nonresident fees for each term previously attended.

f. Review committee. These regulations shall be administered by the registrar or someone designated by the registrar. The decision of the registrar or designated person may be appealed to a university review committee. The decision of the review committee may be appealed to the state board of regents.

1.4(2) *Guidelines.*

a. The following general guidelines are used in determining the resident classification of a student for admission, tuition, and fee purposes:

(1) A financially dependent student whose parents move from Iowa after the student is enrolled remains a resident provided the student maintains continuous enrollment. A financially dependent student whose parents move from Iowa during the senior year of high school will be considered a resident provided the student has not established domicile in another state.

(2) In deciding why a person is in the state of Iowa, the person's domicile will be considered. A person who comes to Iowa from another state and enrolls in any institution of postsecondary education for a full program or substantially a full program shall be presumed to have come to Iowa primarily for educational reasons rather than to establish a domicile in Iowa.

(3) A student who was a former resident of Iowa may continue to be considered a resident provided absence from the state was for a period of less than 12 months and provided domicile is reestablished. If the absence from the state is for a period exceeding 12 months, a student may be considered a resident if evidence can be presented showing that the student has long-term ties to Iowa and reestablishes an Iowa domicile.

A person or the dependent of a person whose domicile is permanently established in Iowa, who has been classified as a resident for admission, tuition, and fee purposes, may continue to be classified as a resident so long as domicile is maintained, even though circumstances may require extended absence of the person from the state. It is required that a person who claims Iowa domicile while living in another state or country will provide proof of the continual Iowa domicile as evidence that the person:

1. Has not acquired a domicile in another state,
2. Has maintained a continuous voting record in Iowa, and
3. Has filed regular Iowa resident income tax returns during absence from the state.

(4) A student who moves to Iowa may be eligible for resident classification at the next registration following 12 consecutive months in the state provided the student is not enrolled as more than a half-time student (6 credits for an undergraduate or professional student, 5 credits for a graduate student) in any academic year term, is not enrolled for more than 4 credits in a summer term for any classification, and provides sufficient evidence of the establishment of an Iowa domicile.

(5) A student who has been a continuous student and whose parents move to Iowa may become a resident at the beginning of the next term provided the student is dependent upon the parents for a majority of financial assistance.

(6) A person who has been certified as a refugee or granted asylum by the appropriate agency of the United States who enrolls as a student at a university governed by the Iowa state board of regents may be accorded immediate resident status for admission, tuition, and fee purposes when the person:

1. Comes directly to the state of Iowa from a refugee facility or port of debarkation, or
2. Comes to the state of Iowa within a reasonable time and has not established domicile in another state.

Any refugee or individual granted asylum not meeting these standards will be presumed to be a nonresident for admission, tuition, and fee purposes and thus subject to the usual method of proof of establishment of Iowa residency.

(7) An alien who has immigrant status establishes Iowa residency in the same manner as a United States citizen.

(8) At the regent institutions, American Indians who have origins in any of the original people of North America and who maintain a cultural identification through tribal affiliation or community recognition with one or more of the tribes or nations connected historically with the present state of Iowa, including the Iowa, Kickapoo, Menominee, Miami, Missouri, Ojibwa (Chippewa), Omaha, Otoe, Ottawa (Odawa), Potawatomi, Sac and Fox (Sauk, Meskwaki), Sioux, and Winnebago (Ho Chunk), will be assessed Iowa resident tuition and fees.

b. Additional guidelines are used in determining the resident classification of a veteran, qualified military person, and dependent children and spouses of a veteran or qualified military person for purposes of admission and undergraduate tuition and mandatory fees:

(1) A person who is stationed on active duty at the Rock Island arsenal as a result of military orders, or the dependent child or spouse of such person, is entitled to resident status for purposes of undergraduate tuition and mandatory fees. However, if the arrival of the person under orders is subsequent to the beginning of the term in which the dependent child or spouse is first enrolled, nonresident fees will be charged in all cases for the dependent child or spouse until the beginning of the next term in which the dependent child or spouse is enrolled. If the qualified military person is transferred, deployed, or restationed while the person's spouse or dependent child is enrolled in an institution of higher education under the control of the board of regents, the spouse or dependent child shall continue to be classified as a resident under this subparagraph until the close of the fiscal year in which the spouse or dependent child is enrolled.

(2) A veteran who is domiciled or moves to the state of Iowa and who is eligible for benefits, or has exhausted benefits under the federal Post-9/11 Veterans Educational Assistance Act of 2008, is entitled to resident status for purposes of undergraduate tuition and mandatory fees. The dependent child or spouse of a veteran who meets these requirements is entitled to resident status for undergraduate tuition. However, if the arrival of the veteran in Iowa is subsequent to the beginning of the term in which the dependent child or spouse is first enrolled, nonresident fees will be charged in all cases for the dependent child or spouse until the beginning of the next term in which the dependent child or spouse is enrolled.

(3) A person who is moved into the state as the result of military or civil orders from the government for other than educational purposes, or the dependent child or spouse of such a person, is entitled to resident status. However, if the arrival of the person under orders is subsequent to the beginning of the term in which the dependent child or spouse is first enrolled, nonresident fees will be charged in all cases until the beginning of the next term in which the dependent child or spouse is enrolled. Legislation, effective July 1, 1977, requires that military personnel who claim residency in Iowa (home of record) will be required to file Iowa resident income tax returns.

1.4(3) *Facts.*

a. The following circumstances, although not necessarily conclusive, have probative value in support of a claim for resident classification:

(1) Reside in Iowa for 12 consecutive months, and be primarily engaged in activities other than those of a full-time student, immediately prior to the beginning of the term for which resident classification is sought.

(2) Reliance upon Iowa resources for financial support.

(3) Domicile in Iowa of persons legally responsible for the student.

(4) Former domicile in the state and maintenance of significant connections therein while absent.

(5) Acceptance of an offer of permanent employment in Iowa.

(6) Military orders, if for other than educational purposes.

(7) Other facts indicating the student's domicile will be considered by the universities in classifying the student.

b. The following circumstances, standing alone, do not constitute sufficient evidence of domicile to effect classification of a student as a resident under these regulations:

(1) Voting or registration for voting.

(2) Employment in any position normally filled by a student.

(3) The lease of living quarters.

(4) Admission to a licensed practicing profession in Iowa.

(5) Automobile registration.

(6) Public records, for example, birth and marriage records, Iowa driver's license.

(7) Continuous presence in Iowa during periods when not enrolled in school.

(8) Ownership of property in Iowa, or the payment of Iowa taxes.

This rule is intended to implement Iowa Code section 262.9(3).

[**ARC 7911B**, IAB 7/1/09, effective 7/1/09]

681—1.5(262) Registration and transcripts—general. A person may not be permitted to register for a course or courses at a state board of regents institution until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

A state board of regents institution may withhold official transcripts of the academic record of a person until any delinquent accounts owed by the person to an institution or any affiliated organization for which an institution acts as fiscal agent have been paid.

This rule is intended to implement Iowa Code section 262.9.

681—1.6(262) College-bound program.

1.6(1) *Definitions.*

"Accredited private institution" means an institution of higher education as defined in Iowa Code section 261.9, subsection 5.

"Commission" means the college aid commission.

"Financial need" means the difference between the student's financial resources, including resources available from the student's parents and the student, as determined by a completed parents' financial statement and including any non-campus-administered federal or state grants and scholarships, and the student's estimated expenses while attending the institution. A student shall accept all available federal and state grants and scholarships before being considered eligible for grants under the Iowa minority academic grants for economic success program. Financial need shall be reconsidered on at least an annual basis.

"Full-time student" means an individual who is enrolled at an accredited private institution or board of regents university for at least 12 semester hours or the trimester or quarter equivalent.

"Minority person" means an individual who is black, Hispanic, Asian, or a Pacific Islander, American Indian, or an Alaskan Native American.

"Part-time student" means an individual who is enrolled at an accredited private institution or board of regents university in a course of study including at least three semester hours or the trimester or quarter equivalent of three semester hours.

"Program" means the Iowa minority academic grants for economic success program established in this division.

1.6(2) *Policy on college-bound program.*

a. The regent institutions will cooperate with other state and local agencies, including the department of education, the college aid commission, and educational institutions in implementing the college-bound program.

b. The universities will develop programs for elementary, middle and secondary school students and their families in the following areas:

(1) Encouragement to consider attending a postsecondary institution;

(2) Enrichment and academic preparation;

(3) Information about how to apply for admission.

c. College-bound program vouchers will be awarded to students on the basis of the participation of the student and the student's family in the college-bound program. One voucher will be awarded for participation in each college-bound program sponsored by a university.

(1) Each university will maintain records concerning those students who participate in the college-bound program, according to its established policies and procedures. The records will include information on those students who have received college-bound program vouchers which are described in Iowa Code section 262.92(2). The University of Iowa will maintain a central record on all students who have received college-bound program vouchers on behalf of all regent institutions and will make appropriate information available to the college aid commission.

(2) College-bound program vouchers may be used by students enrolled at a regent institution or at a private college or university in Iowa.

(3) A student holding vouchers and enrolling at a regent institution will receive priority in the award of funds under the Iowa minority academic grants for economic success (IMAGES) program. Awards under the IMAGES program are made on the basis of financial need. A student may be eligible for an additional award from the institution in which the student is enrolled.

(4) A student holding vouchers and enrolling at a private college or university in Iowa will receive priority in the award of funds under the Iowa minority academic grants for economic success program as provided by the rules of the college aid commission.

(5) The presidents, or their designees, will administer and coordinate the college-bound program at the universities. As part of the coordination, they will establish liaison with the appropriate state and local agencies, serve as the university contact and promote collaborative efforts among the regent universities and other appropriate agencies and institutions. Annual reports to the board of regents shall be prepared by each regent university. The reports shall contain relevant information as to the accomplishments of the program in the past year and a plan of action with goals and objectives for the forthcoming year. Reports shall be submitted to the board of regents on October 1 of each year.

This rule is intended to implement Iowa Code section 262.92.

681—1.7(262) Application fees. Application fees required for admission to the University of Iowa, Iowa State University and the University of Northern Iowa are as follows:

University of Iowa

Undergraduate domestic student	$40
Undergraduate international student	$60
Graduate/professional domestic student	$60
Graduate/professional international student	$85
PharmD student	$100
Re-entry fee	$20

Iowa State University

Undergraduate domestic student	$30
Undergraduate international student	$50
Graduate domestic student	$30
Graduate international student	$70
Veterinary Medicine	$60

University of Northern Iowa

Undergraduate domestic student	$40
Undergraduate international student	$50
Graduate domestic student	$30
Graduate international student	$50

This rule is intended to implement Iowa Code section 262.9(3).

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CHAPTER 4
TRAFFIC AND PARKING AT UNIVERSITIES

[Prior to 4/20/88, Regents, Board of[720]]

UNIVERSITY OF IOWA

681—4.1(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of traffic and of parking vehicles on the campus of the state University of Iowa.

681—4.2(262) Definitions. For the purpose of these rules, the following definitions shall apply unless the context clearly requires otherwise, and all other words shall have meaning according to their common usage.

"Bicycle" means any wheeled vehicle which is not self-propelled and which is designed to be pedaled by the rider.

"Director" means the director of parking and transportation at the university or any other person designated by the president of the university to perform any function or duty of the director hereunder.

"Employee" means any person regularly employed by the university who is not a student.

"Handrail" is any railing intended to provide physical support to a pedestrian.

"Immobilization" of a bicycle consists of restricting the bicycle's use by detaining it at the point of infraction with a university locking device.

"Impoundment of a bicycle" consists of removing the owner's locking device, transporting the bicycle to a university facility, and detaining it with a university locking device.

"In-line skates" means shoes which are attached to multiple wheels for the purpose of individual transportation.

"Motorcycle" means any vehicle which is self-propelled and has less than four wheels in contact with the ground.

"Motor vehicle" means any vehicle which is self-propelled and has four or more wheels in contact with the ground.

"Roller skates" means shoes which are attached to multiple wheels for the purpose of individual transportation.

"Skateboards" means any board or platform with attached wheels used for individual transportation.

"Street furniture" is any structure or accessory in a university pedestrian area or slow zone designed for the benefit of pedestrians. This includes, but is not limited to, benches, tables, lampposts, and trash receptacles.

"Student" means any person registered with the university for academic credit who is not employed by the university on a full-time salaried or equivalent basis.

"University" means the state University of Iowa.

"Vehicle" means any wheeled or treaded device used or designed for use as a means of transportation or conveyance of persons or property.

"Visitor" means any person who owns, operates or parks a vehicle on the university campus who is not a student or an employee.

681—4.3(262) General traffic.

4.3(1) The director shall establish such rules governing the safe operation of all vehicles, including motor vehicles, motorcycles, skateboards, in-line skates, roller skates and bicycles as the director deems necessary. Such traffic rules shall be available for inspection during business hours at the office of the director and the state board of regents. Such traffic violations may also be charged and prosecuted as violations of Iowa Code chapter 321 and Iowa Code section 262.68.

4.3(2) The director shall erect speed limit signs in conformity with maps of the institutional roads and property of the university designating such speed limits as adopted by the state board of regents. The maps will be available for inspection during business hours at the office of the director and the state board of regents.

4.3(3) The director is delegated authority to make temporary changes in traffic patterns, including establishment of one-way roads and road closures, where necessary because of construction or special events being held on university property.

4.3(4) The director is delegated authority to erect traffic control signs and devices, and to designate pedestrian crosswalks and bicycle lanes, as well as no bicycling and no skateboard, in-line skating and roller skating areas, bicycle dismount zones and pedestrian-only areas.

4.3(5) Pedestrians shall be given the right-of-way at all crosswalks or when in compliance with existing traffic controls.

4.3(6) Driving of vehicles, motor vehicles, and motorcycles on university property other than roads is prohibited, unless specific areas have been designated for such use by the director or special permission has been granted by the director for emergency conditions.

4.3(7) Driving of vehicles, motor vehicles, and motorcycles on parts of institutional roads marked as bicycle lanes is prohibited.

4.3(8) The director is delegated authority to have the university public safety department investigate accidents which occur on university property.

681—4.4(262) Registration. Motor vehicles and motorcycles shall be registered as follows:

4.4(1) *Students.* Every motor vehicle and motorcycle which is operated or maintained by a student on campus must be registered with the university and a registration decal must be displayed on the vehicle in the manner prescribed by the director. Any student who operates or maintains a motor vehicle or motorcycle on campus or who owns a vehicle which is so operated or maintained is responsible for the proper registration of such vehicle and the display of the registration decal thereon.

4.4(2) *Employees.* Motor vehicles and motorcycles owned or operated by employees may be registered with the university if the employee so desires, but registration of such vehicles is not required unless the employee is granted parking privileges on the campus. A registration decal may be issued for display on vehicles registered by employees.

4.4(3) *Procedure.* Applications for registration shall be submitted to the director in the manner the director prescribes. No student shall register any vehicle owned or actually maintained by another student. No fee shall be charged for registration without parking privileges.

4.4(4) *Bicycles.* Bicycle registration is optional.

a. To register a bicycle with the university, a current registration form is to be filled out at the parking and transportation offices. Required information includes current name of owner, address, social security number, description of the bicycle, and the bicycle manufacturer's identification number. Proof of name and address is required. Once the registration form is completed, a decal will be issued.

b. Bicycles may also be registered with the cities of Iowa City and Coralville. If these registrations are current and the decal is affixed to the bicycle, the university will accept them in lieu of a university registration.

c. Placement of registration decal. The registration process is completed when the registration decal is permanently and visibly affixed to the down- or seat-tube on the bicycle.

d. An official university bicycle registration decal is valid if the address and ownership given on the registration form are current. Change in ownership of a bicycle must be reported to the parking and transportation office. Proof of change in ownership is required.

681—4.5(262) Parking facilities. The director may set aside and designate certain areas of the university property for the parking of motor vehicles, motorcycles, and bicycles, and the use of any lot, ramp, or part of the parking facilities so established may be restricted to students, employees, or visitors. The director shall cause signs to be erected and maintained clearly identifying those areas of the university campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.5(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.5(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.5(3) *Hours of operation.* Reasonable hours shall be established by the director for the normal operation of the parking facilities and a schedule of hours of operation shall be published and available for public inspection in the office of the director.

4.5(4) *Closing.* The director may temporarily close any parking facility for cleaning, maintenance or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The director shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical.

4.5(5) *Restricted zones.* The director may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and such restricted zones shall be conspicuously posted. No parking shall be permitted in such restricted zones except as authorized.

4.5(6) *No parking.* Motor vehicle and motorcycle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls. No parking is permitted in prohibited zones, such as in the vicinity of fire hydrants or fire lanes, and such zones shall be conspicuously posted or marked by painted curbs or other standard means. No parking is permitted on grass or other vegetation or in pedestrian areas.

4.5(7) *Motorcycle parking.* The director may designate areas of the parking facilities for motorcycle parking, and such areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in such areas.

4.5(8) *Bicycle parking.* The director may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking.

4.5(9) *Violations.* Bicycles attached to, or rested against, trees, shrubs, handrails, handicapped parking meters, or limiting access to, or use of, any university facility may be impounded, the owners fined, or both. Bicycles parked inside a university building which is not designated for bicycle parking may be impounded or the owners fined, or both. Bicycles bearing proper registration decals which are attached to, or rested against, street furniture may be ticketed or immobilized and the owners fined. If the bicycles interfere with the use of the furniture, they may be impounded. Bicycles considered abandoned may be labeled for impending impoundment by placing impoundment tags on the bicycles. If the bicycles display the proper registration decals, an attempt will be made to contact the owners to remove the bicycles. If the bicycles do not display the proper registration decals, the owners have two weeks to contact the parking and transportation office from the time the bicycles are tagged until the bicycles may be impounded.

681—4.6(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon such other reasonable terms and conditions as may be established by the university.

4.6(1) *Students.* Students may be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of the student's residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.6(2) *Employees.* Employees may be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.6(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as determined by the director. Reasonable classifications may be established on the basis of the time, duration or purpose of the visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.6(4) *Procedure.* Applications for parking privileges shall be submitted to the director in the manner the director prescribes. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The director shall determine the eligibility and priority of each applicant for parking privileges within the classifications established in 4.6(1), 4.6(2) and 4.6(3) and shall make all parking assignments. A parking decal or other means of identification may be issued to each applicant who is granted parking privileges, and such decal or other identification must be displayed on the vehicle in the manner prescribed by the director. Parking privileges shall not be granted to a student and to an employee for the same vehicle, and a student parking decal and an employee parking decal shall not be displayed on the same vehicle.

4.6(5) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of such fees and charges shall be established by the university and approved by the state board of regents, and a schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the director and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.6(6) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by the director.

4.6(7) *Responsibility.* Any person who owns or operates a vehicle which is parked on the campus or in whose name the vehicle is registered or to whom parking privileges have been granted is responsible for the proper parking of the vehicle at all times when it is on the campus and for all parking violations involving the vehicle.

4.6(8) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of such facilities or a bailment of the vehicle by the university. Use of university parking facilities is at the owner's or visitor's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.6(9) *Revocation.* Parking privileges on the campus may be revoked by the university for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.7(262) Violations. Sanctions may be imposed for violation of traffic, registration and parking rules as follows:

4.7(1) *Notice of violations.* The university shall give written notice of all parking violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and such notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.7(2) *Sanctions.* Reasonable monetary sanctions may be imposed upon students, employees, and visitors for violation of university traffic, vehicle registration or parking rules. The amount of such sanctions, not to exceed $50 for each offense, shall be established by the university and approved by the state board of regents except sanctions established by statute will be imposed at the current statutory amount. A schedule of all sanctions for traffic violations, improper registration and parking shall be published and available for public inspection during normal business hours in the office of the director and in the office of the state board of regents. Traffic, registration, and parking sanctions may be

assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and charged to the person's university account. Registration and parking sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.7(3) *Impoundment and immobilization.* Any vehicle parked on the campus in violation of parking rules may be impounded, removed or immobilized. The university shall give written notice of impoundment to the owner of the vehicle or to the person in whose name the vehicle is registered or parking privileges have been granted. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold under procedures set forth in Iowa Code chapter 579 and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage and sale. The balance, if any, shall be sent to the owner.

a. Immobilization. Immobilized bicycles bearing proper registration decals may be claimed by proving ownership and payment of immobilization fees and any fines. Immobilized bicycles not bearing proper registration decals may be claimed by proving ownership, registering the bicycle under a valid name and address, and paying the appropriate fines and immobilization fees. Immobilization fees for first-time offenders may be waived after immobilized bicycles have been registered. Immobilized bicycles not reclaimed after two working days may be impounded.

b. Impoundment. Impounded bicycles bearing proper registration may be claimed by proving ownership and paying the impoundment fees and any fines. Impounded bicycles not bearing proper registration decals may be claimed by proving ownership, registering the bicycles under a valid name and address, and paying the appropriate fines and impoundment fees. Impoundment fees for first-time offenders may be waived after impounded bicycles have been registered. All impounded bicycles will be held for 60 days, during which time they may be claimed by the owners upon payment of all outstanding fines and charges. After 60 days, all unclaimed impounded bicycles will be deemed abandoned property and sold pursuant to Iowa law, and the proceeds applied to the costs of impoundment, storage, and sale. The balance, if any, shall be sent to the owner, if known.

4.7(4) *Administrative hearing.* Students and employees may request a hearing and administrative ruling concerning a controversy, based on the imposition of a sanction for a registration or parking violation, or an impoundment procedure, by the appropriate hearing body as set forth in the motor vehicle and bicycle regulations published by the university. Visitors may request the director to conduct a hearing and issue an administrative ruling in such cases.

681—4.8(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of presidential duties hereunder, and any procedure so established shall be published and available for public inspection during normal business hours in the office of the director and in the office of the state board of regents. The president may delegate presidential authority under these rules to the director or to any other person designated by the president to perform any function or duty hereunder.

681—4.9 to **4.24** Reserved.

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IOWA STATE UNIVERSITY OF SCIENCE AND TECHNOLOGY

681—4.25(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of traffic and of parking vehicles on the campus of Iowa State University.

681—4.26(262) Definitions. For the purposes of these rules, the following definitions shall apply unless the context requires otherwise, and all other words shall have meaning according to their common usage.

"Bicycle" means any vehicle which is not self-propelled and which is designed to be pedaled by the rider. Any bicycle equipped with a motor is considered a motorcycle and subject to the traffic and parking regulations for motorcycles.

"Campus" means all property under the control of the university.

"Employee" means any person regularly employed by the university who is not a student.

"Manager" means the person(s) designated by the president of the university to perform any function or duty of the manager hereunder. At Iowa State University, that person is the director of public safety, who further delegates the duties and responsibilities to the manager of the parking division within the university's department of public safety.

"Motorcycle" or *"moped"* means any vehicle which is self-propelled and has less than four wheels in contact with the ground. For purposes of these rules, a moped is considered a motorcycle.

"Motor vehicle" means any vehicle which is self-propelled and has four or more wheels in contact with the ground.

"Roller blades" means any frame or shoe with a single row of wheels that is used for gliding or skating. Roller blades are also known as in-line skates.

"Roller skates" means any frame or shoe with a pair of small wheels near the heel and near the toe that is used for gliding or skating.

"Skateboard" means a board with small wheels that is usually ridden by a person. For purposes of these rules, a nonmotorized scooter (a board with a handle) is considered a skateboard.

"Student" means any person registered with the university for academic credit who is not employed by the university on a full-time salaried or equivalent basis.

"University" means Iowa State University of science and technology.

"Vehicle" means any wheeled or treaded device used or designed for use as a means of transportation or conveyance of persons or property.

"Visitor" means any person who owns, operates or parks a vehicle on the university campus who is neither a student nor an employee.

681—4.27(262) General traffic.

4.27(1) These rules shall not apply to moving traffic violations on institutional roads and property of the university. Such violations will be charged and prosecuted as violations of Iowa Code chapters 262 and 321. All state of Iowa motor vehicle laws are in effect on campus.

4.27(2) The manager shall erect speed limit signs in conformity with maps of the institutional roads and property of the university designating such speed limits as adopted by the board of regents, state of Iowa. The maps will be available for inspection during business hours at the office of the manager and the board of regents, state of Iowa.

4.27(3) The manager is delegated authority to make temporary changes in traffic patterns, including establishment of one-way roads and road closures, where necessary because of construction or special events being held on campus.

4.27(4) The manager is delegated authority to erect traffic control signs and devices, and to designate pedestrian crosswalks and bicycle lanes. All vehicle operators must obey all signs directing traffic flow on campus.

4.27(5) Pedestrians shall be given the right-of-way at all crosswalks or when in compliance with existing traffic controls.

4.27(6) Driving of vehicles, motor vehicles, and motorcycles on university property other than roads is prohibited, unless specific areas have been designated for this use by the manager or special permission has been granted by the manager for emergency conditions.

4.27(7) Driving of vehicles, motor vehicles, and motorcycles in parts of institutional roads marked as bicycle lanes or on designated bicycle paths is prohibited.

4.27(8) Every person riding a bicycle on a street or highway on campus is granted all the privileges and is subject to all the regulations applicable to a driver of any motor vehicle on that street or highway and to the special regulations of this subrule. A bicycle rider on campus must:

a. Obey the instructions of official traffic control devices, signs and signals applicable to motor vehicles, unless otherwise directed by a peace officer or other authorized traffic director;

b. Obey the direction of any sign whenever authorized signs are erected indicating that no right, left or U-turn is permitted;

c. Obey the regulations applicable to pedestrians when the bicycle rider dismounts from the bicycle;

d. Yield the right-of-way to all vehicles approaching on a street whenever a rider is on a separate bicycle path that intersects the street;

e. Not use campus sidewalks except those specifically designated as bicycle paths;

f. Yield the right-of-way to any pedestrian in a designated crosswalk;

g. Not ride on lawns.

This subrule does not apply to peace officers of the university's department of public safety while they are acting within the scope of their regularly assigned duties.

4.27(9) Roller skates, roller blades and skateboards are permitted on campus sidewalks. Roller skates, roller blades and skateboards are not permitted on or in university structures or buildings, on stairways, sub-walks, elevated sidewalks, access ramps, steps, retaining walls, handrails or other architectural elements, on or in planting, grass or seeded areas, or where otherwise prohibited by sign, peace officer or other authorized traffic director. Any person on roller skates, roller blades or a skateboard must yield the right-of-way to any wheelchair or other mobility assistance device for the disabled, pedestrian or bicycle.

681—4.28(262) Registration. Motor vehicles, motorcycles, mopeds and bicycles shall be registered as follows:

4.28(1) *Students.* Any student who operates, maintains or owns a vehicle on university property is responsible for the proper registration of the vehicle and the display of the registration identification thereon in the manner prescribed by the manager. A student must register the vehicle within 48 hours of initial operation of the vehicle on campus.

4.28(2) *Employees.* Vehicles owned or operated by employees may be registered with the university if the employee so desires, but registration of these vehicles is not required unless the employee desires parking privileges on the campus. A registration identification shall be displayed on vehicles registered by employees in the manner prescribed by the manager.

4.28(3) *Visitors.* Vehicles owned or operated by visitors may be registered with the university if the visitor so desires, but registration of these vehicles is not required unless the visitor desires parking privileges on campus. A registration identification shall be displayed on registered vehicles by visitors in the manner prescribed by the manager.

4.28(4) *Bicycles.* Any person who rides, parks or propels a bicycle on any university property must display a bicycle identification sticker issued by Iowa State University.

4.28(5) *Procedure.* Applications for registration shall be submitted in the manner prescribed by the manager. No student shall register any vehicle owned or actually maintained by another student.

681—4.29(262) Parking facilities. The manager may set aside and designate certain areas of the campus as parking facilities for vehicles and the use of any part of the parking facilities so established may be restricted to students, employees or visitors. The manager shall cause signs to be erected

and maintained clearly identifying those areas of the campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.29(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.29(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.29(3) *Hours of operation.* Reasonable hours shall be established for the normal operation of the parking facilities, and a schedule of hours of operation shall be published and available for public inspection in the office of the manager. Overnight parking is prohibited except in residence hall and vehicle storage parking facilities. Parking regulations remain in effect during semester breaks and seasonal holidays.

4.29(4) *Closing.* The manager may temporarily close any parking facility for cleaning, maintenance, or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The manager shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical. No parking fees will be refunded during the temporary closing of a parking facility.

4.29(5) *Restricted areas.* The manager is delegated authority to restrict access to campus streets, parking lots and other facilities by means of gates or other barriers. Streets or portions of streets may be closed to vehicle traffic or limited to specific vehicles. Access to restricted areas is limited to established gate openings or designated entrances, and no other means of access is permitted. Moving or driving around authorized barriers is prohibited.

4.29(6) *Restricted zones.* The manager may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and the restricted zones shall be conspicuously posted. No parking shall be permitted in restricted zones except as authorized.

4.29(7) *No parking.* Vehicle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus.

a. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls.

b. No parking is permitted in prohibited zones, such as in the vicinity of fire lanes, and these zones shall be conspicuously posted or marked by painted curbs or other standard means.

c. Motor vehicles are not allowed in university buildings except:

(1) Where a shop or garage is designated as a vehicle repair or storage area;

(2) Where there is a designated vehicle loading area; or

(3) Where there is a parking ramp or deck.

d. Illegal parking is parking in any place on campus other than those areas designated for parking.

e. Improper parking is parking incorrectly in designated parking areas. Improper parking includes, but is not limited to:

(1) Parking in an area restricted by signs;

(2) Parking without an appropriate permit;

(3) Parking in an area designated for persons with disabilities;

(4) Parking in a loading zone over the time limit; and

(5) Parking over a stall marker line.

4.29(8) *Motorcycle and moped parking.* The manager may designate areas of the parking facilities for motorcycle parking, and these areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in these areas. The university may require that a parking permit be displayed on all motorcycles and mopeds.

4.29(9) *Bicycle parking.* The manager may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking. Improperly or illegally parked and abandoned bicycles may be impounded. Locking devices may be cut and removed when necessary. Bicycles may not be taken inside university buildings except as approved by the manager.

681—4.30(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon reasonable terms and conditions as may be established by the manager. An application for parking privileges may be denied if the applicant has fines for parking violations that are unpaid and past the appeal date set by these rules.

4.30(1) *Students.* Students will be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.30(2) *Employees.* Employees will be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.30(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as established by the manager. Reasonable classifications may be established on the basis of the time, duration or purpose of visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.30(4) *Persons with disabilities.* Persons with disabilities will be granted parking privileges in parking facilities designated for use by persons with disabilities. Persons with disabilities may apply for special parking privileges for up to six months upon issuance of a letter by the director of student health service, or the director's designee; rehabilitation counselor, student counseling service; or by a personal physician, indicating the character, extent, probable duration of the disability, and certifying the need for special parking. After an initial six months, a faculty or staff member or a student must present a currently valid department of transportation parking permit for persons with disabilities to renew the campus permit. Parking facilities designated for persons with disabilities shall be so regulated all hours of all days.

4.30(5) *Procedure.* Applications for parking privileges shall be submitted in the manner prescribed by the manager. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The manager shall determine the eligibility and priority of each applicant for parking privileges within the classifications established in 4.30(1), 4.30(2) and 4.30(3) and shall make parking assignments. A parking permit will be issued to each applicant who is granted parking privileges, and the permit shall be displayed on the vehicle in the manner prescribed by the manager. Parking permits are not transferable. The unauthorized possession, use, alteration, forging or counterfeiting of a parking permit, or any portion thereof, is prohibited. Parking privileges will not be granted to a student and to an employee or visitor for the same vehicle, and a student parking permit and an employee or visitor parking permit shall not be displayed on the same vehicle. Temporary parking permits may be issued to accommodate special situations. The manager shall adopt a procedure to replace lost, stolen and destroyed parking permits and controlled access entry cards.

4.30(6) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of these fees and charges shall be approved by the state board of regents. A schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the manager and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, daily, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.30(7) *University business.* Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by the manager.

4.30(8) *Responsibility.* Any person who maintains, operates, or owns a vehicle which is on the campus or in whose name the vehicle is registered or parking privileges have been granted is responsible for the proper parking of the vehicle at all times and for all parking violations involving the vehicle.

4.30(9) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of the facilities or a bailment of the vehicle by the university. Use of university parking facilities is at the owner's or applicant's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.30(10) *Revocation.* Parking privileges on the campus may be revoked by the manager for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.31(262) Violations. Sanctions may be imposed for violation of these parking rules as follows:

4.31(1) *Notice of violations.* The university shall give written notice of all parking violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and the notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.31(2) *Sanction.* Reasonable monetary sanctions may be imposed for violation of these rules. The amount of the sanction approved by the board of regents, state of Iowa, is as follows:

Offenses	Sanctions for Each Offense
Altering, forging or counterfeiting any parking permit (4.30(5))	$150
Unauthorized possession and use of a parking permit (4.30(5))	$150
Failure to comply with signs regulating campus traffic flow (4.27(262))	$30
Driving on campus walks or lawns (4.27(6), 4.27(8))	$30
Driving on closed streets (4.27(3))	$30
Driving on bike paths (4.27(7))	$30
Access to restricted areas by means other than established gate openings (4.29(5))	$30
Moving or driving around a barricade (4.29(5))	$30
Improper use of gate card (4.29(262))	$20
Illegal parking (4.29(7))	$30
Improper parking (4.29(7))	$15
Overtime parking at meters (4.29(2))	$10
Parking without an appropriate permit in a reserved lot or space (4.29(262))	$25
Improper affixing or failure to display a permit (4.28(262))	$5
Failure to purchase a parking receipt (4.29(2))	$10
Improper parking in a space or stall designated for persons with disabilities (4.29(262), 4.30(4))	$100
Failure to display a current bicycle registration (4.28(4))	$5
Bicycle improperly parked (4.29(9))	$7.50
Improper use of roller skates, roller blades or skateboard (4.27(9))	$25
All other violations	$15

Violations that continue for more than one hour may receive additional sanctions.

Sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and may be charged to the violator's university account. Sanctions may be added to student tuition bills or

may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.31(3) *Impoundment.* Any vehicle parked on the campus in violation of these rules may be either impounded or removed, or both. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle by the university or by contract with private operators. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold under procedures set forth in Iowa Code chapter 579, and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage, sale, and amounts due the university. The balance, if any, shall be sent to the owner.

4.31(4) *Appeal of sanction or impoundment decisions.* A person may request a hearing and administrative ruling concerning a controversy, based on the imposition of a sanction for a registration or parking violation, or an impoundment procedure, by the appropriate university official or hearing body. A written request for a hearing and administrative ruling shall be made at the office of the university's department of public safety within ten business days of the imposition of the sanction. The manager is delegated the authority to establish a procedure, appoint an appropriate official or board, and to adopt forms and schedules to facilitate the provisions of this subrule.

4.31(5) *Judicial review.* Judicial review of an administrative ruling may be sought in an Iowa district court in accordance with the terms of the Iowa administrative procedure Act.

[**ARC 7904B**, IAB 7/1/09, effective 8/5/09]

681—4.32(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish traffic and parking procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of the duties hereunder, and any procedure so established shall be published and available for public inspection during the normal business hours in the office of the manager and the office of the board of regents, state of Iowa. The document in which such rules are published shall be known as the Department of Public Safety Parking Division Manual. The president may delegate the authority under these rules to the manager to perform any function or duty hereunder.

Rules 4.25(262) to 4.32(262) are intended to implement Iowa Code section 262.69.

681—4.33 to **4.65** Reserved.

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UNIVERSITY OF NORTHERN IOWA

681—4.66(262) Purpose. The purpose of these rules is to provide for the policing, control and regulation of parking of vehicles on the campus of the University of Northern Iowa.

681—4.67(262) Definitions. For the purpose of these rules, the following definitions shall apply unless the context clearly requires otherwise, and all other words shall have meaning according to their common usage.

"Bicycle" is any two-wheeled vehicle which is not self-propelled and which is designed to be pedaled by the rider.

"Committee" refers to the traffic and safety committee at the university.

"Employee" is any person regularly employed by the university who is not a student.

"Motorcycle" is any vehicle which is self-propelled and has less than four wheels in contact with the ground.

"Motor vehicle" is any vehicle which is self-propelled and has four or more wheels in contact with the ground.

"Student" is any person registered with the university for academic credit or for short courses or workshops for more than a one-week period.

"Supervisor" refers to the supervisor of security at the university or to any other person or persons designated by the president of the university to perform any function or duty of the supervisor hereunder.

"University" refers to the University of Northern Iowa, located in Cedar Falls, Iowa.

"Vehicle" is any wheeled device used or designed for use as a means of transportation or conveyance of persons or property.

"Visitor" is any person who owns, operates, or parks a vehicle on the university campus who is not a student or an employee.

681—4.68(262) Registration. Vehicles shall be registered as follows:

4.68(1) *Students.* Every motor vehicle and motorcycle which is operated or maintained by a student within Black Hawk County, Iowa, which may, at any time, use university parking facilities, must be registered with the university and a registration permit be displayed on the vehicle in the manner prescribed by the supervisor. Any student who operates or maintains a motor vehicle or motorcycle in Black Hawk County or who owns a vehicle which is so operated or maintained and which may, at any time, use university parking facilities, is responsible for the proper registration of such vehicle and the display of the registration permit thereon.

4.68(2) *Employees.* Motor vehicles and motorcycles owned or operated by employees may be registered with the university if the employee so desires, but registration of such vehicles is not required unless the employee desires parking privileges on the campus. A registration permit may be issued for display on vehicles registered by employees.

4.68(3) *Procedure.* Applications for registration shall be submitted to the supervisor in the manner prescribed by the supervisor. No student shall register any vehicle owned or actually maintained by another student.

681—4.69(262) Parking facilities. The university may set aside and designate certain areas of the campus for the parking of motor vehicles, motorcycles, and bicycles, and the use of any lot, ramp, or part of the parking facilities so established may be restricted to students, employees, or visitors. The supervisor shall cause signs to be erected and maintained clearly identifying those areas of the university campus designated for vehicle parking, and any restrictions applicable thereto shall be conspicuously posted.

4.69(1) *Parking control devices.* Gates and other devices may be installed and maintained to control access to any parking facility.

4.69(2) *Parking meters.* Parking meters, toll houses, and other devices may be installed and maintained to regulate the use of any parking facility.

4.69(3) *Hours of operation.* Reasonable hours shall be established for the normal operation of the parking facilities and a schedule of hours of operation shall be published and available for public inspection in the office of the supervisor.

4.69(4) *Closing.* The supervisor may temporarily close any parking facility for cleaning, maintenance, or other university purpose, or may temporarily restrict or reassign the use of any facility as may be necessary or convenient. The supervisor shall give advance notice of such temporary closing, restriction, or reassignment by posting or otherwise when practical.

4.69(5) *Restricted zones.* The supervisor and committee may designate areas of the campus as restricted zones, such as loading zones or service vehicle zones, and such restricted zones shall be conspicuously posted. No parking shall be permitted in such restricted zones except as authorized.

4.69(6) *No parking.* Vehicle parking on the campus shall be restricted to designated parking facilities, and no parking shall be permitted at any other place on the campus. Vehicles shall not be parked in such a manner as to block or obstruct sidewalks, crosswalks, driveways, roadways, or designated parking stalls. No parking is permitted in prohibited zones, such as in the vicinity of fire hydrants or fire lanes, and such zones shall be conspicuously posted or marked by painted curbs or other standard means.

4.69(7) *Motorcycle parking.* The supervisor and committee may designate areas of the parking facilities for motorcycle parking, and such areas shall be conspicuously posted. Motorcycles shall be parked only in areas designated for motorcycle parking, and no other vehicles shall be parked in such areas.

4.69(8) *Bicycle parking.* The supervisor and committee may install and maintain bicycle parking racks or designate other facilities for bicycle parking. Bicycles shall be parked only in bicycle racks or other facilities designated for bicycle parking.

681—4.70(262) Parking privileges. Students and employees may be granted parking privileges on the campus in accordance with these rules and upon such reasonable terms and conditions as may be established by the university.

4.70(1) *Students.* Students may be granted parking privileges in parking facilities designated for student use. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of a student's age, class, college or department, course load, proximity of the student's residence to the campus, physical disability, employment, the availability of facilities, or any other relevant criterion to determine the eligibility of students for parking privileges or any optional plan or facility.

4.70(2) *Employees.* Employees may be granted parking privileges in parking facilities designated for employee use. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of an employee's job classification, length of service, place of work or the nature thereof, physical disability, the availability of facilities, or any other relevant criterion to determine the priority of employees for assignment of parking privileges or any optional plan or facility.

4.70(3) *Visitors.* Visitors may be granted parking privileges in parking facilities designated for visitor parking. Optional plans and facilities may be offered as determined by the supervisor and committee. Reasonable classifications may be established on the basis of the time, duration or purpose of the visit, physical disability, the availability of facilities, or any other relevant criterion to determine the eligibility of visitors for parking privileges or any optional plan or facility.

4.70(4) *Procedure.* Applications for parking privileges shall be submitted to the supervisor in the manner the supervisor prescribes. No student shall apply for parking privileges for any vehicle owned or actually maintained by another student. The supervisor shall determine the eligibility and priority of each applicant for parking privileges and shall make all parking assignments. A parking permit or other means of identification may be issued to each applicant who is granted parking privileges, and such permit or other identification must be displayed on the vehicle in the manner prescribed by the supervisor.

4.70(5) *Parking fees.* The university may assess and collect from students, employees, and visitors reasonable fees or charges for parking privileges and the use of parking facilities. The amount of such fees and charges shall be established by the university and approved by the state board of regents, and a schedule of all parking fees and charges shall be published and available for inspection during normal business hours in the office of the director and in the office of the state board of regents. Parking fees and charges may be assessed and collected on an annual, semester, monthly, or hourly basis. Parking fees and charges may be added to student tuition bills and may by agreement be withheld from the salaries or wages of employees by payroll deduction. Parking fees and charges may be collected by means of

parking meters or toll houses. Use of any parking facility constitutes an implied agreement to pay the prescribed fee or charge therefor.

4.70(6) *University business* **.** Special parking privileges may be granted for vehicles being used on official university business on the conditions and in the manner prescribed by supervisor and committee.

4.70(7) *Responsibility.* Any person who owns or operates a vehicle which is parked on the campus or in whose name the vehicle is registered or parking privileges have been granted is responsible for the proper parking of the vehicle at all times when it is on the campus and for all parking violations involving the vehicle.

4.70(8) *Liability.* Parking privileges granted hereunder constitute a license to use university parking facilities and do not constitute a lease of such facilities or a bailment of the vehicle by the university. Use of the university parking facilities is at the owner's or applicant's risk, and the university shall not be liable or responsible for loss of or damage to any vehicle parked on the campus.

4.70(9) *Revocation.* Parking privileges on the campus may be revoked by the university for good cause at any time upon five days' written notice and refund of any advance payment of parking fees or charges on a pro rata basis for the revoked period.

681—4.71(262) Violations. Sanctions may be imposed for violation of registration and parking rules as follows:

4.71(1) *Notice* of *violations.* The university shall give written notice of all parking or registration violations. Such notice may be given by means of a notice of parking violation placed conspicuously on the offending vehicle, and such notice shall constitute constructive notice of the violation to the owner and operator of the vehicle and to any person in whose name the vehicle is registered or parking privileges have been granted.

4.71(2) *Sanctions.* Reasonable monetary sanctions may be imposed upon students, employees, and visitors for violation of vehicle registration or parking rules. The amount of such sanctions, not to exceed $50 for each offense, shall be established by the university and approved by the state board of regents except sanctions established by statute will be imposed at the current statutory amount. A schedule of all sanctions for improper registration and parking shall be published and available for public inspection during normal business hours in the office of the supervisor and in the office of the state board of regents. Registration and parking sanctions may be assessed against the owner or operator of the vehicle involved in each violation or against any person in whose name the vehicle is registered or parking privileges have been granted and charged to their university account. Registration and parking sanctions may be added to student tuition bills or may be deducted from student deposits or from the salaries or wages of employees or from other funds in the possession of the university.

4.71(3) *Impoundment.* Any vehicle parked on the campus in violation of parking or registration rules may be impounded and removed. The university shall give written notice of impoundment to the owner of the vehicle or to the person in whose name the vehicle is registered or parking privileges have been granted. A reasonable fee may be charged for the cost of impoundment and storage, which fee must be paid prior to the release of the vehicle. Impounded vehicles which are not claimed within 60 days will be deemed abandoned property and may be sold, under procedures set forth in Iowa Code chapter 579, and the proceeds of the sale will be applied to the payment of the costs of impoundment, storage and sale. The balance, if any, shall be sent to the owner.

4.71(4) *Hearing.* Students and employees may have a hearing on any registration or parking violation. A hearing request shall be submitted to the supervisor in writing within seven days after notice of the violation was given and shall state the grounds of the hearing request. The supervisor may allow additional time within which to request a hearing for good cause shown. Hearings shall be conducted by an impartial committee to be chosen in a manner approved by the president of the university. The person requesting said hearing shall be afforded the opportunity for an administrative hearing by the hearing committee and shall be given reasonable notice of the time and place of the hearing. The decision of the hearing committee shall be final and may be reviewed *de novo* by the district court as provided by law.

681—4.72(262) Effect of rules. These rules constitute a condition of registration as a student at the university and a condition of employment as an employee of the university. Registration as a student or acceptance of employment constitutes an acceptance of these rules and an agreement to pay all prescribed fees and monetary fines imposed in accordance with these rules.

681—4.73(262) Administration of rules. The president of the university shall be responsible for the proper administration of these rules. The president is authorized to establish procedures not inconsistent with these rules as may be reasonably necessary and convenient for the effective administration of presidential duties hereunder, and any procedure so established shall be published and available for public inspection during normal business hours in the office of the supervisor and in the office of the state board of regents. The president may delegate presidential authority under these rules to the supervisor or to any other person designated by the president to perform any function or duty hereunder.

These rules are intended to implement Iowa Code chapter 262.

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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 1
ORGANIZATION OF THE DEPARTMENT OF TRANSPORTATION

[Prior to 6/3/87, Transportation Department[820]—(01,A)Ch1]

761—1.1(307) Definitions.

"Commission" means the state transportation commission.

"Department" means the Iowa department of transportation.

"Director" means the director of transportation or the director's designee.

761—1.2(17A) Mission statement. The mission of the department is to promote a transportation system to satisfy user needs and maximize economic and social benefits for Iowa citizens, to encourage and support programs to provide commodity movement and mobility for all citizens, and to promote financing of the transportation system through user and nonuser sources in an equitable manner.

761—1.3(17A) Location and business hours. The main office of the department is located at 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1101. The department's business hours are 8 a.m. to 4:30 p.m. Monday through Friday, excluding legal holidays.

761—1.4(17A) Information and forms. Information, applications and forms may be obtained from the department or from the division or office which is responsible for the area of concern. Specific instructions may also be given in administrative rules.

761—1.5(307) History. The Sixty-fifth General Assembly created the department as of July 1, 1974, and transferred to it the duties and responsibilities formerly administered by the state highway commission; the Iowa aeronautics commission; the Iowa reciprocity board; the department of public safety relating to motor vehicle registration, motor vehicle dealer licensing, and operator and chauffeur licensing; and the Iowa state commerce commission relating to the regulation of railroads and motor carrier transportation. Certain duties and responsibilities relating to river transportation and public transit were also assigned to the department.

761—1.6(17A,307,307A) Commission. A seven-member transportation commission approves the departmental budget, develops a comprehensive transportation policy and plan for the state, identifies transportation needs, and develops programs to meet these needs. Other commission duties and responsibilities are broadly stated in Iowa Code chapters 307 and 307A. Inquiries and requests may be submitted to the commission at the address given in rule 1.3(17A).

761—1.7(17A,307) Director of transportation. The director of transportation is based in Ames and serves as the chief administrative officer of the department. The director is responsible for the management of the department and for statutory duties including but not limited to those listed in Iowa Code section 307.12. The following units report to the director:

1.7(1) The deputy director.

1.7(2) The divisions described in rule 1.8(17A,307).

1.7(3) The bureau of policy and information, which identifies, analyzes and develops options for transportation policy issues, coordinates the department's legislative program, and communicates transportation programs and information to the department and the public.

1.7(4) The bureau of transportation safety, which investigates methods of improving highway safety and administers risk management programs for the department.

1.7(5) The bureau of management, which provides management support, program evaluation and development, and administration of employee safety and environmental safety concerns.

[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—1.8(17A,307) Divisions. The department is made up of the following divisions, which report to the director:

1.8(1) *Administration division.* The administration division is based in Ames, telephone (515)239-1340, and provides general administrative support for the department in these areas: Management of facilities, equipment, and supplies; data processing and internal information services; toll bridge operations; auditing; and all phases of fiscal management.

1.8(2) *Air and transit division.* The address for the air and transit division is: Air and Transit Division, Iowa Department of Transportation, Park Fair Mall, 100 East Euclid Avenue, Suite 7, Des Moines, Iowa 50313; telephone (515)237-3301.

a. The office of aeronautics administers the Iowa Code provisions which relate to air transportation, including: airport development, registration and zoning; aircraft registration; state aircraft pool; safety promotion; public education and air service analysis. Telephone (515)237-3301.

b. The office of public transportation provides advice and assistance regarding financial, technical and management matters to urban and regional transit systems, compiles and analyzes data from transit systems, certifies providers of transit services for the purpose of coordinating these services, and administers state and federal funds for public transit assistance. Telephone (515)237-3302.

1.8(3) *General counsel division.* The department's general counsel is based in Ames; telephone (515)239-1521. It is made up of a special assistant attorney general and assistant attorneys general. It provides legal services for the department.

1.8(4) *Highway division.* The highway division's headquarters are in Ames; telephone (515)239-1124. The division is responsible for design, right-of-way acquisition, construction and maintenance of the interstate and primary highway systems, state park roads, and institutional roads; administers Iowa Code chapters 306 to 306C, 308, and 309 to 320; and assists counties and cities with their road and street systems.

Responsibilities for highway operations are divided among six districts. Each district has maintenance garages, maintenance offices, and construction offices which are listed in local telephone directories. The six district offices are:

District 1 1020 S. 4th St., Ames, Iowa 50010	(515)239-1635
District 2 1420 4th St., S.E., Mason City, Iowa 50401	(515)423-7584
District 3 2800 E. Gordon Dr., Sioux City, Iowa 51102	(712)276-1451
District 4 Box 406, U.S. 6 East, Atlantic, Iowa 50022	(712)243-3355
District 5 307 W. Briggs Ave., Fairfield, Iowa 52556	(515)472-4171
District 6 430 16th Ave. S.W., Cedar Rapids, Iowa 52404	(319)364-0235

1.8(5) *Motor vehicle division.* The motor vehicle information center telephone number is 1-800-532-1121. The division's headquarters are located at Park Fair Mall, 100 Euclid Avenue, Des Moines, Iowa; telephone (515)244-8725. The mailing address is P.O. Box 10382, Des Moines, Iowa 50306-0382.

The motor vehicle division is responsible for administering and enforcing Iowa Code provisions relating to:

a. The licensing and financial responsibility of drivers, including motor vehicle accident records and driver improvement.

b. The titling of motor vehicles and mobile homes, the titling and licensing of official vehicles, and the registration of vehicles. The division also issues handicapped identification devices.

c. The licensing of motor vehicle, mobile home and travel trailer dealers, manufacturers and distributors, and the licensing of motor vehicle lessors, salvagers and recyclers. The division also receives applications to discontinue or terminate motor vehicle franchises or to establish additional motor vehicle dealerships of the same line-make in the community.

d. The proportional registration of commercial vehicles operated in interstate commerce.

e. The size and weight of vehicles, including permit provisions for the movement of vehicles and loads of excess size and weight.

f. The payment of fuel taxes for interstate motor vehicle operations.

g. Carriers engaged in the business of transporting passengers or property for compensation, excluding railroads. This responsibility includes the issuance of operating authority for intrastate carriers and the registration of interstate commerce commission authority for interstate carriers.

h. Odometers. The responsibility includes the enforcement of federal odometer laws.

i. Vehicle equipment and safety.

1.8(6) *Planning and research division.* The planning and research division is based in Ames; telephone (515)239-1661. The division compiles statistical transportation data; prepares assessments of economic and fiscal impacts of legislation, policies and programs upon the state; coordinates state transportation planning, administers general transportation research projects; annually develops a program of transportation projects; prepares highway corridor studies; and conducts economic, social and environmental assessments of projects.

1.8(7) *Rail and water division.* The rail and water division is based in Ames; telephone (515)239-1367. The division administers state and federal funds for railroad track and grade crossing improvements, reviews and develops policy position recommendations on rail abandonments and mergers, performs track safety inspections, reviews and recommends financing projects to the transportation commission, promotes river transportation and coordinates river programs with other transportation modes, and administers other railroad and river related Iowa Code responsibilities assigned to the department.

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These rules are intended to implement Iowa Code section 17A.3 and chapters 307 and 307A.

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CHAPTER 4
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

761—4.1(22,304) General provisions.

4.1(1) *Scope of chapter.*

a. This chapter describes the provisions governing public access to records that are owned by or in the physical possession of the department. However, access to personnel and payroll records may also be subject to the rules of the department of administrative services.

b. This chapter does not affect the policy of the department to respond, without charge, to routine oral or written inquiries that do not involve the furnishing of records.

c. This chapter does not make available records compiled by the department in reasonable anticipation of court litigation or formal administrative proceedings. The availability of these records to the public or to any subject individual or party to such litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the department.

4.1(2) *Custodian.* The custodian of a record is the person who heads the departmental office responsible for that record. The department's Records Management Manual identifies the offices that are responsible for particular records.

a. As used in this chapter, the term "custodian" includes the custodian's superiors and the custodian's designees.

b. The custodian's designees may include but are not limited to the records center and the department's general counsel.

c. The custodian of a record is authorized to provide or deny access to that record in accordance with the provisions of this chapter. However, the custodian's authority to provide access to a confidential record is limited to the persons listed in subrule 4.4(2).

4.1(3) *Address of records center.* The address of the department's records center is: Records Center, Office of Document Services, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010.

4.1(4) *Records Management Manual.*

a. The department's Records Management Manual contains the records management information required by Iowa Code chapter 304.

b. Chapter III of the manual contains the descriptive information on records that is required by Iowa Code section 22.11. Chapter III, as revised through 2001, is made a part of these rules.

c. The manual is available for examination and copying at the department's records center and at various other departmental offices located throughout the state. A copy of the manual may be obtained at cost from the records center.

4.1(5) *Availability of open records.* Open records of the department are available to the public for examination and copying unless otherwise provided by rule or statute.

4.1(6) *Data processing matching.* All departmental data processing systems that have common data elements can potentially match, collate and compare personally identifiable information.

4.1(7) *Warranty.* No warranty of the accuracy or completeness of a record is made.

4.1(8) *Existing records.* A request for access shall apply only to records that exist at the times the request is made and access is provided. The department is not required to create, compile or procure a record solely for the purpose of making it available. EXCEPTIONS: See Iowa Code section 22.3A and subrule 4.4(5).

4.1(9) *Definitions.* As used in this chapter:

"Confidential record" means a record that is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information contained in records that the department is prohibited by law from making available for examination by members of the public, and records or information contained in records that are specified as confidential by Iowa Code section 22.7 or another provision of law, but that may be disclosed upon order of the court, the custodian of the record, or by another person duly authorized

to release the record. Mere inclusion in a record of information declared confidential by an applicable provision of law does not necessarily make that entire record a confidential record.

"Open record" means a record other than a confidential record.

"Personally identifiable information" means information about an individual in a record that identifies the individual and is retrievable by a unique personal identifier associated with the individual.

"Public" means those persons who are not officials, employees or agents of the department.

"Record" means the whole or a part of a "public record" as defined in Iowa Code section 22.1 that is owned by or in the physical possession of the department.

"Requester" means a member of the public.

This rule is intended to implement Iowa Code chapter 22 and section 304.17.

[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—4.2(22) Statement of policy and purpose. It is the policy of the department that free and open examination of public records is generally in the public interest. The purpose of these rules is to facilitate broad public access to open records and sound determinations with respect to the handling of confidential records.

This rule is intended to implement Iowa Code chapter 22.

761—4.3(22) Access to records.

4.3(1) *Submission of request for access.*

a. A request for access to a record shall be submitted to the custodian of the record. If the requester does not know the identity of the custodian, the request may be submitted to the records center at the address in subrule 4.1(3). The records center will forward the request to the custodian.

b. Notwithstanding paragraph *"a"* of this subrule, any request that may be related to a potential or an actual tort claim or other litigation shall be submitted to the following address: General Counsel, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. If the custodian receives a request of this nature, the custodian shall forward the request to the department's general counsel.

c. If a request for access is misdirected, department personnel will forward the request to the custodian.

4.3(2) *Office hours.* Open records are available during customary office hours, which are 8 a.m. to 4:30 p.m., excluding Saturdays, Sundays, and legal holidays.

4.3(3) *Form of request.* A request for access to a record shall reasonably describe the record requested. A request for access to an open record may be made orally or in writing. A requester shall not be required to give reasons for requesting an open record.

4.3(4) *Response to request.* The custodian shall provide access to an open record promptly upon request. However, if the size or nature of the request makes prompt access infeasible, the custodian shall fill the request as soon as feasible and give the requester an estimate of when the record will be available.

4.3(5) *Delay.* Access to a record may be delayed for one of the purposes authorized by Iowa Code subsection 22.8(4) or 22.10(4). The custodian shall inform the requester of the reason for the delay and the estimated length of the delay.

4.3(6) *Security of records.* No person may, without permission from the custodian, search agency files or remove any record from the place where it is made available. The custodian shall supervise the examination and copying of records and protect the records from damage and disorganization. Original paper records shall be released from department custody only upon court order. At least one certified copy shall be retained in the file if the original record is released.

4.3(7) *Copies.* A photocopy of an open record may be made on department photocopiers. If a photocopier is not available in the office where an open record is kept, the custodian shall permit its examination in that office and, if requested, arrange to have a copy made elsewhere.

4.3(8) *Fees.* The department may charge fees for records as authorized by Iowa Code section 22.3 or another provision of law. Under Iowa Code section 22.3, the fee for the copying service shall not exceed the cost of providing the service.

This rule is intended to implement Iowa Code sections 22.2, 22.3, 22.4, 22.8, 22.10, and 22.11.

761—4.4(22) Access to confidential records. The following provisions are in addition to those specified in rule 761—4.3(22) and are minimum requirements. A statute or another department rule may impose additional requirements for access to certain classes of confidential records.

4.4(1) *Procedure.*

a. Form of request. The custodian shall ensure that there is sufficient information to provide reasonable assurance that access to a confidential record may be granted. Therefore, the custodian may require the requester to:

(1) Submit the request in writing.

(2) Provide proof of identity and authority to secure access to the record.

(3) Sign a certified statement or affidavit listing the specific reasons justifying access to the record and provide any proof necessary to establish relevant facts.

b. Response to request. The custodian shall notify the requester of approval or denial of the request for access. If the requester indicates to the custodian that a written notice is desired if the request for access is denied, the custodian shall provide such notice promptly. The notice shall be signed by the custodian and include:

(1) The name and title or position of the custodian, and

(2) A brief statement of the grounds for denial, including a citation to the applicable statute or other provision of law.

c. Reconsideration of denial. A requester whose request is denied by the custodian may apply to the director of transportation for reconsideration of the request.

4.4(2) *Release of confidential records by the custodian.* The custodian may release a confidential record or a portion of it:

a. To the legislative services agency pursuant to Iowa Code section 2A.3.

b. To the citizens' aide pursuant to Iowa Code section 2C.9.

c. To other governmental officials and employees only as needed to discharge their duties.

d. To those persons as permitted or required by rule 761—4.9(22).

e. To persons authorized by the subject of the record in accordance with rule 761—4.5(22).

4.4(3) *Release of confidential records by the director.*

a. The director of transportation may release a confidential record or a portion of it to a person not covered in subrule 4.4(2) if the release:

(1) Is permitted by statute, rule or another provision of law, and

(2) Is not inconsistent with the stated or implied purpose of the law which establishes or authorizes confidentiality.

b. Before the director releases a record to a person not covered in subrule 4.4(2), the director may notify the subject of the record of the impending release and may give the subject a reasonable amount of time to seek an injunction.

4.4(4) *Mixed record.* A confidential record may, due to its nature or the way it is compiled or stored, contain a mixture of confidential and nonconfidential information. The department shall not refuse to release the nonconfidential information simply because the record is compiled or stored in this fashion.

4.4(5) *Information released.* If a person is provided access to less than an entire record, the department shall take measures to ensure that the person is furnished only the information that is to be released. This may be done by providing to the person either an extraction of the information to be released, or a copy of the record from which the information not to be released has been deleted.

This rule is intended to implement Iowa Code section 22.11.

761—4.5(22) Consent to release a confidential record to a third party. To the extent permitted by law, the subject of a confidential record may consent to its release to a third party. The consent must be in writing and must identify the particular record that may be disclosed and the particular person or class of persons to whom the record may be disclosed. The subject of the record may be required to provide proof of identity. Appearance of counsel before the agency on behalf of a person who is the subject of

a confidential record may be deemed to constitute consent for the department to disclose records about that person to the person's counsel.

This rule is intended to implement Iowa Code section 22.11.

761—4.6(22) Requests for confidential treatment.

4.6(1) A person may request that all or a portion of a record be confidential. The request must be submitted in writing to the custodian and:

a. Identify the information for which confidential treatment is sought.

b. Cite the legal basis that justifies confidential treatment.

c. Give the reasons why the person would be aggrieved or adversely affected by disclosure of the information. The person may be required to provide any proof necessary to support these reasons.

4.6(2) The custodian shall notify the requester in writing of the granting or denial of the request and, if denied, the reasons therefor.

4.6(3) If the request is denied, the requester may apply to the director of transportation for reconsideration of the request.

This rule is intended to implement Iowa Code section 22.11.

761—4.7(22) Procedure by which additions, dissents, or objections may be entered into records. Except as otherwise provided by law, the person who is the subject of a record may have a written statement of additions, dissents or objections entered into that record. The statement shall be filed with the custodian. The statement must be dated and signed by the person who is the subject of the record and include the person's current address and telephone number. This rule does not authorize the person who is the subject of the record to alter the original record or to expand the official record of any agency proceeding.

This rule is intended to implement Iowa Code section 22.11.

761—4.8(22) Notice to suppliers of information. When the department requests a person to supply information about that person, the department shall notify the person of the use that will be made of the information, which persons outside the agency might routinely be provided this information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in these or other rules of the department, on the written form used to collect the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, orally, or by other appropriate means.

This rule is intended to implement Iowa Code section 22.11.

761—4.9(22) Confidential records. This rule describes the types of departmental information or records that are confidential. This rule is not exhaustive. A citation of the legal authority for confidentiality follows each description.

As related to particular types of confidential information or records, this rule also includes exceptions to confidentiality, the rights of certain persons to have access, and permissible disclosures.

Descriptions:

4.9(1) Hospital, medical and professional counselor records of the condition, diagnosis, care or treatment of present or former patients or counselees. (Iowa Code section 22.7)

a. This category of records includes but is not limited to hospital, medical and professional counselor records of present or former departmental employees.

b. Notwithstanding this subrule, State of Iowa Employers Work Injury Report forms are not confidential.

c. The subject of a hospital, medical or professional counselor record has the right of access to it.

4.9(2) Trade secrets which are recognized and protected by law. (Iowa Code section 22.7)

a. The person who furnished the trade secret information has the right of access to this information.

b. Reserved.

4.9(3) Records which constitute attorney work product, attorney-client communications, or that are otherwise privileged. (Attorney work product is confidential under Iowa Code sections 22.7, 622.10 and 622.11, Iowa R. C. P. 1.503(3), Fed. R. Civ. P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code sections 622.10 and 622.11, the rules of evidence, the Code of Professional Responsibility, and case law.)

a. This category of records includes but is not limited to:

(1) Investigations conducted in anticipation of tort claims or other litigation.

(2) Records directly related to threatened litigation over title.

b. Reserved.

4.9(4) Peace officers' investigative reports, except where disclosure is required or authorized by the Iowa Code. However, the date, time, specific location, and immediate facts and circumstances surrounding a crime or incident are not confidential except in those unusual circumstances where disclosure would plainly and seriously jeopardize an investigation or would pose a clear and present danger to the safety of an individual. (Iowa Code section 22.7)

4.9(5) Reports to the department which, if released, would give advantage to competitors and serve no public purpose. (Iowa Code section 22.7)

a. Examples of records which could in the proper circumstances be determined to be within this category include but are not limited to:

(1) Financial reports filed by contractors for departmental use in determining their eligibility to bid on projects advertised for letting. This includes financial information from these reports that is stored on computer.

(2) Documents submitted by firms for departmental use in certifying their eligibility as disadvantaged business enterprises.

(3) Prequalification forms filed with the department under rule 761—20.8(307). This includes the selection committee's working papers; however, the final selection committee report is not confidential once it has been approved by the appropriate division director. Selection committee activities may also fall under subrule 4.9(20).

(4) Financial reports filed with the department for the purpose of seeking certificates of self-insurance under Iowa Code section 321A.34.

(5) Copies of agreements between sign owners and landowners filed with the department in support of the issuance of outdoor advertising permits.

(6) Copies of private contracts between railroads and shippers or other private parties.

(7) Barge terminal surveys which ask for shipping and financial information from barge companies.

b. The subject of the record has the right of access to it.

4.9(6) Criminal identification files, except for the records of current and prior arrests. (Iowa Code section 22.7)

a. The custodian may disseminate criminal identification data to a peace officer, a criminal justice agency, or a state or federal regulatory agency if the custodian is satisfied that the need to know and the intended use are reasonable.

b. The custodian shall also comply with Iowa Code chapter 692.

4.9(7) Personal information in confidential personnel records of present or former departmental employees. (Iowa Code section 22.7)

a. Submission by an employee of an employment application form shall constitute authorization for the release of a copy of the employee's complete personnel records to the selecting authority.

b. Confidential personnel information relating to a particular program shall be released to that agency or company which is administering the program.

c. The subject of a personnel record has the right of access to it.

4.9(8) Communications not required by law, rule or procedure that are made to the department by identified persons outside of government, to the extent that it could reasonably be believed that those persons would be discouraged from making the communications if they were made available for general public examination. (Iowa Code section 22.7)

a. This category of records includes but is not limited to exit interviews for voluntary terminations.

b. Exceptions to confidentiality:

(1) A communication is not confidential if its author consents to its release.

(2) Information in a communication that can be disclosed without identifying its author or enabling others to ascertain that identity is not confidential.

(3) Information in a communication that indicates the date, time, specific location, and immediate facts and circumstances surrounding the occurrence of a crime or other illegal act is not confidential unless disclosure would plainly and seriously jeopardize a continuing investigation or would pose a clear and present danger to the safety of any person.

c. The author of a communication has the right of access to it.

4.9(9) Examinations, including but not limited to cognitive and psychological examinations for law enforcement officer candidates administered by or on behalf of a government body, to the extent that their disclosure could reasonably be believed by the lawful custodian to interfere with the accomplishment of the objectives for which they are administered. (Iowa Code section 22.7)

4.9(10) Information concerning the nature and location of an archaeological resource or site if, in the opinion of the state archaeologist, disclosure of the information will result in unreasonable risk of damage to or loss of the resource or site where the resource is located. (Iowa Code section 22.7)

4.9(11) Information concerning the nature and location of an ecologically sensitive resource or site if, in the opinion of the director of the department of natural resources after consultation with the state ecologist, disclosure of the information will result in unreasonable risk of damage to or loss of the resource or site where the resource is located. (Iowa Code section 22.7)

4.9(12) Those portions of the department's staff manuals, instructions or other statements issued which set forth criteria or guidelines to be used by departmental staff in auditing, in making inspections, in settling commercial disputes or negotiating commercial arrangements, or in the selection or handling of cases, such as operational tactics or allowable tolerances or criteria for the defense, prosecution or settlement of cases, when disclosure of these statements would enable law violators to avoid detection, facilitate disregard of requirements imposed by law, or give a clearly improper advantage to persons who are in an adverse position to the department. (Iowa Code sections 17A.2 and 17A.3)

4.9(13) The detailed minutes and tape recording of a closed session of the commission. However, if the closed session regards a real estate purchase, the minutes and tape recording shall be available for public inspection when the transaction discussed is completed. (Iowa Code section 21.5)

4.9(14) Vehicle accident reports submitted to the department by drivers and peace officers. (Iowa Code sections 321.266 and 321.271)

a. However, access shall be granted to those persons authorized by Iowa Code section 321.271.

b. Rescinded IAB 1/8/03, effective 2/12/03.

4.9(15) All information filed with the court for the purpose of securing a warrant for an arrest until the arrest has been made and the warrant has been returned. (Iowa Code section 804.29)

4.9(16) All information filed with the court for the purpose of securing a warrant for a search until the warrant has been executed and returned. (Iowa Code section 808.13)

4.9(17) Information obtained by the department from the examining of reports or records required to be filed or kept under the provisions of Iowa Code chapter 452A, except where disclosure is authorized by chapter 452A. (Iowa Code section 452A.63)

4.9(18) Sealed bids received prior to the time set for public opening of bids. (Iowa Code section 72.3)

4.9(19) Except as required by Iowa Code section 6B.45, the parcel file for a right-of-way acquisition until title has passed to the state and all contract and relocation claims have been paid. (Iowa Code section 22.7)

4.9(20) Those records which, if disclosed, would diminish competition or would give an improper advantage to persons who are in an adverse position to the department. These records shall be kept confidential until the transaction to which they relate is consummated. However, if disclosure would reveal information which would hinder future competition, the records shall be kept confidential. (Iowa Code sections 17A.2, 17A.3, 22.7 and 313.10, Iowa Code chapter 553, and rules 761—Chapter 20)

a. Examples of records which could, in the proper circumstances, be determined to be within this category include but are not limited to:

(1) Detailed estimates of the cost of a proposed contract.

(2) Economic analyses for determining pavement types.

(3) Negotiations for a proposed contract.

(4) Methodology for determining unfair bidding practices or bid rigging.

(5) Price quotations solicited.

(6) The value of points assigned to a bid rating formula prior to the time set for public opening of bids.

(7) Laboratory testing reports of suppliers' products. These may also be trade secrets. The subject of the report has the right of access to it.

b. Reserved.

4.9(21) Income tax forms or rental, income or expense statements furnished by relocatees as documentation for relocation assistance payments. (Iowa Code sections 22.7 and 422.20, 5 U.S.C. §§ 552 and 552a)

a. The subject of the form or statement has the right of access to it.

b. Reserved.

4.9(22) Audit reviews for determining EEO contract compliance. (Iowa Code section 22.7, 5 U.S.C. §§ 552 and 552a)

a. The subject of the audit review has the right of access to it.

b. Reserved.

4.9(23) Tax records made available to the department. (Iowa Code section 422.20)

4.9(24) Personal information in motor vehicle records. (Iowa Code section 321.11 and 18 U.S.C. § 2721 et seq.)

a. This information may be disclosed only as provided in Iowa Code section 321.11, 18 U.S.C. § 2721 et seq., and 761—Chapters 415, 610 and 611.

b. The subject of the personal information has the right of access to the information.

4.9(25) A report received by the department from a physician or optometrist regarding a person who has been diagnosed as having a physical or mental condition which would render the person physically or mentally incompetent to operate a motor vehicle in a safe manner. (Iowa Code section 321.186)

4.9(26) Certain records regarding undercover driver's licenses issued to peace officers, as specified in 761—Chapter 625. (Iowa Code sections 22.7 and 321.189A)

a. The subject of the record and the head of the law enforcement agency employing the subject have the right of access to the record.

b. Reserved.

4.9(27) Records related to confidential plates issued for government vehicles. (Iowa Code section 321.19)

a. The head of the agency to which the vehicle is assigned has the right of access to the record.

b. Reserved.

4.9(28) Data processing software developed by the department. (Iowa Code section 22.7)

a. The custodian may provide, restrict or prohibit access to this software in accordance with Iowa Code section 22.3A.

b. Reserved.

4.9(29) Records containing information that would disclose, or might lead to the disclosure of, private keys used in a digital signature or other similar technologies as provided in Iowa Code chapter 554D, and records which, if disclosed, might jeopardize the security of an electronic transaction pursuant to Iowa Code chapter 554D. (Iowa Code section 22.7)

4.9(30) The portion of a record request that contains an Internet protocol number which identifies the computer from which a person requests a record. However, such record may be released with the express written consent of the requester. (Iowa Code section 22.7)

4.9(31) Certified transcripts of labor payrolls (also known as certified payroll records) filed by contractors for federal-aid construction contracts, in accordance with the following paragraphs. (Iowa Code section 22.7, 5 U.S.C. §§ 552 and 552a, 42 U.S.C. § 405)

a. The social security numbers in a certified payroll record are confidential. The record itself may be confidential if its release would give advantage to competitors and serve no public purpose.

b. The prime contractor and subcontractor, if applicable, that filed the record have the right of access to it.

c. Certified payroll records shall be released to the U.S. Department of Labor and Federal Highway Administration during investigations.

d. The custodian may release a certified payroll record with social security numbers withheld to representatives of the Iowa Labor Management Work Preservation Fund.

e. The custodian may release a certified payroll record with social security numbers withheld to persons outside the department other than the persons listed in paragraphs *"b"* to *"d"* according to the following procedure:

(1) The request for the record must be in writing.

(2) The custodian shall send a copy of the request by registered mail to the prime contractor. If the request is for subcontractor information, the custodian shall send copies of the request to both the subcontractor and prime contractor.

(3) The requested record shall not be released until 14 calendar days have expired from receipt of the request by the contractor(s). This gives the contractor(s) an opportunity to seek an injunction.

4.9(32) Information concerning an open or pending railroad accident investigation conducted on behalf of or in conjunction with the Federal Railroad Administration or National Transportation Safety Board to the extent necessary to prevent denial of funds, services or essential information from the United States government. (Iowa Code section 22.9)

4.9(33) All other information or records that by law are or may be confidential, with the following exceptions:

a. Records of the departmental library.

b. Reserved.

This rule is intended to implement Iowa Code chapters 22, 553 and 692; Iowa Code sections 6B.45, 17A.2, 17A.3, 21.5, 72.3, 313.10, 321.11, 321.19, 321.186, 321.189A, 321.266, 321.271, 422.20, 452A.63, 602.10112, 622.10, 622.11, 804.29 and 808.13; 5 U.S.C. §§ 552 and 552a; and 18 U.S.C. § 2721 et seq.

761—4.10(22) Release of confidential records. Rescinded IAB 1/8/03, effective 2/12/03.

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CHAPTER 529
FOR-HIRE INTERSTATE MOTOR CARRIER AUTHORITY

[Prior to 6/3/87, Transportation Department[820]—(07,F)Ch 5]

761—529.1(327B) Motor carrier regulations. The Iowa department of transportation adopts the Code of Federal Regulations, 49 CFR Parts 365-368 and 370-379, dated October 1, 2008, for regulating interstate for-hire carriers.

Copies of this publication are available from the state law library or through the Internet at http://www.fmcsa.dot.gov.

[**ARC 7901B**, IAB 7/1/09, effective 8/5/09]

761—529.2(327B) Registering interstate authority in Iowa. Registration for interstate exempt and nonexempt authority shall be either mailed to the Office of Motor Carrier Services, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; delivered in person to 6310 SE Convenience Blvd., Ankeny, Iowa; or sent by facsimile to (515)237-3257.

761—529.3(327B) Waiver of rules. In accordance with 761—Chapter 11, the director of transportation may, in response to a petition, waive provisions of this chapter. A waiver shall not be granted unless the director finds that special or emergency circumstances exist.

"Special or emergency circumstances" 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 events such as, but not limited to, pollution of natural resources, a potential fire or explosion.
5. Circumstances where weather or transportation problems create an undue hardship for citizens of the state of Iowa.
6. Circumstances where 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 hazard to the safety of the traveling public or undue damage to private or public property.

These rules are intended to implement Iowa Code chapter 327B.

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CHAPTER 601
APPLICATION FOR LICENSE

761—601.1(321) Application for license.

601.1(1) *General.* In addition to the information required under Iowa Code sections 321.182 and 321.196, the information in this rule is required from an applicant for a driver's license. Additional requirements for a commercial driver's license are found in 761—Chapter 607.

601.1(2) *Name.* The applicant's full name shall be given on the application. Civilian and military titles and nicknames shall not be used.

601.1(3) *Out-of-state verification.* If a person is licensed in another licensing jurisdiction but does not have a current out-of-state license to surrender, the department may require an official letter from the out-of-state licensing agency before issuing a license. The official letter must verify the person's driving record to assist the department in determining whether it is safe to grant the person a license.

601.1(4) *Disabilities.* The applicant shall indicate and explain any mental or physical disabilities which might affect the applicant's ability to operate a motor vehicle safely.

601.1(5) *Physical description.* Physical description shall include the applicant's weight to the nearest pound.

601.1(6) *Address.* The applicant shall provide the applicant's residential address and mailing address, if different from the residential address.

601.1(7) *Signature.*

a. The applicant's signature shall be without qualification and shall contain only the applicant's usual signature without any other titles, characters or symbols.

b. The applicant's signature certifies that the statements on the application are true and the fee collected was correct.

c. The applicant's signature acknowledges that the applicant is aware of the requirement to notify the department of a change in mailing address within 30 days of the change.

d. A driver's license clerk or examiner will initial the application as witness.

This rule is intended to implement Iowa Code sections 321.182, 321.196 and 321C.1, Article V.

761—601.2(321) Surrender of license and nonoperator's identification card. An applicant for a driver's license shall surrender all other driver's licenses and nonoperator's identification cards. This includes those issued by jurisdictions other than Iowa.

This rule is intended to implement Iowa Code section 321.182.

761—601.3 and **601.4** Reserved.

761—601.5(321) Proofs submitted with application. A person who applies for a new driver's license or nonoperator's identification card or a duplicate license or card to replace one that is lost or destroyed shall submit proof of age, identity and social security number.

601.5(1) *Social security number verification.* One or more of the following documents may be accepted as verification of an applicant's social security number. The documents must be issued in the United States.

a. Social security card issued by the Social Security Administration. A metal version of the card is not acceptable.

b. Letter from the Social Security Administration.

c. Document issued by the Internal Revenue Service or a state tax agency. Form W-2 tax form completed by the employer is acceptable.

d. Financial statement containing the social security number.

e. Payroll stub containing the social security number.

f. Military identification card containing the social security number.

601.5(2) *Proof of age and identity.* An applicant shall submit one primary document and one secondary document from the following lists as proof of age and identity. The documents must be issued in the United States unless otherwise specified.

a. Acceptable primary documents include:

(1) An Iowa photo driver's license.

(2) An Iowa photo identification card.

(3) Birth certificate issued in the United States. It must be a certified copy, have the stamp or raised seal of the issuing authority, and be issued by the state bureau of vital statistics, the state board of health, or a comparable agency. A hospital-issued certificate is not acceptable.

(4) United States Citizenship and Immigration Service document from the following list:

1. Certificate of Naturalization (N-550, N-570 or N-578).
2. Certificate of Citizenship (N-560, N-561 or N-645).
3. Permanent Resident Card (I-551).
4. Record of Arrival and Departure (I-94) with attached photo that is stamped "Temporary Proof of Lawful Permanent Resident."
5. "Processed for I-551" stamp in a valid foreign passport.
6. Travel Document indicating Permit to Re-enter (I-327) or Refugee Travel Document (I-571).
7. Record of Arrival and Departure (I-94) in a Certificate of Identity.
8. Employment Authorization Card (I-688A, I-688B, or I-766).
9. Record of Arrival and Departure (I-94) stamped "Refugee," "Parole," "Parolee," or "Asylee."
10. Record of Arrival and Departure (I-94) coded Section 207 (Refugee), Section 208 (Asylum), Section 209 (Refugees), Section 212d(5) (Parolee), HP (Humanitarian Parolee), or PIP (Public Interest Parolee).

(5) Military identification card. This does not include a military dependent identification card.

(6) Valid United States passport.

(7) Inmate Descriptor Inquiry, Client Information Inquiry or Offender Snapshot document issued by the Iowa department of corrections. The document must contain the full name and date of birth and be notarized.

b. Acceptable secondary documents include:

(1) Any primary document.

(2) Bureau of Indian Affairs or Indian Treaty Card. A tribal identification card is not acceptable.

(3) Photo driver's license or state-issued photo identification card that has not been expired for more than one year.

(4) Court order that does not contain the applicant's date of birth but does contain the full name.

(5) Foreign birth certificate. It must be translated by an approved translator, if translation is necessary.

(6) Military discharge, military orders or separation papers.

(7) Military dependent identification card.

(8) Employer identification card.

(9) Health insurance card.

(10) Document issued by the Internal Revenue Service or a state tax agency. Form W-2 tax form completed by the employer is acceptable.

(11) Marriage certificate.

(12) Gun permit.

(13) Pilot's license.

(14) School record or transcript. It must be certified.

(15) Social security card issued by the Social Security Administration. A metal version of the card is not acceptable.

(16) Social insurance card issued by the Canadian government.

(17) Photo student identification card.

(18) Voter registration card.

(19) Welfare card.

(20) Prison release document.

(21) Parent or guardian affidavit. The parent or guardian must appear in person, submit proof of the parent's or guardian's age and identity, and submit a certified or notarized affidavit regarding the child's identity. This applies only to minors.

c. The department may require additional documentation if the department believes that the documentation submitted is questionable or if the department has reason to believe that the person is not who the person claims to be.

601.5(3) *Name change verification.* The name listed on the license or nonoperator's identification card that is issued shall be identical to the name contained on the primary document submitted unless the applicant submits an affidavit of name change on Form 430043. The affidavit must be accompanied by one of the following documents:

a. Court-ordered name change. It must contain the full name, date of birth, and court seal.

b. Divorce decree.

c. Marriage certificate.

This rule is intended to implement Iowa Code sections 321.182 and 321.189.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—601.6(321) Parental consent. An unmarried person under the age of 18 who applies for an Iowa license shall submit parental consent and birth date confirmation on Form 430018, Parent's Written Consent to Issue Privilege to Drive or Affidavit to Obtain Duplicate. The parent's signature must be notarized; however, in lieu of notarization it may be witnessed by a driver's license examiner or clerk. No exception shall be made for parental absence from Iowa. A married person under the age of 18 shall submit an original or certified copy of a marriage certificate to avoid submission of the consent form.

This rule is intended to implement Iowa Code section 321.184.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

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CHAPTER 602
CLASSES OF DRIVER'S LICENSES

761—602.1(321) Driver's licenses.

602.1(1) *Classes.* The department issues the following classes of driver's licenses. All licenses issued, including special licenses and permits, shall carry a class designation. A license shall be issued for only one class, except that Class M may be issued in combination with another class.

Class A—commercial driver's license (CDL)
Class B—commercial driver's license (CDL)
Class C—commercial driver's license (CDL)
Class C—noncommercial driver's license
Class D—noncommercial driver's license (chauffeur)
Class M—noncommercial driver's license (motorcycle)

602.1(2) *Special licenses and permits.* The department issues the following special licenses and permits. More than one type of special license or permit may be issued to an applicant. On the driver's license, a restriction number designates the type of special license or permit issued, as follows:

1 — Motorcycle instruction permit—includes motorcycle instruction permits issued under Iowa Code subsections 321.180(1) and 321.180B(1)

2 — Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)—includes instruction permits, other than motorcycle instruction permits, issued under Iowa Code subsection 321.180(1) and section 321.180A and subsection 321.180B(1)

3 — Commercial driver's instruction permit
4 — Chauffeur's instruction permit
5 — Motorized bicycle license
6 — Minor's restricted license
7 — Minor's school license

602.1(3) *Commercial driver's license (CDL).* See 761—Chapter 607 for information on the procedures, requirements and validity of a commercial driver's license (Classes A, B and C), a commercial driver's instruction permit, and their restrictions and endorsements.

This rule is intended to implement Iowa Code sections 321.178, 321.180, 321.180A, 321.180B, 321.189, and 321.194.

761—602.2(321) Information and forms. Applications, forms and information about driver's licensing are available at any driver's license examination station. Assistance is also available at the address in rule 761—600.2(17A).

602.2(1) *Certificate of completion.* Form 430036 shall be used to submit proof of successful completion of an Iowa-approved course in driver education, motorcycle rider education or motorized bicycle education.

a. If a student completed a course in another state, a public or licensed commercial or private provider of the Iowa-approved course may issue the form for the student if the provider determines that the out-of-state course is comparable to the Iowa-approved course.

b. If the out-of-state course is comparable but lacks certain components of the Iowa-approved course, the provider may issue the form after the student completes the missing components.

602.2(2) *Affidavit for school license.* Form 430021 shall be used for submitting the required statements, affidavits and parental consent for a minor's school license. See rule 761—602.26(321).

602.2(3) *Waiver of accompanying driver for intermediate licensee.* Form 431170 is the waiver described in Iowa Code subsection 321.180B(2). This form allows an intermediate licensee to drive unaccompanied between the hours of 12:30 a.m. and 5 a.m. and must be in the licensee's possession when the licensee is driving during the hours to which the waiver applies.

a. If the waiver is for employment, the form must be signed by the licensee's employer.

b. If the waiver is for school-related extracurricular activities, the form must be signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent.

c. The form must be signed by the licensee's parent or guardian. However, the parent's or guardian's signature is not required if the licensee is married and the original or a certified copy of the marriage certificate is in the licensee's possession when the licensee is driving during the hours to which the waiver applies.

This rule is intended to implement Iowa Code sections 321.8, 321.178, 321.180B, 321.184, 321.189, and 321.194.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—602.3(321) Examination and fee. Rescinded IAB 8/9/00, effective 7/24/00.

761—602.4(321) Definitions of immediate family.

602.4(1) A "member of the permittee's immediate family" as used in Iowa Code subsection 321.180(1) means the permittee's parent or guardian or a brother, sister or other relative of the permittee who resides at the permittee's residence.

602.4(2) A "member of the permittee's immediate family" as used in Iowa Code section 321.180B, subsections 1 and 2, means a brother, sister or other relative of the permittee who resides at the permittee's residence.

This rule is intended to implement Iowa Code sections 321.180 and 321.180B.

761—602.5 to **602.10** Reserved.

761—602.11(321) Class C noncommercial driver's license. This rule describes a noncommercial Class C driver's license that is not a special license or permit.

602.11(1) *Validity and issuance.*

a. The license is valid for operating:

(1) A motor vehicle that does not require a commercial driver's license or a Class D driver's license for its operation.

(2) A motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

b. The license is issued for either two years or five years.

(1) A qualified applicant who is at least 17 years, 11 months of age but not yet 70 years of age shall be issued a five-year license.

(2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 70 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

602.11(2) *Requirements.*

a. An applicant shall be at least 16 years of age.

b. Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

This rule is intended to implement Iowa Code sections 321.177, 321.178, 321.180B, 321.189, and 321.196.

761—602.12(321) Class D noncommercial driver's license (chauffeur). This rule describes a noncommercial Class D driver's license.

602.12(1) *Validity and issuance.*

a. The license is valid for operating:

(1) A motor vehicle as a chauffeur as specified by the endorsement on the license, unless the type of vehicle or type of operation requires a commercial driver's license.

(2) A motor vehicle that may be legally operated under a noncommercial Class C driver's license, including a motorized bicycle.

(3) A motorcycle only if the license has a motorcycle endorsement.

b. The license shall have one endorsement authorizing a specific type of motor vehicle or type of operation, as listed in 761—subrule 605.4(2). The gross vehicle weight rating shall be determined pursuant to rule 761—604.35(321).

c. The license is issued for either two years or five years.

(1) A qualified applicant who is at least 18 years of age but not yet 70 years of age shall be issued a five-year license.

(2) A two-year license shall be issued to a qualified applicant who is 70 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

d. Rescinded IAB 11/8/06, effective 12/13/06.

602.12(2) *Requirements.*

a. An applicant shall be at least 18 years of age.

b. Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177, 321.189, and 321.196.

761—602.13(321) Class M noncommercial driver's license (motorcycle). This rule describes a noncommercial Class M driver's license that is not a special license or permit.

602.13(1) *Validity and issuance.*

a. The license is valid for operating:

(1) A motorcycle. However, the license may have a restriction which limits operation to a three-wheel motorcycle.

(2) A motorized bicycle.

b. The license is issued for either two years or five years.

(1) A qualified applicant who is at least 17 years, 11 months of age but not yet 70 years of age shall be issued a five-year license.

(2) A two-year license shall be issued to a qualified applicant who is under 17 years, 11 months of age or who is 70 years of age or older.

(3) A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

c. An Iowa driver's license issued before March 15, 1968, which is still valid because of an extension, is valid for motorcycles. An Iowa driver's license issued from March 15, 1968, through June 30, 1972, which is still valid because of an extension, is valid for motorcycles unless the back of the license is stamped "Not valid for motorcycles."

602.13(2) *Requirements.*

a. An applicant shall be at least 16 years of age.

b. Except as otherwise provided in Iowa Code subsection 321.178(3), an applicant under 18 years of age must meet the requirements of Iowa Code section 321.180B and submit proof of successful completion of an Iowa-approved course in driver education.

c. An applicant under 18 years of age must submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 321.177, 321.178, 321.180B, 321.189 and 321.196.

761—602.14 Reserved.

761—602.15(321) Minor's restricted license. Renumbered as 761—602.25(321) IAB 1/8/92, effective 2/12/92.

761—602.16(321) Temporary instruction permit. Rescinded IAB 1/8/92, effective 2/12/92.

761—602.17(321) Minor's school license. Renumbered as 761—602.26(321) IAB 1/8/92, effective 2/12/92.

761—602.18(321) Motorcycle instruction permit. This rule describes a motorcycle instruction permit issued under Iowa Code subsection 321.180(1) or 321.180B(1).

602.18(1) *Validity and issuance.*

a. The motorcycle instruction permit is a permit that is added to another driver's license.

b. The permit is valid for operating a motorcycle when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.

c. The permit is not valid for operating a motorized bicycle.

d. The permit is issued for four years and is not renewable.

602.18(2) *Requirement.* An applicant shall be at least 14 years of age.

This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

761—602.19(321) Noncommercial instruction permit. This rule describes a noncommercial instruction permit, other than a motorcycle instruction permit, issued under Iowa Code subsection 321.180(1) or 321.180B(1).

602.19(1) *Validity and issuance.*

a. The permit is a restricted, noncommercial Class C driver's license.

b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver's license when the permittee is accompanied by a person specified in Iowa Code subsection 321.180(1) or 321.180B(1), as applicable to the age of the permittee.

c. The permit is not valid for operating a motorized bicycle.

d. The permit is not valid as a motorcycle instruction permit.

e. The permit is issued for four years.

602.19(2) *Requirement.* An applicant shall be at least 14 years of age.

This rule is intended to implement Iowa Code sections 321.177, 321.180 and 321.180B.

761—602.20 Rescinded IAB 11/18/98, effective 12/23/98.

761—602.21(321) Special noncommercial instruction permit. This rule describes a special noncommercial instruction permit issued under Iowa Code section 321.180A.

602.21(1) *Validity and issuance.*

a. The permit is a restricted, noncommercial Class C driver's license that is issued to a person whose application for driver's license renewal has been denied or whose driver's license has been suspended for incapability due to a physical disability.

b. The permit is valid for operating a motor vehicle that may be legally operated under a noncommercial Class C driver's license when the permittee is accompanied by a person specified in Iowa Code section 321.180A.

c. The permit is not valid for operating a motorized bicycle.

d. The permit is not valid as a motorcycle instruction permit.

e. The permit is valid for six months from the date of issuance. It is invalid after the expiration date on the permit.

f. The permit may be reissued for one additional six-month period.

602.21(2) *Requirement.* An applicant must submit a medical report pursuant to 761—subrule 600.4(6).

This rule is intended to implement Iowa Code section 321.180A.

761—602.22 Reserved.

761—602.23(321) Chauffeur's instruction permit.

602.23(1) *Validity and issuance.*

a. A chauffeur's instruction permit is a permit that is added to a Class D license or a noncommercial Class C license that is not a special license or permit.

b. The license with the permit is valid for operating:

(1) A motor vehicle that may be legally operated under the class of license (and for Class D, the endorsement) held by the licensee, including a motorized bicycle.

(2) A motor vehicle, other than a commercial motor vehicle or a motorcycle, as a chauffeur if accompanied by a person with a valid Class D license or a commercial driver's license valid for the vehicle being operated.

c. The permit is issued for two years.

602.23(2) *Requirements.*

a. An applicant shall be at least 18 years of age.

b. Reserved.

This rule is intended to implement Iowa Code sections 321.1, 321.177 and 321.180.

761—602.24(321) Motorized bicycle license.

602.24(1) *Validity and issuance.*

a. A motorized bicycle license is a restricted, noncommercial Class C license.

b. The license is valid for operating a motorized bicycle.

c. The license is issued for two years.

602.24(2) *Requirements.*

a. An applicant shall be at least 14 years of age.

b. An applicant under 16 years of age must submit proof of successful completion of an Iowa-approved course in motorized bicycle education.

This rule is intended to implement Iowa Code sections 321.177 and 321.189.

761—602.25(321) Minor's restricted license.

602.25(1) *Validity and issuance.*

a. A minor's restricted license is a restricted, noncommercial Class C or Class M driver's license.

b. The license is valid for driving to and from the licensee's place of employment or to transport dependents to and from temporary care facilities, if necessary to maintain the licensee's present employment.

c. The type of motor vehicle that may be operated is controlled by the class of driver's license issued. A Class C minor's restricted license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor's restricted license is valid for operating a motorized bicycle only for the purposes specified in paragraph *"b"* of this subrule.

d. The license is issued for two years.

602.25(2) *Requirements.*

a. The applicant shall be at least 16 years of age but not yet 18.

b. The applicant shall submit to the department a statement from the employer confirming the applicant's employment.

c. Proof of nonattendance is required. Proof of nonattendance is receipt of notification from the appropriate school authority that the applicant does not attend school, as set out in 761—subrule 615.23(2).

d. The applicant shall submit proof of successful completion of an Iowa-approved course in driver education.

e. For a Class M minor's restricted license or a motorcycle endorsement, the applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

This rule is intended to implement Iowa Code sections 299.1B, 321.178, 321.180B, 321.189, 321.196 and 321.213B.

761—602.26(321) Minor's school license.

602.26(1) *Validity and issuance.*

a. A minor's school license is a restricted, noncommercial Class C or Class M driver's license.

b. The license is valid for driving unaccompanied from 6 a.m. to 10 p.m. on the most direct route between a licensee's residence and schools of enrollment or the closest school bus stop or public transportation service, and between schools of enrollment, to attend scheduled courses and extracurricular activities within the school district.

c. The license is also valid for driving when the licensee is accompanied by a person specified in Iowa Code subsection 321.180B(1).

d. The type of motor vehicle that may be operated is controlled by the class of driver's license issued. A Class C minor's school license is valid for operating a motorcycle only if the license has a motorcycle endorsement. A minor's school license is valid for operating a motorized bicycle only for the purposes specified in paragraph *"b"* of this subrule.

e. The license is issued for two years.

602.26(2) *Requirements.*

a. An applicant shall be at least 14 years of age but not yet 18 and meet the requirements of Iowa Code section 321.194.

b. An applicant shall submit a statement of necessity signed by the chairperson of the school board, the superintendent of the school, or the principal of the school if authorized by the superintendent. The statement shall be on Form 430021.

c. An applicant shall submit proof of successful completion of an Iowa-approved course in driver education.

d. For a Class M minor's school license or a motorcycle endorsement, an applicant shall also submit proof of successful completion of an Iowa-approved course in motorcycle rider education.

602.26(3) *Exemption.*

a. An applicant is not required to have completed an approved driver education course if the applicant demonstrates to the satisfaction of the department that completion of the course would impose a hardship upon the applicant; however, the applicant must meet all other requirements for a school license. "Hardship" means:

(1) If the applicant is 14 years old, that a driver education course will not begin at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence within one year following the applicant's fourteenth birthday; or

(2) If the applicant is 15 years old, that a driver education course will not begin at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence within six months following the applicant's fifteenth birthday; or

(3) If the applicant is between 16 and 18 years old, that a driver education course is not offered at the applicant's school(s) of enrollment or at a public school in the applicant's district of residence at the time the request for hardship status is submitted to the department; or

(4) That the applicant is permanently handicapped. In this rule, "handicapped" means that, because of a disability or impairment, the applicant is unable to walk in excess of 200 feet unassisted or cannot walk without causing serious detriment or injury to the applicant's health.

b. "Demonstrates to the satisfaction of the department" means that the department has received an affidavit on Form 430021 attesting that completion of the course would impose a hardship upon the applicant. The affidavit shall be signed by the applicant's parent, custodian or guardian and by the superintendent of the applicant's school, the chairperson of the school board, or the principal of the applicant's school if authorized by the superintendent.

This rule is intended to implement Iowa Code sections 321.177, 321.180B, 321.189, 321.194 and 321.196.

761—602.27 to **602.29** Reserved.

761—602.30(321) Special instruction permit. Rescinded IAB 1/8/92, effective 2/12/92.

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CHAPTER 604
LICENSE EXAMINATION

[Prior to 6/3/87, see Transportation Department[820]—(07,C)rules 13.3 and 13.17]

761—604.1(321) Authority and scope.

604.1(1) The department is authorized to determine by examination an applicant's ability to operate motor vehicles safely upon the highways and to issue all driver's licenses.

604.1(2) This chapter of rules shall apply to the examination for all driver's licenses. Information on the additional examination procedures and requirements for a commercial driver's license or commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code sections 321.2, 321.3, 321.13, 321.177, and 321.186.

761—604.2(321) Definitions.

"Representative vehicle" is a vehicle which is characteristic of and requires operating skills comparable to those vehicles that may legally be operated under the class of license or endorsement desired.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.

761—604.3(17A) Information and forms.

604.3(1) Applications, forms, and information about driver's license examinations are available at any driver's license examination station. Assistance is also available from the office of driver services at the address in 761—600.2(17A).

604.3(2) The "Iowa Driver Manual" and the "Iowa Motorcycle Operator Manual" are also available from the department.

This rule is intended to implement Iowa Code section 17A.3.

761—604.4 to **604.6** Reserved.

761—604.7(321) Examination.

604.7(1) An examination shall include:

a. A vision screening if the person has not filed a vision report.

b. A knowledge test of Iowa traffic laws and highway signs.

c. A driving test of the person's ability to operate a motor vehicle.

604.7(2) The examination required for a driver's license depends upon the class of license requested, applicable endorsements, and the qualifications of the applicant.

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

761—604.8 and **604.9** Reserved.

761—604.10(321) Vision screening.

604.10(1) *Requirement.* Vision screening or a vision report is required of an applicant for a driver's license.

604.10(2) *Method.* At driver's license examination stations, a vision screening instrument or a wall chart shall be used to screen the applicant's vision. An applicant who has corrective lenses may be screened with or without the corrective lenses.

604.10(3) *Report.* A vision report shall be submitted on Form 430032 signed by a licensed vision specialist and shall report the person's visual acuity level and field of vision as measured within 30 days prior to the date of the application. In lieu of Form 430032, a vision report signed by a licensed vision specialist on the specialist's letterhead may be accepted if it contains all the information specified on Form 430032.

This rule is intended to implement Iowa Code sections 321.186, 321.186A and 321.196.

761—604.11(321) Vision standards. The visual acuity and field of vision standards for licensing and the applicable restrictions are as follows.

604.11(1) *Visual acuity standards.*

a. When the applicant is screened without corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, no restriction will be imposed. If the visual acuity is less than 20/40 but at least 20/50 with both eyes or with the better eye, the applicant shall be restricted to driving when headlights are not required. If the visual acuity is less than 20/50 but at least 20/70 with both eyes or with the better eye, the applicant shall be restricted to driving when headlights are not required and restricted to a maximum speed of 35 m.p.h.

b. When the applicant is screened with corrective lenses. If the visual acuity is 20/40 or better with both eyes or with the better eye, the applicant shall be required to wear corrective lenses. If the visual acuity is less than 20/40 but at least 20/50 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses and shall be restricted to driving when headlights are not required. If the visual acuity is less than 20/50 but at least 20/70 with both eyes or with the better eye, the applicant shall be required to wear corrective lenses, restricted to driving when headlights are not required, and restricted to a maximum speed of 35 m.p.h.

c. Other standards. If the visual acuity in the left eye is less than 20/100, the applicant shall be restricted to driving a vehicle with a left outside rearview mirror. However, if the applicant has a visual acuity of 20/40 in the right eye and less than 20/100 in the left eye without corrective lenses and has corrective lenses that improve the vision in the left eye to better than 20/100, the applicant shall have the option of being restricted to driving with corrective lenses or driving a vehicle with a left outside rearview mirror.

604.11(2) *Field of vision standards.*

a. If the binocular field of vision is at least 140 degrees, no restriction will be imposed.

b. If the binocular field of vision is less than 140 degrees but at least 115 degrees and one eye has a monocular field of vision of at least 70 degrees temporal and 45 degrees nasal, the applicant shall be restricted to driving a vehicle with both left and right outside rearview mirrors.

This rule is intended to implement Iowa Code sections 321.186, 321.193, and 321.196.

761—604.12(321) Vision referrals.

604.12(1) *Referral.*

a. If an applicant on first screening cannot attain 20/40 but can attain 20/70 with at least one eye, the department shall not issue a license to the applicant. Instead, the department shall advise the applicant to consult a licensed vision specialist.

b. A vision report, pursuant to subrule 604.10(3), shall be required before the department will reconsider licensing.

604.12(2) *License.*

a. The department shall affix a sticker to the applicant's license stating: "Renewal or license issuance denied due to vision."

b. If the applicant's license is valid for less than 30 days, the department may issue a temporary driving permit with restrictions appropriate to the applicant's visual acuity level and field of vision. The temporary driving permit is valid for not more than 30 days from the end of the current license validity.

604.12(3) *Report.* If the vision report recommends a restriction, the department shall issue a restricted license even though it would not be required by departmental standards.

604.12(4) *Applicant refusal.* If an applicant refuses to consult a licensed vision specialist, the department shall issue or deny the license based on the results achieved on the vision screening.

This rule is intended to implement Iowa Code sections 321.181, 321.186, 321.186A, 321.193 and 321.196.

761—604.13(321) Vision screening results.

604.13(1) *Two-year license.* An applicant who cannot attain a visual acuity of 20/40 with both eyes or with the better eye shall be issued a two-year license. This restriction may be waived by the department

when a vision report pursuant to subrule 604.10(3) certifies that the vision has stabilized and is not expected to deteriorate.

604.13(2) *License denied.*

a. An applicant who cannot attain a visual acuity of 20/70 with both eyes or with the better eye shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

b. If the applicant's binocular field of vision (sum of temporal measurements) is less than 115 degrees, or if neither eye has a monocular field of vision of at least 70 degrees temporal and 45 degrees nasal, the applicant shall not be licensed, subject to discretionary issuance under subrule 604.13(4).

604.13(3) *Reapplication.* An applicant who cannot meet the vision standards in subrule 604.13(2) may reapply when the vision improves and meets the vision standards. If a suspension or denial notice was served, reapplication must be made to the office of driver services at the address in 761—600.2(17A), and not at a driver's license examination station.

604.13(4) *Discretionary issuance.*

a. An applicant whose license is restricted under rule 761—604.11(321) or who cannot meet the vision standards in subrule 604.13(2) may submit a written request for review by an informal settlement officer.

b. Based upon consideration of the applicant's vision screening results or vision report, driving test and driving record, the written recommendation of the applicant's licensed vision specialist, and traffic conditions in the vicinity of the applicant's residence, the officer may recommend issuing a license with restrictions suitable to the applicant's capabilities. However:

(1) An applicant who cannot attain a visual acuity of 20/100 with both eyes or with the better eye may be considered for licensing only after recommendation by the medical advisory board.

(2) An applicant who cannot attain a visual acuity of 20/200 with both eyes or with the better eye shall not be licensed.

(3) If an applicant's binocular field of vision (sum of temporal measurements) is less than 95 degrees, or if neither eye has a monocular field of vision of at least 60 degrees temporal and 35 degrees nasal, the applicant may be considered for licensing only after recommendation by the medical advisory board.

c. The officer's recommendation denying discretionary issuance or regarding the extent and nature of restrictions is subject to reversal or modification upon review or appeal only if it is clearly characterized by an abuse of discretion.

This rule is intended to implement Iowa Code sections 321.186, 321.186A, 321.193 and 321.196.

761—604.14 to **604.19** Reserved.

761—604.20(321) Knowledge test.

604.20(1) *Written test.* A knowledge test is a written test to determine an applicant's ability to read and understand Iowa traffic laws and the highway signs that regulate, warn, and direct traffic. A test may be revised at any time but each test states the minimum passing score.

604.20(2) *Three types of tests.* There are three types of knowledge tests: an operator's test, a chauffeur's test, and a motorcycle test. The requirement for a license depends upon the class of license desired, applicable endorsements, and the qualifications of the applicant.

604.20(3) *Oral test.* An applicant who is unable to read or understand a written test may request an oral test. The oral test may be administered by an examiner or by an automated testing device.

604.20(4) *Waiver.* Rescinded IAB 1/8/92, effective 2/12/92.

This rule is intended to implement Iowa Code section 321.186.

761—604.21(321) Knowledge test requirements and waivers.

604.21(1) *Knowledge test requirements.* The knowledge test requirements are as follows:

a. Operator's test. An operator's knowledge test is required for all classes of driver's licenses and all types of special driver's licenses and permits.

b. Motorcycle test. A motorcycle knowledge test is required for all:

(1) Motorcycle instruction permits.
(2) Class M driver's licenses.
(3) Motorcycle endorsements.

c. Chauffeur's test. A chauffeur's knowledge test is required for all:
(1) Chauffeur's instruction permits.
(2) Class D driver's licenses except those with an endorsement for "passenger vehicle less than 16-passenger design."

604.21(2) *Knowledge test waivers.* The department may waive a knowledge test listed in subrule 604.21(1) if the applicant meets one of the following qualifications:

a. The applicant has passed the same type of test for another Iowa driver's license or an equivalent out-of-state license that is still valid.

b. The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

c. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

This rule is intended to implement Iowa Code sections 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.196 and 321.198.

761—604.22(321) Knowledge test results.

604.22(1) *Proof of Passing score.* When necessary, the department shall give the applicant a form, valid for 90 days, which certifies that the applicant has passed the knowledge test.

604.22(2) *Retesting.* An applicant who fails a knowledge test may repeat the test at the discretion of the examiner, but at least two hours shall elapse between tests.

This rule is intended to implement Iowa Code section 321.186.

761—604.23 to **604.29** Reserved.

761—604.30(321) Driving test. A driving test is a demonstration of an applicant's ability to exercise ordinary and reasonable control in the operation of a motor vehicle under actual traffic conditions. The test is also called a road test, field test, or driving demonstration. A motorcycle skill test is an off-street demonstration of an applicant's ability to control the motorcycle in a set of standard maneuvers, and a motorcycle driving test is an on-street demonstration.

604.30(1) *Vehicle type and safety.*

a. For the driving test, the applicant shall provide a representative vehicle as defined in 761—604.2(321).

b. The examiner or other authorized personnel shall visually inspect the vehicle. If a vehicle is illegal or unsafe, or is not a representative vehicle, the examiner shall refuse to administer the test until corrections are made or an acceptable vehicle is provided.

604.30(2) *Criteria and route.* Form 430024, "Your Driving Test," explains the criteria for passing the test and shall be given to the applicant before any required test, except a motorcycle skill test. The applicant shall be directed over one of the routes which have been preselected by the examiner to test driving skills and maneuvers.

604.30(3) *Test score.* The examiner shall use the standard departmental score sheet and shall enter the test score and the licensing decision in the spaces provided. At the end of the test, the examiner shall explain the test score and give the applicant the original score sheet which is valid for 90 days.

604.30(4) *Retesting.* If an applicant fails a driving test, the test may be rescheduled at the discretion of the examiner.

This rule is intended to implement Iowa Code sections 321.174 and 321.186.

761—604.31(321) Driving test requirements and waivers for noncommercial driver's licenses.

604.31(1) *Driving test requirements.* The driving test requirements for noncommercial driver's licenses are as follows:

a. Instruction permits. A driving test is not required to obtain an instruction permit.

b. Class C driver's licenses. For a Class C driver's license other than an instruction permit or a motorized bicycle license, an operator's driving test in a representative vehicle is required.

c. Class D driver's licenses. For a Class D driver's license, a driving test in a representative vehicle for the endorsement requested, as set out in 761—subrule 605.4(2), is required.

d. Class M driver's licenses and motorcycle endorsements. The driving test for a Class M driver's license or motorcycle endorsement consists of two parts: an off-street motorcycle skill test and an on-street driving test.

(1) The off-street motorcycle skill test is required. The on-street motorcycle driving test is also required if the applicant does not have another driver's license that permits unaccompanied driving.

(2) A motorcycle shall be used for these tests. If a three-wheeled motorcycle is used, the driver's license shall be restricted: "Not valid for 2-wheel vehicle."

e. Motorized bicycle licenses. For a motorized bicycle license, an off-street or on-street driving test may be required. A motorized bicycle shall be used for the test.

604.31(2) *Driving test waivers.* The department may waive a required driving test listed in subrule 604.31(1) if the applicant meets one of the following qualifications:

a. The applicant is applying for the applicant's first Iowa driver's license that permits unaccompanied driving following successful completion of the appropriate Iowa-approved course or courses. The appropriate Iowa-approved courses are the following: driver education for a Class C driver's license other than motorized bicycle, driver education and motorcycle rider education for a Class M driver's license or motorcycle endorsement, and motorized bicycle education for a motorized bicycle license. However:

(1) The department may select dates and require a driving test of applicants whose birth dates fall on the selected dates. The department shall notify the Iowa department of education quarterly of the dates selected.

(2) If an applicant is under the age of 18, a driving test is required if so requested by the applicant's parent, guardian, or instructor.

b. The applicant is renewing a Class C, Class D or Class M Iowa driver's license or endorsement within 14 months after the expiration date.

c. The applicant has passed the same type of driving test for another Iowa driver's license or endorsement that is still valid or has expired within the past 14 months.

d. The applicant has a military extension and is renewing the applicant's Iowa driver's license within six months following separation from active duty.

e. The applicant is applying for a Class C Iowa driver's license that permits unaccompanied driving and has an equivalent out-of-state license that is valid or has expired within the past year.

f. The applicant is applying for a Class D Iowa driver's license and has an equivalent out-of-state license that is valid or has expired within the past year.

g. The applicant is applying for a Class M driver's license or a motorcycle endorsement and has an equivalent out-of-state Class M driver's license or motorcycle endorsement that is valid or has expired within the past year.

h. The applicant has a valid, equivalent driver's license issued by a foreign jurisdiction with which Iowa has a nonbinding reciprocity agreement.

This rule is intended to implement Iowa Code sections 321.174, 321.178, 321.180, 321.180A, 321.180B, 321.186, 321.189, 321.193, 321.196 and 321.198.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—604.32(321) Driving tests requirements. Rescinded IAB 1/8/92, effective 2/12/92.

761—604.33 and **604.34** Reserved.

761—604.35(321) Determination of gross vehicle weight rating. For a vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight

rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

This rule is intended to implement Iowa Code section 321.1.

761—604.36 to **604.39** Reserved.

761—604.40(321) Failure to pass examination.

604.40(1) An applicant who fails to pass a required examination or reexamination shall not be licensed.

a. If the applicant does not have a valid Iowa license, the department shall deny the applicant a license.

b. If the applicant has a valid Iowa license, the department shall suspend the license for incapability. However, if the applicant's license is valid for less than 30 days, the department shall deny further licensing. The department shall serve a notice of suspension or denial.

c. See 761—615.4(321) for further information on denials and 761—615.14(321) for further information on suspensions for incapability.

d. An applicant may contest a denial or suspension in accordance with 761—615.38(321).

604.40(2) Limitations on the hearing and appeal process.

a. After a suspension or denial for failure to pass a required knowledge or driving test, a person who contests the suspension or denial shall be deemed to have exhausted the person's administrative remedies after three unsuccessful attempts to pass the required test.

b. After the three unsuccessful attempts, no further testing shall be allowed until six months have elapsed from the date of the last test failure, and then only if the applicant demonstrates a significant change or improvement in those physical or mental factors that resulted in the original decision. A request for further testing must be submitted in writing to the office of driver services at the address in rule 761—600.2(17A).

c. Notwithstanding paragraphs *"a"* and *"b"* of this subrule, no testing shall occur if the director determines that it is unsafe to allow testing.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177, 321.180A and 321.210.

761—604.41 to **604.44** Reserved.

761—604.45(321) Reinstatement. A person whose license has been suspended or denied for failure to pass a required examination or reexamination shall meet the vision standards for licensing, pass the required knowledge examination(s), and pass the required driving test(s) before an Iowa license will be issued.

This rule is intended to implement Iowa Code sections 321.177 and 321.186.

761—604.46 to **604.49** Reserved.

761—604.50(321) Special reexaminations. The department may require a special reexamination consisting of a vision screening, knowledge test and driving test of any licensee.

604.50(1) The department may require a special reexamination when a licensee has been involved in a fatal motor vehicle accident and the investigating officer's report of the accident indicates the licensee contributed to the accident.

604.50(2) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officer's report of each accident lists one of the following "Driver/Vehicle Related Contributing Circumstances" for the licensee:

a. Ran traffic signal.

b. Ran stop sign.

c. Passing, interfered with other vehicle.

d. Left of center, not passing.
e. Failure to yield right-of-way at uncontrolled intersection.
f. Failure to yield right-of-way from stop sign.
g. Failure to yield right-of-way from yield sign.
h. Failure to yield right-of-way making left turn.
i. Failure to yield right-of-way to pedestrian.
j. Failure to have control.

604.50(3) The department may require a special reexamination when a licensee has been involved in two accidents within a three-year period and the investigating officers' reports for both accidents list a driver condition for the licensee of "apparently asleep."

604.50(4) The department may require a special reexamination when a licensee who is 65 years of age or older has been involved in an accident and information in the investigating officer's or the person's own report of the accident indicates the need for reexamination. A circumstance that may indicate a need for reexamination includes, but is not limited to, any one of the following:

a. The licensee made a left turn that resulted in the accident.
b. The licensee failed to yield the right-of-way at a stop sign.
c. The licensee failed to yield the right-of-way at a yield sign.
d. The licensee failed to yield the right-of-way at an uncontrolled intersection.
e. The licensee failed to yield the right-of-way at a traffic control signal.
f. The licensee's vision may be a contributing factor to a nighttime accident.
g. The licensee has a physical disability-related license restriction other than "corrective lenses" and the accident involved one of the circumstances listed in paragraphs *"a"* to *"f"* above.

604.50(5) The department may require a special reexamination when recommended by a peace officer, a court, or a properly documented citizen's request. A factor that may indicate a need for reexamination includes, but is not limited to, any one of the following:

a. Loss of consciousness.
b. Confusion, disorientation or dementia.
c. Inability to maintain a vehicle in the proper lane.
d. Repeatedly ignoring traffic control devices in a nonchase setting.
e. Inability to interact safely with other vehicles.
f. Inability to maintain consistent speed when no reaction to other vehicles or pedestrians is required.

This rule is intended to implement Iowa Code sections 321.177, 321.186 and 321.210.

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[1] Effective date of 604.11(2) and 604.13(2)*"b"* delayed until adjournment of the 1988 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its June 1987 meeting.

CHAPTER 605
LICENSE ISSUANCE

761—605.1(321) Scope. This chapter of rules applies to the issuance of all Iowa driver's licenses. Additional information on the issuance of a commercial driver's license or a commercial driver's instruction permit is given in 761—Chapter 607.

This rule is intended to implement Iowa Code section 321.174.

761—605.2(321) Contents of license. In addition to the information specified in Iowa Code subsection 321.189(2), the following information shall be shown on a driver's license.

605.2(1) *Address.* A business address shall be used only when the licensee does not have an Iowa address and will not be able to establish a residence address in Iowa.

605.2(2) *Physical description.* The physical description of the licensee on the face of the driver's license shall include:

a. The licensee's eye color using these abbreviations: Blk-black, Blu-blue, Bro-brown, Gry-gray, Grn-green, Haz-hazel, and Pnk-pink.

b. The licensee's height in inches.

c. Rescinded IAB 11/8/06, effective 12/13/06.

This rule is intended to implement Iowa Code section 321.189.

761—605.3(321) License class. The driver's license class shall be coded on the face of the driver's license using these codes:

Class A—commercial driver's license
Class B—commercial driver's license
Class C—commercial driver's license
Class C—noncommercial driver's license
Class D—noncommercial driver's license, chauffeur
Class M—noncommercial driver's license, motorcycle only

This rule is intended to implement Iowa Code section 321.189.

761—605.4(321) Endorsements. The endorsements shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.4(1) *For a commercial driver's license.* The following endorsements may be added to a Class A, B or C commercial driver's license using these letter codes:

H—Hazardous material
P—Passenger
N—Tank
X—Hazardous material and tank
T—Double/triple trailers
S—School bus

605.4(2) *For a Class D driver's license (chauffeur).* The following endorsements may be added to a Class D driver's license using these number codes:

1—Truck-tractor semitrailer combination

2—Vehicle with 16,001 pounds gross vehicle weight rating or more. Not valid for truck-tractor semitrailer combination

3—Passenger vehicle less than 16-passenger design

605.4(3) *Motorcycle endorsement.* A motorcycle endorsement may be added to any driver's license that permits unaccompanied driving, other than a Class M driver's license or a motorized bicycle license, using the following letter code:

L—Motorcycle

This rule is intended to implement Iowa Code section 321.189.

761—605.5(321) Restrictions. Restrictions shall be coded on the face of the driver's license and explained in text on the back of the driver's license.

605.5(1) *For all licenses.* The following restrictions may apply to any driver's license:

B—Corrective lenses required
C—Mechanical aid (as detailed in the restriction on the back of the card)
D—Prosthetic aid (as detailed in the restriction on the back of the card)
E—Automatic transmission
F—Left outside mirror
G—No driving when headlights required
H—Temporary restricted license or permit (work permit)
I—Ignition interlock required
J—Restrictions on the back of card
S—SR required (proof of financial responsibility for the future)
T—Medical report required at renewal
U—Not valid for 2-wheel vehicle
V—Left and right outside mirrors
W—Restricted commercial driver's license (CDL)
Y—Intermediate license

605.5(2) *For a noncommercial driver's license.* The following restrictions apply only to a noncommercial driver's license:

P—Special instruction permit
Q—No interstate or freeway driving
R—Maximum speed of 35 mph

605.5(3) *For a commercial driver's license.* The following restrictions apply only to a commercial driver's license:

K—Commercial driver's license intrastate only
L—Vehicle without air brakes
M—Except Class A bus
N—Except Class A and Class B bus
O—Except tractor-trailer

605.5(4) *Special licenses.* A numbered restriction will designate a special driver's license using these codes:

1—Motorcycle instruction permit
2—Noncommercial instruction permit (vehicle less than 16,001 gross vehicle weight rating)
3—Commercial driver's instruction permit
4—Chauffeur's instruction permit
5—Motorized bicycle license
6—Minor's restricted license
7—Minor's school license

605.5(5) *Additional information.*

a. Hearing impairment. A person with a hearing aid or a noticeable loss of hearing may be restricted to a motor vehicle equipped with a left outside rearview mirror.

b. Reexamination or report. The department may issue a restriction requiring a person to reappear at a specified time for examination. The department may require a medical report to be submitted. The department shall send Form 430029 as a reminder to appear.

c. Loss of consciousness or voluntary control.

(1) If a person is licensed pursuant to 761—subrule 600.4(4), the department shall issue the first driver's license with a restriction stating: "Medical report to be furnished at the end of six months."

(2) If this medical report shows that the person has been free of episodes of loss of consciousness or voluntary control since the previous medical report and the report recommends licensing, the department shall issue a duplicate driver's license with a restriction stating: "Medical report required at renewal." At

each renewal accompanied by a favorable medical report, the department shall issue a two-year driver's license with the same restriction.

(3) If the latest medical report indicates the person experienced only a single nonrecurring episode, the cause has been identified, and the physician is not treating or has not treated the person for the episode and believes it is unlikely to recur, the department may waive the medical report requirement upon recommendation by the medical advisory board.

d. Financial responsibility. When a person is required under Iowa Code chapter 321A to have future proof of financial responsibility on file, the license restriction will read: "SR required." The license shall be valid only for the operation of motor vehicles covered by the class of license issued and by the proof of financial responsibility filed.

e. Vision restriction. Restrictions relating to vision are addressed in 761—Chapter 604.

This rule is intended to implement Iowa Code chapter 321A and sections 321.178, 321.180, 321.180A, 321.180B, 321.189, 321.193, 321.194, 321.215, 321J.4, and 321J.20.

761—605.6 Reserved.

761—605.7(321L) Handicapped designation. Rescinded IAB 2/11/98, effective 3/18/98.

761—605.8 Reserved.

761—605.9(321) Fees for driver's licenses. Fees for driver's licenses are specified in Iowa Code section 321.191. A license fee may be paid by cash, check or money order. If payment is by check, the following requirements apply:

605.9(1) The check shall be for the exact amount of the fee and shall be payable to: Treasurer, State of Iowa. An exception may be made when a traveler's check is presented.

605.9(2) One check may be used to pay fees for several persons, such as members of a family or employees of a business firm. One check may pay all fees involved, such as the license fee and the reinstatement fee.

This rule is intended to implement Iowa Code section 321.191.

761—605.10(321) Waiver or refund of license fees.

605.10(1) The department may waive payment of or refund the fee for a renewal or duplicate of a driver's license if:

a. An error occurs during the issuance process and is discovered by the applicant at the time of issuance. However, the fee shall not be waived or refunded if the error is discovered by department staff and is corrected within the 30-minute time period specified in paragraph *"c"* of this subrule.

b. An error occurs during the issuance process and is discovered during the edit process of updating the driver record, and the error requires the applicant to return to the driver's license station to have the error corrected.

c. The applicant is required to wait more than 30 minutes to renew a license or obtain a duplicate license. This 30-minute time period is determined by using an automated customer numbering system that monitors waiting time.

605.10(2) The department shall not waive payment of or refund a fee if the applicant does not have in the applicant's possession at the time of application the previously issued driver's license.

605.10(3) The department shall not waive payment of or refund fees for any of the following transactions: reinstatements following sanctions, new applications, or applications requiring knowledge or skills testing.

This rule is intended to implement Iowa Code section 321.192.

761—605.11(321) Duplicate license.

605.11(1) *Lost or destroyed license.* To replace a valid license that is lost or destroyed, the licensee shall submit Form 430052 and proof of age, identity and social security number. The replacement fee is $3.

605.11(2) *Voluntary replacement.* The department shall issue a duplicate of a valid license to an eligible licensee if the license is surrendered to the department and the $1 voluntary replacement fee is paid. Voluntary replacement includes but is not limited to:

a. Replacement of a damaged license.

b. Replacement to change the address on a license.

c. Replacement to change the name on a license. The licensee shall submit an affidavit of the name change on Form 430043. The affidavit must be accompanied by one of the following documents:

(1) Court-ordered name change. It must contain the full name, date of birth, and court seal.

(2) Divorce decree.

(3) Marriage certificate.

d. Replacement to change the sex on a license. The licensee shall submit court documentation of the sex change.

e. Issuance of a license without the words "under 21" to a licensee who is 21 years of age or older.

f. Issuance of a license without the words "under 18" to a licensee who is 18 years of age or older. (If the licensee is under 21 years of age, the words "under 21" will replace the words "under 18.")

g. Issuance of a noncommercial driver's license to an eligible person who has been disqualified from operating a commercial motor vehicle.

h. Replacement of a valid license before its expiration date to obtain a license issued under the new classification system.

This rule is intended to implement Iowa Code sections 321.189, 321.195, and 321.208.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—605.12(321) Address changes.

605.12(1) A licensee shall notify the department of a change in the licensee's mailing address within 30 days of the change. Notice shall be given by:

a. Submitting the address change in writing to the office of driver services, or

b. Appearing in person to change the mailing address at any driver's license examination station.

605.12(2) Parents or legal guardians may provide written notice of a mailing address change on behalf of their minor children.

605.12(3) The department may use U.S. Postal Service address information to update its address records.

This rule is intended to implement Iowa Code sections 321.182 and 321.184.

761—605.13 and **605.14** Reserved.

761—605.15(321) License extension.

605.15(1) *Six-month extension.* An Iowa resident may apply for a six-month extension of a license if the resident:

a. Has a valid license,

b. Is eligible for further licensing, and

c. Is temporarily absent from Iowa or is temporarily incapacitated at the time for renewal.

605.15(2) *Procedure.* The licensee shall apply for an extension by submitting Form 430027 to the department. The form may be obtained from and submitted to a driver's license examination station. The licensee may also apply by letter to the address in 761—600.2(17A).

a. A six-month extension shall be added to the expiration date on the license. When the licensee appears to renew the license, the expiration date of the renewed license will be computed from the expiration date of the original license, notwithstanding the extension.

b. The department shall allow only two six-month extensions.

This rule is intended to implement Iowa Code section 321.196.

761—605.16(321) Military extension.

605.16(1) *Form 430028.* A person who qualifies for a military extension of a valid license should request Form 430028 from the department and carry it with the license for verification to peace officers. Form 430028 explains the provisions of Iowa Code section 321.198 regarding military extensions.

605.16(2) *Request for retention of record.* A person with a military extension may request that the department retain the record of license issuance for the duration of the extension or reenter the record if it has been removed from department records. The request may be made by letter or by using Form 430081. The letter or Form 430081 shall be signed by the person's commanding officer to verify the military service and shall be submitted to the department at the address in 761—600.2(17A).

605.16(3) *Renewal of license after military extension.* When an applicant renews a license after a military extension, the department may require the applicant to provide documentation of both the military service and the date of separation from military service.

605.16(4) *Reinstatement after sanction.* A person with a military extension whose license has been canceled, suspended or revoked shall comply with the requirements of 761—615.40(321) to reinstate the license.

This rule is intended to implement Iowa Code section 321.198.

761—605.17 to **605.19** Reserved.

761—605.20(321) Fee adjustment for upgrading license. The fee for upgrading a driver's license shall be computed on a full-year basis. The fee is charged for each year or part of a year between the date of the change and the expiration date on the license.

605.20(1) The fee to upgrade a driver's license from one class to another is determined by computing the difference between the current license fee and the new license fee as follows:

a. Converting noncommercial Class C to Class D—$4 per year of new license validity.

b. Converting Class M to Class D with a motorcycle endorsement—$4 per year of new license validity.

c. Converting Class M to noncommercial Class C with a motorcycle endorsement—$1 one-time fee.

605.20(2) The fee to add a privilege to a driver's license is computed per year of new license validity as follows:

Noncommercial Class C (full privileges from a restricted Class C)	$4 per year
Motorized bicycle	$4 per year
Minor's restricted license	$4 per year
Minor's school license	$4 per year
Motorcycle instruction permit	$1 per year
Motorcycle endorsement	$1 per year

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

761—605.21 to **605.24** Reserved.

761—605.25(321) License renewal.

605.25(1) A licensee who wishes to renew a license shall apply at a driver's license examination station and, if required, pass the appropriate examination.

605.25(2) A valid license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier.

605.25(3) A valid license may be renewed within 60 days after the expiration date, unless otherwise specified.

This rule is intended to implement Iowa Code sections 321.186 and 321.196.

761—605.26(321) License renewal by mail. Rescinded IAB 3/20/02, effective 4/24/02.

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CHAPTER 607
COMMERCIAL DRIVER LICENSING

761—607.1(321) Scope. This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

761—607.2(17A) Information.

607.2(1) *Information and location.* Applications, forms and information about the commercial driver's license (CDL) are available at any driver's license examination station. Assistance is also available by mail from the Office of Driver Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (800)532-1121 or (515)244-8725; or by facsimile at (515)237-3071.

607.2(2) *Manual.* A copy of a study manual for the commercial driver's license tests is available upon request at any driver's license examination station.

This rule is intended to implement Iowa Code section 17A.3.

761—607.3(321) Definitions. The definitions in Iowa Code section 321.1 apply to this chapter of rules. In addition, the following definitions are adopted:

"Air brake system" means a system that uses air as a medium for transmitting pressure or force from the driver's control to the service brake. "Air brake system" shall include any braking system operating fully or partially on the air brake principle.

"Commercial motor vehicle" as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. "Commercial motor vehicle" also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

"Controlled substance" as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

"Passenger vehicle" means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.
2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

"School bus" means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events. "School bus" does not include a bus used as a common carrier.

"State," as used in "another state" in Iowa Code subsection 321.174(2), "Former state of residence" in Iowa Code subsection 321.188(5), or "any state" in Iowa Code subsection 321.208(1), means one of the United States, the District of Columbia, a Canadian province or a Mexican state unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.188, 321.191, 321.193 and 321.208.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—607.4 and **607.5** Reserved.

761—607.6(321) Exemptions.

607.6(1) *Persons exempt.* A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

607.6(2) *Exempt until April 1, 1992.* Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

761—607.7(321) Records. The operating record of a person who has been issued a commercial driver's license or a person who has been disqualified from operating a commercial motor vehicle shall be maintained as provided in the department's "Record Management Manual" adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 and 321.199.

761—607.8 and **607.9** Reserved.

761—607.10(321) Adoption of federal regulations.

607.10(1) *Code of Federal Regulations.* The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.

b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.

c. The following portions of 49 CFR Part 383 (October 1, 2008):

(1) Section 383.51(b), Disqualification for major offenses, and Section 383.51(a)(5), Reinstatement after lifetime disqualification.

(2) Subpart E—Testing and Licensing Procedures, which contains Sections 383.71-383.77.

(3) Subpart G—Required Knowledge and Skills, which contains Sections 383.110-383.123.

(4) Subpart H—Tests, which contains Sections 383.131-383.135.

607.10(2) *Copies of regulations.* Copies of the federal regulations may be reviewed at the state law library or through the Internet at http://www.fmcsa.dot.gov.

This rule is intended to implement Iowa Code sections 321.187, 321.188, 321.208 and 321.208A.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—607.11 to **607.14** Reserved.

761—607.15(321) Application. An applicant for a commercial driver's license shall comply with the requirements of Iowa Code sections 321.182 and 321.188 and 761—Chapter 601.

This rule is intended to implement Iowa Code sections 321.182 and 321.188.

761—607.16(321) Commercial driver's license (CDL).

607.16(1) *Classes.* The department may issue a commercial driver's license only as a Class A, B or C driver's license. The license class identifies the types of vehicles that may be operated. A commercial driver's license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

607.16(2) *Validity.*

a. A Class A commercial driver's license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code paragraph 321.189(1)*"a."* With the required endorsements and subject to the applicable restrictions, a Class A commercial driver's license is valid to operate any vehicle.

b. A Class B commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)*"b."* With the required endorsements and subject to the applicable restrictions, a Class B commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A commercial driver's license.

c. A Class C commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)*"c."* With the required endorsements and subject to the applicable restrictions, a Class C commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver's license.

d. A commercial driver's license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver's license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

e. A commercial driver's license valid for five years shall be issued to a qualified applicant who is at least 18 years of age but not yet 70 years of age.

f. A commercial driver's license valid for two years shall be issued to a qualified applicant 70 years of age or older. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

g. A commercial driver's license is valid for 60 days after the expiration date.

h. A person with a commercial driver's license valid for the vehicle operated is not required to obtain a Class D driver's license to operate the vehicle as a chauffeur.

607.16(3) *Requirements.*

a. The minimum age to obtain a commercial driver's license is 18 years.

b. The applicant shall meet the requirements of Iowa Code sections 321.182 and 321.188.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, and 321.196.

761—607.17(321) Endorsements. All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver's license are:

607.17(1) *Hazardous material.* A hazardous material endorsement (Hazmat) is required to transport hazardous material of a type or quantity requiring placarding. Upon license renewal, retesting and fee payment are required. Retesting and fee payment are also required when an applicant upgrades an Iowa license or transfers a commercial driver's license from another state unless the applicant provides evidence of passing the endorsement test within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer's farm to transport supplies to or from the farm.

607.17(2) *Passenger vehicle.* A passenger vehicle endorsement (Pass) is required to operate a passenger vehicle as defined in rule 607.3(321).

607.17(3) *Tank vehicle.* A tank vehicle endorsement (Tank) is required to operate a tank vehicle as defined in Iowa Code section 321.1. A commercial motor vehicle upon which is transported an empty storage tank as the vehicle cargo is not a tank vehicle. A vehicle transporting a tank, regardless of the tank's capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

607.17(4) *Double/triple trailer.* A double/triple trailer endorsement (Dbl/Trpl Trlr) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

607.17(5) *Hazardous material and tank.* A combined endorsement (Hazmat & Tank) authorizes both hazardous material and tank vehicle operations.

607.17(6) *School bus.* After September 30, 2005, a school bus endorsement is required to operate a school bus as defined in rule 607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement.

607.17(7) *Exceptions for towing operations.*

a. A driver who tows a vehicle in an emergency "first move" from the site of a vehicle malfunction or accident on a highway to the nearest appropriate repair facility is not required to have the endorsement(s) applicable to the towed vehicle. In any subsequent move, a driver who tows a vehicle from one repair or disposal facility to another is required to have the endorsement(s) applicable to the towed vehicle with one exception: A tow truck driver is not required to have a passenger endorsement to tow a passenger vehicle.

b. The double/triple trailer endorsement is not required to operate a commercial motor vehicle with two or more towed vehicles that are not trailers.

This rule is intended to implement Iowa Code sections 321.1, 321.176A, and 321.189.

761—607.18(321) Restrictions. The restrictions that may limit commercial motor vehicle operation with a commercial driver's license are listed in 761—subrule 605.5(3) and are explained below:

607.18(1) *Air brake.* The air brake restriction (Vehicle without air brakes) prohibits the operation of a commercial motor vehicle equipped with an air brake system, as defined in rule 607.3(321), until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when renewing the license.

607.18(2) *Class B vehicle.* The Class B vehicle restriction (except tractor-trailer) prohibits operation of a motor vehicle that meets the criteria for a Class A commercial motor vehicle.

607.18(3) *Class B passenger vehicle.* The Class B passenger vehicle restriction (except Class A bus) prohibits operation of a passenger vehicle that meets the criteria for a Class A commercial motor vehicle.

607.18(4) *Class C passenger vehicle.* The Class C passenger vehicle restriction (except Class A and Class B bus) prohibits operation of a passenger vehicle that meets the criteria for a Class A or Class B commercial motor vehicle.

This rule is intended to implement Iowa Code sections 321.189 and 321.191.

761—607.19 Reserved.

761—607.20(321) Commercial driver's instruction permit.

607.20(1) *Validity.*

a. A commercial driver's instruction permit allows the permit holder to operate a commercial motor vehicle when accompanied by a person licensed for the vehicle being operated. Examples of permissible vehicle operation include but are not limited to:

(1) Operation of a vehicle requiring a higher class license than the license to which the permit is added.

(2) Operation of a vehicle requiring an endorsement other than a hazardous material endorsement.

(3) Operation of a vehicle equipped with air brakes.

b. A commercial driver's instruction permit is valid for six months and may be renewed once within two years from the date of issuance of the first permit.

c. A commercial driver's instruction permit is invalid after the expiration date of the license to which the permit is added or the expiration date of the permit whichever occurs first.

607.20(2) *Requirements.*

a. An applicant for a commercial driver's instruction permit must be at least 18 years of age and eligible for a commercial driver's license.

b. The applicant must have a valid Class A, B, C, or D license other than an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license.

c. The applicant must successfully pass the general knowledge test for a commercial driver's license.

This rule is intended to implement Iowa Code sections 321.180, 321.186 and 321.188.

761—607.21 to **607.24** Reserved.

761—607.25(321) Examination for a commercial driver's license. In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver's license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

761—607.26(321) Vision screening. An applicant for a commercial driver's license must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

761—607.27(321) Knowledge tests.

607.27(1) *General knowledge test.* The general knowledge test for a commercial driver's license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

607.27(2) *Additional tests.* In addition to the general knowledge test for a commercial driver's license, an additional knowledge test is required for each of the following:

a. Class A license for combination vehicle operation as required in 49 CFR Section 383.111.

b. Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.

c. Passenger vehicle endorsement as required in 49 CFR Section 383.117.

d. Tank vehicle endorsement as required in 49 CFR Section 383.119.

e. Double/triple trailer endorsement as required in 49 CFR Section 383.115.

f. School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.

g. Removal of the air brake restriction as required in 49 CFR Section 383.111.

607.27(3) *Oral test.* An oral test shall be offered only at specified locations. Information about the locations is available at any driver's license examination station.

607.27(4) *Waiver.* A waiver of any knowledge test is permitted only as provided in Iowa Code subsection 321.188(5). The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.

607.27(5) *Requirement.* An applicant must pass the applicable knowledge test(s) before taking the skills test.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.

761—607.28(321) Skills test.

607.28(1) *Content and order.* The skills test for a commercial driver's license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H. The three parts must be taken in the following order: the pretrip inspection, the basic vehicle control skills, and an on-the-road driving demonstration. Those elements of the skills test that are not applicable to the vehicle being used in the skills test may be waived by the department. The basic vehicle control skills may be accomplished as part of the on-the-road driving demonstration. The department shall terminate the skills test when it is determined that the applicant has failed the test.

607.28(2) *Vehicle.* The applicant shall provide a representative vehicle for the skills test. "Representative vehicle" means a commercial motor vehicle that meets the statutory description for the class of license applied for.

a. To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

b. To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 607.3(321), in the same vehicle class as the applicant will drive, as required in 49 CFR Section 383.123. Up to and including September 30, 2005, the skills test for a school bus endorsement is waived for an applicant meeting the requirements of 49 CFR Section 383.123(b).

c. To remove an air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 607.3(321) and as required in 49 CFR Section 383.113.

607.28(3) *Locations.* The skills test for a commercial driver's license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver's license examination station for the location of the nearest skills testing station. A skills test by appointment shall be offered only at specified regional test sites.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.

761—607.29(321) Waiver of skills test. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.30 Reserved.

761—607.31(321) Test results.

607.31(1) *Proof of passing score.* When necessary, the department shall issue a form valid for 90 days showing the knowledge test(s) or part(s) of the skills test that the applicant passed. The applicant shall retain the form(s) until all tests are passed and present the form(s) to the department to obtain the license.

607.31(2) *Retesting.* An applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day.

This rule is intended to implement Iowa Code section 321.186.

761—607.32 to **607.34** Reserved.

761—607.35(321) Issuance of commercial driver's license. A commercial driver's license issued by the department shall be identified by "commercial driver's license" or "CDL" on the face of the license.

This rule is intended to implement Iowa Code section 321.189.

761—607.36(321) Conversion to commercial driver's license. Rescinded IAB 6/23/93, effective 7/28/93.

761—607.37(321) Commercial driver's license renewal.

607.37(1) To renew a commercial driver's license, the licensee shall apply at a driver's license examination station, certify eligibility and, if required, pass the appropriate test(s).

607.37(2) A valid commercial driver's license may be renewed 30 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed one year prior to the expiration date. The department may allow renewal earlier than one year prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

607.37(3) A valid commercial driver's license may be renewed within 60 days after the expiration date, unless otherwise specified.

This rule is intended to implement Iowa Code sections 321.186 and 321.196.

761—607.38(321) Transfers from another state. Upon initial application for an Iowa license, an Iowa resident who has a valid commercial driver's license from a former state of residence is not required to retest except as specified in Iowa Code subsection 321.188(5) but is required to pay the applicable endorsement and restriction removal fees.

This rule is intended to implement Iowa Code sections 321.188 and 321.191.

761—607.39(321) Disqualification.

607.39(1) *Date.* A disqualifying act, action or offense under Iowa Code section 321.208, that occurred before July 1, 1990, shall not be grounds for disqualification from operating a commercial motor vehicle.

607.39(2) *Notice.* A 30-day advance notice of disqualification shall be served by the department in accordance with rule 761—615.37(321). Pursuant to Iowa Code subsection 321.208(9), a peace officer on behalf of the department may serve the notice of disqualification immediately.

607.39(3) *Hearing and appeal process.* A person who has received a notice of disqualification may contest the disqualification in accordance with 761—615.38(17A,321).

607.39(4) *Reduction of lifetime disqualification.* Reserved.

This rule is intended to implement Iowa Code chapter 17A and section 321.208.

761—607.40(321) Sanctions. When a person's motor vehicle license is denied, canceled, suspended, revoked or barred, the person is also disqualified from operating a commercial motor vehicle.

This rule is intended to implement Iowa Code section 321.208.

761—607.41 to **607.44** Reserved.

761—607.45(321) Reinstatement. To reinstate a commercial driver's license after completion of a period of disqualification, a person shall appear at a driver's license examination station. The person must also meet the vision standards for licensing, pass the applicable knowledge test(s) and the skills test, and pay the required reinstatement fee and the fees for a new license.

This rule is intended to implement Iowa Code sections 321.191 and 321.208.

761—607.46 to **607.48** Reserved.

761—607.49(321) Restricted commercial driver's license.

607.49(1) *Scope.* This rule pertains to the issuance of restricted commercial driver's licenses to suppliers or employees of suppliers of agricultural inputs. Issuance is permitted by 49 CFR 383.3(f). A restricted commercial driver's license shall meet all requirements of a regular commercial driver's license, as set out in Iowa Code chapter 321 and this chapter of rules, except as specified in this rule.

607.49(2) *Agricultural inputs.* The term "agricultural inputs" means suppliers or applicators of agricultural chemicals, fertilizer, seed or animal feeds.

607.49(3) *Validity.*

a. A restricted commercial driver's license allows the licensee to drive a commercial motor vehicle for agricultural input purposes. The license is valid to:

(1) Operate Group B and Group C commercial motor vehicles including tank vehicles and vehicles equipped with air brakes, except passenger vehicles.

(2) Transport the hazardous materials listed in paragraph 607.49(3)*"b."*

(3) Operate only during the current, validated seasonal period.

(4) Operate between the employer's place of business and the farm currently being served, not to exceed 150 miles.

b. A restricted commercial driver's license is not valid for transporting hazardous materials requiring placarding, except as follows:

(1) Liquid fertilizers such as anhydrous ammonia may be transported in vehicles or implements of husbandry with total capacities of 3,000 gallons or less.

(2) Solid fertilizers such as ammonium nitrate may be transported provided they are not mixed with any organic substance.

(3) A hazardous material endorsement is not needed to transport the products listed in the preceding subparagraphs.

c. When not driving for agricultural input purposes, the license is valid for operating a noncommercial motor vehicle that may be legally operated under the noncommercial license held by the licensee.

607.49(4) *Requirements.*

a. The applicant must have two years of previous driving experience. This means that the applicant must have held a license that permits unaccompanied driving for at least two years. This does not include a motorized bicycle license, a minor's school license or a minor's restricted license.

b. The applicant must have a good driving record for the most recent two-year period, as defined in subrule 607.49(5).

c. An applicant who currently holds a commercial driver's license or a commercial driver's instruction permit is not eligible for issuance of a restricted commercial driver's license.

607.49(5) *Good driving record.* A "good driving record" means a driving record showing:

a. No multiple licenses.

b. No driver's license suspensions, revocations, disqualifications, denials, bars, or cancellations of any kind.

c. No convictions in any type of motor vehicle for:

(1) Driving under the influence of alcohol or drugs.

(2) Leaving the scene of an accident.

(3) Committing any felony involving a motor vehicle.
(4) Speeding 15 miles per hour or more over the posted speed limit.
(5) Reckless driving.
(6) Improper or erratic lane changes.
(7) Following too closely.
(8) Accident-connected traffic law violations.

d. No record of at-fault accidents.

607.49(6) *Issuance.*

a. The knowledge and skills tests described in rules 761—607.27(321) and 761—607.28(321) are waived.

b. A restricted commercial driver's license shall be coded with restriction "W" on the face of the driver's license, with the restriction explained in text on the back of the driver's license. In addition, the license shall be issued with a restriction stating the license's validity.

c. The expiration date for a restricted commercial driver's license that is converted to this license from another Iowa license shall carry the same expiration date as the previous license.

d. A restricted commercial driver's license may be renewed for the period of time specified in Iowa Code section 321.196. The licensee's good driving record shall be confirmed at the time of renewal.

e. The fee for a restricted commercial driver's license shall be as specified in Iowa Code section 321.191.

f. There are two periods of validity for commercial motor vehicle operation: March 15 through June 30, and October 4 through December 14. These are referred to as "seasonal periods." Validity shall not exceed 180 days in any 12-month period. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day maximum period of validity.

g. A restricted commercial driver's license must be validated for commercial motor vehicle operation for each seasonal period. This means that the applicant/licensee must appear at a driver's license examination station during the current seasonal period or not more than 30 days before the beginning of the period to have the person's good driving record confirmed. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that seasonal period, provided the person is otherwise eligible for the license. The fee for a replacement license shall be as specified in Iowa Code section 321.195.

h. The same process must be repeated for each seasonal period.

This rule is intended to implement Iowa Code section 321.176B.

761—607.50 Reserved.

761—607.51(321) Determination of gross vehicle weight rating.

607.51(1) *Vehicle other than towed vehicle.* For a vehicle other than a towed vehicle that has no legible manufacturer's certification label, the applicant may provide documentation of the gross vehicle weight rating, such as a manufacturer's certificate of origin, a title, a vehicle registration document, or the vehicle identification number information for the vehicle. In the absence of the above documentation, the registered weight of the vehicle shall be presumed to be the gross vehicle weight rating.

607.51(2) *Towed vehicle.* For a towed vehicle without a gross vehicle weight rating specified by the manufacturer, the gross vehicle weight rating shall be its gross weight.

This rule is intended to implement Iowa Code section 321.1.

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CHAPTER 610
RELEASE OF COMPUTERIZED DRIVER'S LICENSE AND NONOPERATOR'S IDENTIFICATION CARD RECORDS

[Appeared as Ch 14, Department of Public Safety, July 1974 IDR Supplement.]
[Prior to 6/3/87, Transportation Department[820]—(07,C) Ch 15]

761—610.1(321) Applicability. This chapter applies to the release of computerized records of driver's licenses and nonoperator's identification cards.

761—610.2(321) Definitions.

"Certified abstract of operating record" means the same as described in Iowa Code subsection 321A.3(1).

"Driver's Privacy Protection Act" is defined in 761—Chapter 611.

"Highly restricted personal information" means an individual's photograph or image, social security number, or medical or disability information.

"Person" means an individual, organization or entity.

"Personal information" means the same as defined in 761—Chapter 611.

"Recipient" means an individual who has obtained a certified abstract of operating record from the department.

"Sanction" is defined in rule 761—615.1(321).

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—610.3(321) Copying files to computer tape cartridges.

610.3(1) Two types of files are available for copying onto blank computer tape cartridges supplied by requesters:

a. Driver's license master file. This file can be sorted by Iowa driver's license number, NDL (no driver's license) number or nonoperator's identification card number. For each individual, the file includes the information that is on the face of the driver's license or nonoperator's identification card: name, address, license or card number, height, weight, gender, eye color, birth date, class of license, restrictions and endorsements. The file does not include the individual's photograph, social security number, or medical or disability information.

b. Driver's license suspension and revocation file. This file can be sorted by Iowa driver's license number, NDL (no driver's license) number or nonoperator's identification card number. For each individual whose privilege to operate motor vehicles or to register vehicles is sanctioned, the file includes the information that is on the face of the driver's license or nonoperator's identification card, plus information on the sanction. The file does not include the individual's photograph, social security number, or medical or disability information. The file is available on a bimonthly basis.

610.3(2) These files may be released only to requesters who are authorized by the Driver's Privacy Protection Act to use the information.

610.3(3) To obtain a copy of either of these files, a requester shall submit a written request to the office of driver services. The blank cartridges needed to copy the files and the appropriate fee for copy preparation and mailing shall accompany the request. The department may require the requester to:

a. Provide proof of identity and authority to secure access to the information.

b. Sign a certified statement or affidavit listing the specific reasons justifying access to the information and provide any proof necessary to establish relevant facts.

610.3(4) Data in a file will be provided only in the sequence currently maintained by the department.

610.3(5) A requested file will be provided within a reasonable period of time but shall not be given priority over other department work.

610.3(6) No warranty is provided concerning the accuracy or completeness of the data. If a copy is unreadable due to the department's negligence or error, the department shall provide a duplicate copy without charge.

761—610.4(321,321A) Certified abstract of operating records.

610.4(1) In accordance with Iowa Code section 321A.3, a printed, certified abstract of the operating record of an individual is available. The record includes the information that is on the face of the individual's driver's license, plus information on the individual's sanctions, reportable vehicle accidents, and convictions. The certified abstract of operating record does not include the individual's photograph, social security number, or medical or disability information.

610.4(2) To obtain a certified abstract of operating record, a requestor shall complete Form 431069, "Privacy Act Agreement for Request of Motor Vehicle Records," and submit it to the office of driver services. Form 431069 must be completed with all required attachments before the department will consider a request for a certified abstract of operating record. A requestor must attach a legible photocopy of the requestor's driver's license or nonoperator's identification card to the form. The statutory fee, if applicable, shall accompany the form.

610.4(3) Personal information and highly restricted personal information protected by Iowa Code section 321.11 and the Driver's Privacy Protection Act may be released only in the following situations:

a. The requestor has complied with each of the following requirements:

(1) Completed Form 431069 and submitted it to the office of driver services;

(2) Included all required attachments with the form, including a photocopy of the requestor's driver's license or nonoperator's identification card; and

(3) Paid the fee, if applicable, for the requested record.

b. The department is satisfied that the requestor provided adequate and truthful information on Form 431069 and in the documents that the requestor attached to Form 431069.

610.4(4) The single-use restriction in Iowa Code subsection 321A.3(8) applies only to the certified abstract of operating records and to persons who are subject to the fee listed in Iowa Code subsection 321A.3(1).

610.4(5) Any person who obtains a certified abstract of operating record from the department is required to comply with Iowa Code section 321.11 and the Driver's Privacy Protection Act.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

These rules are intended to implement Iowa Code sections 22.2, 22.3, 321.11 and 321A.3.

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CHAPTER 611
DRIVER'S PRIVACY PROTECTION—DRIVER'S LICENSE AND NONOPERATOR'S IDENTIFICATION CARD

761—611.1(321) Applicability.

611.1(1) This chapter applies to personal information in records pertaining to drivers' licenses and nonoperators' identification cards. In addition to information on current licensees and cardholders, these records include information on individuals who do not currently hold a driver's license or nonoperator's identification card. Operating records and records of driver sanctions are two examples.

611.1(2) Rules regarding personal information about vehicle owners in records pertaining to certificates of title and vehicle registration are found in 761—Chapter 415.

761—611.2(321) Adoption. The department adopts the Driver's Privacy Protection Act of 1994 (18 U.S.C. § 2721 et seq.) as amended through calendar year 2000 (P.L. 106-346) for driver's license records and nonoperator's identification card records.

761—611.3(321) Definitions.

"Driver's license" is defined in Iowa Code section 321.1.

"Driver's Privacy Protection Act" or *"Act"* means the Act adopted in rule 761—611.2(321).

"Law enforcement agency" includes, but is not limited to, county attorneys, federal district attorneys, attorneys general, and state and federal departments of justice.

"Motor vehicle record" as used in the Act means any record that pertains to a driver's license, nonoperator's identification card, certificate of title, registration receipt, or registration renewal receipt issued by the department or the county treasurer.

"Personal information" means information that identifies an individual, including the items listed in Iowa Code section 321.11 and 18 U.S.C. § 2725 of the Driver's Privacy Protection Act adopted in rule 761—611.2(321). "Personal information" also includes information on an individual's nonoperator's identification card.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—611.4(321) Requirements and procedures. Notwithstanding Iowa Code chapter 22 and 761—Chapter 4, the following procedures implement the Driver's Privacy Protection Act and Iowa Code section 321.11 as they pertain to driver's license records and nonoperator's identification card records. The department does not provide the waiver procedure described in the Driver's Privacy Protection Act (codified as Sec. 2721(d)).

611.4(1) The department may require a person who requests personal information about an individual to:

a. Submit the request in writing.

b. Provide proof of identity and authority to secure access to the information.

c. Sign a certified statement or affidavit listing the specific reasons justifying access to the information and provide any proof necessary to establish relevant facts.

611.4(2) Form 431069, "Privacy Act Agreement for Request of Motor Vehicle Records," must be completed by an applicant and approved by the department before the department may disclose personal information to the applicant without the express written consent of the individual to whom such information applies. On the form, the applicant shall indicate the provision of law that allows the release of personal information to that applicant. For the purpose of this subrule, "applicant" means a person who is not an authorized employee of the department.

611.4(3) An individual's signature on the document providing express written consent allowing disclosure of the individual's personal information to another person must be notarized.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

These rules are intended to implement Iowa Code section 321.11.

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CHAPTER 615
SANCTIONS
[Prior to 6/3/87, Transportation Department[820]—(07,C) Ch 6]

761—615.1(321) Definitions. The definitions in 761—600.1(321) apply to this chapter. In addition:

"Accident free" as used in Iowa Code section 321.180B means the driver has not been involved in a contributive accident. "Involvement in a motor vehicle accident" as used in Iowa Code section 321.180B means involvement in a contributive accident.

"Contributive accident" means an accident for which there is evidence in departmental records that the driver performed an act which resulted in or contributed to the accident, or failed to perform an act which would have avoided or contributed to the avoidance of the accident.

"Conviction free" as used in Iowa Code section 321.180B means the driver has not been convicted of a moving violation.

"Deny" or *"denial"* means a rejection of an application for a license or a refusal to issue, renew or reinstate a license.

"Moving violation," unless otherwise provided in this chapter, means any violation of motor vehicle laws except:

1. Violations of equipment standards to be maintained for motor vehicles.
2. Parking violations as defined in Iowa Code section 321.210.
3. Child restraint and safety belt and harness violations under Iowa Code sections 321.445 and 321.446.
4. Violations of registration, weight and dimension laws.
5. Operating with an expired license.
6. Failure to appear.
7. Disturbing the peace with a motor vehicle.
8. Violations of Iowa Code Supplement section 321.20B for failure to provide proof of financial liability coverage.

"Sanction" means a license denial, cancellation, suspension, revocation, bar or disqualification.

This rule is intended to implement Iowa Code sections 321.1, 321.178, 321.180A, 321.189, 321.194, 321.210, 321.215, 321.445, 321.446 and 321.555.

761—615.2(321) Scope. This chapter of rules applies to any license, as defined in 761—600.1(321). However:

615.2(1) Rules specifically addressing denial, cancellation or disqualification of a commercial driver's license are found in 761—Chapter 607, "Commercial Driver Licensing."

615.2(2) Rules implementing Iowa Code chapter 321J are found in 761—Chapter 620, "OWI and Implied Consent."

615.2(3) Rules implementing Iowa Code chapter 321A are found in 761—Chapter 640, "Financial Responsibility."

This rule is intended to implement Iowa Code chapters 321, 321A and 321J.

761—615.3(17A) Information and address. Applications, forms and information concerning license sanctions are available at any driver's license examination station or at the address in 761—600.2(17A).

This rule is intended to implement Iowa Code section 17A.3.

761—615.4(321) Denial for incapability.

615.4(1) A person who has a valid Iowa license that would otherwise be suspended for incapability shall, in lieu of a suspension, be denied further licensing if there is less than 30 days' validity on the license.

a. The denial shall be effective when the license is no longer valid.

b. The license shall be surrendered to the department. The department shall issue a temporary driving permit which allows the person to drive until the effective date of the denial.

615.4(2) If a person who is denied licensing for incapability does not have a valid Iowa license, the department may refuse orally to issue a license, effective immediately, or may deny licensing in writing, effective on the date the denial notice is served.

This rule is intended to implement Iowa Code sections 321.177 and 321.210.

761—615.5 and **615.6** Reserved.

761—615.7(321) Cancellations.

615.7(1) The department shall cancel the license of an unmarried minor upon receipt of a written withdrawal of consent from the person who consented to the minor's application. The department shall also cancel a minor's license upon receipt of evidence of the death of the person who consented to the minor's application.

615.7(2) The department shall cancel a motorized bicycle license when the licensee is convicted of one moving violation. Reapplication may be made 30 days after the date of cancellation.

615.7(3) The department may cancel a license when the person was not entitled or is no longer entitled to a license, failed to give correct and required information, or committed fraud in applying.

615.7(4) A cancellation shall begin ten days after the department's notice of cancellation is served.

This rule is intended to implement Iowa Code sections 321.184, 321.185, 321.189, 321.201 and 321.215.

761—615.8 Reserved.

761—615.9(321) Habitual offender.

615.9(1) The department shall declare a person to be a habitual offender under Iowa Code subsection 321.555(1) in accordance with the following point system:

a. Points shall be assigned to convictions as follows:

Conviction	Points
Perjury or the making of a false affidavit or statement under oath to the department of public safety	2 points
Driving while under suspension, revocation or denial (except Iowa Code chapter 321J)	2 points
Driving while under Iowa Code chapter 321J revocation or denial	3 points
Driving while barred	4 points
Operating a motor vehicle in violation of Iowa Code section 321J.2	4 points
An offense punishable as a felony under the motor vehicle laws of Iowa or any felony in the commission of which a motor vehicle is used	5 points
Failure to stop and leave information or to render aid as required by Iowa Code sections 321.261 and 321.263	5 points
Eluding or attempting to elude a pursuing law enforcement vehicle in violation of Iowa Code section 321.279	5 points
Serious injury by a vehicle in violation of Iowa Code subsection 707.6A(3)	5 points
Manslaughter resulting from the operation of a motor vehicle	6 points

b. Based on the points accumulated, the person shall be barred from operating a motor vehicle on the highways of this state as follows:

Points	Length of bar
6 – 7	2 years
8 – 9	3 years
10 – 12	4 years
13 – 15	5 years
16+	6 years

615.9(2) A person declared to be a habitual offender under Iowa Code subsection 321.555(2) shall be barred from operating a motor vehicle on the highways of this state for one year.

615.9(3) A person declared to be a habitual offender under Iowa Code Supplement section 321.560, unnumbered paragraph 2, shall be barred from operating a motor vehicle on the highways of this state beginning on the date the previous bar expires.

This rule is intended to implement Iowa Code sections 321.555, 321.556 and 321.560.

761—615.10 Reserved.

761—615.11(321) Periods of suspension.

615.11(1) *Length.* The department shall not suspend a person's license for less than 30 days nor for more than one year unless a statute specifies or permits a different period of suspension.

615.11(2) *Extension of suspension.* The department shall extend the period of license suspension for an additional like period when the person is convicted of operating a motor vehicle while the person's license is suspended, unless a statutory exception applies. If the person's driving record does not indicate what the original grounds for suspension were, the period of license suspension shall not exceed six months.

This rule is intended to implement Iowa Code sections 321.212 and 321.218.

761—615.12(321) Suspension of a habitually reckless or negligent driver.

615.12(1) The department may suspend a person's license if the person is a habitually reckless or negligent driver of a motor vehicle.

a. "Habitually reckless or negligent driver" means a person who has accumulated a combination of three or more contributive accidents and convictions for moving violations or three or more contributive accidents within a 12-month period.

b. "Contributive or contributed" means that there is evidence in departmental records that the driver performed an act which resulted in or contributed to an accident, or failed to perform an act which would have avoided or contributed to the avoidance of an accident.

615.12(2) In this rule, the speeding violations specified in Iowa Code paragraph 321.210(2)*"d"* are not included.

615.12(3) The suspension period shall be at least 60 days.

This rule is intended to implement Iowa Code section 321.210.

761—615.13(321) Suspension of a habitual violator.

615.13(1) The department may suspend a person's license when the person is a habitual violator of the traffic laws. "Habitual violator" means that the person has been convicted of three or more moving violations committed within a 12-month period.

615.13(2) The minimum suspension periods shall be as follows unless reduced by a driver's license hearing officer based on mitigating circumstances:

3 convictions in 12 months	90 days
4 convictions in 12 months	120 days
5 convictions in 12 months	150 days
6 convictions in 12 months	180 days
7 or more convictions in 12 months	1 year

615.13(3) In this rule, the speeding violations specified in Iowa Code paragraph 321.210(2)*"d"* are not included.

This rule is intended to implement Iowa Code section 321.210.

761—615.14(321) Suspension for incapability. The department may suspend a person's license when the person is incapable of safely operating a motor vehicle.

615.14(1) Suspension for incapability may be based on one or more of the following:

a. Receipt of a medical report stating that the person is not physically or mentally capable of safely operating a motor vehicle.

b. Failure of the person to appear for a required reexamination or failure to submit a required medical report within the specified time.

c. Ineligibility for licensing under Iowa Code subsections 321.177(4) to 321.177(7).

615.14(2) The suspension period shall be indefinite but shall be terminated when the department receives satisfactory evidence that the licensee has been restored to capability.

615.14(3) A person whose license has been suspended for incapability may be eligible for a special noncommercial instruction permit under rule 761—602.21(321).

This rule is intended to implement Iowa Code sections 321.177, 321.210, and 321.212.

761—615.15(321) Suspension for unlawful use of a license.

615.15(1) The department may suspend a person's license when the person has been convicted of unlawful or fraudulent use of the license or if the department has received other evidence that the person has violated Iowa Code section 321.216, 321.216A or 321.216B.

615.15(2) The suspension period shall be at least 30 days.

615.15(3) A suspension for a violation of Iowa Code section 321.216B shall not exceed six months.

This rule is intended to implement Iowa Code sections 321.210, 321.212, 321.216, 321.216A and 321.216B.

761—615.16(321) Suspension for out-of-state offense. The department may suspend a person's license when the department is notified by another state that the person committed an offense in that state which, if committed in Iowa, would be grounds for suspension. The notice may indicate either a conviction or a final administrative decision. The period of the suspension shall be the same as if the offense had occurred in Iowa.

This rule is intended to implement Iowa Code sections 321.205 and 321.210.

761—615.17(321) Suspension for a serious violation.

615.17(1) The department may suspend a person's license when the person has committed a serious violation of the motor vehicle laws.

615.17(2) *"Serious violation"* means that:

a. The person's conviction for a moving violation was accompanied by a written report from the arresting officer, the prosecuting attorney or the court indicating that the violation was unusually serious. The suspension period shall be at least 60 days.

b. The person was convicted of a moving violation which contributed to a fatal motor vehicle accident. "Contributed" is defined in paragraph 615.12(1)*"b."* The suspension period shall be at least 120 days.

c. The person was convicted for speeding 25 miles per hour (mph) or more above the legal limit. The minimum suspension period shall be as follows unless reduced by a driver's license hearing officer based on mitigating circumstances:

25 mph over the legal limit	60 days
26 mph over the legal limit	65 days
27 mph over the legal limit	70 days
28 mph over the legal limit	75 days
29 mph over the legal limit	80 days
30 mph over the legal limit	90 days
31 mph over the legal limit	100 days
32 mph over the legal limit	110 days
33 mph over the legal limit	120 days
34 mph over the legal limit	130 days
35 mph over the legal limit	140 days
36 mph over the legal limit	150 days
37 mph over the legal limit	160 days
38 mph over the legal limit	170 days
39 mph over the legal limit	180 days
40 mph over the legal limit	190 days
41 mph over the legal limit	210 days
42 mph over the legal limit	230 days
43 mph over the legal limit	250 days
44 mph over the legal limit	270 days
45 mph over the legal limit	290 days
46 mph over the legal limit	310 days
47 mph over the legal limit	330 days
48 mph over the legal limit	350 days
49 mph or more over the legal limit	one year

This rule is intended to implement Iowa Code sections 321.210 and 321.491.

761—615.18(321) Suspension under the nonresident violator compact.

615.18(1) The department may suspend a person's license when a report is received from another state under the nonresident violator compact that an Iowa licensee has failed to comply with the terms of a traffic citation.

615.18(2) The suspension shall begin 30 days after the department's notice of suspension is served.

615.18(3) The suspension shall continue until the department issues a notice terminating the suspension. The department shall terminate the suspension when it receives evidence of compliance with the terms of the citation.

This rule is intended to implement Iowa Code sections 321.210 and 321.513.

761—615.19(321) Suspension for a charge of vehicular homicide. In accordance with Iowa Code section 321.210D, the department shall suspend a person's license when the department receives notice from the clerk of the district court that an indictment or information has been filed charging the person with homicide by vehicle under Iowa Code section 707.6A, subsection 1 or 2. The suspension shall begin ten days after the department's suspension notice is issued.

This rule is intended to implement Iowa Code section 321.210D.

761—615.20(321) Suspension for moving violation during probation. The department may suspend the license of a person convicted of a moving violation pursuant to Iowa Code section 321.210C. The suspension period shall not exceed one year.

This rule is intended to implement Iowa Code section 321.210C.

761—615.21(321) Suspension of a minor's school license and minor's restricted license.

615.21(1) *Suspension of a minor's school license.*

a. The department may suspend a minor's school license upon receiving notice of the licensee's conviction for one moving violation or evidence of one or more accidents chargeable to the licensee.

b. The department may also suspend a minor's school license when the department receives written notice from a peace officer, parent, custodian or guardian, school superintendent, or superintendent's designee that the licensee has violated the restrictions of the license.

c. The suspension period under this subrule shall be at least 30 days.

615.21(2) *Suspension of a minor's restricted license.* The department may suspend a minor's restricted license upon receiving notice of the licensee's conviction for one moving violation. The suspension period shall be at least 30 days.

This rule is intended to implement Iowa Code sections 321.178 and 321.194.

761—615.22(321) Suspension for nonpayment of fine, penalty, surcharge or court costs.

615.22(1) *Report to the department.* The department shall suspend a person's privilege to operate motor vehicles in Iowa:

a. When the department is notified by a clerk of the district court on Form No. 431037 that the person has been convicted of violating a law regulating the operation of motor vehicles, that the person has failed to pay the fine, penalty, surcharge or court costs arising out of the conviction, and that 60 days have elapsed since the person was mailed a notice of nonpayment from the clerk of the district court, and

b. When, in accordance with subrule 615.22(2), the person has not timely raised the defense of inability to pay, or the department determines that the person is able to pay the fine, penalty, surcharge and court costs.

615.22(2) *Ability to pay.*

a. The department shall presume that a person is able to pay the fine, penalty, surcharge and court costs when it receives the "Notice to Suspend" copy of Form No. 431037 from the clerk of the district court.

b. The department shall not consider inability to pay as a defense to license suspension unless the person files Form No. 431038 with the department within 45 days after the clerk of the district court mailed notice of nonpayment to the person.

c. If the department determines that the person is unable to pay, the department shall notify the person and the clerk of the district court of that decision and shall take no further action. If the department determines that the person is able to pay, the department shall suspend the person's privilege to operate motor vehicles in Iowa as outlined in subrule 615.22(1).

615.22(3) *Suspension.*

a. The suspension period shall begin 30 days after the notice of suspension is served.

b. The suspension shall continue until the department has issued a notice terminating the suspension. The department shall terminate the suspension when it receives evidence that all appropriate payments have been made.

c. An informal settlement, hearing or appeal to contest the suspension shall be limited to a determination of whether the facts required by Iowa Code section 321.210A and this rule are true. The merits of the conviction shall not be considered.

This rule is intended to implement Iowa Code section 321.210A.

761—615.23(321) Suspensions for juveniles.

615.23(1) *Suspension for juveniles adjudicated delinquent for certain offenses.*

a. Pursuant to Iowa Code section 321.213A, the department shall suspend the license of a person for one year upon receipt of an adjudication and dispositional order from the clerk of the juvenile court.

b. The department may issue to a person suspended under this subrule a temporary restricted license in accordance with rule 761—615.45(321) if issuance is permitted under Iowa Code section 321.215 and the person is otherwise eligible for the license. To obtain a temporary restricted license that is valid for educational purposes, the applicant must meet the requirements for issuance of a minor's school license under Iowa Code section 321.194 and rule 761—602.26(321).

615.23(2) *Suspension for juvenile's failure to attend school.*

a. The department shall suspend the driver's license of a person under the age of 18 upon receipt of notification from the appropriate school authority that the person does not attend school.

b. "School" means a public school, an accredited nonpublic school, competent private instruction in accordance with the provisions of Iowa Code chapter 299A, an alternative school or adult education classes.

c. "Appropriate school authority" means the superintendent of a public school or the chief administrator of an accredited nonpublic school, an alternative school or adult education.

d. The suspension shall continue until the person reaches the age of 18 or until the department receives notification from the appropriate school authority that the person is attending school.

e. The department may issue to the person a minor's restricted license in accordance with Iowa Code section 321.178 and rule 761—602.25(321) if the person is eligible for the license.

This rule is intended to implement Iowa Code sections 232.52(2)*"a"*(4), 299.1B, 321.213, 321.213A, 321.213B, and 321.215.

761—615.24(252J,261,272D) Suspension upon receipt of a certificate of noncompliance.

615.24(1) *From child support recovery unit.*

a. The department shall suspend a person's Iowa-issued driver's license upon receipt of a certificate of noncompliance from the child support recovery unit.

b. The suspension shall begin 30 days after the department's notice of suspension is served.

c. The suspension shall continue until receipt of a withdrawal of the certificate of noncompliance from the child support recovery unit.

d. The filing of an application pursuant to Iowa Code section 252J.9 stays the suspension pending the outcome of the district court hearing.

615.24(2) *From college student aid commission.*

a. The department shall suspend a person's Iowa-issued driver's license upon receipt of a certificate of noncompliance from the college student aid commission.

b. The suspension shall begin 30 days after the department's notice of suspension is served.

c. The suspension shall continue until receipt of a withdrawal of the certificate of noncompliance from the college student aid commission.

d. The filing of an application pursuant to Iowa Code section 261.127 stays the suspension pending the outcome of the district court hearing.

615.24(3) *From department of revenue.*

a. The department shall suspend a person's Iowa-issued driver's license upon receipt of a certification of noncompliance from the department of revenue.

b. The suspension shall begin 30 days after the department's notice of suspension is served.

c. The suspension shall continue until receipt of a withdrawal of the certificate of noncompliance from the department of revenue.

d. The filing of an application pursuant to Iowa Code section 272D.9 stays the suspension pending the outcome of the district court hearing.

This rule is intended to implement Iowa Code sections 252J.1, 252J.8, 252J.9, 261.126, 261.127, 272D.8 and 272D.9.

[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—615.25(321) Suspension—driver's license indebtedness clearance pilot project. Rescinded IAB 11/8/06, effective 12/13/06.

761—615.26(321) Suspension or revocation for violation of a license restriction. The department may suspend or revoke a person's license when the department receives satisfactory evidence of a violation of a restriction imposed on the license. The suspension or revocation period shall be at least 30 days.

This rule is intended to implement Iowa Code section 321.193.

761—615.27 and **615.28** Reserved.

761—615.29(321) Mandatory revocation.

615.29(1) The department shall revoke a person's license upon receipt of a record of the person's conviction for an offense listed under Iowa Code section 321.209 or upon receipt of an order issued pursuant to Iowa Code subsection 901.5(10).

615.29(2) The department shall revoke a person's license under Iowa Code subsection 321.209(2) upon receipt of a record of the person's conviction for a felony:

a. Which provides specific factual findings by the court that a motor vehicle was used in the commission of the offense,

b. Which is accompanied by information from the prosecuting attorney indicating that a motor vehicle was used in the commission of the crime, or

c. Where the elements of the offense actually required the use of a motor vehicle.

615.29(3) The revocation period shall be at least one year except:

a. The revocation period for two convictions of reckless driving shall be at least five days and not more than 30 days.

b. The revocation period for a first offense for drag racing shall be six months if the violation did not result in personal injury or property damage.

c. The revocation period for an order issued pursuant to Iowa Code subsection 901.5(10) is 180 days.

This rule is intended to implement Iowa Code sections 321.209, 321.212, 321.261 and 707.6A.

761—615.30(321) Revocation for out-of-state offense.

615.30(1) The department may revoke an Iowa resident's license when the department is notified by another state that the person committed an offense in that state which, if committed in Iowa, would be grounds for revocation. The notice may indicate either a conviction or a final administrative decision. The period of the revocation shall be the same as if the offense had occurred in Iowa.

615.30(2) Rescinded IAB 11/20/96, effective 12/25/96.

This rule is intended to implement Iowa Code section 321.205.

761—615.31(321) Revocation for violation of a license restriction. Rescinded IAB 11/18/98, effective 12/23/98.

761—615.32(321) Extension of revocation period. The department shall extend the period of license revocation for an additional like period when the person is convicted of operating a motor vehicle while the person's license is revoked.

This rule is intended to implement Iowa Code sections 321.218 and 321J.21.

761—615.33(321) Revocation of a minor's license.

615.33(1) The department shall revoke a minor's restricted license upon receiving a record of the minor's conviction for two or more moving violations.

615.33(2) The department shall revoke a minor's school license upon receiving a record of the minor's conviction for two or more moving violations.

This rule is intended to implement Iowa Code subsection 321.178(2) and section 321.194.

761—615.34(321J) Other revocations. Rescinded IAB 11/18/98, effective 12/23/98.

761—615.35 Reserved.

761—615.36(321) Effective date of suspension, revocation, disqualification or bar. Unless otherwise specified by statute or rule, a suspension, revocation, disqualification or bar shall begin 30 days after the department's notice of suspension, revocation, disqualification or bar is served.

This rule is intended to implement Iowa Code sections 321.208, 321.209, 321.210, and 321.556.

761—615.37(321) Service of notice.

615.37(1) The department shall send a notice of denial, cancellation, suspension, revocation, disqualification or bar by first-class mail to the person's mailing address as shown on departmental records.

615.37(2) In lieu of service by mail, the notice may be delivered by a peace officer, a departmental employee, or any person over 18 years of age.

a. The person serving the notice shall prepare a certificate of personal service certifying delivery, specifying the name of the receiver, the address and the date, or certifying nondelivery.

b. The department shall pay fees for personal service of notice by a sheriff as specified in Iowa Code section 331.655. The department may also contract for personal service of notice when the department determines that it is in the best interests of the state.

615.37(3) The denial, cancellation, suspension, revocation, disqualification or bar shall become effective on the date specified in the notice.

615.37(4) The department may prepare an affidavit of mailing verifying the fact that a notice was mailed by first-class mail. To verify the mailing of a notice, the department may use its records in conjunction with U.S. Postal Service records available to the department.

615.37(5) The department shall prepare an affidavit of mailing if the department determines, under Iowa Code section 321.211A, that it failed to serve a notice of suspension or revocation. The department shall send the affidavit to the court that rendered the conviction.

This rule is intended to implement Iowa Code sections 321.16, 321.211, 321.211A, 321.556, 321J.9, 321J.12, and 331.655.

761—615.38(17A,321) Hearing and appeal process.

615.38(1) *Applicability.* This rule applies to:

a. License denials, cancellations and suspensions under Iowa Code sections 321.177 to 321.215 and 321A.4 to 321A.11 except denials under Iowa Code subsection 321.177(10) and suspensions under Iowa Code sections 321.210B, 321.210D, 321.213A and 321.213B.

b. License suspensions and revocations under Iowa Code sections 321.218 and 321J.21.

c. License revocations under Iowa Code sections 321.193 and 321.205.

d. Disqualifications from operating a commercial motor vehicle under Iowa Code section 321.208.

e. License bars under Iowa Code section 321.556.

615.38(2) *Submission of request or appeal.*

a. A person subject to a sanction listed in subrule 615.38(1) may contest the action by following the provisions of 761—Chapter 13 as supplemented by this rule.

b. A request for an informal settlement, a request for a contested case hearing, or an appeal of a presiding officer's decision shall be submitted to the director of the office of driver services at the address in 761—600.2(17A).

c. The request or appeal shall include the person's name, date of birth, driver's license or permit number, complete address and telephone number, and the name, address and telephone number of the person's attorney, if any.

615.38(3) *Informal settlement or hearing.*

a. The person may request an informal settlement. Following an unsuccessful informal settlement procedure, or instead of that procedure, the person may request a contested case hearing.

b. Notwithstanding paragraph *"a"* of this subrule, a request received from a person who has participated in a driver improvement interview on the same matter shall be deemed a request for a contested case hearing.

c. A request for an informal settlement or a request for a contested case hearing shall be deemed timely submitted if it is delivered to the director of the office of driver services or postmarked within the time period specified in the department's notice of the sanction.

(1) Unless a longer time period is specified in the notice or another time period is specified by statute or rule, the time period shall be 20 days after the notice is served.

(2) If the department fails to specify a time period in the notice, the request may be submitted at any time.

615.38(4) *Appeal.* An appeal of a presiding officer's decision shall be submitted in accordance with 761—13.7(17A).

615.38(5) *Stay of sanction.*

a. When the department receives a properly submitted, timely request for an informal settlement, request for a contested case hearing or appeal of a presiding officer's proposed decision regarding a sanction listed in subrule 615.38(1), it shall, after a review of its records to determine eligibility, stay (stop) the sanction pending the outcome of the settlement, hearing or appeal unless prohibited by statute or rule or unless otherwise specified by the requester/appellant.

(1) If the stay is granted, the department shall issue and send to the person a notice granting the stay. The stay is effective on the date of issuance. The notice allows the person to drive while the sanction is stayed if the license is valid and no other sanction is in effect.

(2) A person whose stay authorizes driving privileges shall carry the notice of stay at all times while driving.

b. Of the sanctions listed in subrule 615.38(1), the department shall not stay the following, and the person's driving privileges do not continue:

(1) A suspension for incapability.

(2) A denial.

(3) A disqualification from operating a commercial motor vehicle.

(4) A suspension under Iowa Code section 321.180B.

(5) A suspension or revocation under Iowa Code section 321.218 or 321J.21.

This rule is intended to implement Iowa Code chapter 17A and sections 321.177 to 321.215, 321.218, 321.556, 321A.4 to 321A.11, and 321J.21.

761—615.39(321) Surrender of license. A person whose Iowa license has been canceled, suspended, revoked or barred or who has been disqualified from operating a commercial motor vehicle shall surrender the license to the designated representative of the department on or before the effective date of the sanction.

This rule is intended to implement Iowa Code sections 321.201, 321.208, 321.212, 321.216, 321.556, and 321A.31.

761—615.40(321) License reinstatement or reissue. A person who becomes eligible for a license after a denial, cancellation, suspension, revocation, bar or disqualification shall be notified by the department to appear before a driver license examiner to obtain or reinstate the license. The license may be issued if the person has:

615.40(1) Filed proof of financial responsibility under Iowa Code chapter 321A, when required, for all vehicles to be operated. The class of license issued will depend on the examinations passed and other qualifications of the applicant. Regardless of the class of license issued, the license shall be valid only for the operation of the motor vehicles covered under the proof of financial responsibility filed by the applicant.

615.40(2) Paid the civil penalty when required. The civil penalty is specified in Iowa Code Supplement section 321.218A or 321A.32A.

615.40(3) Complied with the specific instructions given in the department's notice terminating the sanction.

615.40(4) Successfully completed the required driver license examination.

615.40(5) Paid the reinstatement fee when required. The reinstatement fee is specified in Iowa Code section 321.191.

615.40(6) Paid the appropriate license fee or duplicate license fee. These fees are specified in Iowa Code sections 321.191 and 321.195.

This rule is intended to implement Iowa Code sections 321.186, 321.191, 321.195, 321.208, 321.212, and 321A.17 and Iowa Code Supplement sections 321.218A and 321A.32A.
[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—615.41 Reserved.

761—615.42(321) Remedial driver improvement action under Iowa Code section 321.180B.

615.42(1) The department shall require remedial driver improvement action when a person holding an instruction permit, an intermediate license or a full-privilege driver's license under Iowa Code section 321.180B is convicted of a moving violation or has a contributive accident and the violation or accident occurred during the term of the instruction permit or intermediate license.

615.42(2) Completion of remedial driver improvement action means any or all of the following as determined by the department: suspension, safety advisory letter, additional restriction(s), vision screening, knowledge examination, and driving examination.

615.42(3) A suspension period under this rule shall be for no less than 30 days nor longer than one year. A person whose driving privilege has been suspended under this rule is not eligible for a temporary restricted license.

615.42(4) Remedial driver improvement action or suspension under this rule terminates when a person attains the age of 18.

This rule is intended to implement Iowa Code section 321.180B.
[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—615.43(321) Driver improvement program.

615.43(1) *When required.*

a. In lieu of suspension, the department may require the following persons to attend and successfully complete, at the person's own expense, a driver improvement program approved by the department:

(1) A habitual violator.

(2) A person who is convicted for speeding at least 25 but not more than 29 miles per hour over the legal limit.

(3) A person whose license is subject to suspension under Iowa Code section 321.210C.

b. However, a person shall not be assigned to a driver improvement program more than once within a two-year period.

615.43(2) *Scheduling.* The department shall schedule attendance at a program nearest the person's last known address.

a. One request for rescheduling may be granted if the program begins within 30 days of the originally scheduled date and if space is available.

b. A request to attend a program in another state may be granted if the curriculum is approved by the department.

615.43(3) *Probation.* When a person is required to attend and successfully complete a driver improvement program, the department shall also require the person to complete a probationary driving period not to exceed one year. One conviction for a moving violation committed during probation may result in suspension of the person's license. The suspension period shall be at least 90 days, unless reduced by a driver's license hearing officer based on mitigating circumstances.

615.43(4) *Failure to attend.* The department shall suspend the license of a person who is required to attend a driver improvement program and who does not attend, or does not successfully complete, the program. The suspension period shall be at least 90 days.

This rule is intended to implement Iowa Code sections 321.210 and 321.210C.

761—615.44(321) Driver improvement interview.

615.44(1) The department may require a person whose license is subject to suspension to appear for a driver improvement interview.

615.44(2) The department may take one or more of these remedial actions following the interview:

a. Suspend the person's license and issue a temporary driving permit which will allow the person to drive until the effective date of the suspension.

b. Place the person on probation. One conviction for a moving violation committed during probation may result in suspension of the person's license.

c. Restrict the person's license to specified vehicles, times, routes, locations, or other conditions.

d. Order the person to successfully complete a driver improvement program in accordance with rule 615.43(321).

e. Take no further action.

615.44(3) The department shall suspend the license of a person who is required to appear for a driver improvement interview and fails to appear.

This rule is intended to implement Iowa Code sections 321.193 and 321.210.

761—615.45(321) Temporary restricted license (work permit).

615.45(1) *Ineligibility.* The department shall not issue a temporary restricted license under Iowa Code subsection 321.215(1) to an applicant:

a. Whose license has been denied or canceled.

b. Whose license has been suspended for incapability.

c. Whose license has been suspended for noncompliance with the financial responsibility law.

d. Whose minor's school license or minor's restricted license has been suspended or revoked.

e. Whose license has been suspended for failure to pay a fine, penalty, surcharge or court costs.

f. Whose period of suspension or revocation has been extended for operating a motor vehicle while under suspension or revocation.

g. Whose license has been mandatorily revoked under Iowa Code section 321.209, subsections 1 to 5 or subsection 7, or for a second or subsequent conviction for drag racing.

h. Whose license has been suspended under the nonresident violator compact.

i. Who is barred under Iowa Code section 321.560.

j. Whose license has been suspended or revoked for a drug or drug-related offense.

k. Whose license has been suspended due to receipt of a certificate of noncompliance from the child support recovery unit.

l. Whose license has been suspended due to receipt of a certificate of noncompliance from the college student aid commission.

m. Whose license has been suspended for a charge of vehicular homicide.

n. Who has been suspended under Iowa Code subsection 321.180B(3).

615.45(2) *Application.*

a. To obtain a temporary restricted license, an applicant shall submit a written request for an interview with a driver's license hearing officer. The request shall be submitted to the office of driver services at the address in 761—600.2(17A).

b. If the driver's license hearing officer approves the issuance of a temporary restricted license, the officer shall furnish to the applicant application Form 430100, which is to be completed and submitted to the office of driver services.

c. A temporary restricted license issued for employment may include permission for the licensee to transport dependent children to and from a location for child care when that activity is essential to continuation of the licensee's employment.

615.45(3) *Statements.* A person applying for a temporary restricted license shall submit all of the following statements that apply to the person's situation. Each statement shall explain the need for the license and shall list specific places and times for the activity which can be verified by the department.

a. A statement from the applicant.

b. A statement from the applicant's employer unless the applicant is self-employed including, when applicable, verification that the applicant's use of a child care facility is essential to the applicant's continued employment.

c. A statement from the health care provider if the applicant or the applicant's dependent requires continuing health care.

d. A statement from the educational institution in which the applicant is enrolled.

e. A statement from the substance abuse treatment program in which the applicant is participating.

f. A copy of the court order for community service and a statement describing the assigned community service from the responsible supervisor.

g. A statement from the child care provider.

615.45(4) *Additional requirements.* An applicant for a temporary restricted license shall also:

a. Provide a description of all motor vehicles to be operated under the temporary restricted license.

b. File proof of financial responsibility under Iowa Code chapter 321A, if required, for all motor vehicles to be operated under the temporary restricted license.

c. Pay the required civil penalty specified in Iowa Code Supplement section 321.218A or 321A.32A.

615.45(5) *Issuance and restrictions.*

a. When the application is approved and all requirements are met, the applicant shall be notified by the department to appear before a driver's license examiner. The applicant shall pass the appropriate examination for the type of vehicle to be operated under the temporary restricted license. An Iowa resident shall also pay the reinstatement and license fees.

b. The department shall determine the restrictions to be imposed by the temporary restricted license. The licensee shall apply to the department in writing with a justification for any requested change in license restrictions.

615.45(6) *Denial.* An applicant who has been denied a temporary restricted license or who contests the license restrictions imposed by the department may contest the decision in accordance with rule 761—615.38(321).

These rules are intended to implement Iowa Code chapter 321A and sections 252J.8, 321.177, 321.178, 321.184, 321.185, 321.186, 321.189, 321.191, 321.193, 321.194, 321.201, 321.205, 321.209, 321.210, 321.210A, 321.212, 321.213A, 321.213B, 321.215, 321.218, 321.513, and 321.560 and Iowa Code Supplement sections 321.218A and 321A.32A.

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◊ Two or more ARCs

CHAPTER 640
FINANCIAL RESPONSIBILITY
[Prior to 6/3/87, Transportation Department[820]—(07,C)Ch l4]

761—640.1(321A) General provisions.

640.1(1) *Definitions.* The definitions contained in Iowa Code section 321A.1 are hereby adopted. In addition:

a. *"Department"* means the Iowa department of transportation.

b. Reserved.

640.1(2) *Exceptions.* Except for accident reporting requirements, this chapter of rules does not apply to the owners or operators of motor vehicles excepted by Iowa Code section 321A.33. To establish availability of an exception, the person required to show proof shall submit to the department a letter from the owner of the motor vehicle authorizing the person to use the motor vehicle.

640.1(3) *Submissions and information.* All required submissions shall be either mailed to the Office of Driver Services, Iowa Department of Transportation, P.O. Box 9235, Des Moines, Iowa 50306-9235; delivered in person to 6310 SE Convenience Blvd., Ankeny, Iowa; or sent by facsimile to (515)237-3071. Information about the financial responsibility law is available from these sources or by telephone at (800)532-1121.

This rule is intended to implement Iowa Code sections 17A.3, 321A.1 and 321A.33.

761—640.2(321A) Hearing and appeal process. A person who is aggrieved by an action of the department implementing Iowa Code sections 321A.4 to 321A.11 may contest the action in accordance with 761—615.38(17A,321). The administrative law judge in a contested case hearing may subpoena witnesses and conduct any investigation deemed necessary to:

640.2(1) Determine if the person is properly identified with the accident.

640.2(2) Determine if there is any reasonable possibility that judgment could be rendered against the person.

640.2(3) Determine if the person is entitled to any exceptions provided by law.

640.2(4) Determine if the security required following an accident is reasonable and make adjustments deemed necessary or proper.

This rule is intended to implement Iowa Code chapter 17A and section 321A.2.

761—640.3(321A) Accident reporting requirements. Accident reporting requirements are specified in Iowa Code section 321.266 and on Form 433002, "Iowa Accident Report Form," which is available from law enforcement officers, driver's license examination stations, or from the office of driver services at the address in subrule 640.1(3).

This rule is intended to implement Iowa Code sections 321.266 and 321A.4.

761—640.4(321A) Security required following accident. Following an accident, security is required pursuant to Iowa Code section 321A.5.

640.4(1) *Suspension.*

a. If the security requirements of Iowa Code section 321A.5 are not met, the department shall suspend all licenses of the driver and all registrations of the owner.

b. The suspension shall become effective 30 days after a suspension notice is served pursuant to rule 761—615.37(321). The notice shall inform the person of the amount of security required. The duration of the suspension is provided in Iowa Code section 321A.7. When the suspension ends, the department shall issue a suspension termination notice to the person.

640.4(2) Reserved.

640.4(3) *Security—amounts and type.*

a. The amount of security required of the uninsured driver and owner shall be determined from reports of the drivers involved in the accident, reports of investigating officers and from supplemental information obtained from persons involved in the accident concerning amounts of damage and injury sustained. Form 431020 may be mailed to parties to the accident for supplemental information. The

security required shall not be increased after the suspension notice has been served, but may be reduced if evidence of exact costs is submitted to the department. The amount of security shall not exceed the minimum limits of liability for death or injury specified in Iowa Code chapter 321A.

b. The security shall be deposited with the office of driver services at the address in subrule 640.1(3). The department shall issue to the depositor a receipt when the security is received. The depositor shall surrender the receipt when a refund is requested. Security shall be one of the following types:

(1) Cash.

(2) Cashier's check, certified check, bank draft, or postal money order payable to: Treasurer, State of Iowa.

(3) Surety bond issued by a company authorized to transact insurance business in Iowa.

640.4(4) *Security disposition.*

a. Security is held by the state treasurer and can be released only for payment of a judgment or as otherwise provided in Iowa Code section 321A.10 or by a court "Order for Release of Security," Form 431097, or by "Assignment and Release," Form 433010.

b. The security can be refunded at any time as follows:

(1) When compliance as provided in 640.4(5) is presented to the office of driver services; or

(2) When Form 433007, "District Court Affidavit," is completed by the clerk of the district court of the county where the accident occurred, the form indicates that no action has been initiated or judgment rendered, and the form is submitted to the office of driver services.

640.4(5) *Exceptions to requirement of security.* Compliance can be shown as follows: general releases, agreement releases, confession of judgment, accord and satisfaction, covenant not to sue, no-fault or no reasonable possibility of judgment, adjudication nonliability, and bankruptcy.

a. General release. Form 431036, "General Release," may be obtained from the office of driver services at the address in subrule 640.1(3). The signature of the party giving the release shall be notarized or witnessed by a disinterested person. The release shall be accompanied by a power of attorney or subrogation authority if signed by a person other than the party sustaining damage or injury.

b. Agreement release. Form 181301, "Agreement Release," may be obtained from the office of driver services at the address in subrule 640.1(3). Complete information shall be provided on the form including the total amount of settlement agreed upon by the parties involved and a release of liability upon fulfillment of payments. The signatures of all parties to the agreement shall be notarized. The release shall be accompanied by a power of attorney or subrogation authority if signed by a person other than a party sustaining damage or injury. Compliance shall be credited only to a party who has agreed to make payment and whose signature appears on the agreement release.

c. Confession of judgment. A court certified copy of a confession of judgment including the payment schedule agreed to by the parties is acceptable compliance. No specific form is provided by the office of driver services.

d. Accord and satisfaction. Accord and satisfaction may be shown by documentation that one party to an accident or the party's insurance carrier has accepted liability for the accident and has compensated the other party to the accident for damages and injuries. This documentation does not serve as compliance for a third party.

e. Covenant not to sue. A covenant not to sue can be given to a party to an accident as compliance by another party to the accident when a release would damage any claim against a third party.

f. No-fault or no reasonable possibility of judgment. Security cannot be required of a person if there is no reasonable possibility that judgment could be rendered against such person. Freedom from fault or immunity from judgment is acceptable compliance when presented in the following manner:

(1) The investigating officer's report of the accident indicates the other driver caused the accident.

(2) The other driver admits causing the accident.

(3) Witness statements indicate the other driver caused the accident.

(4) The other driver is convicted of a violation which caused the accident.

g. Adjudication. Adjudication of nonliability may be shown by a certified copy of a final court judgment that is rendered in a civil damage action resulting from the accident and that relieves the uninsured of any obligation to pay damages.

h. Bankruptcy. Security is not required of a person when all possible claims against the person arising from the accident have been scheduled in the bankruptcy petition. To establish this exception, the person shall submit a copy of the petition for bankruptcy to the office of driver services at the address in subrule 640.1(3).

640.4(6) *Owner exceptions—requirements.*

a. An owner can be excepted from the security requirements if the vehicle was being used at the time of an accident without the owner's consent. The owner may qualify for this exception if the police report indicates the vehicle was stolen, or if the driver was convicted of operating without the owner's consent. In the absence of such police report or conviction, the owner may furnish a sworn affidavit that the vehicle was operated without permission or the owner may furnish affidavits of witnesses that the driver had been denied use of the vehicle.

b. A person may be exempted from the security requirements applicable to an owner if the motor vehicle had been sold but the title had not been transferred when the accident occurred.

(1) The person who sold the motor vehicle may qualify for this exemption by submitting to the department an "Affidavit of Buyer-Seller," Form 431125. This form must be completed by both the buyer and seller with signatures notarized or attested to by an officer of the department.

(2) A sworn affidavit by the seller and witnesses to the sale that the vehicle had been sold may be furnished in lieu of Form 431125. The affidavit must include a description of the vehicle, the date of the sale, the monetary consideration, facts concerning the assignment of title and delivery of possession, and the names of witnesses to the sale.

c. Ownership transferred by operation of law can be shown by furnishing certified copies of any court order by which ownership of a vehicle was awarded to another party.

This rule is intended to implement Iowa Code sections 321A.4 to 321A.11 and 321A.31.

761—640.5(321A) Judgments. A suspension of license and registrations is required when the department receives a certified copy of a judgment which has remained unsatisfied for at least 60 days.

640.5(1) *Suspension.* The suspension becomes effective on the date Form 431010, a suspension notice, is served pursuant to 761—615.37(321). The notice shall inform the person that the privilege to operate and register motor vehicles in Iowa is suspended until the judgment is satisfied and proof of financial responsibility is shown. The duration of the suspension is provided in Iowa Code section 321A.14. When the suspension ends, the department shall issue to the person Form 431009, a suspension termination notice.

640.5(2) *Suspension—exceptions.*

a. Creditor's consent. The judgment debtor may request consent from the judgment creditor for issuance of the debtor's license and registrations while paying the judgment. If the creditor consents in writing and the debtor provides proof of financial responsibility, the suspension shall be terminated. If this consent is withdrawn, a new suspension is required in accordance with subrule 640.5(1).

b. Satisfaction of judgment. The judgment suspension will be terminated when the debtor obtains from the clerk of court a certificate of satisfaction or receipt for payment of the judgment and presents the certificate or receipt to the department and files proof of financial responsibility.

c. Bankruptcy. If the debtor submits to the department a copy of the petition for bankruptcy which includes the judgment debt, the department shall terminate the suspension.

d. Court order for installment payments. If the debtor submits to the department a court order authorizing payment of the judgment in installments and files proof of financial responsibility, the department shall terminate the suspension. A new suspension, as provided in subrule 640.5(1), is required when the department receives notice of a default in the payments. The default suspension continues until the judgment is satisfied.

e. Insurance coverage exception. The debtor can be relieved of the suspension if there was liability insurance coverage in effect at the time of the accident from which the judgment was rendered. The

requirements are the same as provided in Iowa Code section 321A.13. The department will accept a letter from the insurance carrier confirming that they were authorized to issue liability insurance and that they did provide coverage for the debtor in amounts required by the financial responsibility law.

This rule is intended to implement Iowa Code sections 321A.12 to 321A.29 and 321A.31.

761—640.6(321A) Proof of financial responsibility for the future. Proof of financial responsibility for the future is required pursuant to Iowa Code sections 321A.13, 321A.14, 321A.16 and 321A.17. Unless the person has filed proof of financial responsibility for all motor vehicles registered to that person, the department shall also suspend the person's motor vehicle registrations.

640.6(1) *Duration of proof.* Proof of financial responsibility is required for two years starting on the effective date of the person's last suspension or revocation. The requirement terminates if the person required to give proof dies or becomes incapable of operating a motor vehicle, or surrenders license and plates to the department. Reinstatement within the two-year requirement is possible only if the person refiles such proof.

640.6(2) *Methods of giving proof.*

a. Proof of financial responsibility may be shown by a liability insurance certificate pursuant to Iowa Code section 321A.19. Form SR-22, "AAMVA Uniform Financial Responsibility Form," is required as the form of the certificate. The form may describe an owner's or operator's policy and shall identify the policyholder by name, address, driver license number, and birth date. The effective date of the policy shall be the same as the effective date on the form. The vehicles covered shall be identified by year, make, model and vehicle identification number. The form shall be certified in accordance with the Iowa financial responsibility law by an insurance carrier authorized to transact insurance business in Iowa or by a company authorized by power of attorney. The policy shall be canceled only as provided in Iowa Code section 321A.22. Certification of coverage for an owner's policy authorizes the policyholder to have registrations for the described vehicles. Certification of coverage for an operator's policy does not authorize registrations.

(1) In lieu of Form SR-22, the department shall accept a copy of the form if the copy is no larger than 8½ by 11 inches and is generated by a process that produces an unaltered image or reproduction, except for size and color, of Form SR-22.

(2) In lieu of Form SR-22, the department shall accept an electronic record if the format of the record is approved by the department.

b. Proof may be given for a person who is an operator in the employ of the owner of the motor vehicle, or who is a member of the immediate family or household of the owner pursuant to Iowa Code section 321A.26, if the owner's insurance company certifies Form SR-22 for the person required to show proof. The requirements are given in paragraph 640.6(2)*"a"* except that the form shall identify both the policyholder and the person for whom proof is given. This certification does not authorize the person required to give proof to register a motor vehicle.

c. Proof may be given for a person who is an operator in the employ of an owner of a fleet of motor vehicles on Form SR-23, "AAMVA Uniform Financial Responsibility Form." The form shall identify the policyholder's name and address, policy number, policy dates and effective date. This certification does not authorize the person required to give proof to register a motor vehicle.

d. Proof may be given for a person who is an operator in the employ of an owner who has qualified as a self-insurer pursuant to Iowa Code section 321A.34. A certificate of self-insurance may be issued by the department to a person in whose name more than 25 vehicles are registered and who submits a financial statement which is found to be satisfactory to the department. Form SR-1, "Application for Self Insurance," shall be completed and submitted to the department with a list of all the owner's motor vehicles registered in Iowa identified by make, year, model, and vehicle identification number. When the application is approved, the department shall issue Form SR-2, "Self Insurance Certificate." Failure to pay a judgment pursuant to Iowa Code section 321A.34 or failure to submit an annual financial statement shall be reasonable grounds for cancellation of the certificate.

640.6(3) Rescinded, effective 1/26/83.

640.6(4) *Terminating the suspension upon filing of proof.* When future proof of financial responsibility is shown and the person is otherwise eligible for licensing, the department shall issue Form 431009, a suspension termination notice, to the person whose privileges were suspended under Iowa Code sections 321A.13, 321A.14, 321A.16 or 321A.17 or rules 640.5(321A) and 640.6(321A). To regain operating privileges, the person shall appear before an Iowa driver license examiner, pass the required examinations, and pay the required fees. The person's operating and registration privileges are restricted to the motor vehicles covered under the proof of financial responsibility filed by the applicant.

640.6(5) *Cancellation of future proof.* An insurance carrier shall only cancel or terminate a certificate of insurance pursuant to Iowa Code section 321A.22. The cancellation shall be certified by an authorized company representative on Form SR-26, "AAMVA Uniform Financial Responsibility." The Form SR-26 shall identify the SR-22 or SR-23 certificate to be canceled by name and address of the person, social security number, birth date, driver license number, number of the policy to be canceled and the effective date of cancellation.

640.6(6) *Suspension when future proof is canceled.*

a. When a person's future proof is canceled, the person shall immediately refile future proof or surrender the license and registrations to the department.

b. If the person fails to refile, Form 431010, a suspension notice, shall be served in accordance with 761—615.37(321). The effective date of the suspension shall be the date the notice is served. The notice shall inform the person that the privilege to operate and register motor vehicles in Iowa is suspended until future proof is refiled. When the person refiles future proof, the department shall issue to the person Form 431009, a suspension termination notice.

640.6(7) *Terminating the two-year proof requirement.* Form 431009, a suspension termination notice, shall be issued to a person who has completed future proof requirements. The form shall notify the person that proof is no longer required and that the person may operate and register motor vehicles without the proof restrictions. If the person's license is still valid, the person shall appear before an Iowa driver license examiner to obtain a duplicate license without the proof restrictions. If the license has expired or has not been reinstated and the person is otherwise eligible for licensing, the person shall pass the required examinations and pay the required fees. The suspension termination notice may also be presented to the county treasurer to obtain a new registration.

This rule is intended to implement Iowa Code sections 321A.12 to 321A.29, 321A.31 and 321A.34.
[**ARC 7902B**, IAB 7/1/09, effective 8/5/09]

761—640.7(321A) Transfer of suspended registration. A person whose motor vehicle registration privileges have been suspended may make a bona fide sale pursuant to Iowa Code sections 321.493 and 321A.30. The department shall release the suspended registration to permit the registration of the motor vehicle by the purchaser when presented with either the seller's sworn statement on Form 433015, "Affidavit of Bona Fide Sale," or confirmation from the county treasurer that the sale has been made and release of the registration is necessary to complete the transfer of title.

This rule is intended to implement Iowa Code sections 321.493 and 321A.30.

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CHAPTER 801
RELATIONSHIP WITH IOWA RAILWAY FINANCE AUTHORITY

[Prior to 6/3/87, Transportation Department[820]—(10,C)Ch 2]

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

CHAPTER 822
RAILROAD REVOLVING LOAN AND GRANT FUND PROGRAM
[Prior to 7/1/09, see 765—Ch 5]

761—822.1(327H) Introduction. The railroad revolving loan and grant fund program provides funding in the form of loans and grants for railroad-related improvement projects that spur economic development and job growth. The railroad revolving loan and grant fund is established in Iowa Code section 327H.20A as amended by 2009 Iowa Acts, Senate File 151, section 11, and is under the control of the department.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.2(327H) Definitions.

"Rail facilities" includes railroad main lines, branch lines, switching yards, sidings, rail connections, intermodal yards and highway grade separations.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.3(327H) Information. Information may be obtained at the following address: Office of Rail Transportation, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)239-1140. Completed applications shall be submitted to this address.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.4(327H) Purpose of program. The purpose of the railroad revolving loan and grant fund program is to provide loans and grants for railroad-related improvement projects that will provide benefits to Iowa in terms of direct economic development and job growth or through economic benefits derived from railroad transportation service improvements.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.5(327H) Funding.

822.5(1) The transportation commission is responsible for determining the projects to be funded and the amount of funding for each project.

822.5(2) The minimum amount of matching funds required of an applicant is 20 percent of the project cost.

822.5(3) Rescinded IAB 7/1/09, effective 7/1/09.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.6(327H) Project criteria.

822.6(1) All rail facilities are eligible for project funding except:

a. At-grade crossing surface repair or replacement unless the repair or replacement is a part of railroad line construction or reconstruction.

b. Signals, gates or other crossing protection unless the crossing protection is a part of new railroad line construction.

822.6(2) An applicant must demonstrate that its project will provide benefits to Iowa in terms of direct economic development and job growth or through economic benefits derived from railroad transportation service improvements.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.7(327H) Applicant eligibility. A railroad company, railroad user, city, county, metropolitan planning organization, regional planning affiliation, or any other entity with an interest in a rail transportation improvement is eligible to apply for funding. Joint applications are allowed and encouraged, but the applicants shall designate one contact person.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.8(327H) Eligible and ineligible project costs.

822.8(1) *Eligible costs.* Activities or items eligible for funding include, but are not limited to, the following:

a. Modernization, upgrading or reconstruction of existing rail facilities.

b. Construction of new rail facilities.

c. Railroad bridge and culvert modernization, replacement or removal.

d. Right-of-way acquisition costs.

822.8(2) *Ineligible costs.* The following activities or items are ineligible for funding:

a. Contract administration.

b. Freight car or locomotive lease, purchase or repair.

c. Feasibility studies, environmental studies or major investment studies related to a railroad improvement project.

d. Refinancing of a completed project that would have otherwise qualified under this chapter.

[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.9 Reserved.

761—822.10(327H) Project application.

822.10(1) *Submission.* Applications may be submitted at any time.

a. The applicant shall submit an original and two copies of a project application to the address in rule 761—822.3(327H).

b. If an application is incomplete, department staff shall return the application to the applicant to be resubmitted when it is complete.

c. An application may be withdrawn at any time after submission.

822.10(2) *Contents of application.* Each application shall contain the following:

a. The applicant's name, address, telephone number, facsimile number and E-mail address (if available) and the name of a designated contact person for the project.

b. A detailed description of the project proposed for funding, including a map or sketch plan.

c. The justification for the project, including the following information:

(1) The need for and purpose of the project.

(2) How the project will impact the local and state economies, including the number of new jobs to be created, the number of potential jobs that may be created and the number of jobs to be retained as a result of the project.

(3) The long-term growth and development potential of the area or industry to be supported and the direct and indirect economic, transportation, and environmental impacts of the project.

d. An itemized estimate of all project costs and the proposed match or cost sharing based on the requested funding. A detailed financial plan to explain the funding for the entire project should be included, along with any associated development costs.

e. A time schedule for the completion of the project.

f. The total amount of loan and grant funds requested.

g. If loan funds are requested, the proposed loan term and interest rate and a detailed description of the applicant's ability to repay the loan. Department staff may require the applicant to provide audited financial statements for the past two years plus a current balance sheet and profit/loss statement for the entity that is to repay the loan. If the entity that is to repay the loan is a new entity, the applicant shall, instead, provide a pro forma balance sheet and pro forma profit/loss statement.

h. If requested by department staff, endorsement of the project by a local government(s) that will be affected by the project and a description of how the project will impact the local government's transportation and economic development plans.

[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.11(327H) Project evaluation and approval.

822.11(1) *Staff review.* Department staff shall review the contents of each application for completeness. Department staff may visit the project site and may require the applicant to verify the information in the application. After department staff determines that the application is complete, the staff shall develop a funding recommendation and shall schedule the project for submission to the transportation commission for approval.

822.11(2) *Commission evaluation.* The transportation commission shall be responsible for selecting and determining the funding for each project, subject to the availability of railroad revolving loan and grant funds. The transportation commission may fund all or part of a project and may make funding dependent upon the applicant's adherence to a time schedule or fulfillment of specified conditions, including job creation commitments.

822.11(3) *Commission approval.* In making its decision to fund a project, the transportation commission may consider the railroad transportation service benefits of the project, the economic development benefits of the project, the applicant's total capital investment, the number of direct and indirect jobs to be created or preserved by the project, the financing requested, an analysis of public benefits versus public costs, and other potential impacts or benefits of the project.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

761—822.12(327H) Project agreement and administration.

822.12(1) *Agreement.* After the transportation commission has approved funding for a project, department staff shall negotiate and execute an agreement with the applicant. Department staff shall administer the agreement.

a. The agreement shall specify the scope of the project, the approved funding level, and other conditions for project funding.

b. As applicable, the agreement shall address responsibilities for project design, right-of-way acquisition, contracting, construction and materials inspection; documentation required for reimbursement of project costs; audit requirements; and maintenance of the completed project.

822.12(2) *Reimbursement.* The applicant will be reimbursed for eligible project costs in accordance with the agreement.

822.12(3) *Audits.*

a. Prior to execution of the agreement, department staff may perform a preaudit evaluation of the applicant or others as defined in the agreement. A preaudit evaluation typically includes an examination of accounting methods to determine the applicant's ability to segregate and accumulate costs to be charged against the project, and an analysis of costs factors to ensure their propriety and allowability.

b. Department staff may conduct a final audit of all project costs.

822.12(4) *Default.* Department staff may revoke a funding commitment, seek repayment of funds loaned or granted or take both actions if the applicant fails to fulfill the terms of the agreement.
[**ARC 7909B**, IAB 7/1/09, effective 7/1/09]

These rules are intended to implement Iowa Code section 327H.20A as amended by 2009 Iowa Acts, Senate File 151, section 11.

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PUBLIC TRANSIT

CHAPTERS 823 to 829
Reserved

CHAPTER 830
RAIL ASSISTANCE PROGRAM
[Prior to 6/3/87, Transportation Department [820]—(10,C)Ch 1]
Rescinded IAB 4/11/07, effective 5/16/07

CHAPTER 831
RAILROAD REVOLVING LOAN FUND
Rescinded IAB 4/11/07, effective 5/16/07

CHAPTERS 832 to 839
Reserved

CHAPTER 840
RAIL RATE REGULATION
Rescinded IAB 5/5/99, effective 6/9/99

CHAPTERS 841 to 899
Reserved

CHAPTER 900
CONTRACTS SET ASIDE FOR
DISADVANTAGED BUSINESS ENTERPRISES
[Prior to 6/3/87, Transportation Department [820]—(09,A)Ch 1]
Rescinded IAB 9/28/94, effective 11/2/94

CHAPTERS 901 to 909
Reserved

RAILWAY FINANCE AUTHORITY[765]

Prior to 6/3/87, Railway Finance Authority[695]. Under Iowa Code section 7E.7(4) "The Iowa railway finance authority shall be considered part of the department of transportation."

Pursuant to 2009 Iowa Acts, Senate File 151, 765—Chapters 1 to 4 were rescinded and 765—Chapter 5 was transferred to 761—Chapter 822, IAB 7/1/09, effective 7/1/09.

CHAPTER 1
ORGANIZATION AND OPERATION
[Prior to 6/3/87, Railway Finance Authority[695], Ch 1]

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

CHAPTER 2
ITEMS OF GENERAL APPLICABILITY
[Prior to 6/3/87, Railway Finance Authority[695], Ch 2]

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

CHAPTER 3
FINANCIAL ASSISTANCE
[Prior to 6/3/87, Railway Finance Authority[695], Ch 3]

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

CHAPTER 4
PROJECTS
[Formerly Ch 3; Ch 4 IAB 5/23/83]
[Prior to 6/3/87, Railway Finance Authority[695], Ch 4]

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

CHAPTER 5
RAILROAD REVOLVING LOAN AND GRANT FUND PROGRAM
Transferred to 761—Chapter 822, IAB 7/1/09, effective 7/1/09.

CHAPTER 10
IOWA VETERANS HOME

[Prior to 2/29/84, Social Services[770] Ch 134]
[Prior to 2/11/87, Human Services[498] Ch 10]
[Prior to 1/20/93, Human Services[441] Ch 10]

PREAMBLE

The Iowa Veterans Home is a long-term health care facility located in Marshalltown, Iowa, operated by the Commission of Veterans Affairs.

801—10.1(35D) Definitions relevant to Iowa Veterans Home. The following definitions are unique to rules pertaining to the Iowa Veterans Home.

"Acute alcoholic" means any disturbance of emotional equilibrium caused by the consumption of alcohol resulting in behavior not currently controllable.

"Acutely mentally ill" means any disturbance of emotional equilibrium manifested in maladaptive behavior and impaired functioning caused by genetic, physical, chemical, biological, psychological, social or cultural factors which requires hospitalization.

"Addicted to drugs" means a state of dependency as medically determined resulting from excessive or prolonged use of drugs as defined in Iowa Code chapter 124.

"Adjutant" means the chief executive assistant of the commandant who functions as the chief operations officer.

"Admissions committee" means the committee appointed by the commandant to review applications to determine eligibility for admission and appropriate level and category of care.

"Applicant" means a person who is applying for admission into the Iowa Veterans Home.

"Assets" means items of value held by, or on behalf of, an applicant or member. Assets include, but are not limited to, cash, savings and checking accounts; stocks; bonds; contracts for sale of property; homestead or nonhomestead property. Nonrecurring windfall payments such as, but not limited to, inheritances; death benefits; insurance or tort claim settlements; and cash payments received from the conversion of a nonliquid asset to cash shall be considered assets upon receipt.

"At once" or *"timely"* means within ten calendar days.

"Commandant" means the chief executive officer of the Iowa Veterans Home.

"Commission" means the Iowa commission of veterans affairs.

"Continuously disruptive" means any behavior, on a recurring basis, which has been documented by Iowa Veterans Home staff, that causes harm to a member or staff or conflicts with the member responsibilities set forth in subrule 10.12(1).

"Countable asset" means an asset to be considered in calculation of member support obligation.

"Dangerous to self or others" means any activity by a member which would result in injury to the member or others.

"Dependent" means a person for whose financial support an applicant or member is legally responsible or obligated.

"Director of admissions" means the public service executive responsible for the admissions process, benefits programming, and member financial affairs.

"Director of resident and family services" means the administrator responsible for social work services and chaplain services for members.

"Diversion" means income that is transferred to a spouse before the member support is determined.

"DVA" means the U.S. Department of Veterans Affairs.

"Free time" means 15 days of furlough time each calendar year for which the member is not charged for care during absence.

"Full support" means the maximum daily rate of support times the billable days of care received in any month less any offsets.

"Honorable discharge" means separation or retirement from active military service. The veteran must be eligible for medical care in the DVA system (excluding financial eligibility). Honorable discharge includes general discharges under honorable conditions.

"Income" means money gained by labor or service, or money paid periodically to an applicant or member. Income includes, but is not limited to, disability, retirement pensions or benefits; interest, dividends, payments from long-term care insurance, or other income received from investments; income from property rentals; certain moneys related to real estate contracts; earnings from regular employment or self-employment enterprises.

"IVH" means the Iowa Veterans Home.

"Legal representative" for purposes of applicant or member personal and care decisions means durable power of attorney for health care, guardian, or next-of-kin (spouse, adult children, parents, adult siblings), as provided in Iowa Code chapters 144A, 144B, and 633. For applicant or member financial decisions, "legal representative" means conservator, power of attorney, fiduciary or representative payee.

"Medical provider" means a doctor of medicine or osteopathic medicine who is licensed to practice in the state of Iowa. Except as defined by Iowa law, a medical provider also means an advanced registered nurse practitioner or physician assistant who is licensed to practice in the state of Iowa.

"Member" means a patient or resident of IVH.

"Member support" means the dollar amount which is billed monthly to the member or legal representative for the member's care.

"PASARR" means preadmission screening and annual resident review.

"Resource" means assets and income.

"Spouse" means a person of the opposite sex who is the legal or common-law wife or husband of a veteran.

"Surviving spouse" means a person of the opposite sex who is the legal or common-law widow or widower of a veteran.

"Veteran" means a person who served in the active military and who was discharged or released therefrom under conditions other than dishonorable. Honorable and general discharges qualify a person as a veteran. The veteran must be eligible for medical care in the DVA system (excluding financial eligibility).

In addition, veteran includes a person who served in the merchant marine or as a civil service crew member between December 7, 1941, and August 15, 1945.

"Voluntary discharge" means a member wishes to terminate the member's association with IVH on a permanent basis. This includes discharge for medical reasons which have been approved by a qualified medical provider. All other discharges are involuntary.

801—10.2(35D) Eligibility requirements. Veterans and spouses of veterans shall be eligible for admission to IVH in accordance with the following:

10.2(1) Veterans shall be eligible for admittance to IVH in accordance with the following conditions:

a. The individual does not have sufficient means for the individual's support, or the individual is disabled by reason of disease, wounds, old age or otherwise and is in need of one of the multilevels of care available at IVH and is unable to defray the expenses of the necessary care, except as described at paragraph *"e."*

b. The individual cannot be employed on the day of admission.

c. The individual shall have met the residency requirements of the state of Iowa on the date of admission to IVH.

d. An individual who has been diagnosed by a qualified health care professional as acutely mentally ill, as an acute alcoholic, as addicted to drugs, as continuously disruptive, or as dangerous to self or others shall not be admitted to or retained at IVH.

e. Individuals who have sufficient means for their own care but who are otherwise eligible to become members of IVH may, if there is room for individuals described in paragraph *"a"* above, be admitted and allowed to remain at IVH upon payment of the cost of the individual's care in accordance with rules 801—10.14(35D) to 801—10.23(35D).

f. The individual must be eligible for care and treatment at a DVA medical center (excluding financial eligibility).

g. Individuals admitted to the domiciliary level of care must meet DVA criteria stated in Department of Veterans Affairs, State Veterans Homes, Veterans Health Administration, M-1, Part 1, Chapter 3.11(h) (1), (2), and (3), and have prior DVA approval if the individual's income level exceeds the established cap.

10.2(2) Spouses and surviving spouses shall be admitted in accordance with the following:

a. The spouse or surviving spouse shall have been married to a veteran for at least one year preceding date of application or date of death of veteran.

b. The spouse of a veteran is eligible for admittance to IVH only if the veteran is admitted.

c. The surviving spouse of a deceased veteran is eligible for admittance to IVH if the deceased veteran would also be eligible for admittance to IVH if still living.

d. Spouses and surviving spouses admitted to IVH shall not exceed more than 25 percent of the total number of members at IVH as provided in U.S.C. Title 38.

10.2(3) An individual who was not a member of the United States armed forces may be eligible for admittance in accordance with the limitations described in subrule 10.2(1), if the following conditions are met:

a. The individual was a member of the armed services of a nation with which the United States was allied during a time of conflict.

b. The individual is eligible for admission to a DVA medical center in accordance with U.S.C. Title 38, Chapter 17, Medical Care, Subchapter 2, Section 1710.

801—10.3(35D) Application. All applicants shall apply for admission to IVH in accordance with the following subrules:

10.3(1) All applicants shall make application to IVH through the county commission of veterans affairs in the applicant's county of residence.

10.3(2) Application shall be made on the "Veteran Application for Admission to the Iowa Veterans Home," Form 475-0409, or on the "Spouse's Application for Admission to the Iowa Veterans Home," Form 475-0410. Separate application shall be required for an eligible veteran and the spouse of the veteran when both veteran and spouse are applying for admission. The applications may be obtained at:

a. The county commission of veterans affairs' office.

b. DVA medical centers located in or serving veterans in the state of Iowa.

c. IVH.

10.3(3) The applicant shall be scheduled for a physical examination by a medical provider, and the results of the examination shall be entered on the application by the examining medical provider. If the applicant has had a complete physical examination within three months of application, a copy of this physical shall suffice. Information must be authenticated by the medical provider's original signature or electronic signature.

10.3(4) The following items shall be attached to the application before it is forwarded to IVH:

a. An affidavit signed by two members of the county commission of veterans affairs and notarized by the appropriate county official attesting to the best of their knowledge and belief that the applicant is a resident of that county and is an eligible applicant.

b. An original or a certified copy of the veteran's honorable discharge from the armed forces of the United States.

c. If the applicant is a married or surviving spouse, a copy of the marriage certificate or evidence of a common-law marriage on which a prudent person would rely.

d. An original or a certified copy of applicant's birth certificate if not in receipt of Social Security.

e. A copy of divorce decrees or death certificate for the spouse, if applicable.

f. A completed "Personal Functional Assessment," Form 475-0837.

g. A completed "Supplement to Application for Admission to the Iowa Veterans Home," Form 475-0843.

h. A completed "Financial Affidavit," Form 475-0839.

10.3(5) Once the requirements of subrules 10.3(2), 10.3(3) and 10.3(4) have been met, the county commission of veterans affairs shall forward the completed application to the admissions office at IVH. No county shall require additional requirements for the application for admission beyond the requirements stated in these rules. Neither shall a county require additional forms to be filled out or provided by the applicant other than the forms required by these rules.

10.3(6) Eligibility determinations are subject to approval by the commandant.

801—10.4(35D) Application processing.

10.4(1) Applications received by the admissions office shall be reviewed for completeness. The county commission of veterans affairs shall be required to submit additional information if needed.

10.4(2) The admissions committee shall assign the level and category of care required by the applicant. If a special care unit or treatment is required, this shall be designated.

10.4(3) Regardless of whether or not the applicant can be immediately admitted, the applicant shall be notified by the director of admissions or designee of the applicant's designated level and category of care. An applicant who does not wish to be admitted to the designated level and category of care may submit evidence to show that another level or category of care may be more appropriate. However, once the admissions committee makes a final determination, the applicant who does not wish to be admitted under the designated level or category of care may withdraw the application in writing or have the application denied.

10.4(4) When space is not immediately available in the level and category of care assigned or on the appropriate special care unit, the applicant's name shall be placed on the appropriate waiting list for that level and category of care or special care unit in the order of the date the application was received.

10.4(5) When space is available at time of application, or when space becomes available in accordance with the designated waiting list, the applicant shall be scheduled for admittance to IVH as follows:

a. An applicant whose physical examination or personal functional assessment, or both if applicable, was completed more than three months prior to the scheduled date of admittance may be required to obtain another physical examination by a medical provider or complete a current personal functional assessment, or both if applicable. This information shall be reviewed to determine that the applicant is capable of functioning at the previously determined level of care and category.

b. An applicant who requires a different level and category of care than previously determined shall be admitted to the level of care required if a bed is available or shall have the applicant's name placed on the waiting list for the appropriate level and category of care in accordance with the date the original application was received.

c. If there is a question regarding the level and category of care for which the applicant qualifies, the applicant shall be scheduled for a preadmission examination with appropriate staff in order to make a determination of appropriate level and category of care. If there is a question of whether or not the applicant can be appropriately treated within the scope of existing programs or facility license or both, the applicant shall be scheduled for a preadmission screening by appropriate staff.

d. If planned admission is to a Title XIX certified area, the PASARR must be completed and approval obtained prior to admission.

801—10.5(35D) Applicant's responsibilities. Prior to admission to IVH, the applicant or a person acting on the applicant's behalf shall:

10.5(1) Report any change in the applicant's condition that could affect the previously determined level of care.

10.5(2) Report changes in mailing address, county or state of residency.

10.5(3) Provide additional information, verification or authorization for verification concerning the applicant's circumstances, condition of health, and resources if required.

10.5(4) Participate in a preadmission evaluation for level of care if required.

801—10.6(35D) Admission to IVH.

10.6(1) The applicant shall be notified by the director of admissions or designee to appear for admission to IVH.

10.6(2) Upon arrival at IVH, the applicant or legal representative shall report to the admissions office for an admission interview.

10.6(3) During the interview, the director of admissions or designee shall review the following items with the applicant or legal representative:

a. The applicant's resources.

b. The member support, billing process and banking services.

c. The "Contractual Agreement," Form 475-0694.

10.6(4) In order to meet the requirements of subrule 10.6(3), the applicant or legal representative shall complete and sign the following forms as applicable:

a. Permission for Treatment, Form 475-0814.

b. Financial Affidavit, Form 475-0839.

10.6(5) An applicant becomes a member at that point in time when the applicant or legal representative signs and dates the "Contractual Agreement," Form 475-0694, or otherwise authorizes, in writing, acceptance of the terms of admittance specified in the Contractual Agreement.

10.6(6) Each member shall be placed on a unit providing the appropriate level and category of care based on individual needs.

a. A member requiring a change in placement based on individual care needs shall be transferred to a unit which provides the appropriate level and category of care within the scope of its licensure.

b. Members shall have priority over new admissions for placement on a unit when a vacant bed becomes available.

10.6(7) Care at IVH shall be provided in accordance with Iowa Code chapter 135C; 481—Chapter 57, Residential Care Facilities; 481—Chapter 58, Nursing Facilities; and DVA State Veterans Homes, Veterans Health Administration, M-5, Part 8, Chapter 2, 2.06, 2.07 and 2.09, November 4, 1992.

801—10.7 to **10.10** Reserved.

801—10.11(35D) Member rights.

10.11(1) Member rights shall be in accordance with those listed in 481—Chapter 57 for members residing in the residential care facility level of care, 481—Chapter 59 for members residing in the nursing facility level of care, and those noted in Department of Veterans Affairs, State Veterans Homes, Veterans Health Administration, pertaining to residents of state veterans homes.

10.11(2) A member has the right to share a room with the member's spouse when both member and spouse consent to the arrangement and both require the same level of care.

10.11(3) If a member is incompetent and not restored to legal capacity, or if the medical provider determines that a member is incapable of understanding and exercising these rights, the rights devolve to the member's legal representative.

10.11(4) In some cases, a member may be determined to be in need of a fiduciary or agent by the DVA, the Social Security Administration or by a similar funding source. In these cases the commandant or designee may serve as agent subject to Iowa Code section 135C.24. All rights and responsibilities regarding the financial awards shall devolve to the commandant or designee.

801—10.12(35D) Member responsibilities.

10.12(1) The member or legal representative has the responsibility:

a. To timely report the existence of or changes in the member's income, spouse's income, assets or marital status, including the conversion of nonliquid assets to liquid assets. The member shall also complete the change report which is enclosed with the monthly member support bill.

b. To apply for all benefits due (such as, but not limited to, Title XIX, DVA pension, DVA compensation, Social Security, private pension programs, or any combination), and accept the available billing programs offered at IVH.

c. To provide information concerning the physical condition and, to the best of the member's knowledge, accurate and complete information concerning present physical complaints, past illnesses, hospitalizations, medications and other matters related to the member's health.

d. To report unexpected changes in the member's condition to the attending medical provider or other clinician.

e. To make it known if the member clearly comprehends a contemplated course of treatment and the member's role in that treatment. If a member feels that a particular treatment is of no benefit, the member is responsible for reporting this to staff so that other alternatives may be considered.

f. To participate in treatment planning, cooperate with the treatment team in carrying out the treatment plan, and to participate in the evaluation of the member's care.

g. To be considerate of the rights of other members and staff and control behavior in respect to smoking, noise, and number of visitors.

h. To treat other members and staff with dignity and respect.

i. To respect the property of other members, staff, and IVH. A member or legal representative may be held financially responsible for any property damaged or destroyed by the member.

j. To ask questions about anything that the member may not understand about the member's care or IVH.

k. To accept the consequences of the member's actions if the member refuses treatment or fails to follow prescribed care.

l. To follow the rules and regulations of IVH regarding member care and conduct as set out in subrule 10.40(1).

m. To keep scheduled appointments with staff. If unable to do so, the member is responsible for notifying appropriate staff.

n. To maintain personal hygiene, including clothing, and maintain personal living area based on the member's physical and mental capabilities.

o. To follow all fire, safety and sanitation regulations as established by IVH and applicable regulatory agencies.

p. To provide information and verification of resources. A member or legal representative must fulfill the member support obligation for member health care.

q. To carry Medicare Part B insurance if eligible. IVH shall buy the medical insurance portion of Medicare Part B if member is not eligible to receive Medicare Part B under Social Security.

r. To delegate to IVH the authorization to enroll the member in a prescription drug plan. The premium shall be deducted from the member's social security.

10.12(2) The member or legal representative is responsible for the full payment of the member's support charges within the calendar month that the monthly support bill is received. Failure to pay a monthly support bill within 30 days of issuance may result in discharge from IVH unless prior arrangements have been made.

10.12(3) In those instances when a legal representative is responsible for the handling of the member's resources, the legal representative shall keep any records necessary and provide all information or verification required for the computation of member support as set out in rule 801—10.14(35D). Failure of the legal representative to do so may result in the discharge of the member. In some cases, IVH may act to have the commandant or designee established as the member's fiduciary or agent as set out in subrule 10.11(4). In those cases when a guardian or conservator of a member fails to keep necessary records or provide needed information or verification or to meet the member support obligation, IVH may notify the court of problems and request to establish another individual as guardian or conservator. The conservator of a member shall submit a copy of the annual conservatorship report to IVH.

10.12(4) When a member temporarily needs a level of care that is not offered by IVH, the member shall be referred by IVH medical staff to a DVA medical center or to another medical facility. When a member goes to a DVA medical center, that member is responsible for the payment of any DVA charges except those charges exempted by the commandant.

a. If a member who is treated at a DVA medical center has coinsurance to supplement Medicare, this coinsurance shall be used for the DVA medical center charges. IVH shall be responsible for all DVA medical center charges if the member does not carry coinsurance supplement.

b. If a member chooses a medical facility other than a DVA medical center or other medical facility as referred by IVH medical staff, the member is responsible for costs resulting from care at the medical facility chosen.

801—10.13 Reserved.

801—10.14(35D) Computation of member support. As a condition of admittance to and residency in IVH, each member is required to contribute toward the cost of that member's care based on that member's resources and ability to pay.

10.14(1) A monthly member support bill shall be sent to the member or legal representative charging the member for care in the previous month with any necessary adjustment for prior months. A member may be required to pay member support charges from the member's liquid assets, long-term care insurance benefits, or from the member's income. The monthly member support charge shall be the billable days, as set out in subrule 10.14(3), multiplied by the appropriate per diem from rule 801—10.15(35D). This amount shall be reduced by any offsets as set out in subrules 10.15(2) and 10.15(3). The member or legal representative shall pay an amount not to exceed the amount calculated based on the resources available for the cost of care as set out in this chapter.

10.14(2) Title XIX residents. If a member is certified as eligible and participating in the Title XIX program, the amount of payment shall be determined by the department of human services income maintenance worker.

10.14(3) Billable days (non-Title XIX). Billable days for members not participating in the Title XIX program shall be counted as follows:

a. All days in the month for which the member received care (in-house).

b. All days away from IVH on pass status.

c. All furlough days in excess of the 15 free days up through the fifty-ninth furlough day. Any furlough days in excess of 59 days shall be considered billable, but the member must pay the full member support, not the amount determined by resources.

d. The first ten days of each hospitalization. On the eleventh day the member's bed shall be held without charge until the termination of hospital stay and member returns to IVH.

801—10.15(35D) Per diems.

10.15(1) For members not participating in the Title XIX program, the per diem by which the billable days shall be multiplied shall be established as follows:

a. Nursing and infirmary levels of care.

(1) The charge for care is the per diem submitted by IVH to department of human services for the Title XIX certified units as calculated in January and July of each year for the preceding six months.

(2) The charge for care shall be adjusted, if necessary, semiannually on March 1 and September 1 of each year.

(3) Members or financial legal representatives shall be sent a notice one month in advance of the rate change.

b. Domiciliary level of care.

(1) The total cost of care per member shall be determined in January and July of each year for the preceding six months and calculated in a manner similar to the nursing level of care. This cost shall be the charge for care.

(2) The charge for care shall be adjusted, if necessary, semiannually on March 1 and September 1 of each year.

(3) Members or financial legal representatives shall be sent a notice one month in advance of the rate change.

10.15(2) Veteran members not living on Title XIX certified units and those living on Title XIX certified units but not eligible for Title XIX medical assistance for whom IVH receives a per diem from the U.S. DVA (under Title 38). IVH shall consider this per diem as a third-party reimbursement to the charge for care and shall be an offset to the member support bill. The offset of the per diem received (billed to DVA) shall be shown as an offset for the month billed.

10.15(3) For members not living on Title XIX certified units and those living on Title XIX certified units but not eligible for Title XIX medical assistance. The daily per diem charge shall be reduced by an amount equal to the "usual" Medicare premium calculated as a per diem. This offset shall be available only to members eligible for Medicare insurance.

10.15(4) For members not living on Title XIX certified units and those living on Title XIX certified units but not eligible for Title XIX medical assistance. The member support charge shall be reduced in accordance with subrules 10.15(2) and 10.15(3), if applicable. The member shall then contribute all remaining available resources up to the charge for care.

Members receiving DVA pension and aid and attendance shall be considered as having used the amount equal to aid and attendance first in payment for their care at IVH.

10.15(5) Payment of support is due on the tenth of the month in which the monthly support bill is received, or ten business days after the member's last income deposit for that month.

a. If payment is not received by IVH within 30 days following the due date, a notice of discharge may be issued.

b. If there are extenuating circumstances, the member or legal representative should meet with the commandant or designee to work out a schedule of payments.

801—10.16(35D) Assets. The following rules specify the treatment of assets, as defined in rule 801—10.1(35D), in the payment of member support as described in rule 801—10.14(35D). Only liquid assets shall be considered in the payment of member support.

10.16(1) For members living on Title XIX certified units who have applied for and are eligible to receive Title XIX medical assistance, rule 441—75.5(249A) shall apply. Financial eligibility for Title XIX shall be determined by the department of human services income maintenance worker.

10.16(2) For members not living on Title XIX certified units and those living on Title XIX certified units but not eligible for Title XIX medical assistance, the following rules apply:

a. Assets considered. The assets considered shall include all assets owned by the member, or if married, both the member and the spouse living in the community, except for the following:

(1) The homestead is exempt as follows: The exempt homestead is defined as the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. Contiguous means that portions of the homestead cannot be separated from the home by intervening property owned by others. However, the homestead is considered contiguous if portions of it are separated from the home only because of roads or other public rights-of-way. Property that is not exempt as part of the homestead shall be treated in accordance with the rules of this chapter.

The homestead, as defined, can retain its exempt status for a period of time not to exceed 36 months, while the member, spouse and dependents are temporarily absent, provided the following conditions are met:

1. There is a specific purpose for the absence.

2. The member, spouse or dependents intend to return to the homestead when the reason for the absence has been accomplished.

3. The member, spouse or dependents can reasonably be expected to return to the home during the 36-month time limitation.

4. If a person is an applicant at the time the homestead becomes vacant due to the absence of the applicant, spouse or dependents, the first month of the 36-month period is the month of admission to IVH.

5. If a person is a member when the homestead becomes vacant due to the absence of the member, spouse or dependents, the first month of the 36-month period is the month following the month in which the homestead is vacated.

6. Any homestead that does not qualify for this exemption or any homestead that is vacant for a period of time exceeding the 36-month limit shall be treated in accordance with subrule 10.16(3).

(2) Household goods, personal effects and motor vehicles.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of the member, spouse or any other member of the immediate family.

(4) Exempt income-producing property includes, but is not limited to, tools, equipment, livestock, inventory and supplies, and grain held in storage.

(5) Other property essential to the means of self-support of either the member or spouse as to warrant its exclusion under the Supplemental Security Income program.

(6) Assets of a blind or disabled person who has a plan for achieving self-support as determined by the division of vocational rehabilitation or the department of human services.

(7) Assets of Native Americans belonging to certain tribes arising from judgment fund and payments from certain land and subsurface mineral rights.

(8) Any amounts arising from Public Law 101-239 which provides assistance to veterans under the Agent Orange product liability litigation.

(9) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute as a result of a presidential disaster declaration 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.

(10) An amount that is irrevocable and separately identifiable, not in excess of $8514 principal, without an itemized billing, for the member or spouse to meet the burial and related expenses of that person.

(11) Federal assistance paid for housing occupied by the spouse living in the community.

(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 member or spouse comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

(14) Any other asset excluded by statute.

b. Assets of a single member. When liquid assets not exempted in paragraph *"a"* above are equal to or exceed $2,000, those liquid assets shall be considered an available resource for the payment of member support. These assets shall be considered available for payment of member support until such time that the remaining liquid assets total less than $500, but leaving at least $140.

c. Assets of a married member with spouse in a care facility. If a member's spouse is residing in a nursing facility, including IVH, the member shall be treated as a single member for asset determination purposes. If the spouse is residing in a residential care facility, the rules pertaining to a spouse living in the community apply.

d. Assets of a married member with spouse living in the community. When liquid assets not exempted in paragraph *"a"* above are equal to or exceed $2,000, those liquid assets shall be considered an available resource for the payment of member support. These assets shall be considered available for payment of member support until such time that the remaining liquid assets total less than $500, but leaving at least $140.

The assets attributed to the member shall be one-half of the documented assets of both the member and spouse living in the community as of the first day of admission to IVH after the first $24,000 is exempted for the community spouse. However, if one-half of the resources is less than $24,000 (the amount set by 441 IAC 75.5(3)*"d"* and *"f,"* Public Law 100-365 and Public Law 100-485), then that amount shall be protected for the spouse living in the community. Other resources attributed to the spouse living in the community shall be determined by the department of human services through the attribution process.

(1) If the member has transferred assets to the spouse living in the community under a court order for the support of the spouse, the amount transferred shall be the amount attributed to the spouse to the extent it exceeds the specified limits above.

(2) After the month in which the member is admitted, no attributed resources of the spouse living in the community shall be deemed available to the member during the continuous period in which the member is at IVH. Resources which are owned wholly or in part by the member and which are not transferred to the spouse living in the community shall be counted in determining member support. The assets of the member shall not count for member support to the extent that the member intends to transfer and does transfer the assets to the spouse living in the community within 90 days.

(3) Report of results. The department of human services shall provide the member and spouse and legal representative, if applicable, a report of the results of the attribution. The report shall state that either has a right to appeal the attribution in accordance with rule 801—10.45(35D).

e. Exception based on estrangement. When it is established by a disinterested third-party source and confirmed by the commandant or designee that the member is estranged from the spouse living in the community, member support shall be determined on the basis of resources of a single member.

10.16(3) When a member owns an available, nonliquid, nonexempt asset, the value of which would affect the computation of member support as described in rule 801—10.14(35D), the asset shall be liquidated. The value of that asset shall be considered in the computation of member support. The following paragraphs are to be considered when liquidating assets:

a. Net market value, or equity value, is the gross price for which property or an item can be sold on the open market less any legal debts, claims or liens against the property or item. IVH shall consider the condition and location of an item or property and local market conditions in determining the gross sales price of the item or property. In order for a loan or claim to be considered a lien or encumbrance against an asset, the loan or claim must be made under circumstances that result in the creditors having a recorded legal right to satisfy the debt.

b. An asset must be available in order for it to be treated in accordance with the rules of this chapter. An asset is considered available when:

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

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

c. A member must take all appropriate action to gain title and control of any asset of which the value would affect the computation of member support.

d. The value of the asset may be adjusted if the member or legal representative:

(1) Advertises the asset for sale, through appropriate methods, on a continual basis.

(2) Lists the asset with a real estate broker or other agent appropriate to the asset.

(3) Asks a reasonable price which is consistent with the asking price of similar items of property in the community.

(4) Does not refuse a reasonable offer.

(5) Does not sell the asset for an unreasonably low price.

e. Cash proceeds from the sale of an asset, conversion of an asset to cash, or receipt of any cash asset as defined in rule 801—10.1(35D) shall be used in the computation of member support beginning with the calendar month of receipt.

801—10.17(35D) Divestment of assets.

10.17(1) "Intentional divestment of assets" means:

a. To knowingly sell, give or transfer by member or legal representative for less than fair market value, any asset, the value of which would affect member support; or

b. To knowingly and voluntarily place an asset, the value of which would affect member support, under a trust or other legal instrument that ends or limits the availability of that asset.

10.17(2) Transfers of resources shall be presumed to be divestiture unless the individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose. In addition

to giving away or selling assets for less than fair market value, examples of transferring resources include, but are not limited to, establishing a trust, contributing to a charity or other organization, removing a name from a joint bank account, or decreasing the extent of ownership interest in a resource or any other transfer as defined in the Supplemental Security Income program.

a. Convincing evidence to establish that the transaction was not a divestiture may include documents, letters, and contemporaneous writings, as well as other circumstantial evidence.

b. In rebutting the presumption that the transfer was a divestiture, the burden of proof is on the individual to establish:

(1) The fair market value of the compensation;

(2) That the compensation was provided pursuant to an agreement, contract, or expectation in exchange for the resource; and

(3) That the agreement, contract, or expectation was established at the time of transfer.

10.17(3) An applicant or legal representative shall not knowingly and intentionally divest an asset, as set out in subrule 10.17(1), within the period established by Title XIX statute prior to admission, with the intention of reducing the applicant's member support or of obtaining admission to IVH.

When it is determined by the commandant or designee that an applicant did intentionally divest an asset, upon admission that applicant shall be charged member support as if divestment did not occur.

10.17(4) A member or legal representative shall not knowingly and intentionally divest an asset, as described in subrule 10.17(1), while a member with the intention of reducing the member support.

When it is discovered that a member or legal representative improperly divested an asset(s), that member shall be charged member support as if divestment did not occur.

801—10.18(35D) Commencement of civil action. The commandant or designee may file a civil action for money judgment against a member or discharged member or the member's legal representative for support charges when the member or discharged member fails to pay member support in accordance with 801—Chapter 10.

801—10.19(35D) Income. This rule describes the treatment of income, as defined at rule 801—10.1(35D), in the computation of member support as described at rule 801—10.14(35D).

10.19(1) For members living on Title XIX certified units who are eligible for Title XIX medical assistance, rule 441—75.5(249A) shall apply. For those members participating in the Title XIX medical assistance program, the difference between the $140 personal needs allowance and the Title XIX personal needs allowance shall be returned to the member out of individual member participation.

10.19(2) For members living on units which are not Title XIX certified and members living on Title XIX certified units who are not eligible for Title XIX, the following shall apply:

a. The following types of income are exempt in the computation of member support:

(1) The earned income of the spouse or dependents.

(2) Unearned income restricted to the needs of the spouse or dependents (Social Security, DVA, etc.).

(3) Any other income that can be specifically identified as accruing to the spouse or dependents.

(4) Nonrecurring gifts, contributions or winnings, not to exceed $60 in a calendar quarter.

(5) Interest income of less than $20 per month from any one source.

(6) State bonus for military services.

(7) Any earnings received by a member for that member's participation in money-raising activities administered by veterans organizations or auxiliaries.

(8) Any money received by a member from the sale of items constructed or grown at IVH as part of a therapy program.

(9) The first $150 received by a member in a month for participation in the incentive therapy or other programs as described at rule 801—10.30(35D), for members in the domiciliary level of care. For members in the nursing level of care, the first $75 shall be exempted.

(10) Personal loans.

(11) In-kind contributions to the member.

(12) Title XIX payments.

(13) Yearly DVA compensation clothing allowance for those who qualify.

(14) Other income as specifically exempted by statute.

(15) Any income similar in its origin to the assets excluded in subparagraphs 10.16(2)*"a"*(6) and (7).

(16) Income from participating as outlined in the community reentry program (IVH policy #265A) or the IVH discharge planning policy (IVH policy #265).

b. Personal needs allowance. All members shall have a monthly income intended to cover the purchase of clothing and incidentals.

(1) All income up to the first $140 shall be kept as a personal needs allowance.

(2) The personal needs allowance shall be subtracted from the member's income prior to determination of moneys to which the spouse may be entitled.

c. Any type of income not specifically exempted shall be considered for the payment of member support as provided in rule 801—10.14(35D).

d. Determining income from property.

(1) Nontrust property. Where there is nontrust property, income paid in the name of one person shall be available only to that person unless the document providing income specifies differently. 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, the income shall be considered in proportion to their ownership interest. If the member or spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

(2) Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

e. The amount of income to consider in the computation of member support shall be as follows:

(1) Regular monthly pensions and entitlements. The amount of income to be considered is the amount of the monthly entitlement or pension received.

(2) Investments or nonrecurring lump-sum payments. Net unearned income from investments or nonrecurring lump-sum payments shall be determined by deducting income-producing costs from the gross unearned income. Income-producing costs include, but are not limited to, brokerage fees, property manager's salary, maintenance costs and attorney fees.

(3) Property sold on contract. The amount of income to consider shall be the amount received minus any payments for mortgage, taxes, insurance or assessments still owed on the property.

(4) Earned income from a rental, sole or partnership enterprise. The amount of income to consider shall be the net profit figure as determined for the Internal Revenue Service on the member's income tax return.

EXCEPTION: The deductions of the previous year's state and federal taxes and depreciation on the income tax return are not allowable deductions for the purpose of the computation of member support. If a tax return is not available, the member or legal representative shall provide all information and verification needed in order to correctly compute member support.

(5) Partnership income. The member's share of the net profit shall be determined in the same manner as the partnership percentage as determined for Internal Revenue Service's purposes.

10.19(3) Member income diversion to dependent spouse not living at IVH. A portion of the member's income shall be diverted to the spouse according to the following:

a. Spouse living in the community. One-half the income in exclusion of an amount equal to aid and attendance and after reduction of personal needs allowance.

b. Spouse in another nursing home not on Title XIX. The same amount as a spouse living in the community in accordance with paragraph 10.19(3)*"a."*

c. Spouse in nursing home on Title XIX. Member shall be treated as single. If member is in receipt of DVA pension, the amount of income provided Title XIX spouse would be the DVA pension dependency amount.

d. Spouses living in a residential care facility. Spouses shall be treated under the same rules as a spouse living in the community in accordance with paragraph 10.19(3)*"a."*

e. All current court order proceedings and guardian/conservatorship appointments regarding financial obligations, except child support or alimony, shall be honored.

10.19(4) Income disbursements.

a. All monthly diversions to spouse or valid court orders shall be mailed as designated or on a monthly basis.

b. All checks shall be mailed no later than the eighth day of any given month to proper recipient or, at IVH's option, five business days after the member's last income deposit for that month.

c. Monthly income disbursements to a community spouse may be delayed or canceled if there is an overdue amount owed for support payments.

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801—10.20(35D) Other income.

10.20(1) When a member receives regular monthly payments of unearned income, it shall be included in the resources available for the payment of member support.

10.20(2) When a member receives periodic recurring income which is received less frequently than monthly, this countable income, after the deduction of any allowable income-producing expenses, shall be considered in the month received.

10.20(3) When a member receives a nonrecurring retroactive payment from a specific entitlement source for a prior period of time, it shall be considered as income in the month received. The aid and attendance amount of the DVA pension shall be computed as a manual adjustment (available to member due to IVH nursing care).

10.20(4) Income from a particular source is considered terminated as of the date the member receives the last income payment from that source or the date that a sole or partnership enterprise ends, whichever is later.

10.20(5) When income from a particular source decreases in a calendar month, the decrease in income shall be considered in the computation of that month's member support. Income from a particular source is considered to be decreased as of the date the member receives the first income payment in the decreased amount.

10.20(6) When income from a particular source increases in a month, the increase in income shall be considered in the computation of that month's member support. Income from a particular source is considered to be increased as of the date the member receives the first income payment in the increased amount.

10.20(7) Recurring lump-sum payments shall be treated as income in the month received.

10.20(8) Nonrecurring lump-sum payments earned prior to admission, regardless of when received, shall not be counted as income but may be considered as an available liquid asset.

10.20(9) Any income as defined in rule 801—10.20(35D) that exceeds the member support billing for that month shall thereafter be considered a liquid asset available under rule 801—10.16(35D).

10.20(10) Through IVH programs, employment is only allowed in the community reentry program (IVH policy #265A) or the IVH discharge planning policy (IVH policy #265).

801—10.21(35D) Fraud. Applicants, members or legal representatives who knowingly conceal the existence of resources may be subject to the billing of full member support, discharge for failure to pay for member's care or denial of admission. Further, members who knowingly conceal liquid assets or income which would have affected member support shall be charged for the amount not previously billed due to the fraudulent act. If upon admission it is determined that medical or other pertinent information provided during the application process was fraudulent, notice of discharge may be issued. In addition, any applicant, member or legal representative suspected of fraud may be referred to the department of inspections and appeals, division of investigations, for possible criminal or civil action. The attorney general's office shall conduct the investigation.

801—10.22(35D) Overcharges. When it is discovered that a member was charged for support in excess of the amount actually due, the member shall receive a refund or credit to the member's account. If the member is discharged or deceased, a refund shall be conveyed to the member or legal representative.

801—10.23(35D) Penalty.

10.23(1) All members who have resources in excess of the full support rate shall be charged the full member support rate. If any member does not apply for all benefits due (such as, but not limited to, Title XIX, DVA pension, DVA compensation, Social Security, or any combination), fails to report resources accurately in order to not pay full support, or refuses to accept the available billing programs offered at IVH, that member shall be charged up to full member support as if these responsibilities had been followed. Failure to comply with these rules may result in discharge from IVH.

10.23(2) If a member is required to pay full member support under these rules, the monthly charge shall be calculated as the per diem in paragraph 10.15(1)*"a"* or 10.15(1)*"b"* times the billable days less any offsets. The only exception to this monthly charge will be the additional amount of aid and attendance in the DVA retroactive payment for the time period of nursing care at IVH. This amount, in total, shall be due regardless of resources available. If a member is required to pay member support based on additional resources, these figures shall be obtained from the appropriate agencies.

801—10.24 to **10.29** Reserved.

801—10.30(35D) Incentive therapy and nonprofit rehabilitative programs. Members may be offered the opportunity to perform services for IVH through the incentive therapy program as part of their plan of care. Participating members shall be compensated for their involvement in the incentive therapy program according to applicable guidelines established by the U.S. Department of Labor, Wage, and Hour Division, and the commandant or designee if members enrolled in nonprofit rehabilitative programs receive an income from such programs, that income shall be treated in the same manner as the incentive therapy program or IVH policy.

This rule is intended to implement Iowa Code section 35D.7(3).

801—10.31 to **10.34** Reserved.

801—10.35(35D) Handling of pension money and other funds. Each member who has not been assigned a guardian, conservator, fiduciary or representative payee or has not designated a power of attorney while competent or as otherwise specified, may manage that member's own personal financial affairs. Upon the receipt of written authorization from the member or legal representative to the commandant or designee, the commandant or designee may assist the member in the management of the member's financial affairs.

10.35(1) Pension money or other funds deposited with IVH are not assignable except as specified at subrule 10.19(3) or 10.40(2)*"b"*(1).

10.35(2) If authorized by a member, the commandant or designee may act on behalf of that member in receiving, disbursing, and accounting for personal funds of the member received from any source subject to the requirements of Iowa Code section 135C.24. The authorization may be given or withdrawn in writing by the member or legal representative at any time. The authorization shall not be a condition of admission to or retention at IVH.

10.35(3) IVH shall maintain a commercial account with a federally insured bank for the personal deposits of its members. The account shall be known as the IVH membership account. The commandant or designee shall record each member's personal deposits individually and shall deposit the funds in the membership account where the members' deposits shall be held in the aggregate. Interest shall accrue on those accounts that are on deposit the last working Friday of each month.

10.35(4) If authorized in writing by the member or legal representative, the commandant or designee may make withdrawals against that member's personal account to pay regular bills and other expenses incurred by the member. The authorization may be given or withdrawn in writing by the member or

legal representative at any time. The authorization shall not be a condition of admission to or retention at IVH.

10.35(5) The commandant or designee shall maintain a written record of each member's funds which are received by or deposited with IVH. The member or legal representative shall receive a monthly statement showing deposits, withdrawals, disbursements, interest and current balances. If the commandant or designee is made representative payee for the member's financial transactions, this statement shall be maintained in the member's administrative file.

10.35(6) Except as otherwise specified, funds deposited with IVH shall be released to the member or legal representative upon request with a statement showing deposits, disbursements, interest, and the final balance at the time the funds are withdrawn. When the member continues to maintain residency at IVH, the funds shall be released and statement provided within three working days following the request. When a member is being discharged from IVH, the funds shall be released and a statement provided no later than the tenth day of the month following the month of discharge.

10.35(7) Upon the death of a member with personal funds deposited with IVH, IVH must convey promptly the member's funds to any outstanding funeral home bill, the individual paying last funeral expenses, or whoever is administering the member's estate. If probate papers are produced, a final accounting of those funds must also be provided to the individual administering the member's estate. If the value of the member's estate is so small as to make the granting of administration inadvisable, IVH must hold, then deliver all money plus interest within one year to the proper heirs equally or adhere to the member's request in the member's last will and testament.

This rule is intended to implement Iowa Code sections 35D.11(2) and 35D.12(2).

801—10.36(35D) Passes, furloughs, and room retention.

10.36(1) *Non-Title XIX members.*

a. Members are free to leave IVH grounds unless contraindicated by medical determination. In cases where it is determined to be medically contraindicated and a member chooses to leave, the member or legal representative must sign "Discharge/Furlough Against Medical Advice," Form 475-0940.

b. Passes are required if the member expects to be absent past midnight. A pass shall not exceed 96 hours. If a member expects to be gone more than 96 hours, a furlough is required.

c. Upon return from a pass or furlough, the member must spend 24 hours in residence at IVH before another pass or furlough is issued. The commandant or designee may, in an emergency situation such as family illness or death, grant exceptions.

d. All furloughs other than free time shall require payment of member support charges as though the member were in residency. Failure to pay regular member support charges shall result in discharge of the member. Furlough length may be changed by notification from the member or legal representative to the nursing unit social worker or domiciliary office.

e. Medical furloughs. Furloughs spent in approved medical facilities away from IVH shall not be counted against the 59-day furlough time limit as set out in paragraph 10.14(3)*"c."*

Hospital furloughs shall be granted and the charges for such furloughs shall be as follows: During the first ten days of any hospital stay, the member shall pay the regular and usual assessed charge of the level of care of the bed held. Beginning on the eleventh day through the remainder of the hospitalization, the member shall not be charged. Each monthly member support bill shall reflect any adjustments related to hospitalization. Members discharged from IVH shall have the account closed before the first of the month following the discharge.

Furloughs to other medical facilities for the purpose of treatment shall be treated as hospital furloughs.

f. General furloughs.

(1) Fifteen days of furlough time each calendar year shall be free time.

(2) The member shall be charged the usual support charge for furlough time over 15 days up to and including 59 days.

(3) The member shall be charged the full member support for the level of care in which the member resides for furlough time over 59 days.

(4) Free time and other furlough time are not cumulative from one calendar year to another calendar year.

(5) Free time the member has not utilized or cannot utilize shall not be credited toward the member's support.

(6) Support charges for the member on furlough wishing to retain the member's room or bed shall be due and payable as though the member were in residency as set forth in paragraph 10.36(1)*"d."*

g. When a member is on pass, the member shall remain on in-house status for DVA per diem purposes and IVH shall be financially responsible for medical expenses unless these are assumed by the member or legal representative in relation to choice of medical facility.

h. When a member is on furlough, IVH is not financially responsible for any medical charges for the member.

10.36(2) *Members who are receiving Title XIX benefits.*

a. Members are free to leave IVH grounds unless contraindicated by medical determination. In cases where it is determined to be medically contraindicated and a member chooses to leave, the member or legal representative must sign "Discharge/Furlough Against Medical Advice," Form 475-0940.

b. A pass or furlough as set out in paragraph 10.36(1)*"b"* (whichever is appropriate) is required if a member expects to be absent past midnight. Free time does not apply to Title XIX members.

c. The member's bed shall be held while the member is visiting away from IVH for a period not to exceed 18 days in any calendar year. There is no restriction as to the amount of days taken in any one month or during any one visit, as long as the days taken in the calendar year do not exceed 18. Additional days shall be allowed if the member's medical provider recommends in the plan of care that additional days would be rehabilitative.

d. A member or a legal representative who wishes to exceed the 18 visitation days and retain the member's bed, but does not have medical provider recommendation for an extension, must make arrangements with the director of admissions or designee for payment of the rate determined by the department of human services income maintenance worker for all days in excess of the 18 visitation days. If prior arrangements and payment are not made, a member may be discharged in accordance with subrule 10.12(2).

e. A bed shall be held for a hospitalized member. The member's client participation shall be paid according to the department of human services' income maintenance worker for all hospitalized days until member returns or is discharged.

f. IVH is not financially responsible for any medical charges for the member when visiting away from IVH.

801—10.37 to **10.39** Reserved.

801—10.40(35D) Requirements for member conduct. The commandant shall administer and enforce all requirements for member conduct. Subject to these rules and Iowa Code section 135C.23, the commandant may transfer or discharge any member from IVH when the commandant determines that the health, safety or welfare of the members or staff is in immediate danger, and other reasonable alternatives have been exhausted.

10.40(1) In addition to the member responsibilities as set out in rule 801—10.12(35D), each member shall also comply with the following requirements:

a. The use of intoxicants or alcoholic beverages on IVH premises is prohibited unless prescribed by a medical provider.

b. The bringing of alcoholic beverages or illicit substances on IVH premises is prohibited. Any illicit substances or drug paraphernalia or both found in the member's possession shall be grounds for immediate discharge.

c. The use of illegal substances while a member of IVH is prohibited. A urinalysis shall confirm the presence of illegal substances. A member's refusal to submit to a urinalysis in response to a request based on probable cause shall be considered a positive result and is grounds for discharge.

d. Firearms or weapons of any nature shall be turned in to the adjutant or designee for safekeeping. The adjutant or designee shall decide if an instrument is a weapon. Firearms or weapons in the possession of a member which constitute a hazard to self or others shall be removed and stored in a place provided and controlled by the facility.

e. Smoking in members' rooms is prohibited. Members who smoke shall do so within designated smoking areas so as not to endanger self or others.

f. Continuously disruptive behavior on the part of a member, such as fighting with other members, visitors or staff, assault or theft, is grounds for transfer or discharge.

g. Members shall comply with legal requests and orders of the commandant or designee.

h. Members shall not violate state and federal statutes.

i. Members shall report to the director of admissions or designee any changes in assets/income, and pay support by the tenth of each month.

10.40(2) When a member is found in violation of the requirements of conduct established in subrule 10.40(1), the following steps may be taken:

a. A period of counseling from an appropriate staff member.

b. IVH control of the member's personal funds as follows:

(1) The pension money and other incomes and available liquid assets shall be deposited by the commandant or designee in a separate account for and on behalf of the member. The commandant or designee shall, under the procedures established in subrules 10.35(3) and 10.35(4), make withdrawals and disbursements to meet the regular bills and other expenses of the member.

(2) If, after a period of up to six months, the member's behavior is deemed appropriate by the facility, the handling of funds will be reviewed, and funds may be returned to the member.

(3) If the member is discharged from IVH, the balance of the deposit shall be paid to the member or financial legal representative within 30 days of discharge.

c. Discharge from IVH in accordance with subrule 10.40(3).

10.40(3) The steps described in subrule 10.40(2) shall generally be followed in that order. However, if the member's violation is of an extreme nature and the member is not amenable to counseling, the commandant or designee shall choose to discharge the member after the expiration of a 30-day written notification period which begins when the notice is personally delivered. In an emergency situation, a written notice shall be given prior to or within 48 hours following the discharge.

The member's county commission of veterans affairs and the legal representative shall be informed in writing of the decision to discharge. Written notification shall also be issued to appropriate governmental agencies including the commission, department of inspections and appeals, and the department of elder affairs long-term care ombudsman to ensure that the member shall not be in danger of health, safety or welfare upon release.

10.40(4) A member who has been previously discharged under the provisions of subrule 10.40(2) or 10.40(3) shall be readmitted to IVH only upon the approval of the commandant or designee. If not approved, the applicant shall receive written notice of the denial. A copy of the denial notice shall be forwarded to the commission and the appropriate county commission of veterans affairs. Any decision to deny readmittance is subject to the review of the commission.

801—10.41(35D) County of settlement upon discharge. A member does not acquire legal settlement in the county in which IVH is located unless the member is voluntarily or involuntarily discharged from IVH, continuously resides in the county for a period of one year subsequent to the discharge and during that year is not readmitted to IVH and does not receive any services from IVH.

801—10.42(35D) Disposition of personal property and funds.

10.42(1) A discharged member shall remove all personal property at the time of discharge or within 30 days. Personal property not removed within 30 days after discharge shall become the property of IVH to dispose of as the commandant or designee directs. Personal property may be forwarded at the member's expense to the member's last-known address. When the member is discharged from IVH, the

member's funds shall be released to the member or legal representative with a statement provided no later than the tenth day of the month following the month of discharge.

10.42(2) Following written notification to the legal representative or first next of kin, a deceased member's personal property remaining at IVH 30 days after written notification shall become the property of IVH to dispose of as the commandant or designee directs. If there is a known legal representative or first next of kin, the property may be shipped to the legal representative or first next of kin at the expense of the estate, legal representative, or first next of kin.

10.42(3) Upon death of a member with personal funds deposited at IVH, IVH shall convey the member's funds with a final statement to the legal representative administering the member's estate. When an estate is not opened or in cases where no executor is appointed, IVH shall attempt to locate the deceased member's heirs and deliver the funds and property to the heirs within one year after date of death.

801—10.43 and **10.44** Reserved.

APPEAL PROCESS

801—10.45(35A,35D) Applicant appeal process. An applicant who believes that any of the provisions of 801—Chapter 10 have not been upheld, or have been upheld unfairly, may file an appeal directly with the commandant containing a statement of the grievance and requested action. The commandant shall investigate and may hold an informal hearing with the applicant and other involved individuals. Subrules 10.46(4) to 10.46(8) apply subsequently. The commandant shall notify the applicant of the decision in writing within ten working days of receipt of the grievance.

801—10.46(35A,35D) Member appeal process. A member who believes that any of the provisions of 801—Chapter 10 have not been upheld or have been upheld unfairly may file an appeal.

10.46(1) A member shall discuss the problem and action desired with the assigned social worker within five working days of the incident which caused the problem. The social worker shall investigate the situation and attempt to resolve the problem within five working days of the discussion with the member. If the assigned social worker has allegedly caused the grievance, the member may file the grievance directly with the director of resident and family services.

10.46(2) If unable to resolve the problem, or if the member is dissatisfied with the solution, the social worker shall assist the member with filing a formal grievance and shall submit a report of the facts and recommendations to the director of resident and family services within five working days of the discussion with the member. The director of resident and family services shall inform the member of the decision in writing within five working days of receipt of the social worker's report.

10.46(3) If the member is not satisfied with the decision of the director of resident and family services, or if no decision is given within the time specified in subrule 10.46(2), the member may appeal to the commandant within ten working days of the decision of the director of resident and family services or, if no decision is given, within ten working days of the time limit specified in subrule 10.46(2). The grievance shall be submitted in writing and contain a statement of the cause of the grievance and requested action. A copy of the decision of the director of resident and family services shall be attached to the grievance statement, if applicable. The commandant shall investigate the grievance and may hold an informal hearing with the member, director of resident and family services, and other involved individuals. The commandant shall notify the member and the director of resident and family services of the decision in writing within ten working days of receipt of the grievance.

10.46(4) If the member is not satisfied with the decision of the commandant, or if no decision is given within the time limits specified in subrule 10.46(3), the member may appeal to the commission within ten working days of the commandant's decision. The member and commandant shall be notified in writing within five working days of the commission's receipt of the appeal. The commission shall schedule a hearing with the member, commandant, and other involved individuals to determine the facts and make a final decision.

10.46(5) The member may appoint any individual to represent the member in the appeal process, at the member's expense.

10.46(6) No reprisals of any kind shall be taken against a member for filing an appeal.

10.46(7) The member may obtain judicial review of the commission's final decision in accordance with Iowa Code chapter 17A.

10.46(8) The time limits specified in the above subrules may be extended when mutually agreed upon by the persons involved in the appeal process.

Rules 801—10.45(35A,35D) and 801—10.46(35A,35D) are intended to implement Iowa Code subsection 35A.3(4) and Iowa Code chapter 35D.

801—10.47 to **10.49** Reserved.

GROUNDS AND FACILITY ADMINISTRATION

801—10.50(35D) Visitors. Visitors are welcome to IVH subject to the following conditions:

10.50(1) Member visitation hours are from 8 a.m. to 11 p.m. daily. Visiting hours may be extended on an individual basis with the approval of the commandant or designee.

10.50(2) Visitors are subject to the policies and procedures as established by IVH rules.

10.50(3) Tours of IVH may be arranged by contacting the commandant or designee.

10.50(4) Firearms, drugs, or alcoholic beverages are permitted on IVH grounds only with the permission of the commandant or designee.

10.50(5) Any disruptive behavior on the part of a visitor shall result in modification, denial or termination of visiting privileges.

10.50(6) Trespass. Visitors shall not enter IVH grounds with the intent to commit a public offense, remain upon the grounds or in IVH buildings without justification after being notified or requested to abstain from entering, or to remove or vacate therefrom by any peace officer, magistrate, or public employee whose duty it is to supervise the use or maintenance of IVH and its grounds.

10.50(7) Any visitor violating any of the rules within this chapter may be restricted from IVH for a period of time to be determined by the commandant or designee.

801—10.51(35D) Mail.

10.51(1) Each competent member shall be afforded a choice in the methods of handling the member's business mail and in meeting the member's responsibilities for reporting resources for computation of member support purposes. A member found to be mentally incompetent shall have that member's business mail handled in a manner as to respect that member's dignity and still meet the needs of IVH for complete information regarding resources.

10.51(2) Each competent member shall be allowed to handle that member's business mail to the degree of responsibility chosen by the member. A member may:

a. Elect to receive all business mail personally and provide the admissions office with financial documentation, or

b. Designate that the member shall receive personal mail items, but business mail received at IVH from entitlement sources or concerning assets shall be routed to the director of admissions or designee.

801—10.52(35D) Interviews and statements.

10.52(1) Releases to the news media shall be the responsibility of the commandant or designee. Authority for dissemination and release of information shall be designated to other persons at the discretion of the commandant or designee.

10.52(2) Interviews of members within IVH by the news media or other outside groups are permitted only with the prior written consent of the member to be interviewed or the member's legal representative. At the request of the person or group who wishes to conduct an interview, the commandant or designee shall seek to obtain the required consent from the member or the member's legal representative.

801—10.53(35D) Donations. Donations of money, clothing, books, games, recreational equipment or other gifts shall be made directly to the commandant or designee. The commandant or designee shall evaluate the donation in terms of the nature of the contribution to the facility program. The commandant or designee shall be responsible for accepting the donation and reporting the gift to the commission. All monetary gifts shall be acknowledged in writing to the donor.

801—10.54(35D) Photographing and recording of members and use of cameras.

10.54(1) Photographs and recordings of members within IVH by news media or other outside groups are permitted only with the prior written consent of the member to be photographed or recorded, or the member's legal representative. At the request of the person or group who wishes to make photographs or recordings, the commandant or designee shall seek to obtain the required consent from the member or the member's legal representative.

10.54(2) Every effort shall be made to preserve the inherent dignity of the member and to preclude exploitation or embarrassment of the member or the family of the member.

801—10.55(35D) Use of grounds and facilities.

10.55(1) Persons wishing to use the facilities and grounds for civic purposes, programs for members, meetings, and similar purposes, must contact the commandant or designee at least two weeks in advance of the requested date. The commandant or designee may disapprove a request when the requested facilities are scheduled for use by or for the members, or when the activity would disrupt the normal operation of IVH. Previous arrangements to use the facilities or grounds may be canceled by the commandant or designee in the event of an emergency or when changes in the schedule require the use of the facilities or grounds for the members. Persons who use the facilities or grounds shall be held responsible for leaving the facilities or grounds in satisfactory condition and for any damages caused by or resulting from use.

10.55(2) Members of outside organizations permitted to use facilities or grounds shall observe the same rules as visitors to the facility.

801—10.56(35D) Nonmember use of cottages. Cottages may be made available to persons on the staff of IVH or to other members of the public with the commandant's approval and at the established rate.

10.56(1) Expenses incurred as a result of damage or need for exceptional cleaning/sanitizing procedures, or both, may result in additional charges to the visitor as determined by IVH.

10.56(2) Posted occupancy capacities shall not be exceeded and may be grounds for denial of use.

10.56(3) Pets are not allowed inside the cottages. Visitors may maintain portable pet kennels outside.

801—10.57(35D) Operating motor vehicles on grounds.

10.57(1) The operator of a motor vehicle shall have a valid license for the type of vehicle being driven upon IVH grounds.

10.57(2) All persons operating a motor vehicle on IVH grounds shall comply with the applicable state and local laws and IVH policies.

10.57(3) No driver of a motor vehicle or motorcycle shall disobey the instructions of any traffic-control device, warning, or sign placed.

10.57(4) No person shall drive any vehicle in such a manner as to indicate either a willful or wanton disregard for the safety of person or property. The person operating the motor vehicle or motorcycle shall have same under control and shall reduce the speed to 20 miles per hour on IVH grounds and reduce the speed to a lower, reasonable rate when approaching and passing a person walking in the traveled portion of a street.

10.57(5) No person shall stop, park, or leave standing any type vehicle in established fire lanes, emergency vehicle areas, and other essential lanes. No person shall park any type vehicle on roadways.

10.57(6) No person shall leave any type vehicle unattended by not locking doors or removing keys.

10.57(7) Failure to comply with rules may cause limitation or curtailment of driving privileges on IVH grounds for an indefinite period.

10.57(8) Motor vehicles belonging to members may be parked in member-designated parking on IVH grounds.

This chapter is intended to implement Iowa Code subsection 35A.3(4) and chapter 35D.

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VOTER REGISTRATION COMMISSION[821]

Prior to 3/21/90, Voter Registration Commission[845]

CHAPTER 1
ORGANIZATION, PURPOSE, PROCEDURES AND DEFINITIONS

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CHAPTER 1
ORGANIZATION, PURPOSE, PROCEDURES AND DEFINITIONS

[Prior to 3/21/90, see Voter Registration Commission[845], Ch 1]

821—1.1(47) Voter registration commission composition. The commission consists of four members: the state commissioner of elections, and the chairpersons of the two state political parties whose candidates for President of the United States or for governor, as the case may be, in the most recent general election, received the greatest and the second greatest number of votes, or their designees, and a person appointed by the president of the Iowa State Association of County Auditors.

821—1.2(47) State registrar of voters. The state commissioner of elections is designated the state registrar of voters. The state registrar is responsible for the regulation of the preservation, preparation and maintenance of voter registration records. This regulation activity is in accordance with the policies of the voter registration commission.

This rule is intended to implement Iowa Code section 47.7(1).

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—1.3(47) General operating rules.

1.3(1) The chair of the commission is the state commissioner of elections or the state commissioner's designee.

1.3(2) Any member of the commission, including the chair, may make and second any motion.

1.3(3) To prevail, a motion, declaratory ruling, or ruling in a contested case must receive the votes of a majority of commissioners present and voting.

1.3(4) Rescinded IAB 10/25/95, effective 10/6/95.

1.3(5) A designee of a statutory member shall present a letter from the statutory member appointing the designee.

1.3(6) A quorum of the commission is four members. No official action may be taken in the absence of a quorum.

1.3(7) Any member of the public may petition the commission concerning any subject under the commission's authority. Any member of the public may propose new rules or modifications to existing rules of the commission. Petitions or proposed rule changes may be in letter form, filed with the registrar and addressed to the commission. Any such letter must include a discussion of the problem or issue, addressing and supporting rationale for any proposed action by the commission. In addition, any such petition must state the legal authority which petitioner believes confers jurisdiction over the subject matter to the commission. Action on petitions received shall be taken not later than the second regular commission meeting following receipt of the petition. In the event a hearing is held on an issue, the hearing shall be scheduled within 90 days of receipt of the petition.

821—1.4(47) Voter registration staff.

1.4(1) *Voter registration system.* Under the general direction of the state registrar of voters, the voter registration staff conducts and directs those activities necessary to implement and maintain the statewide voter registration system. The voter registration staff includes clerical and technical personnel temporarily or permanently assigned by the registrar to support the voter registration function.

1.4(2) *Intergovernmental relations.* The voter registration staff is responsible for working with and assisting county commissioners in performing their voter registration duties under the law, including acquisition of voter registration data processing services, preparation of election registers, maintaining voter registration files, processing registration applications and related activities. The staff is responsible for communicating with state and federal court officials to arrange for the provision of information from voter registration records to the courts for use in the jury selection process. The staff is also responsible for ensuring the transfer of electronic registration data from registration agencies and the department of transportation to the appropriate county commissioner.

1.4(3) *Staff support to the commission.* The registrar and voter registration staff provide support services to the commission as required in the performance of the commission's official duties.
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—1.5(47) Declaratory ruling by voter registration commission. Any member of the commission or the public may petition the commission for a declaratory ruling as to the applicability of any statutory provision, rule or other written statement of law or policy. The petition must be filed with the registrar at least seven days before the regular or special meeting at which the petition is to be considered. The registrar shall provide a copy of the petition to each voter registration commissioner at least four days before the meeting. Declaratory rulings shall be made in writing and placed on file with the registrar.

821—1.6(47) Contested cases.

1.6(1) *Hearings.* Hearings for contested cases under the authority of the voter registration commission shall be presided over by the voter registration commission. Notice shall be given, the hearing conducted and the records of the hearing kept in accordance with Iowa Code section 17A.12.

1.6(2) *Rules of evidence.* Rules of evidence shall be those enumerated under Iowa Code section 17A.14.

821—1.7(47) Definitions. The following terms have the meanings assigned to them by this rule wherever the terms appear in these rules, unless the context of usage clearly requires otherwise.

"Agency" means a voter registration agency and the office of driver services, department of transportation.

"Commission" or *"voter registration commission"* means the voter registration commission as defined in Iowa Code section 47.8.

"Commissioner" or *"county commissioner"* means the county commissioner of registration as defined in Iowa Code section 48.1.

"Driver license clerk" means an employee of the office of driver services, department of transportation, who has face-to-face contact with clients seeking a driver license or nonoperator identification card, or a county employee in the office of the county treasurer who performs a similar function.

"NCOA" means National Change of Address, and refers to the collection and distribution of information by the United States Postal Service or its licensed vendors; programs instituted to support that collection and distribution; or the information itself.

"Registrar" or *"state registrar"* means the state registrar of voters as defined in Iowa Code section 47.7.

"Voter registration agency" means any department, division, or bureau in state government which provides voter registration services pursuant to Iowa Code section 48A.19. A department, division, or bureau which merely makes mail-in voter registration applications available to its clients, employees, or general public is not a voter registration agency, nor is the office of driver services, department of transportation.

"Voter registration commissioner" means a member of the voter registration commission.
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

These rules are intended to implement Iowa Code sections 47.7 and 47.8.

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CHAPTER 2
VOTER REGISTRATION FORMS, ACCEPTABILITY, REGISTRATION DATES, AND EFFECTIVE DATES

[Prior to 3/21/90, see Voter Registration Commission[845], Ch 2]

821—2.1(48A) Voter registration forms.

2.1(1) *Content and completion.*

a. In addition to the spaces required by Iowa Code section 48A.11, every voter registration form shall include room for the county commissioner to make notations indicating such items as the date the form was received, the precinct and school district of the registrant, any other special district or note deemed necessary or appropriate by the commissioner, and the date the registration is effective. The notations may be on the reverse of the form.

b. The spaces on the paper voter registration form required by Iowa Code section 48A.11 and subrule 2.1(1) may be completed electronically. Voter registration forms completed electronically must be printed and, in the event adhesive labels are used, such labels must be firmly affixed to the form. The form must also be signed and dated by the voter.

2.1(2) *Definitions.*

"Agency application" means an application received at a voter registration agency pursuant to Iowa Code section 48A.19.

"Application" means a request to register to vote from a person who is not registered to vote in the county where the voter registration form is submitted. An application shall be made on a voter registration form prescribed by the voter registration commission.

"By-mail application" means an application received through the mail from an individual applicant. "By-mail application" also includes voter registration applications received from organizations that solicit voter registrations. "By-mail application" does not include registration forms sent through the mail by voter registration agencies.

"In-person application" means an application received in person from the applicant either by the registrar, the registrar's designee, the commissioner, the commissioner's designee or a precinct election official.

"New voter registration application" means a voter registration application received from an individual who is not already registered to vote in the county.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.2(48A) Agency code. In addition to the spaces and statements required to be included on registration forms by Iowa Code section 48A.11 and rule 821—2.1(48A), registration forms used by voter registration agencies shall contain a code, to be devised by the registrar, indicating the type of agency.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.3(48A) Federal mail-in application. Rules 821—2.1(48A) and 821—2.2(48A) do not apply to the mail voter registration form prescribed by the federal election commission, which shall be accepted in accordance with Iowa Code section 48A.12 and shall not be used by voter registration agencies.

821—2.4(48A) Paperless (electronic) registration forms. Any voter registration agency and the office of driver services, department of transportation, may devise a system of collecting registration applications without using paper forms, in accordance with the following restrictions:

2.4(1) All information required to be disclosed on a voter registration form shall be collected by the agency and captured electronically. The applicant shall also be asked to disclose the optional information solicited by the form if that information is not captured as a part of the agency's own record-making process.

2.4(2) The applicant shall be shown a list of the eligibility requirements for registering to vote and the penalties for falsely registering, printed in large, easy-to-read type, and shall be advised to read them.

2.4(3) The application to register to vote and the signature of the applicant shall be recorded in digitized form in the agency's computer system and shall be kept permanently by the agency. The system shall ensure that neither the application form nor the signature, once captured, can be edited.

2.4(4) The agency shall develop procedures so that the digitized signature can be retrieved and reproduced on paper. Within three working days of receipt of an order from a state or federal court, the agency shall provide a reproduction of the requested application and signature.

2.4(5) The agency shall transmit electronic registration records to the registrar in accordance with 821—Chapter 8.

821—2.5(48A) Acquisition of registration forms. To ensure that forms used by the various voter registration agencies contain no distinguishing characteristics that could be used to identify the agency from which the form came, all agency forms shall be ordered through the state registrar of voters. The registrar shall negotiate a contract for the procurement of the forms in accordance with all procurement laws and rules.

821—2.6(48A) Production of forms. Any person or organization, except voter registration agencies, may cause the printing and production of voter registration applications. Applications so produced shall be identical in size, shape, weight and similar in color of paper, type size, and color of ink to those available from the registrar, except that the independently produced applications may not contain an agency type code, may be preaddressed to a particular county commissioner on the reverse of the form, and may contain postage. This rule shall not apply to voter registration forms printed in newspapers or telephone books.
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.7(48A) Availability of forms. Voter registration applications shall be available for purchase, at the cost of production, from the state registrar of voters. Application forms for an individual's personal use shall be available free of charge at the office of the registrar, all voter registration agencies, and the office of driver services, department of transportation.
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.8(48A) Incomplete applications.

2.8(1) No commissioner shall refuse to register or accept an application from an applicant unable to specify the correct ward, precinct, or school district for the applicant's address. The commissioner shall make a determination of the correct political subdivisions from maps, legal descriptions, and other means at the commissioner's disposal.

2.8(2) The notice mailed to applicants who submit incomplete voter registration applications shall instruct the applicant that the applicant may provide the required information in writing by appearing in person at the commissioner's office to complete a new application or by mailing a new and complete application. If the incomplete registration application is received during the period in which registration is closed pursuant to Iowa Code section 48A.9 and by 5 p.m. on the Saturday before the election for general and primary elections or by 5 p.m. on the Friday before the election for all other elections, the commissioner shall send a notice advising the applicant of election day and in-person absentee registration procedures under Iowa Code section 48A.7A.

2.8(3) If the application does not include the applicant's Iowa driver's license number, Iowa department of transportation-issued nonoperator's identification card number, or the last four digits of the applicant's social security number, and the applicant has not indicated that the applicant does not have any of these numbers, the notice described in subrule 2.8(2) shall also include the following statement:

> "Your voter registration application cannot be accepted because it does not include an Iowa driver's license number, an Iowa nonoperator's identification number or the last four numbers of your social security number. You must submit a new voter registration form before you can be registered to vote in this county.

"If you have an Iowa driver's license, you must write that number on your voter registration form. If you do not have an Iowa driver's license, use the number from your Iowa nonoperator's identification card. If you do not have an identification card issued by the state of Iowa, write the last four numbers of your social security number on the form. If you don't have any of these identification numbers, please check the box next to 'NONE' on the form. Please note it is a Class "D" felony to provide false information on a voter registration application."

2.8(4) If the applicant reports that the applicant has not been issued an Iowa driver's license, an Iowa department of transportation-issued nonoperator's identification card number, or a social security number, the commissioner shall assign a unique identifying number that shall serve to identify the registrant for voter registration purposes and code the registration status as "pending."

2.8(5) The commissioner shall keep an incomplete application for voter registration for 22 months after the date of the next general election after the application was received.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.9(48A) Optional data not required. No commissioner shall refuse to register or accept an application from an applicant who fails or declines to reveal the applicant's telephone number or political party affiliation.

821—2.10(48A) Alternate (nonmailable) registration forms. An alternate registration form is authorized for the use of voter registration agencies and nongovernmental organizations engaging in registration programs and registration drives. The form shall contain spaces for all of the required and optional information solicited by the standard form, a list of the qualifications to register to vote, a statement to be signed by the applicant that the applicant is eligible to register to vote, and a statement of the penalty for submission of a false voter registration form. The face of the form shall contain spaces for all the personal information asked of the applicant, along with the attestation and warning. The reverse of the form may contain the list of qualifications, and may contain space for the county commissioner's notations. The form may be printed as a detachable part of a larger piece or may be printed by itself. Because registration forms are frequently kept for many years, registration forms shall be printed on paper at least as thick as 20-pound xerographic paper.

The intent of this rule is to make available a mechanism for individuals, groups and organizations to conduct registration drives without requiring individuals, groups and organizations to purchase registration forms. To that end, the state registrar shall make available, without charge, a limited quantity of forms as determined by the voter registration commission, and PDF versions of a form meeting the requirements of this rule.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.11(48A) Registration forms in languages other than English. Rescinded IAB 7/1/09, effective 7/1/09.

821—2.12(48A) County registration date. For the purposes of determining timeliness of an application to register to vote, the county registration date shall be determined as follows:

2.12(1) The county registration date for an in-person applicant at least 18 years of age is the date the registration application is received by the commissioner or the commissioner's designee. However, when preregistration is closed in the applicant's precinct due to a pending election, the county registration date shall be the date of the day after the pending election unless the applicant registers pursuant to Iowa Code section 48A.7A.

2.12(2) The county registration date for a by-mail applicant at least 18 years of age is the date the registration application is received by the commissioner, unless the application is postmarked on or before the worry-free postmark date established pursuant to Iowa Code section 48A.9, subsection 3. However, when preregistration is closed in the applicant's precinct due to a pending election, the county registration date shall be the date of the day after the pending election unless the applicant registers pursuant to Iowa Code section 48A.7A.

2.12(3) The county registration date for an application received from a source other than in person or by mail is the date the application is received by the commissioner or submitted to the office of driver services, department of transportation, or to a voter registration agency pursuant to Iowa Code section 48A.19, whichever is earlier.

2.12(4) The county registration date for applicants aged 17 ½ to 18 shall be the date of the applicant's eighteenth birthday. However, when preregistration is closed in the applicant's precinct on the applicant's eighteenth birthday, the county registration date shall be the date of the day after the pending election unless the applicant registers pursuant to Iowa Code section 48A.7A.
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.13(48A) Effective date of registration. Rescinded IAB 7/1/09, effective 7/1/09.

821—2.14(48A) Voter registration status codes. Voter registration records shall be coded to show the status of the record.

2.14(1) *Active.* The registration is in good standing. No action is required on the part of either the registrant or the commissioner.

2.14(2) *Inactive*. If either an acknowledgment mailed to the registrant pursuant to Iowa Code section 48A.26 as amended by 2009 Iowa Acts, House File 475, section 17, a notice mailed to the registrant pursuant to Iowa Code section 48A.27 as amended by 2009 Iowa Acts, House File 475, section 18, a notice mailed to the registrant pursuant to Iowa Code section 48A.28 or an absentee ballot mailed to the registrant pursuant to Iowa Code section 53.8 is returned to the commissioner by the United States Postal Service as undeliverable, the registrant's status shall be changed to "inactive" status. In addition, a voter registration record shall be made "inactive" pursuant to Iowa Code section 48A.27, subsection 4, paragraph *"c,"* as amended by 2009 Iowa Acts, House File 475, section 18, during the annual NCOA process. Inactive registrations will be deleted after two general elections unless the registrant responds to a confirmation mailing pursuant to Iowa Code section 48A.27 as amended by 2009 Iowa Acts, House File 475, section 17, 48A.28, 48A.29 or 48A.30, requests an absentee ballot, votes in an election or submits a registration form updating the registration. Inactive registrants shall show identification when voting in person at the polling place, pursuant to Iowa Code section 49.77(3) as amended by 2009 Iowa Acts, House File 475, section 33, or shall restore their voter registration to "active" status pursuant to 721—21.301(53) when voting by absentee ballot.

2.14(3) *Pending.*

a. No DL or SSN Provided. If an applicant indicates that the applicant does not have an Iowa driver's license number, Iowa department of transportation-issued nonoperator's identification card number, or a social security number, the applicant shall be assigned a status of "pending" with reason "No DL or SSN Provided."

b. DL or SSN Not Verified. If the applicant provides an Iowa driver's license number, Iowa department of transportation-issued nonoperator's identification card number, or the last four digits of the applicant's social security number and that information cannot be verified pursuant to 821—2.15(48A), the applicant shall be assigned a status of "pending" with reason "DL or SSN Not Verified."

c. An applicant assigned a status of "pending" shall not be activated until the applicant provides identification pursuant to 721—21.3(49,48A).
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—2.15(48A) Verification of voter registration information. All new voter registration applications shall be verified. The registrar may arrange with the department of transportation for county commissioners of elections to verify voter registration records without submitting the registration information to the registrar.

2.15(1) When the application is received, the commissioner shall compare the Iowa driver's license number, Iowa department of transportation-issued nonoperator's identification card number, or the last four digits of the social security number of each mail application with the records of the department of transportation.

2.15(2) All of the following information on the application must match an existing record:

a. All digits and numerals in the Iowa driver's license number, Iowa department of transportation-issued nonoperator's identification card number, or the last four digits of the social security number.

b. Name.

c. Date of birth, including the month, day and year.

2.15(3) If all three required elements do not match, the applicant shall be assigned a status of "pending" with reason "DL or SSN Not Verified." The applicant shall be notified that the applicant's voter registration is in pending status and the applicant will be required to show identification pursuant to 721—21.3(49,48A) before voting in the county. The notice shall include the following statement:

> "Your voter registration application is pending because the information you provided on your application could not be verified. Your name, date of birth and identification number were compared to the Iowa driver's license records and your identification number cannot be verified.
>
> "Before voting for the first time in this county, you will be required to show identification. You may submit identification either by showing your identification in person when you vote or by mailing a photocopy of your identification to the county auditor's office."

2.15(4) If the application is verified, the registration record shall be made "active." The registrar or commissioner shall keep records showing whether the information in the application was verified and the date of the verification. If the application cannot be verified, the record shall show what information on the application did not match an existing record. The verification record shall be kept for the period of time required in Iowa Code section 48A.32.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapter 48A as amended by 2009 Iowa Acts, House File 475.

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CHAPTER 3
LISTS OF REGISTERED VOTERS

[Prior to 3/21/90, see Voter Registration Commission[845], Ch 3]

821—3.1(48A) List defined. For the purposes of this rule, a "list" of registered voters is any information from one or more voter registration records related to any individual or group of registered voters. Statistical data containing no personally identifiable information is not a "list."

821—3.2(48A) Request for list. A request for a list of registered voters may be made in writing on a Specifications for Voter List form submitted to either a county commissioner or the state registrar. A commissioner or the registrar may accept a request for a list made via telephone provided the commissioner or registrar is confident that both the requester and the commissioner or registrar clearly understand the specifics of the request and provided the requester agrees that the voter registration information will only be used for the purposes set forth in Iowa Code section 48A.39. If a request is unclear or ambiguous, the commissioner or registrar may require that the request be submitted in writing.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—3.3(48A) Contents of written request. Each written request for a list of registered voters shall contain all of the following information:

1. The name of the requester.
2. The address of the requester.
3. The telephone number of the requester.
4. A description of the records to be included in the list.
5. A description of the sequence of the records on the list.
6. A description of the output medium for the list.
7. The date of the request.
8. The date the list is desired.
9. The intended use of the list.
10. The following signed statement: "I am aware that information from voter registration records may be used lawfully only to request a registrant's vote, for a genuine political purpose, for bona fide political research, or for a bona fide official purpose by an elected official. I understand that using the information for any commercial purpose is a serious misdemeanor under Iowa law. I agree to pay the cost of the above ordered list upon delivery."

821—3.4(48A) Contents of telephone request. When a request for a list of registered voters is made by telephone, the person taking the request shall gather and record on a Specifications for Voter List form all of the information specified in 3.3"1" through 3.3"9." In addition, the taker of the request shall read the statement in 3.3"10" to the requester. The taker of the request shall note, on the signature line of the form, the fact that the requester was read the statement. If a requester refuses to provide the requester's identity or refuses to agree to the use restrictions for the voter registration information, the registrar or the commissioner shall not provide the requested information.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—3.5(48A) Requests received by a county commissioner. A request for a list of registered voters submitted to a county commissioner may be honored by that commissioner, or may be forwarded to the registrar. However, a county commissioner shall adhere to a consistent policy regarding the provision of lists. If a commissioner provides a list to any requester, the commissioner shall likewise provide lists to all requesters, provided the commissioner has the data and software necessary to meet the list request specifications. Similarly, if a commissioner refuses to provide a list for which the commissioner has the necessary data and software to any requester, the commissioner shall refuse all requests for lists of registered voters.

821—3.6(48A) Requests received by the state registrar. Requests for lists of registered voters received by the registrar shall be honored in the order in which they are received, provided that the data necessary for compiling the list is available to the registrar. If provision of a list is delayed due to the absence of data, the registrar shall contact the list requester and explain the circumstances. The requester may choose to modify the request, cancel the request, or wait for the necessary data.

821—3.7(48A) Payment for lists required. Notwithstanding any other provision of these rules, no list shall be provided to a requester who has not paid for all previously requested and completed lists. Payment shall be made at the time the list is delivered, except that payment for lists ordered by political subdivisions of the state may be made within 60 days of delivery. A county commissioner or registrar may require an advance payment of 80 percent of the estimated cost of a list if the estimated cost is $1000 or more.

821—3.8(48A) Confidential data. Nothing in these rules shall be construed to authorize or require any county commissioner or the registrar to disclose any information made confidential by the National Voter Registration Act of 1993 or any other federal or state law.

821—3.9(48A) List of a person's own voter registration record. Nothing in these rules shall be construed to prohibit any person from viewing that person's own voter registration record, including any confidential data associated with it.

821—3.10(48A) Driver's license numbers. The county commissioner of registration and the state registrar of voters shall remove a voter's driver's license number, Iowa department of transportation-issued nonoperator's identification card number, or whole or partial social security number from a voter registration list prepared pursuant to Iowa Code section 48A.38.

These rules are intended to implement Iowa Code section 48A.38.

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CHAPTER 5
ELECTION REGISTERS

[Prior to 3/21/90, see Voter Registration Commission[845], Ch 5]

821—5.1(47) Election registers.

5.1(1) Election registers shall contain at least the following information:

a. Full name.

b. Address.

c. Date of birth.

d. Registration status if it is not "active."

e. Political affiliation (for partisan primary elections only).

5.1(2) Other information may be included on the election register upon the approval of the county commissioner of registration.

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CHAPTER 6
DATA PROCESSING SYSTEM REQUIREMENTS FOR VOTER REGISTRATION

[Prior to 3/21/90, see Voter Registration Commission[845], Ch 6]

821—6.1(47) Statewide voter registration system requirements. Every county commissioner is required to use the statewide voter registration system maintained by the state registrar for voter registration and election management purposes. The statewide voter registration system shall enable the county commissioner to:

6.1(1) Create a file of all registered voters in the county.

6.1(2) Automatically identify and post all election districts, including school district and director district (if applicable), area college district and director district, municipality or township, and precinct, and any applicable special districts, to every voter registration record which contains a street number and street name in the residence address fields.

6.1(3) Ensure the uniform spelling of street names in all records containing street names, such that the records of all voters whose residence addresses share a street name contain a common spelling of that street name.

6.1(4) Ensure the uniform spelling of city names, such that the records of all voters whose residence addresses share a city name contain a common spelling of that city name.

6.1(5) Prevent duplicate registrations for a given individual. For the purpose of this subrule, a duplicate registration is one which contains the same information in the Iowa driver's license number, Iowa nonoperator's identification number, last four digits of the applicant's social security number, birth date and sex code fields as another record in the same county.

6.1(6) Ensure the compatibility of election districts manually assigned to records with nonstandard addresses.

6.1(7) Ensure that numeric fields in records contain only numeric data, and that alphabetic fields contain only alphabetic data, except that the field for last name may contain one hyphen.

6.1(8) Ensure that all dates are reasonable, e.g., birth date, county registration date.

6.1(9) Ensure that the ZIP code contained in the record is compatible with the city name.

6.1(10) Assign a unique identification number, in lieu of an identification number, to records of voters whose registration forms indicate the voter does not have any of the requested identification numbers.

6.1(11) Allow the capture, retention and reporting of a mailing address different than the residence address.

6.1(12) Create election registers which contain the names of all voters eligible to vote at a polling place, and no others, for any type of election the commissioner is required to conduct, except annexation and other elections when creation or change of an election district is proposed.

6.1(13) Create election registers which identify those voters who are eligible to vote on an issue or for an office at a polling place when some, but not all, voters are eligible to cast a ballot on that issue or for that office.

6.1(14) Receive maintenance files collected from various agencies by the state registrar.

This rule is intended to implement Iowa Code section 47.7.

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CHAPTER 9
NATIONAL CHANGE OF ADDRESS PROGRAM

821—9.1(48A) State registrar to organize.

9.1(1) The state registrar of voters shall annually offer to every county commissioner the opportunity to participate in the registrar's submittal of voter registration records to a licensed vendor of the United States Postal Service for matching with national change of address (NCOA) records.

9.1(2) The vendor used by the state registrar shall be selected in accordance with all procurement laws and rules of the state and the department of administrative services.

9.1(3) The state registrar shall prepare a file of all registered voters in all counties whose commissioners have chosen to participate in the program. The file shall be in the form and format required by the vendor. The voter records contained in the file shall be categorized according to the following statuses: active, inactive, and pending.

9.1(4) Upon receipt of the NCOA data from the vendor, the state registrar shall promptly prepare a data file for each county to process in a batch-processing module at the county level. There shall be three statuses of NCOA records: processed, unprocessed, and deleted. The batch-processing screen's default shall be a display of all unprocessed records. The state registrar shall prescribe and notify each participating commissioner about how the commissioner shall process the NCOA records.

821—9.2(48A) Commissioner's responsibility upon receipt of NCOA data.

9.2(1) Commissioner to update county records. Each commissioner shall examine the data provided by the NCOA vendor and shall update the county's registration records on the basis of that data in accordance with Iowa Code subsections 48A.27(4) and 48A.27(5).

9.2(2) The commissioner shall process the registration records of voters who have moved within the county as well as the registration records of voters who have moved outside the county. For in-county moves, the commissioner shall change the voter's residential address to the address provided by the NCOA vendor. For out-of-county moves, the commissioner shall change the status of the voter registration record to "inactive."

9.2(3) In order to avoid complications because of scheduled special elections, the state registrar shall provide two date ranges in which the commissioner shall process NCOA records. The primary date range occurs first and shall apply to all counties that do not have a special election scheduled to be held within that date range. The second date range shall apply only to those counties that have a special election scheduled to be held during the primary date range.

821—9.3(48A) State to coordinate mailing of NCOA notifications.

9.3(1) After the county commissioners have processed NCOA records for each of the date ranges, the state registrar shall coordinate the printing and mailing of the required NCOA notifications. The state registrar shall notify the commissioners when the notifications have been mailed. Any postage-paid preaddressed return cards returned by voters will be sent back to the counties, not to the state registrar.

9.3(2) The state registrar shall send one notification to each voter identified as having moved either within or outside a county. The notice shall be mailed to the voter's new address as provided by NCOA records.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—9.4(48A) Fees. The state registrar shall charge the counties for the costs of the NCOA process, including matching the records and the printing of and postage for the mailing. The fees charged to the counties shall reflect actual costs to the state registrar.

These rules are intended to implement Iowa Code sections 48A.27(4) and 48A.28(2).

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CHAPTER 10
NOTICE TO VOTERS WITHOUT ACTIVITY IN FOUR YEARS IN COUNTIES USING NCOA RECORDS; TO ALL VOTERS IN OTHER COUNTIES

821—10.1(48A) NCOA county commissioner determines nonactivity; sends notices.

10.1(1) During the first quarter of each calendar year, every commissioner who elects to participate in the NCOA process that year shall examine voter registration records to identify those without activity during the period between and following the previous two general elections and for which no information has been reported in NCOA data. For the purpose of this subrule, "activity" means any registration application, including an application which duplicates existing information, a notice of change of name, address, mailing address, party affiliation, a vote in any election, or the mailing of a notice pursuant to subrule 10.1(2).

10.1(2) The commissioner shall send a notice of the type described in Iowa Code section 48A.28 to each voter whose record is identified pursuant to subrule 10.1(1).

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—10.2(48A) Non-NCOA county commissioner sends notices. During February of each calendar year, every county commissioner who elects not to participate in the NCOA process shall send a notice of the type described in Iowa Code subsection 48A.28(3) to every registered voter in the county.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—10.3(48A) Voter record not made inactive. The act of mailing the notice required by this chapter does not, in and of itself, make a registration record inactive.

[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—10.4(48A) Notice available. The required notice is available from the state registrar of voters in a document titled "Section 48A.28(3) Notice."

These rules are intended to implement Iowa Code subsections 48A.28(2) and (3).

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CHAPTER 11
REGISTRATION PROCEDURE AT THE OFFICE OF DRIVER SERVICES, DEPARTMENT OF TRANSPORTATION

821—11.1(48A) Registration status may be checked. The state registrar, in cooperation with officials of the department of transportation (DOT), shall develop a mechanism by which the registration status of an individual seeking a driver license or nonoperator identification card from the office of driver services, DOT, can be checked by computer while other business is being transacted.

821—11.2(48A) Driver services client to be afforded opportunity to apply to register to vote or make changes to existing registration. Every client, aged 17 years 6 months or older, of the office of driver services, DOT, shall be advised by the driver license clerk of the availability of voter registration services in substantially the following manner: "Would you like to apply to register to vote, or update your registration? It can be done quickly and easily at the same time as you get your (license — ID — other, as appropriate)."

1. If the client's reply to the driver license clerk's rule 821—11.2(48A) question is negative, the driver license clerk shall not pursue the matter of voter registration.
2. If the client's reply to the driver license clerk's rule 821—11.2(48A) question is affirmative, or the client expresses uncertainty of the client's current registration status, the driver license clerk shall invoke the computer operation required in rule 821—11.1(48A).

821—11.3(48A) Unregistered client who wants to register. If the computer search invoked pursuant to 11.2"2" reveals the client is not a registered voter, and the client has expressed a desire to register, the driver license clerk shall determine the name of the client's county, telephone number, party affiliation, and previous registration information by asking questions in substantially the following form: "In what county do you live?" "What is your telephone number?" "Would you like to declare an affiliation of Democratic, Republican, Green, Libertarian or None?" "Where were you previously registered, if ever?" The driver license clerk shall make computer entries reflecting the client's replies.
[**ARC 7883B**, IAB 7/1/09, effective 7/1/09]

821—11.4(48A) Unregistered clients uncertain of status. If the computer search invoked pursuant to 11.2"2" reveals the client is not a registered voter, and the client has expressed uncertainty of the client's registration status, the driver license clerk shall tell the client the result of the computer search and determine if the client wishes to proceed with registration in substantially the following words: "According to the computer, you are not currently registered to vote in Iowa. Would you like to apply to register now?" If the reply to the inquiry is negative, the driver license clerk shall not pursue the matter of voter registration. If the reply is affirmative, the driver license clerk shall proceed as specified in rule 11.2(48A).

821—11.5(48A) Registered clients. If the computer search invoked pursuant to 11.2"2" reveals the client is a registered voter, the driver license clerk shall review the record. If the name and address in the voter record are the same as the name and address in the driver record, the driver license clerk shall determine if changes are necessary in substantially the following manner: "According to the computer records, (name of client) is registered to vote in (name of county) county at (address, including city) and the telephone number is (telephone number, or "blank"). Are there any changes or corrections to this information?" The driver license clerk shall make appropriate computer entries based on the client's reply. If the name and address in the voter record are not the same as the name and address in the driver license record, the driver license clerk shall determine the changes necessary in substantially the following manner: "According to the computer records, (name of client) is registered to vote in (name of county) county at (address, including city) and the telephone number is (telephone number or "blank"). I will change the ("name"), ("address") or ("name and address") as appropriate to that on the driver record. Is there a change to your county or telephone number?" The driver license clerk shall make appropriate computer entries based on the client's reply.

821—11.6(48A) Signature on attestation required. At the conclusion of the client's business, clients who apply to register, or give information to update an existing registration shall be asked to sign the registration application attestation, either on a paper copy or an electronic version. Any client who fails to sign the attestation shall be deemed to have declined to apply to register to vote.

821—11.7(48A) Electronic voter registration transactions. Registration transactions shall be transmitted electronically to the registrar in accordance with 821—Chapter 8. Every transaction shall include the applicant's Iowa driver's license number or Iowa department of transportation-issued nonoperator's identification card number.

These rules are intended to implement Iowa Code section 48A.18.

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*Rules **645**—chs 6–18 apply to all professional licensure boards

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